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Medicaid and CHIP Retention

A Key Strategy to Reducing the Uninsured

Southern Institute on Children and Families



Acknowledgements

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This report was written by the Southern Institute on Children and Families. The findings and views contained in this report do not necessarily reflect those of the Robert Wood Johnson Foundation.

Founded in 1990, the Southern Institute on Children and Families is a non-profit organization dedicated to improving the well-being of children and families, especially those who are economically disadvantaged. We create opportunities to meet basic needs through achievement of innovative, research-based policies, effective policy implementation and efficient service delivery. In pursuit of these goals, we generate knowledge and build leadership that result in action.

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Introduction

Retaining eligible children and adults in Medicaid and the Children's Health Insurance Program (CHIP) is an important strategy in reducing the number of uninsured. Maximizing enrollment in these public programs through retention of eligible consumers can serve as a vital component of health care reform efforts. This report highlights issues associated with Medicaid and CHIP eligibility policies and procedures at renewal and strategies for addressing the issues, including approaches to reducing churning in public health coverage programs.

The purpose of this report is to share information learned during the *Retention Initiative: Achieving Stability in Medicaid and SCHIP Coverage* (Retention Initiative) and suggest strategies for improving Medicaid and CHIP retention rates across all states. The Retention Initiative was a two-year project funded by the Robert Wood Johnson Foundation. The Southern Institute on Children and Families led the initiative to increase the retention rate of eligible children and adults in Medicaid and CHIP.

The report addresses the retention issues identified by eight states – Alabama, Florida, Iowa, New Hampshire, New Mexico, Pennsylvania, Texas and Washington. The report also provides information on the improvement strategies used by these states that were found to be effective in improving retention rates.

This report can be used by a variety of policy makers, practitioners and advocates. State Medicaid and CHIP officials in particular will find new ideas and approaches to reducing the number of uninsured through maximizing and maintaining enrollment of eligible children and families in public health coverage programs. Specifically, this report can help state Medicaid and CHIP officials in their efforts to implement the reenrollment and retention strategies and align their data reports as outlined in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

CHIPRA presents new opportunities for states to improve and expand their efforts to increase enrollment and renewal into Medicaid and CHIP. For instance, states can receive Medicaid performance bonus funds if they exceed the targeted baseline enrollment levels for their state and have five out of eight enrollment and retention strategies in place for Medicaid and CHIP. The strategies include 1) 12-month continuous eligibility; 2) liberalization of asset requirements; 3) elimination of in-person interview requirement; 4) joint Medicaid and CHIP application; 5) use of administrative renewal; 6) presumptive eligibility for children; 7) express lane eligibility; and 8) premium assistance subsidies. CHIPRA provisions also call for states to submit as a part of their annual reports eligibility and retention data to assess the enrollment of children in Medicaid and CHIP. The data that states will provide include¹:

- eligibility criteria, enrollment and retention data, including data related to continuity of coverage or duration of benefits;
- process measures about the extent to which the state uses certain strategies in determining children's eligibility, including 12-month continuous eligibility, self-declaration of income for applications or renewals or presumptive eligibility; and
- data regarding denials of eligibility and renewals.

In addition, CHIPRA officially replaces the State Children's Health Insurance Program (SCHIP) with CHIP.

¹ Children's Health Insurance Program Reauthorization Act of 2009. The premium assistance subsidies strategy does not have to be adopted by both Medicaid and CHIP. Other data elements are specified, but for purposes of this report they are not highlighted.

Background

Achieving Stability in Medicaid and CHIP Coverage

Retaining eligible children and adults in Medicaid and the Children's Health Insurance Program (CHIP) has become a central strategy in reducing the number of uninsured in the United States. In the effort to maintain gains in enrollment in public health coverage programs, recent research and policy have focused on retention. Multiple research studies indicate that most enrollment losses occur at the time of renewal for Medicaid and CHIP. Furthermore, literature consistently shows that most failures to renew are due to procedural issues, not ineligibility for coverage.

Early research by the Southern Institute found that of the more than one million individuals denied Temporary Assistance for Needy Families (TANF) or Medicaid in the southern region, only 23% were denied because of excess income. The remaining individuals were denied benefits for procedural reasons such as lack of financial documentation or failure to show up for an interview. Also, through the *Covering Kids* (CK) and *Covering Kids & Families* (CKF) Initiatives, common procedural problems were identified that interfere in the retention of Medicaid and CHIP coverage, such as frequent eligibility review periods, complex renewal forms, confusing procedures and lack of coordination between Medicaid and CHIP renewal procedures. Nationally, less than 50% of children are retained in CHIP at the annual renewal period. Churning of individuals on and off of Medicaid and CHIP contributes substantially to the total uninsured rates. It has been projected that the number of low-income uninsured children would drop by almost 40% and adults by more than 25% if persons with public or private coverage at the beginning of a year remained continuously enrolled for twelve months.

Policies and procedures that focus on retention and minimize churning help protect families, enhance the effectiveness of health care and improve the efficiency of public health care programs. In addition, research indicates that extending continuous coverage can lower administrative costs by reducing the staff effort needed to process applications and related paperwork. Studies have found that the average monthly Medicaid expenditure for individuals decreases as the months of continuous enrollment increases. For instance, each month of Medicaid enrollment reduced Medicaid expenditures an additional \$6.49 per month. As a result it is estimated that the second six months of Medicaid coverage costs about 30% less than the first six months of coverage in a year.

Gaps in health care coverage have negative consequences for individuals. It has been well documented in several recent studies that a lack of coverage reduces health care access and increases the intensity of illness among the uninsured. In order for children and adults to benefit fully from health care coverage, it must be consistent and ongoing to support the continuity of health care. Such continuity of care fosters an established relationship with a provider that can improve the timeliness of preventive care, compliance with care regimens, as well as family satisfaction with care. Disruptions in health care coverage do not promote these favorable patterns of care. Losing coverage can:

- reduce continuity of care with primary care providers and thus affect quality of care for children and families;
- place families at risk of paying for health care costs incurred during periods of disenrollment;
- create a loss of anticipated revenues for providers and health plans and erode incentives to provide preventive care;
- impose administrative costs on states and health plans; and
- result in adverse health outcomes for children who become uninsured.

Improving retention of eligible children and adults in public health coverage programs benefits the children and adults, the caseworker and eligibility determination agencies, the community and the state. By focusing on improved eligibility processes at renewal, states can increase the efficiency of their eligibility determination systems and insure the accuracy of their eligibility determination processes resulting in higher retention rates for eligible children and adults. There also are financial reasons for addressing the issue of retention. Some experts argue that continuous coverage through Medicaid or CHIP saves money because people use fewer services over time. Frequent enrollments and dis-enrollments as a result of churning can result in high administrative costs, whereas keeping families enrolled long-term costs less. These cost-effective benefits are appealing to state opinion leaders and Medicaid and CHIP program decision makers regardless of the economic and political environment in the state.

Project Description

The Retention Initiative offered a comprehensive retention improvement approach to states focusing on the reduction of uninsured children and adults eligible for Medicaid and CHIP. The overall outcome for participating states was to retain enrollment of eligible children and adults. The project goals were to:

- reduce inappropriate closures at renewal or during other points of the coverage period;
- improve eligibility policies and procedures at renewal; and
- ensure accuracy of eligibility determination processes at renewal.

The Retention Initiative used a state team approach emphasizing shared learning with peer support from other participating states. Teams from eight states were identified based on each state's capacity to participate in the planned activities and commitment to meet the expectations of the project. Teams included state Medicaid and CHIP policy and eligibility determination officials and members with Medicaid and CHIP state data expertise. Peer-to-peer learning and support was facilitated through meetings, conference calls and an interactive listserv.

The Southern Institute provided specialized consultation and technical assistance to the participating states for the purpose of helping them improve their renewal policies and procedures. The Southern Institute also developed a questionnaire to assess parents' perceptions of retaining Medicaid and CHIP coverage for their children. The state teams provided insights and comments on the survey and survey guide during their development. The *Renewing Medicaid/CHIP Coverage: Parental Perceptions Survey* (Parental Perceptions Survey) is discussed later in this report. See Appendix A for more information on the Retention Initiative.

Identifying and Understanding Renewal Policy and Process Issues

Identifying Renewal Policy Issues

During site visits with each project state, an initial list of current policy and process issues and concerns related to retaining eligible children and adults in Medicaid and CHIP was developed. Most of the challenges articulated in the following section of this report were identified and explored during the site visits.

All project states completed process maps of their Medicaid and CHIP programs (see below). Process mapping is a significant tool in identifying process and policy issues related to eligibility determination at renewal.

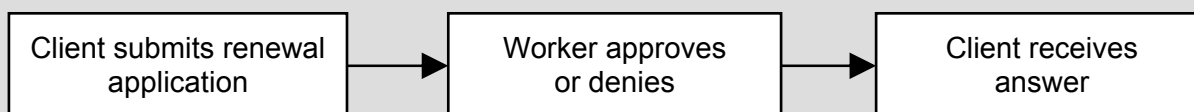
States were encouraged to think in terms of both policy and process issues. These issues were targeted by states in developing the strategies incorporated into their retention improvement plans. States were encouraged to view the identification of renewal policy and procedural issues as a deliberate and ongoing process. In addition, collaboration between eligibility determination and policy staff and coordination between Medicaid and CHIP staff was encouraged and reinforced through the composition of the state teams. Collaboration between Medicaid and CHIP is critical to improving retention since so many families cycle between Medicaid and CHIP eligibility levels.

Understanding the Renewal Process

Process Mapping of Medicaid and CHIP Renewal Procedures Process mapping is an effective assessment tool to assist Medicaid and CHIP staff in diagnosing challenges in the renewal processes for Medicaid and CHIP. Mapping the process is a visual technique for illustrating the process as it actually occurs, not as it should be. It shows decisions that are made, the sequence of events, the staff involved and any wait times or intrinsic delays in the process. It represents the entire process from start to finish at a detailed level of observation, allowing analysis and optimization of workflow.

In the case of the renewal process, the client and the eligibility worker want the simplest process possible.

Figure 1 Desired Renewal Process



However, rarely, if ever, is the process as simple as Figure 1 depicts. There are a number of steps, tasks and decisions that make up the renewal process for Medicaid or CHIP. Mapping the process as it actually occurs, not as it should be, identifies places in the process where there are waste and non value-added steps.

and ensure the accuracy of their eligibility decisions. The retention improvement plans focused not only on the eligibility policies for renewal, but also on the implementation of procedures related to the policies.

Improving the policies and procedures for renewal can increase significantly retention and minimize churning. Reducing the churning of eligible children and adults on and off public health coverage leads to administrative cost savings, increased efficiency in eligibility determination offices, and improved continuity of care for children and adults.

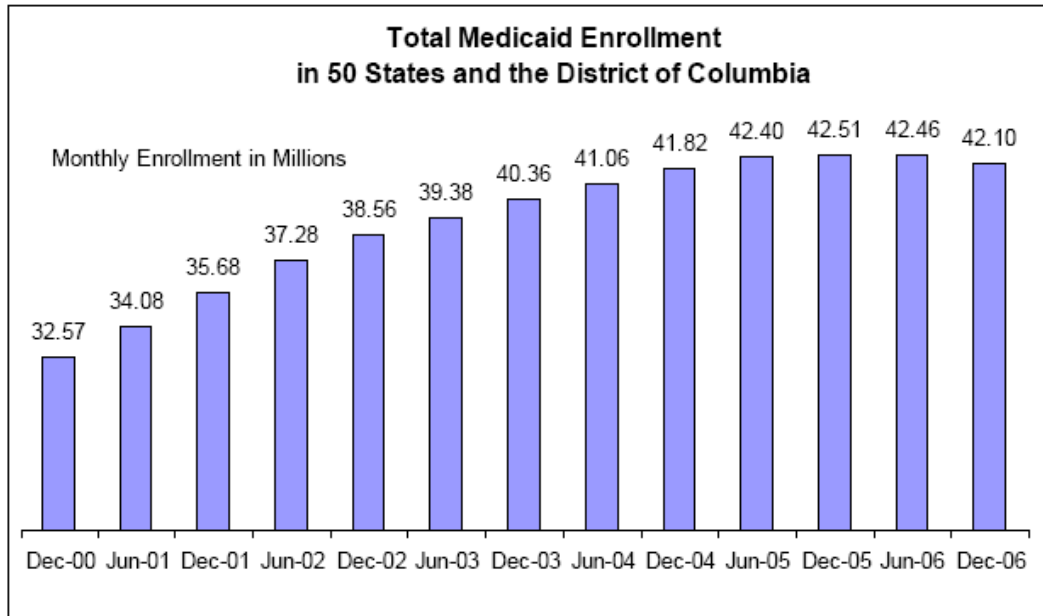
Areas for improvement identified by the state teams in their individualized retention improvement plans included Medicaid and CHIP eligibility policies and procedures at renewal, coordination between Medicaid and CHIP, communication notices for consumers and management of consumer contact information. These improvement strategies were designed to benefit Medicaid and CHIP enrollees, policy makers, administrators of state and local Medicaid and CHIP programs and eligibility determination agencies.

The states' individualized retention improvement plans concentrated on strategies that related to the following major approaches: 1) modifying computer systems; 2) streamlining processes; 3) improving communications; and 4) advancing technologies. These categories represent a myriad of options for improvement that range from a "quick-fix" immediate change to more complex, long-term improvements. Several factors in addition to state and federal policies can influence which strategies to embark upon, such as cost, staff capacity, available time, level of potential impact, value added (for staff and for consumers) and computer system capabilities.

Key Measures in the Renewal Process

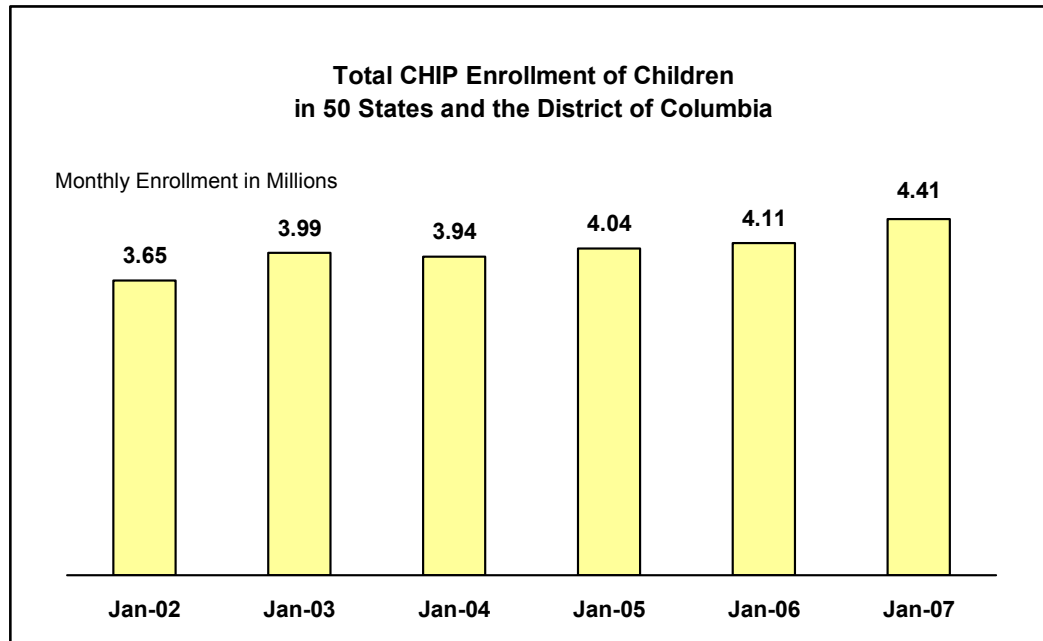
The most basic measure in the renewal process is caseload or enrollment data at a specific point in time. Caseload numbers at one point are usually compared to caseload numbers at another point in the future to assess a state's retention rate. For instance, national Medicaid enrollment increased by more than nine million between December 2000 and December 2006. Likewise, national CHIP enrollment increased by more than 750,000 between January 2002 and January 2007. (See charts below.) While these data are appropriate for assessing programs at a high level, there are details about the renewal process that will not be captured at this level of data collection and analysis. Further, looking at data in this manner does not allow for the identification of issues or for adjustments to be made to the process in order to address these issues so that previously achieved improvements are not eroded. To more adequately assess the renewal process a deeper view of data is required.

Table 1 Total Medicaid Enrollment in 50 States and the District of Columbia



Source: Compiled by Health Management Associates from state Medicaid enrollment reports.

Table 2 Total CHIP Enrollment in 50 States and the District of Columbia



Source: Compiled by Southern Institute on Children and Families from data obtained in the *SCHIP Enrollment in June 2007: An Update on Current Enrollment and SCHIP Policy Directions* report published by the Kaiser Commission on Medicaid and the Uninsured.

Data Collection There are many eligibility categories for Medicaid, and CHIP eligibility categories sit on top of Medicaid eligibility levels. The eligibility groups that usually comprise the bulk of a state's caseload are:

- Medicaid children, including poverty related children, and CHIP children eligible under a Medicaid expansion;
- children eligible for CHIP coverage in states operating CHIP as a program separate and distinct from Medicaid;
- Medicaid children and families receiving Transitional Medicaid (TMA);
- children and families receiving TANF who are covered;
- Section 1931 families; and
- parents and/or childless adults who are eligible due to expansions.

It is important to specify in advance of data collection which eligibility groups will be included. Further, it is important to identify the data components. Make sure it is clear whether individual level data or cases which can include multiple individuals will be gathered. There are considerations to make when choosing which type to gather. If the state operates a separate CHIP program and has not smoothed out the eligibility levels based on family income², some children in the same family may be covered by Medicaid and others by CHIP. Looking at trends in both Medicaid and CHIP over the same period of time may provide greater insights than looking at one or the other.

In addition to determining the data components, it is important that different data units are reviewed. County level or other local level data can provide a more detailed view of the eligibility process, especially if there is a large populous section of the state where a significant portion of consumers reside. Challenges that may be specific to that area of the state may not be the same in other parts of the state. Strategies for addressing the challenges may need to be tailored to the specific needs of the communities in a locale, so looking at county or local level data will help in this analysis.

There are one of three outcomes for renewal in Medicaid and CHIP:

- approved;
- closed; or
- withdrawn at request of the recipient.

Withdrawn cases should be separated from closures because withdrawing a renewal is a consumer's decision as opposed to a decision of the eligibility staff. It is unclear whether the consumer is eligible to continue receiving benefits because the renewal form did not go through the eligibility process for a decision.

There are a number of codes eligibility workers use to designate the reason a case is closed. Gathering data about the number and percent of cases closed for specific reasons can provide useful insights into challenges in the renewal process. The reasons for closure can be grouped into the following categories:

- excess income;
- age not within eligibility criteria;
- excess resources (in states with a resource/assets test);
- failure to comply with procedural requirements, such as missing an appointment for a renewal interview or failure to return required verification documents or reports within the timeframe;

² Federal regulations require that states that receive Medicaid dollars must cover children under age six with family income under 133% of the federal poverty level and children under age 18 with family income below 100% of the federal poverty level (FPL). In designing their CHIP programs states could have maintained the mandatory Medicaid levels and developed a separate program to cover all other children. A family with income at 130% FPL, for example, could have a three-year-old covered by Medicaid and a 10-year-old covered by CHIP.

- failure to pay premiums; and
- other basic eligibility criteria are not met, such as, transitional period has expired, child is not in the home, or the recipient cannot be located.

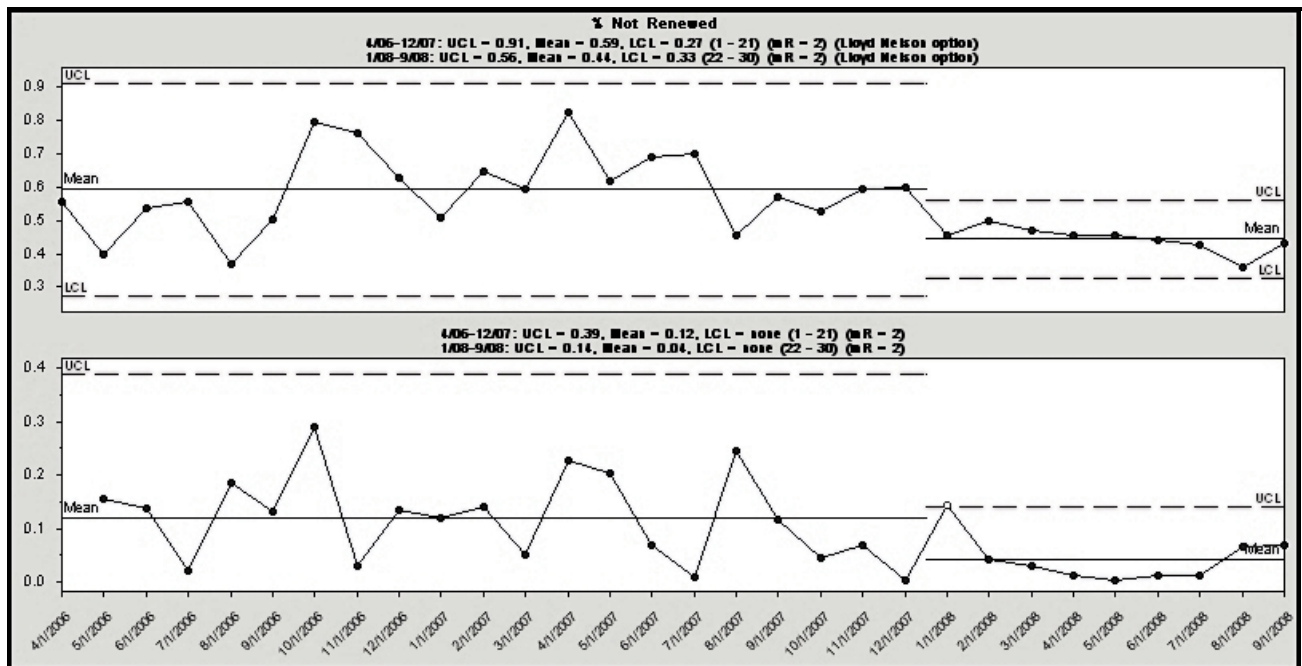
In addition to gathering data about the outcomes of eligibility decisions for those consumers due for renewal, it may be useful to gather data about closures that occur prior to a case coming up for renewal. For instance, if a state has 12-month coverage or 12-month continuous coverage, it may be useful to pull data that show the average time cases are open. A significant portion of the caseload losing coverage prior to reaching the 12-month eligibility period may indicate a serious problem within the eligibility process.

Gathering data by specific groups, by specific areas of a state and by closure reasons, allows for a drilldown in the data that may highlight areas for improvement in the renewal process that statewide aggregate caseload or enrollment data will not.

Process mapping provides another source of data on the renewal process. It should be included in data collection plans.

Data Analysis Caseloads are measured by the net effect of the number of new applications approved and the number of closures in a particular month. While comparing a caseload number at certain points such as December of one year to December of another year may not provide detailed analysis of the eligibility system, looking at caseload data month-to-month over a 12-month or greater time period could provide some insight into changes in the process. A control chart is a good tool for this type of analysis and can be created using basic software such as Microsoft Excel. The control chart is used to study how a process changes over time. For instance, below are caseload data over an 18-month time period. There are eight months sequentially that the caseload numbers fell below the average caseload number for this particular state. This is an indication that something has changed in the eligibility process and it has had a negative impact on the number of people covered by public health coverage. This type of analysis helps to narrow the assessment focus to a specific time period which can increase the chances for identifying the root causes of changes to the process.

Table 3 Percent not Renewed



Federal regulations require that states review consumers’ Medicaid and CHIP cases at least every 12 months for continued eligibility. States may review eligibility more frequently than 12 months if they desire. The number and percentage of cases closed within a time period is important to the overall number in the caseload. It is inefficient, time consuming and disruptive to the process of receiving services for families when their cases are inappropriately closed. A study of closures in one state showed that in 12 months the state closed 61,133 children’s Medicaid cases. Of these total case closures, 32,514 were closed only once, and a number were closed more than once, resulting in the churning phenomenon.

To better understand the outcomes of the renewal process, the reasons for closure should be analyzed. One state found that *“process error rates decreased due to more consistent application of policy”* and reported *“decreases in renewal closures.”* Charting the number of cases that closed because of income, assets or failure to comply with procedural reasons allows for a deeper understanding of what is affecting the renewal process. Table 4 can be used to help in the analysis. This type of chart can be created for each eligibility group for which closure reasons will be tracked. Again, putting these data in a control chart over a period of time can help in identifying where there may be changes to the process that are negatively impacting the number of people whose cases are closing. See Appendix B for an additional template that can be used in analyzing the renewal process.

Table 4 Case Closures Template

Case Closures for Medicaid/CHIP Children Percentage of Case Closures by Reason Age 18 and Under, By County and State [Time Period]								
Area	Total Case Closures	Total Number of Children	Excess Income	Excess Resources	Age	Failure To Comply With Procedures	Failure to Pay Premiums	Other Basic Eligibility Criteria
[State]	#	#	%	%	%	%	%	%
County 1								
County 2								
County 3								
County 4								
County 5								

Notes: 1) The data are not unduplicated. 2) The estimate of persons is based on X persons per Medicaid case. 3) "Other" includes cases where a determination cannot be made because the family did not respond, cases where the family has moved or can't be located, cases where the certificate period has ended, cases withdrawn by recipients, cases with no eligible child and non-residents. Source:

Measuring Improvements Once problems in the process are identified, it is important to identify strategies for eliminating or minimizing the impact of the problems. The Southern Institute offers technical assistance and consultation services utilizing Plan-Do-Study-Act (PDSA) cycles for testing on a small-scale. The Southern Institute espouses the theory that strategies for improvement should be tested on a small-scale within a system prior to full implementation across an organization. Testing a strategy on a small-scale allows for an assessment of the potential outcomes and allows for changes or tweaks to be made to the strategy prior to overall implementation.

Assessing the impact of changes in the eligibility process is very important when making a decision about whether a change was in fact an improvement. More importantly, it is critical to avoid implementing a change that in fact hurts the process and actually turns out to be a barrier to the renewal process.

Surveying Enrollees and Dis-enrollees on Their Decisions

Surveying enrollees and dis-enrollees regarding their decisions to renew or not renew their Medicaid or CHIP coverage can provide valuable information to help states target policies and procedures that may serve as barriers to retaining eligible children and families. Surveys can be used to clarify or expand upon the data collected through the eligibility determination process. Some states also use surveys as an opportunity to initiate the renewal process for those dis-enrollees that did not return their renewal forms and for whom an eligibility determination was not made. In one state, eligibility workers conduct telephone surveys and offer consumers the opportunity to complete their renewal during the call.

To assist states in gaining a better understanding of the reasons parents may not renew coverage for their children, the Southern Institute developed the *Renewing Medicaid/CHIP Coverage: Parental Perceptions Survey* (Parental Perceptions Survey). The Parental Perceptions Survey is designed to gauge parents' perceptions related to retaining Medicaid and CHIP coverage for their children and themselves. The survey focuses on what facilitates or hinders renewal in Medicaid and/or CHIP. The survey guide and survey are included in Appendix C.

The Parental Perceptions Survey can be used by Medicaid and CHIP programs as well as application assistance agencies and Managed Care Organizations. It is intended to be a short survey and is designed to be used with both those who renew (renewers) and those who do not renew (non-renewers) their Medicaid or CHIP coverage.

Interviewing both types of respondents yields information about what encourages as well as discourages renewal of health coverage. Useful information can be learned from experienced renewers about what helps them complete the renewal process which is information that would not be available from interviewing only non-renewers. In addition, it may provide information on strategies some parents use to overcome barriers to renewal.

The survey results can be used to help target policies and procedures that may serve as barriers to retaining eligible children and families in Medicaid and CHIP. The survey results can guide the development of improvements to renewal processes, as well as policy changes that will help more parents maintain coverage for themselves and their eligible children. The survey results also may be used to improve the collection and reporting of data into the eligibility system through identifying more specific data that should be captured related to renewals.

State Challenges in Retaining Eligible Medicaid and CHIP Consumers

There were many common challenges among the eight project states. While all states did not experience all challenges, most states had experienced these challenges at some point in the history of their Medicaid and CHIP programs. The challenges are grouped into the following issue categories: policy, coordination, operational, resource and other.

Policy Issues

Most of the states required a recipient's signature on the renewal form although federal policy and regulations do not require a signature at renewal. The signature on file with the original application is sufficient. Some of the states that require a signature at renewal do accept electronic signatures for their online renewals.

Verification requirements related to income, identity and citizenship presented challenges for all project states. There is variation among the states based on what type of documentation is accepted, how the documentation is obtained and the extent to which the state assists consumers in obtaining documentation.

There are no federal requirements for income verification to be provided by Medicaid consumers for renewal of eligibility. A state can rely on self-declaration. Furthermore, a state must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements) that the state considers accurate, such as current TANF and the Supplemental Nutrition Assistance Program (SNAP)³ files before requiring families to provide state-required verifications.⁴

For CHIP, there are no federal verification requirements. However, federal regulations require states to establish procedures to ensure the integrity of the eligibility determination process. In verifying income, the number of pay stubs required, the method used for calculating income and the extent to which existing data in state or federal databases can be used may vary.

Federal regulations require consumers to provide proof of identity and citizenship documents for Medicaid coverage at renewal if it was not provided at application. When the Retention Initiative began in 2007 most states were still obtaining identity and citizenship documents for the first time on children and adults renewing their Medicaid coverage. The recently passed CHIPRA has revised the implementation of this requirement for Medicaid and CHIP. Now states have the option to accept applicants' social security numbers and match them with the Social Security Administration to verify identity and citizenship. If no match is confirmed, the family has 90 days to produce documentation before being denied coverage. In addition, children born to mothers on Medicaid are exempt from the identity and citizenship requirement.

³ Supplemental Nutrition Assistance Program is the new name for the Food Stamp Program.

⁴ Although consumers do not have to provide documentation, federal regulations require state Medicaid agencies to verify income at renewal under the income and eligibility verification (IEVS) system. States may, with CMS's approval, target the use of IEVS information in ways that are most cost-effective and beneficial. The consumer must be informed in writing at the time of the renewal that the agency will be requesting this information.

Coordination Issues

There were three recurring issues identified by the participating states related to coordination of programs and agencies: transitions between Medicaid and CHIP, coordination between Medicaid and CHIP agencies and coordination between policy and eligibility determination agencies.

With one exception, all states in the project had separate Medicaid and CHIP programs. Transitions or referrals of cases between programs have historically presented challenges for states that have separate CHIP programs. While referrals between Medicaid and CHIP are required, the referrals may not be automated and therefore require eligibility workers to manually transfer the renewal documents and verifications. In addition, the programs may have separate eligibility systems and these systems may not be capable of interfacing. These barriers prevent a seamless transition between programs and can cause consumers to slip through the cracks.

Some states are organized and structured in ways that do not facilitate coordination between the Medicaid and CHIP agencies. In some states the Medicaid and CHIP programs are housed in different state agencies that may or may not be co-located. States also vary in their history of collaboration and working effectively together.

Some Medicaid and CHIP agencies face challenges in how they communicate with each other. Limitations in information systems and communications, such as email and fax, also can adversely affect collaboration between Medicaid and CHIP officials in the same state.

Finally, coordination between policy and eligibility determination agencies can present problems, particularly when they are housed in different agencies. Addressing this challenge requires significant investment in communication processes and collaboration on building skills and knowledge among policy and eligibility determination staff.

Operational Issues

All states identified one or more operational issues with which they had experienced problems. These challenges included caseload management, customer service, maintaining client contact information, collecting premiums and fees, coordination with other assistance programs and the role of third party administrators in the renewal process.

Many project states struggled with workload issues in their eligibility determination offices. Some states use the traditional case management approach with assigned caseloads for eligibility workers. However, some project states were already testing new approaches to workload management. Some were designating staff to work on renewals only and some used teams to handle a caseload. Other states tested the pull method for case management in which eligibility workers “pull” the next package in the queue to be worked and do not have assigned caseloads. At the beginning of the project one state had already implemented a centralized system for handling renewals in one office. States are seeking efficiencies in caseload management that result in reduced processing time in order to maximize staff resources and reduce the time that a case waits before for the eligibility worker gets to it.

All states shared a concern for customer service in their eligibility determination offices. Implementing process efficiencies can support customer service efforts. Traditional customer service concerns, such as wait times to see an eligibility worker and timely responses to phone calls or requests for information, can be addressed through increased efficiency in processing renewals. Processing renewals more quickly can reduce customer service issues by limiting the need for consumers to visit the eligibility determination office or to call for information about their renewal application status. Reducing processing time has

benefits for workers and consumers. For eligibility workers there are fewer interruptions, resulting in higher productivity. For the consumer eligibility determinations are made more quickly, resulting in fewer inappropriate case closures and less disruption of services for those who continue to be eligible.

Maintaining current consumer contact information was a major challenge for all project states. Lack of correct contact information is costly to the state, including processing returned mail, postage and materials for mail-outs, and staff time to follow up to locate the consumer and complete the renewal process. It also is costly to the consumers, who may lose coverage or experience interruptions in coverage that can adversely affect continuity of care. One state that had conducted a non-renewal survey reported, *“Our survey caused us to realize how huge a problem we had regarding returned mail.”*

Collection of premiums or enrollment fees was a challenge for a few of the project states. How and when premiums and fees are collected directly affect retention rates and churning of consumers on and off the program. Policies and procedures around payment methods and payment schedules influence consumer behavior and the state’s ability to collect the premiums and fees.

An additional operational challenge is the role of eligibility determination third party administrators for the CHIP program and the state’s coordination with its third party administrator. Communications, sharing of data and coordination with Medicaid eligibility determination staff all affect the renewal process and thereby retention rates.

In at least one state, there was a problem with inappropriate closures in cases where families were connected with another benefit program. Due to differences in renewal periods, families determined to be no longer eligible for SNAP had both their SNAP and their Medicaid/CHIP cases closed.

Resource Issues

All project states identified limited resources as a critical challenge in improving retention of eligible children and adults in Medicaid and CHIP. Budget constraints, eligibility systems and data access limitations, lack of technology and staffing issues are experienced to some degree by all participating states.

Even prior to the current economic downturn, states were experiencing difficulties due to tight budgets. The severity of these budget constraints varied across the project states. Differences in state resources and differences in state policy makers’ perspectives affect the states’ ability to allocate state funds to match the federal dollars available for Medicaid and CHIP. In addition, concerns over the rising costs of health care can affect policy makers’ perspectives on how much to invest in Medicaid and CHIP.

All project states faced challenges with their eligibility data systems. Several states have older, legacy systems that are costly to maintain and update and are limited in their capabilities. A few states are transitioning to newer and more advanced systems, but most states in the project continue to improvise with labor intensive “work-arounds” and proxy measures for data that cannot be obtained from their existing systems. States also struggle with linking their provider payment systems with their eligibility systems. Some states use data from both systems to obtain the information needed regarding their renewal process and its outcomes. This requires careful attention to the differences in how data are treated in each system. For example, client data in one system may be based on cases or family units and in another it may be based on individual clients.

A related challenge that all states experience is their ability to access the data they need to assess and monitor their renewal policies and processes. Some states have limited capacity in terms of their data reporting systems and in terms of retaining technically proficient staff to operate the systems. In addition,

there are competing priorities for information technology support. Program staff often experience long waits before their data requests can be fulfilled. Timeliness of the data, resulting from delays between when the data is submitted by the eligibility determination offices and when reports are available, is also an issue.

In addition to timeliness of the data, consistency in reporting data is a concern. Eligibility workers may routinely use generic reasons for case closures rather than using more specific closure codes. In some cases, data systems may not allow for drilling down into precise categories of closure codes. For example, many states may use “failure to provide information” as a reason code for closures; however, they do not capture data on what information may have been missing.

Access to technology is a challenge experienced by most project states. Budget constraints have limited Medicaid and CHIP agencies’ ability to keep up with newer technology. Upgrades in automated systems, equipment, software and bandwidth for data transmission have been limited, resulting in fewer process efficiencies and potentially increased costs for program operations. Several states’ computer systems are in flux while planning and transitioning from legacy systems to new advanced systems. This limits opportunities and adds challenges for states making improvements in renewal processes.

Staffing and staff training also are major challenges for all states in the project. Employee turnover in eligibility determination offices can be high with some supervisors carrying caseloads in addition to their supervisory responsibilities. Several states were operating with deficits in staff capacity because vacant positions could not be filled due to state hiring freezes, resulting in large caseloads for remaining staff. For those states that have new staff, recruiting, training and mentoring new employees adds to the cost of administering their Medicaid and CHIP programs. It also causes disruptions in the eligibility determination process. In addition to training of new employees, agencies are responsible for training all employees on policy and process changes as they occur.

Other Issues

The effectiveness of communications with consumers due for renewal has a direct impact on renewal outcomes. Complex and hard to understand letters and forms cause consumers not to take any action at all or only partially respond to requests. Computer-generated notices and letters produced by cumbersome legacy systems present particular challenges since it is difficult to modify correspondence from these systems in a timely manner and other requests may have priority. Good, family-friendly correspondence can result in an increased renewal form return rate, more timely responses, submission of appropriate verification documents and ultimately an increased retention rate.

There have been significant improvements in the communications sent to Medicaid and CHIP consumers over the past decade. However, it can be beneficial to consumers and eligibility staff who must process renewal forms for states to continuously review the forms, notices and electronic communications to determine if there are more improvements that can be made. In addition to written communications, scripts for auto-dialer contact systems, surveys and other routine verbal communications should be reviewed.

Understanding why families do not renew their Medicaid or CHIP coverage and gauging their understanding of the renewal process were challenges for all project states. Most of the states were using surveys of some type to gather customer satisfaction information from their consumers or to obtain data on families that were dis-enrolled at renewal. Both telephone and mail surveys were used but no state was using multiple data collection methods. Some states were using their survey to encourage dis-enrollees to complete their renewal forms or to reapply depending on the state’s regulations on renewal grace periods. For one state the survey also was used to obtain information about dis-enrollees that had acquired other insurance coverage.

State Approaches to Improving Medicaid and CHIP Retention

Promising strategies emerged from the participating states' efforts to improve the retention of eligible children and adults in Medicaid and CHIP. Each state developed individualized retention improvement plans designed to address identified areas for improvement, plan strategies and make changes to their Medicaid and CHIP renewal policies and processes. Strategies focused on improving and streamlining the renewal processes for Medicaid and CHIP, improving and simplifying renewal forms and communications and increasing efficiency in eligibility determination offices. The overall goals were to reduce the number of inappropriate Medicaid and CHIP closures, increase the efficiency and effectiveness of the eligibility offices, and increase the rate of retention. These demonstrated strategies have the potential to work in other states.

Improving Retention through Coordination

When public programs are coordinated, continuity of health coverage is maintained and state and local eligibility offices experience increased efficiency and administrative cost savings. There are potential system modifications states can make at varying levels to simplify and streamline their Medicaid and CHIP renewal eligibility determinations, as well as improve the coordination and transition between the two programs. Aligning Medicaid and CHIP systems to electronically transmit referrals between the two programs benefits the consumers and the programs. For example, if a family income exceeds the eligibility limit for Medicaid at renewal, their renewal information from the Medicaid database is automatically transferred to the CHIP system's data files for processing without requiring additional follow-up from the family. Automated referral and transfer of renewal information between Medicaid and CHIP systems can minimize errors and processing time considerably.

Two of the state teams, Iowa and Pennsylvania, have successfully implemented electronic referral systems between their Medicaid and CHIP systems. Outcome data from both systems demonstrate effective coordination between Medicaid and CHIP, preventing gaps in health coverage for eligible children and adults.

In Iowa, the Department of Human Services (DHS) administers the Medicaid and CHIP programs. Medicaid eligibility is determined by county office income maintenance workers using a legacy mainframe system. Iowa's separate CHIP program is administered centrally by an eligibility determination third party administrator using a proprietary Oracle-based system. The CHIP contractor does not have access to the DHS mainframe system and likewise, the county eligibility offices do not have access to the CHIP system.

Data collected by DHS showed that children who were found to be ineligible for Medicaid because of family income were not consistently being referred to CHIP for an eligibility review. Consequently, children who were potentially eligible for CHIP were falling out of the public health coverage system and losing coverage. With the electronic referral system, the transition is seamless for families. For example, when a child is denied or cancelled from Medicaid due to exceeding income limits, the following steps occur: 1) an email referral message is generated to the CHIP eligibility worker; 2) the child's parent is notified of the CHIP referral; 3) the client's information automatically populates into the third party administrator's system – no manual entry is required; 4) the referral is processed within the same day; and 5) system-generated reports allow supervisors to monitor the referrals.

Pennsylvania's Healthcare Handshake is a collaborative effort between the Pennsylvania Department of Public Welfare (Medicaid agency) and the Pennsylvania Insurance Department (CHIP agency) to improve customer service and promote access to health care. The Healthcare Handshake automates the exchange of information between the two departments to make the referral process more efficient and accurate.

The Healthcare Handshake uses Pennsylvania's online application system, the Commonwealth of Pennsylvania Access to Social Services (COMPASS), to exchange information between the two departments. The Pennsylvania Insurance Department sends information to the Department of Public Welfare if an individual's income appears to fall in the Medicaid eligibility range. The Department of Public Welfare sends information to the Pennsylvania Insurance Department if a household or an individual's income or resources are too high or if an individual, for non-financial reasons, is ineligible for Medicaid.

The auto-referral system provides a seamless transition between Medicaid and CHIP programs and allows eligibility changes to occur more rapidly within both programs. Processing time for referrals has been greatly reduced. For example, Iowa's new average referral time is two minutes. The electronic systems eliminate the risk for manual data entry errors, lost paper documents and discrepancies between Medicaid and CHIP information. Cost savings are realized from the electronic process in reduced staff time and reduced use of supplies such as paper, copy toner, faxes and postage. Ultimately, fewer eligible children are dropped from the system and lose coverage.

The enhanced coordination between the health coverage programs results in more families having a positive experience with the programs. Additionally, the automated referral system lightens the workload on income maintenance workers, who are now available to spend more time assisting families with the application and renewal processes. In both states monthly referrals have steadily increased, resulting in improved continuity of care for children who move from Medicaid to CHIP.

Coordination with public benefit programs and other state programs' data systems enables eligibility staff to facilitate administrative reviews and maintain consumer contact information without engaging the consumer. Administrative reviews can simplify and expedite the renewal process for the staff and consumers, as well as reduce the need for consumer communication mailings.

Improving Retention through System and Process Modifications

A different system modification approach was tested and implemented statewide in New Mexico. In the effort to simplify and streamline the renewal process for staff and for the consumer, New Mexico, a Medicaid expansion state, has successfully implemented a centralized renewal system for Medicaid-only cases along with several other supportive simplification strategies and system modifications. New Mexico implemented a Medicaid renewal project initiative statewide effective October 1, 2007. One centrally located unit was established to be responsible for the Medicaid renewal process for children and families. The outcomes for the renewal project were significant for both the eligibility workers and the consumers. Results demonstrated reduced caseload burden on the county office workers and a streamlined renewal process. Improvements included adoption of simplified pre-populated renewal forms and a consumer-based system providing multiple renewal options: by telephone, email, fax and mail. The centralized system serves as a strategic model for use in Medicaid and other public benefit programs.

After a year of statewide implementation of the streamlined renewal process, New Mexico increased the retention rate from 45% to about 80% and experienced an 11.5% enrollment increase in the children and family categories. Survey results indicated that the new Medicaid renewal process is easier for families, with a 90% rate of customer satisfaction. Quality reviews of renewals processed by the project team show the error rate to be comparable to the error rate prior to the changes. As evidenced by the data reviews, the

changes – allowing multiple methods for families to renew and allowing client statements to meet the verification requirements – have not resulted in increased cases of ineligible individuals receiving coverage.

States that require premium payments for their Medicaid and CHIP programs can help to make the payment process more convenient for families by offering multiple payment options. Among the states in the Retention Initiative, seven states have premium payment programs. These states offer a variety of options to make the payment process more convenient for families, such as outstation payment sites (Pennsylvania), electronic bank transfers (Florida, New Hampshire, Pennsylvania), and payment by check, debit card and credit card (Alabama, Florida, Pennsylvania, Texas). In addition, families can set up payroll deductions through their employer (Florida CHIP).

Extending health coverage periods to 12 months for both Medicaid and CHIP is a cost-effective, efficient policy that impacts the eligibility systems and workloads. As evidenced by research 12-month coverage, particularly 12-month continuous coverage, improves retention, reduces administrative cost and lessens the workload of staff. Of the participating states, all Medicaid and CHIP programs have a 12-month coverage period, except for one state that has 6-month coverage for Medicaid. In addition, all but one of the participating states, have 12-month continuous coverage for CHIP, while fewer Medicaid programs (five) provide 12-month continuous coverage.

Managed Care Organizations (MCOs) are likely partners to help facilitate retention and there are financial incentives for MCOs to retain their members. Breaks in health coverage for eligible families have negative implications, not only for the families, but for the MCOs as well. States such as Florida, Pennsylvania and Washington engage MCOs that are contracted by their states for the delivery of health services to Medicaid and CHIP enrollees to assist in the renewal process. These MCOs promote renewals by contacting their members that are up for renewal and assisting their members in the renewal process.

Improving Renewal Communications

States continue to focus on improving and streamlining written communications for their notification letters, promotional materials, automated phone scripts, email notices and Web site electronic renewal forms and information. The Southern Institute provided consultation and guidance on simplifying the readability and formatting of the project states' communication materials.

Florida embarked upon a comprehensive overhaul of their Medicaid and CHIP communications. In an effort to improve readability and eliminate duplicate and inconsistent correspondence for children's Medicaid and CHIP programs, Florida conducted a comprehensive review of its numerous written communications. A state task force was organized to simplify and streamline the content and reduce the volume of correspondence.

Florida achieved its goals to eliminate duplicative letters and improve effectiveness of correspondence. Sixty different letters were reduced to 19. Letters were re-written in plain language to make them easier for families to read and understand. Most letters were modified so that one letter could include information regarding all children in a family as opposed to one letter per child. The improvement outcomes resulted in cost savings to the Medicaid and CHIP programs with the reduction of paper, printing, postage, staff time and other resources. These savings in resources were redirected toward outreach and other retention work. In 2007, nearly three million letters were mailed out to families enrolled in Florida's KidCare (Medicaid and CHIP). By eliminating duplicate communications, it is anticipated the number of letters distributed will be reduced to approximately 800,000. Reducing the number of communications sent to consumers will yield considerable cost savings to KidCare administration.

Maintaining consumers' current mailing addresses impacts the effectiveness of renewal notices and other important Medicaid and CHIP correspondence. States' data revealed a significant percentage of the monthly renewal notices and other communications being returned as undeliverable due to an incorrect address. New Mexico implemented several strategies to fix the problem, and as a result 64% of the returned mail was successfully delivered. The New Mexico approach utilized multiple methods including postal return mail labels, telephone contacts, Internet searches and administrative data matching with state motor vehicle records and other assistance programs' databases. Another useful tool implemented was a software program that can match consumers to a current address. Other procedural methods utilized to manage consumer contact information include:

- providing an email address for families to send changes (Alabama, New Hampshire, Florida, New Mexico);
- a Web site for updating personal accounts or reporting changes (Alabama-Medicaid only, Florida, Pennsylvania, Washington);
- automated voice response or voicemail telephone features for consumers to report changes; and
- linking consumer contact data across public benefit programs and other data systems, such as state motor vehicle and employment departments.

In addition, there are several procedural improvements related to communications states can adopt based on the favorable results from the participants' retention improvement plans. Specific improvement strategies include sending renewal notices out earlier and sending follow-up reminders by mail, telephone or auto-dialer. States can employ a variety of options to make it convenient for families to communicate with eligibility determination staff in submitting their renewal information such as drop box locations, postal address and dedicated fax number. These improvements simplify the process for the consumer, reduce re-work for the staff and help to retain continuity of coverage for eligible children and adults. See the bar graphs and chart in Appendix D for more information on the options employed by the states.

Improving Renewals by Advancing Technology

Automation and technology tools can replace or reduce paper and manual processes for Medicaid and CHIP renewals. Both eligibility workers and consumers benefit from the simplified, efficient and effective automated systems. As evidenced by the project participants, the application of technology has and continues to significantly advance. States with legacy systems have incorporated "work-around" enhancements to increase efficiencies and capabilities to the extent possible. Even with legacy systems, several participating states were able to develop new renewal data reports to measure progress and identify data quality issues and make appropriate revisions. One state reported, *"Several data quality issues were discovered through analysis of these strategies that have resulted in appropriate revisions."*

Available technological advancements are vast, but opportunities for implementation are dependent upon a state's resource capabilities and capacities, such as computer systems, staffing and budgets. Florida, Pennsylvania and Washington have made impressive strides in moving to "paperless" automated renewal systems where the entire process is facilitated electronically. From the point of issuing the renewal notice to receiving and entering the consumer's information, from making the eligibility decision to notifying the consumer, it is all done electronically.

Administrative renewals incorporate technology using data matching processes with other benefit programs. Increasingly, states are optimizing the use of their government's existing data systems as a way to simplify, expedite and increase the accuracy for Medicaid and CHIP renewal processes and decisions. Washington and Texas are examples of states that use family information from the SNAP database to make a renewal determination for children in Medicaid. The information is transmitted electronically into the Medicaid eligibility determination system and the period of health coverage is automatically extended if the child is deemed eligible.

Although many states now provide online applications for families to complete and submit electronically, fewer states provide an online renewal form. In half of the participating states (Florida, Iowa, Pennsylvania, Washington) families are able to complete and submit their CHIP renewal forms electronically. In addition, families in Pennsylvania and Washington are able to submit renewal forms electronically for their children's Medicaid.

One practical example of technology is the application of auto-dialer systems to send renewal information and reminders. Several participating states have begun using auto-dialer systems and find them to be a cost effective, efficient tool for their renewal efforts. The advantages are many. An agency's call list and message scripts can be tailored as well as the time schedule for the calls to be made, such as in the evening or on Saturdays. In addition, the auto-dialer technology enables staff to conduct outreach campaigns, access multiple languages, achieve greater reach and retrieve outcome data.

As mentioned previously, demonstrated tools states can implement are dedicated email addresses and fax lines for consumers to submit renewal forms and verification documents, as well as report changes, such as address and telephone updates. These tools can reduce staff time and are economical to purchase and install. States are incorporating technological advancements for consumers including online renewals, electronic signatures, and personal accounts allowing consumers to track and manage their Medicaid or CHIP enrollment information. Expanded technological models increase renewal options for families, enhance customer service, and provide "anytime" access to consumers. For detailed information about the eight participating states' renewal policies and procedures for Medicaid and CHIP refer to the bar graphs and chart in Appendix D.

Conclusion

Retaining eligible children and adults in Medicaid and CHIP is a key strategy in reducing the number of uninsured. Improving retention is a vital component of efforts to maximize enrollment of eligible families in existing public health coverage programs.

Examining the renewal process can reveal opportunities to improve both policy and procedures related to renewals. Understanding and improving the renewal process results in increasing retention of children and adults that are eligible for Medicaid and CHIP. As one state reported, *“The initiative reinforced that there are different ways to approach problems. Local staff is now shifting to the importance of retention and preventing interrupted coverage for families. Reducing churning has become a top priority for staff.”*

The Southern Institute’s experience with the eight states in the Retention Initiative demonstrates that all states can benefit from mapping renewal processes, understanding and using data to measure renewal outcomes, surveying consumers and reviewing consumer communications. No matter where a state may be in terms of streamlining its renewal policies and procedures, there are opportunities for improvements. One state indicated that *“Participating in this project truly brought the issue of retention to the forefront, especially on the Medicaid side. It helped bring a cultural change for the staff. Workers began to understand the importance of retention, not only for families but for their workloads.”*

Measuring outcomes is critical to improving retention and may require changes to data collection practices and analysis. Examining processes before designing and implementing new data systems or introducing new technology into the eligibility determination process can result in a better fit between the process and the technology used to support it.

Peer learning is a cost-effective and valuable approach to diagnosing and addressing retention issues and adopting promising practices demonstrated by other states. The shared experience provides states the opportunity to learn from others’ experiences, to learn from more technologically advanced states and to share tools and techniques that have proven to be effective.

The experiences of the eight states participating in the Retention Initiative are useful to all states as they work to improve their Medicaid and CHIP retention rates and to address the CHIPRA requirements.

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Retention Initiative: Achieving Stability in Medicaid and SCHIP Coverage

A. Overview

- The Retention Initiative is a two-year initiative funded by the Robert Wood Johnson Foundation, which began in April 2007.
- The Southern Institute on Children and Families is leading teams from eight states in their efforts to increase the rate of retention of eligible children and adults in Medicaid and SCHIP by encouraging states to:
 - a. Adopt simplification eligibility policies and processes focused on retaining eligible children and adults; and
 - b. Ensure accuracy of their eligibility determination processes at renewal to decrease inappropriate Medicaid and SCHIP closures.
- Participating states include Alabama, Florida, Iowa, New Hampshire, New Mexico, Pennsylvania, Texas and Washington

B. Initiative Format

- Extensive consultation and technical assistance from Southern Institute experts and other national resource persons
- Site visits to each state to meet team and state officials and gain experience with Medicaid/SCHIP renewal processes and the transition between the programs
- Monthly individual state team conference calls with the Southern Institute
- Peer to peer shared learning
 - a. Bi-monthly conference calls – retention topic-focused with Southern Institute experts and other national sources
 - b. Peer to Peer Meetings (February 2008 and November 2008)
 - Development and implementation of Retention Improvement Plan
 - Technical assistance and Peer to Peer problem solving

C. Requirements/Expectations for Participating States

- States required to identify a leadership team to include, but not limited to, Medicaid and SCHIP policy, eligibility determination and data management officials
- Traveling team (3-4 members)
- Access to Medicaid and SCHIP monthly data reports
- Supportive environment and commitment from state Medicaid and SCHIP directors

D. Major Activities for States

- Create process maps of the renewal processes for Medicaid and SCHIP and of the transition process between the two programs
 - a. Engage frontline workers and policy officials in the process mapping activities
 - b. Map the actual process not how it is supposed to be implemented
 - c. Purpose of process mapping is to identify bottlenecks, unnecessary tasks/steps, delays, decision points and rework

- Analyze retention data (from 18 months prior to the project forward) to identify trends, areas of focus
- Develop and implement Retention Improvement Plan including immediate (project period) and Long Term (beyond project) objectives, strategies and impact measures

E. Additional Components

- Retention resources on the Southern Institute's Web site (www.thesoutherninstitute.com)
- Assessment tool for states to use to gauge parents' perceptions of factors that influence their decision to renew Medicaid/SCHIP coverage
- Retention report on issues associated with Medicaid and SCHIP retention and highlights of effective strategies implemented by participating states and recommendations for future actions

Template

Case Closures for Medicaid/CHIP Children Percentage and Number of Case Closures Age 18 and Under, By County and State [Time Period]			
Area	Percentage of Case Closures	Percentage of Case Closures at Renewal	Total Number of Case Closures
[State]	%	%	#
County 1			
County 2			
County 3			
County 4			
County 5			
Note: The data are unduplicated cases. Source:			

Appendix C

Survey Guide Renewing Medicaid/SCHIP Coverage: Parental Perceptions Survey

Introduction

Collecting survey data can be technically challenging. However, Medicaid and State Children’s Health Insurance Program (SCHIP) staff do not have to become survey experts to use the *Renewing Medicaid/SCHIP Coverage: Parental Perceptions Survey* (Parental Perceptions Survey). If needed, technical expertise and support are available from a variety of sources, such as other areas of state government, universities, and private research and consulting firms. It is useful for Medicaid and SCHIP staff to understand what surveys involve, recognize good survey practice, and make decisions about the role that staff members should play in collecting and analyzing data. This knowledge helps ensure that useful, high-quality information is collected.

Survey Purpose

The Parental Perceptions Survey is designed to gauge parents’ perceptions related to retaining Medicaid and SCHIP coverage for their children. The survey can be used by Medicaid/SCHIP programs as well as other organizations, e.g., application assistance agencies. It is intended to be a short survey and is designed to be used with both those who renew (renewers) and those who do not renew (non-renewers). The survey focuses on what facilitates or hinders renewal in Medicaid and/or SCHIP.

Interviewing both types of respondents allows you to learn more about what encourages as well as discourages renewal of health coverage. It enables you to learn from experienced renewers what helps them complete the renewal process which is information that you would not get from interviewing only non-renewers. In addition, it may give you information on strategies some parents use to overcome barriers to renewal.

The survey results can be used to help target policies and procedures that may serve as barriers to retaining eligible children and families in Medicaid and SCHIP. The survey results can guide the development of improvements to renewal processes that help more parents maintain insurance coverage for their eligible children.

Tailor the Survey

The survey as presented is designed to be used as a telephone survey. However, it can be used in other formats. The survey can be adapted easily to be used as an in-person survey (where a staff person asks the questions to recipients in a waiting room, for example). With minor modifications the survey also can be adapted to a written format and self-administered (mailed, handed out at your office, put online or emailed). Modifying the survey to be self-administered would require making the response categories in Question 5 choices and deleting skip patterns by creating separate survey instruments for renewers and non-renewers to make it easier for the respondents to complete the survey.

The Parental Perceptions Survey includes 11 questions: five are “yes” or “no” questions, four are open-ended questions, one question is multiple choice and one question includes nine “agree” or “disagree” statements.

The survey can be tailored to your state's Medicaid and/or SCHIP program and gives you the option to only survey one population, such as SCHIP recipients. Adaptations for specific questions are indicated in brackets in those questions.

There are several places noted in the survey for you to insert the name of your state Medicaid and/or SCHIP program. See the introductory script and Questions 1, 2, 6 and 9. It is best to refer to the state program using the name or wording that is most familiar to Medicaid and SCHIP recipients in your state.

In addition to inserting your state Medicaid and/or SCHIP program name in Question 2, you also will need to insert the appropriate renewal period for your state program. For example, if your state program requires that recipients renew their coverage every 12 months, then you would insert "12 months" at the end of Question 2.

For Question 3, the interviewer may ask for correct address information if the respondent indicates that they did not receive the renewal form. You will need to decide in advance how this information will be incorporated into your contact system.

Question 5 is an open-ended question and not a multiple choice question. The list of possible responses is provided in order to help the interviewer capture the information more quickly. The interviewer should not read the list or prompt the respondent with items from the list.

Questions 5, 6, and 7a are only asked of non-renewers and Question 7b is only asked of renewers, resulting in a skip pattern in the survey. Interviewers should be trained in how to recognize and appropriately use the skip pattern.

Question 9E includes the word "renewal". You should employ the terminology used in your state for the renewal process, e.g., redetermination, in this question. Please note that if you do not use the term "renew" in referring to your state program's renewal process, you will need to change the wording in Questions 2, 3, 4, 5, 7, 8 and 9.

Questions not relevant to your program, such as those pertaining to premiums, can be deleted from your survey. See Questions 9H and 9I. You also may wish to add or delete other questions based on their relevance to your state's Medicaid and SCHIP programs.

Adding basic demographic questions to the survey will allow you to see if there are differences based on gender, race/ethnicity, education, income, or category of benefits during the data analysis stage. If that information is already in your data records you could precode the questionnaire. However, you may only have information on a child as the recipient, whereas you will survey the child's parent or guardian. In that case, gathering the demographics of the parent or guardian surveyed rather than the child in the program could prove useful.

Select the Sample to be Surveyed

Because of the sheer number of recipients in most states, it is not reasonable to survey everyone. Sampling to select only a portion of recipients will be appropriate, for example only certain categories of recipients or only certain geographic sections of your state. Once the relevant group is defined, you need to enumerate all members of that group so the information collected is not biased. Generally enumeration is done using a list maintained in your office of all Medicaid and/or SCHIP recipients who have had a chance to renew their coverage (not new enrollees). This should be an unduplicated roster of recipients that is up-to-date, complete, and accurate. It is important that up-to-date contact information for recipients

is maintained in order for you to locate recipients to administer the survey. Likewise, your results might be biased if you do not survey those recipients who have missing or wrong addresses or phone numbers.

Sampling must be done in a systematic, careful way to assure the findings can be generalized to the entire population of recipients up for renewal. If you wish to compare groups of recipients, such as those who renew and those who do not, or compare responses of recipients in different benefit categories you will need larger samples that include enough recipients in each group.

When you have thousands of recipients you often need surprisingly small numbers of them to get a representative sample. For example, for a simple survey out of a population of 20,000 you would need only 377 people to respond in order to have a representative sample according to Raosoft, Inc. (<http://www.raosoft.com/samplesize.html>) You should consider how much variability is in your recipient base. When recipients are more alike then you need fewer of them to be representative.

Also, you should consider how many recipient subgroups you will need to assess. More groups mean more recipients in total should be surveyed. Generally, larger samples (up to a point) provide more precise information than smaller samples, but cost more in time and resources to survey, so there is a trade-off between precision and cost. In addition, you should consider how easy it will be to get respondents. If you have a lot of parents or guardians you cannot find or who refuse to participate, you will need to have enough replacements which also can add to the cost.

To generalize the findings from your sample to the entire population you should pull a random sample that will be large enough and includes enough replacements to obtain the number of interviews needed for a representative sample. When subgroups of a sample are compared to each other, a statistical calculation can determine the probability that observed differences are real, meaning you would likely get the same results as you would if you could survey everyone. You generally need to double your sample size if you plan to compare two groups. That may mean over-sampling the smaller group (likely non-renewers). At a minimum you should try to sample the number in each group that corresponds to their percentage in your total population.

Survey Administration

Before using the Parental Perceptions Survey with your sample you should pretest the survey and the survey procedures. Pretesting allows you to find out if the instructions, questions, and format are understandable and if respondents are interpreting questions as intended. Pretests can use a small sample as long as those in the pretest represent the range of recipient types that you want to survey. Pretesting also can include interviews with individual respondents to get their feedback about the survey or in-depth focus group discussions with respondents to hear their reactions. Depending on the results of the pretest, the survey or procedures may need to be modified. If there are no changes to the survey or the procedures the pretest respondents can sometimes be included in the final sample.

You need to decide when recipients will be surveyed and how often to conduct a survey. You will have to decide how close to a renewal decision you would like to survey recipients. Generally, the closer to the decision date the better to get the best respondent recall. Surveys could be conducted at fixed points in time after the renewal decision.

Since renewals are on a rolling basis throughout the year, recipients could be surveyed on a rolling basis. For example, a small number of recipients could be surveyed each month following the renewal decision; this spreads the survey workload throughout the year. Survey results can be accumulated, tabulated, and summarized quarterly.

Surveys can be either self-administered or done with an interviewer. They can be conducted in person or over the phone, or self-administered via the mail, email, or on the internet. The Parental Perceptions Survey is intended to be a telephone survey.

Telephone interviews require recipients to have telephones, and for you to have accurate telephone numbers, which sometimes are not available. Some recipients will screen calls and not pick up and many recipients are not available to be interviewed until after hours. Many low income recipients also go in and out of phone service, so it can be challenging to reach respondents. However, it is often more difficult for people to refuse an interviewer than to ignore an emailed, mailed, or internet survey.

Interviewers need to be trained and monitored to make sure they all ask questions the same way and follow the same procedures. Computer assisted telephone interviews also can be done, wherein the interviewer has a computer screen with the survey and types in the answers as they are given. The answers are then automatically logged into a data base for analysis. Generally it costs more to use interviewers rather than to use self-administered surveys.

It is unlikely that conducting in-person interviews will be feasible with your random sample because you cannot control when recipients will come in to your office. Doing in-person home interviews will likely not be feasible, but telephone surveys may be. Using interviewers gives greater control over the questionnaire-administration process and is helpful with recipients who do not have good reading skills.

Self-administration gives less control over the process, does not work as well with lower literacy recipients, and generally has a lower response rate than interviewer surveys. They do tend to be less costly and logistically easier to administer. Mailed or emailed surveys require that you have accurate addresses. If recipients are directed to a Web site then you have to be able to control how many times they do the survey and you have to have a way to contact them. For example, when you send a decision letter you could enclose an invitation to go to the Web site to complete the survey. Web based versions also can be made to go directly into a data base, but require specialized design expertise. Recipients also have to have computer access and be comfortable using a computer.

The Urban Institute's guide *Surveying Recipients About Outcomes* (2003) provides useful guidance on time and cost requirements associated with different approaches to survey administration. Considerations include staff time, use of consultants, printing and materials, Information Technology costs, coding and data entry, and data analysis.

Survey Response Rate

The response rate is the number of recipients who complete a survey divided by the number in the sample. Response rates falling below the adequate range yield questionable results that may not be generalizable to your population of recipients. Acceptable response rates vary by how the survey is administered. The following are acceptable response rates based on different ways to administer a survey:

- Mail: 50% adequate, 60% good, 70% very good
- Phone: 80% good
- Email: 40% average, 50% good, 60% very good
- Online: 30% average
- Face-to-face: 80-85% good

(<http://www.utexas.edu/academic/diia/assessment/iar/teaching/gather/method/survey-Response.php>)

There are steps you can take to improve your response rate. Send a letter explaining the survey (signed by a high-level official) before attempting to conduct the survey. It is best to personalize the letter and put it on your letterhead. Explain the survey's importance and use, express appreciation for the recipient's time and effort, and let respondents know they will be contacted to participate (by phone, email, directed to the web or sent via mail). State in the letter if there is any incentive for participation. Give a phone number and/or email address to contact with questions or to opt out of the survey.

For phone interviews, try calling at different times of the day and different days of the week. You may have to call nights and weekends. Call as many times as possible if there is no answer. It is generally not recommended to leave messages on an answering machine due to privacy issues, but if you have sent an advance letter you may state that you are calling in reference to the recent letter about a survey and give your phone number.

For mailed or emailed surveys, send a reminder postcard or make reminder telephone calls or emails. Send a second survey two weeks later. Include stamped, self-addressed return envelopes with mailed surveys. If returned surveys contain identifying information, send reminders only to those who have not yet returned their surveys. Allow respondents flexibility in returning their survey by offering the option of either mailing their surveys back, bringing them back in person, coming to a service site or going online to complete them.

Recognize that respondents are giving up their time to complete the survey. Incentives, e.g., a small gift card, bus pass, or chance to win a larger prize in a lottery, show you value their time and input. Local businesses may be willing to donate awards.

Privacy and Safety of Respondents

You need to ensure that collection of information for your survey does not cause harm to recipients or pose a risk to them. Recipient privacy needs to be respected. Staff should treat the survey results with the same confidentiality used with all recipient records. If outside entities do the survey data collection, they must sign and adhere to confidentiality agreements.

It should be clear to staff and recipients that participation is voluntary and no penalty will result if the survey is not completed. Recipients should be informed that they can refuse to answer any of the questions or decline to participate entirely. There also should be a promise to maintain confidentiality. Asking for consent before completing a survey also enhances a sense of trust and understanding of the survey's value to the recipient.

Information from recipient records can be linked to individual recipients and their answers, but access to recipient survey answers should be limited only to those who process and analyze the survey. Individual responses should never be made public or used internally beyond those working on the data collection and analysis. Results can be shared in the aggregate by subgroup or the total sample. The link between questionnaire responses and other data from recipients' records is best made by either the case file number or a special survey tracking number to each questionnaire that links back to identifying information.

Data Collection

Survey administration involves not only collecting the survey data but also ensuring the quality of the data collection process. A staff person should be responsible for directing these activities and adhering to the planned procedures and schedule, or serving as the liaison to an outside contractor who may conduct the survey. This staff person also should ensure that the tasks associated with the quality of the data

collection process, e.g., training staff, checking sampling procedures, monitoring interviewers, and enforcing confidentiality procedures, are completed.

Data Entry

Once surveys are completed, they should be reviewed to make sure there is not a lot of missing data, e.g., respondents skipping questions, or ambiguous data, e.g., respondents providing more than one answer when instructed to choose just one. Correcting those issues is called data cleaning. Establish rules for how to handle missing data and other situations so they are handled consistently. Not everything can be cleaned, and some surveys may prove to be unusable or you may have to have missing data on some questions.

The surveys are then collated and entered into a data file. If there is a low response rate you can either continue drawing new samples and surveying more people until you reach the number recommended for a representative sample or you can compare the characteristics of those who responded with the characteristics of all recipients (using organizational records) to check for systematic differences. If there are systematic differences, that is called bias and can affect the quality of your results.

While survey data can be hand tabulated, computer analysis is generally preferred. Simple software programs, such as Microsoft Excel, can be used to perform basic data analysis. Data entry errors are possible with any data entry process. When practical, double entry, or at least double-checking some percentage of each batch of surveys is recommended.

The Parental Perceptions Survey includes mostly categorical data which means the answers are characters rather than actual numbers. For example, yes and no have no true numerical value but can be coded as 1 or 2. Most data management systems work better if these characters are assigned numbers, so you choose what to number each answer and then code accordingly. You can write in the margin of one copy of the survey the codes that correspond to each answer and each question—this will serve as a codebook on how to code the surveys for data entry. Next, assign a unique survey response number and date of receipt for each survey.

Since the Parental Perceptions Survey contains open-ended questions you need to establish a way to handle these questions. You can either code open-ended questions (useful if the same things are said by many different respondents) or keep them as qualitative narrative data. To code them, read a sample of the answers to a question and establish basic categories into which the remaining answers can be grouped. Assign numerical codes to each of the categories. Then, read and code all the questionnaire responses, and enter the codes in the data file that contains responses to the closed-ended questions. To leave them as narrative text, type the responses in a list by each question. These will then have to be kept separate from the numerical analysis.

Data Analysis

Analysis of the Parental Perceptions Survey will be relatively simple. The most basic form of survey analysis entails looking at each question one at a time and running a frequency on the responses and the percentage of recipients giving responses to each question. Most data processing programs can run a frequency table for you. To do it by hand, divide the number of recipients who give a particular response by the total number of respondents.

To compare differences across subgroups you could run chi square tests to check on the significance of the difference between percentages across two or more subgroups. The chi-square statistic, which is available in most data analysis software systems, will tell you whether a difference between 30% of

renewers and 35% of non-renewers choosing a particular response is really significantly different. If you contract out your survey the contractor can often run these simple statistics for you. This survey is short with mostly categorical data, so it does not lend itself to much beyond these basic analyses.

Survey Reports

Reports can be used to present the findings, conclusions and recommendations for action based on the survey data. They also provide documentation of the survey development and administration processes for later use, replication, or reference. Reports should be prepared promptly following survey completion. Also, reports should summarize and succinctly highlight the survey's main findings and implications and should note any significant caveats related to the reliability or generalizability of the information.

A useful approach is to organize the report into sections. The sections may include background information on the purpose of the survey, survey methodology (i.e., research design, description of the survey instrument, sample selection, data collection and data analysis), survey findings, conclusions, and recommendations.

Reports can include a table profiling survey respondents either in demographic or service characteristic terms. Other findings can be displayed as tables with percentage distributions or as line, bar or pie charts. State major findings in text or bullet format and put more important findings up front. Attach an appendix with a description of the survey method, the survey questionnaire, detailed data tables (if not presented in the findings section), response rates, and a discussion of issues or problems that arose in the course of survey administration or data analysis.

The information can be used in a number of ways, such as identifying where improvement is needed and what areas seem to be working well. Recommendations for action or further exploration should be developed from the survey findings. Findings should be shared throughout your office, with others in the state and with colleagues in other states.

References

Instructional Assessment Resources, University of Texas at Austin
<http://www.utexas.edu/academic/diia/assessment/iar/teaching/gather/method/survey-Response.php>

Random number table, University of Minnesota Morris
<http://www.mrs.umn.edu/%7Esungurea/introstat/public/instruction/randbox/randomnumbersII.html>

Raosoft, Inc.
<http://www.raosoft.com/samplesize.html>
To calculate sample size needed.

Super Survey Knowledge Base
<http://knowledge-base.supersurvey.com/survey-response-rate.htm>
This site has tutorials on various aspects of survey methodology.

Surveying Recipients About Outcomes, Urban Institute (2003) <http://www.urban.org/url.cfm?ID=310840>
This guide is part of a series on outcome management for nonprofit organizations. There is also a guide on analysis issues for outcomes research.

Renewing Medicaid/SCHIP Coverage: Parental Perceptions Survey

May I please speak to [name of adult beneficiary or parent/guardian for minor children]? Hello, my name is [name of interviewer] and I'm calling on behalf of the [state program name]. I'm calling because the [state program name] wants to know more about what makes it easier or harder to stay enrolled in the program.

We have a few short questions to ask you that will only take a few minutes of your time. We will make sure your name is kept separate from your answers so that others will not link your name to what you say. Your answers will be combined with answers from other people without using your name and phone number.

Would it be OK to start my questions now? (YES, PROCEED TO Q1)

IF NO: Could you please suggest a time I could call you back to complete the questions?

IF NO TO ALTERNATIVE TIME: Thank you for your time, good-bye.

CHECK ENROLLMENT STATUS OF INTERVIEWEE

1. Our records show [you/beneficiary] [are/is enrolled/is not enrolled] in [state program name]. Is this correct?
 1. Yes (RENEWER)
 2. No (NON-RENEWER)
 3. Don't know or do not remember

2. Did you know you would need to renew after being in [state program name] for [12 months or 6 months]??
 1. Yes
 2. No
 3. Don't know or do not remember

3. Did you get a renewal form?
 1. Yes
 2. No [NOTE: CAN GET CORRECTED ADDRESS INFORMATION HERE]
 3. Don't know or do not remember

4. What is the easiest way for you to renew?
 1. By mail
 2. Online
 3. Over the phone
 4. In person
 5. By e-mail
 6. Other (list) _____

ASK #5 OF NON-RENEWER ONLY (Q1 = No); RENEWER SKIP TO Q7b

5. Could you tell me the reasons [you/beneficiary] did not renew?

CIRCLE NUMBER ON ALL THAT APPLY—DO NOT READ THEM

1. I forgot to renew.
 2. I could not get the forms completed.
 3. I did not understand how to renew.
 4. The forms were too difficult to complete.
 5. I could not get the documents needed to renew (e.g., pay stubs).
 6. We make too much money to qualify.
 7. Child is too old to qualify.
 8. We tried to renew and were turned down.
 9. We got other insurance.
 10. Did not like the program.
 11. Did not like changes to the program.
 12. Did not like the health care providers (e.g., dr., nurses).
 13. Could not find a doctor who would accept my card.
 14. My regular health care provider did not accept my card.
 15. We could not afford the premiums.
 16. Had too many assets to qualify (e.g., vehicle, savings).
 17. We can get free health care another way (e.g., school clinic).
 18. I am or my child(ren) are healthy and do not need the program.
 19. We do not like government programs.
 20. Some other reason (list). _____
-

IF THEY LIST MORE THAN ONE REASON ASK

5a. Of the reasons you have just told me which is the main reason you did not renew?

6. (NON-RENEWERS) Would [you/beneficiary name] have preferred to stay on [the state program name]?

1. Yes
2. No
3. Don't know or do not remember

7a. (NON-RENEWERS) What would make [you/beneficiary] want to renew?

7b. (RENEWERS) What makes [you/beneficiary] want to renew?

8. What would make it easier for you to renew?

9. Here are some statements about renewing for [state program name]. Would you please tell me if you agree or disagree with each statement?

		Agree	Disagree
A	The renewal process was harder than it needs to be.	1	2
B	It was easy to know what things I needed to send in.	1	2
C	It was easy to find out what I needed to do to renew.	1	2
D	The forms are easy to understand.	1	2
E	There is too much paperwork for [renewal].	1	2
F	It was hard to get proof of income.		
G	I had lots of choices about how to renew (e.g., by mail, online, over the phone). (IF NO PREMIMUMS SKIP TO Q10)	1	2
H	[For premium programs only] Paying a premium is worth it for the services received.	1	2
I	[For premium programs only] The premium payments are too high.	1	2

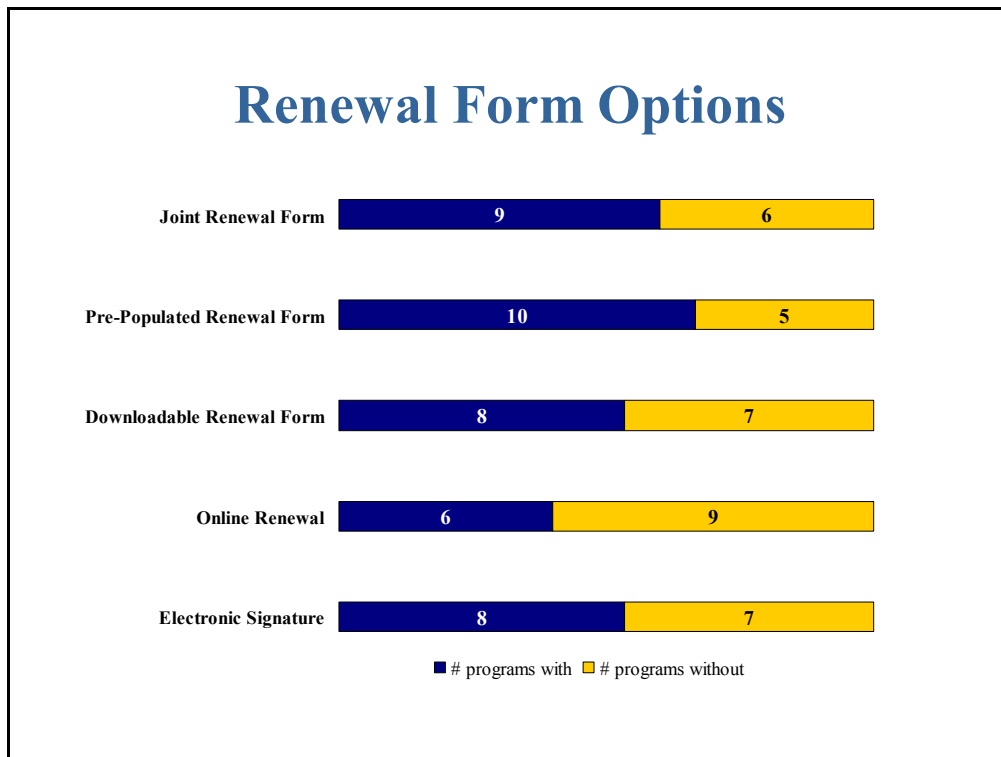
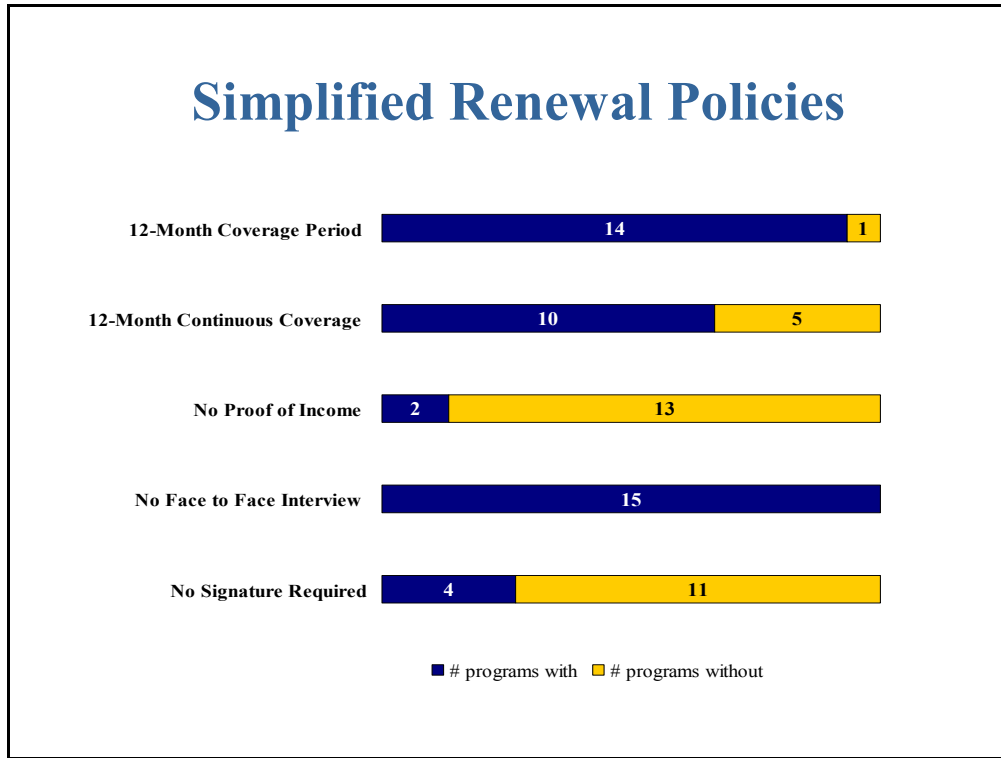
10. Do(es) [you/beneficiary] have other health insurance now?

1. Yes
2. No
3. Don't know or do not remember

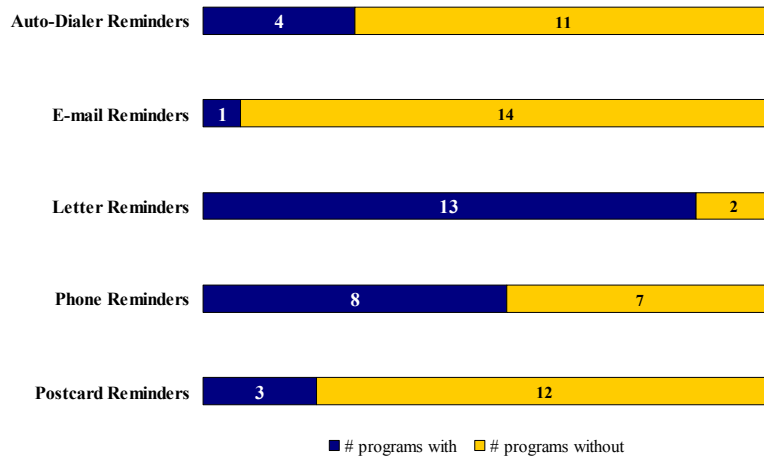
11. Is there anything else you would like to tell me?

Thank you for your time. Your answers will help us make the renewal process better. Goodbye.

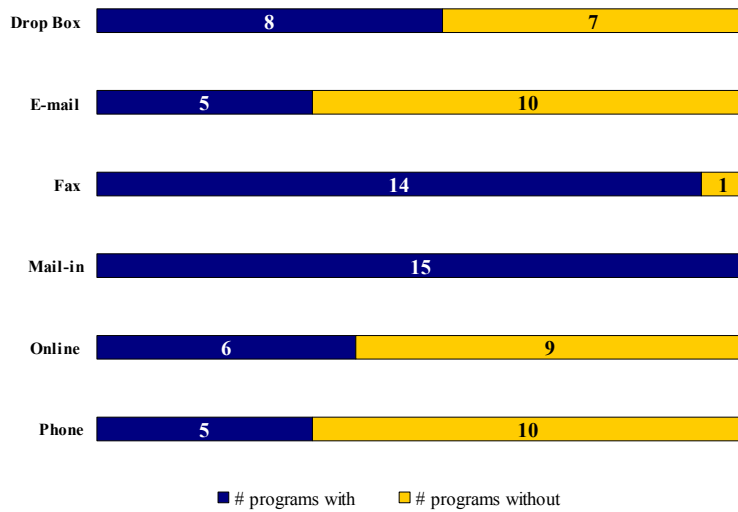
Appendix D



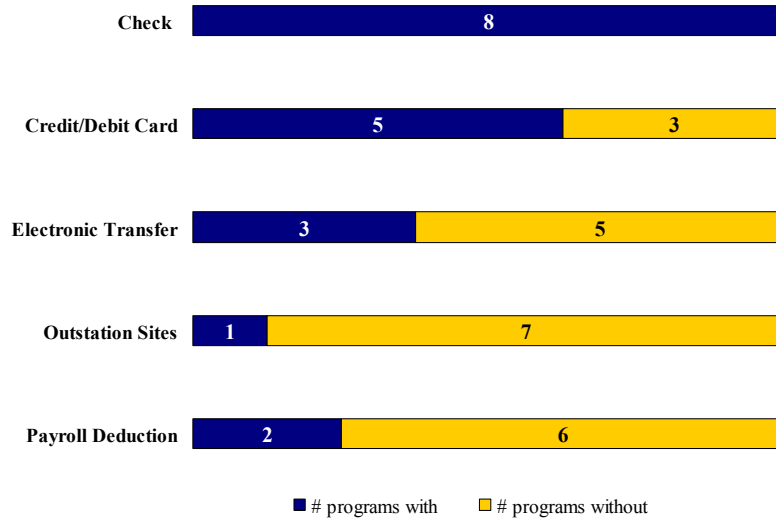
Renewal Reminder Options



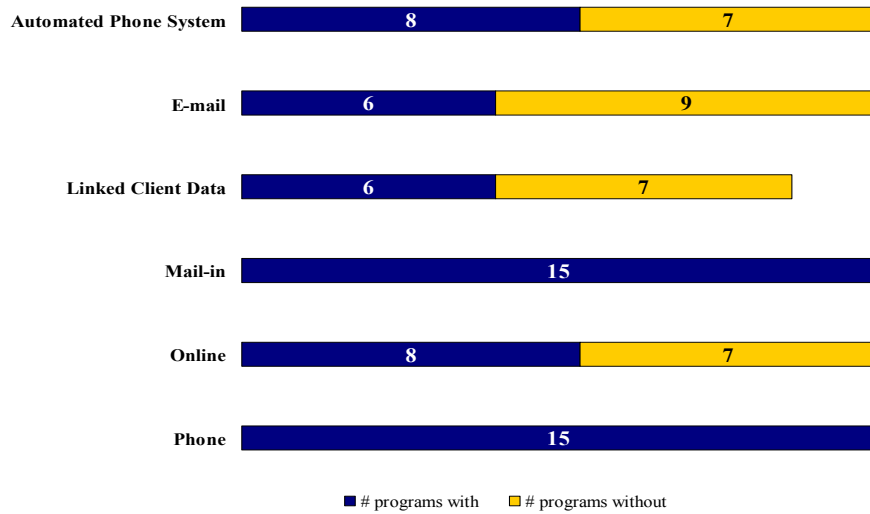
Renewal Submittal Options



Cost Sharing Payment Options



Reporting Household Changes



Retention Initiative: Achieving Stability In Medicaid and CHIP Coverage -- Renewal Policies and Procedures for Medicaid and CHIP																	
Renewal Policies and Procedures		Alabama		Florida		Iowa		New Hampshire		New Mexico		Pennsylvania		Texas		Washington	
		Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid/Expansion	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	
Coverage Period	# of months	12	12	12	12	12	12	12	12	12	12	12	12	6	12	12	12
12-Month Cont. Eligibility	Y or N	Y	Y	Y for < 5	Y	Y	Y	N	N	N	N	Y	N	Y	Y	Y	Y
Proof of Income Required	Y or N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Face to Face Interview	Y or N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Signature Required	Y or N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	N	N
Joint Renewal Form	Y or N	Y	Y	?	N	N	N	Y	Y	Y	N	N	Y	Y	Y	Y	Y
Pre-populated Renewal Form	Y or N	Y	Y	N	Y	N	Y	N	N	Y	N (3)	Y (6)	Y	Y	Y	Y	Y
Downloadable Renewal Form	Y or N	N	N	Y	Y	N	N	Y	Y	N	N	N	Y	Y	Y	Y	Y
Online Renewal	Y or N	N*	N*	N	Y	N	Y	N	N	N	Y	Y	N	N	Y	Y	Y
Electronic Signature	Y or N	Y	Y	N	Y	Y	Y	N	N	N	Y	Y	Y	N	N	N	N
Renewal Reminders	Auto Dialer	Y or N	N	N	Y	N	N	N	Y	N	N	N	N	N	N	Y	Y
	E-mail	Y or N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
	Letter	Y or N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
	Phone	Y or N	N	N	N	Y	Y	Y	Y	Y	N	Y	N	N	Y	Y	Y
	Postcards	Y or N	N	Y	N	Y	N	Y	N	N	N	N	N	N	N	N	N
Closure Date Extended for Pending Verification Documents	Y or N	Y	Y	by request	Y	N	N	Y	Y	Y	N (4)	N (7)	N	N	Y	Y	Y
	if Y, # of days	60	30	10	30			10	10	30	60					until redetermined	until redetermined
Ex-Parte Renewal	Food Stamps	Y or N	N	N	N	N	N	N	N	Y	N	N	N	N	N	Y	Y
	TANF	Y or N	N	N	N	N	N	N	N	Y	N	N	N	N	Y	Y	Y
	WIC	Y or N	N	N	N	N	N	N	N	N	N	N	unknown	unknown	N	N	N
Express Renewal	Y or N		N	N	N	N	N	N	N	Y		N	N	N	Y	Y	
Options for Submitting Renewal	Drop Box	Y or N	Y	N	Y	N	Y	N	N	Y	Y	N	N	N	N	Y	Y
	E-mail	Y or N	N	Y	N	Y	N	Y*	Y*	Y	N	N	N	N	N	N	N
	Fax	Y or N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Mail-in	Y or N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Online	Y or N	N*	N*	N	Y	N	Y	N	N	N	Y	Y	N	N	Y	Y
Phone	Y or N	Y	N	N	N	N	N	N	N	Y	N	Y	N	N	Y	Y	
Premium / Cost Sharing Frequency	Y or N	N	Y	N	Y	N	Y	N	Y	N	Y (5)	Y	N	Y	N	Y	
	if Y, frequency	n/a	annually	n/a	monthly	n/a	monthly	n/a	monthly	n/a	monthly	monthly	n/a	annually	n/a	monthly	
Premium / Cost Sharing Payment Options	Check	Yes	n/a	Y	n/a	Y	n/a	Y	n/a	Y	n/a	Y	Y	n/a	Y	n/a	Y
	Credit/Debit Card	Yes	n/a	Y	n/a	Y	n/a	N	n/a	N	n/a	Y	Y	n/a	Y	n/a	N
	Electronic Transfer	Yes	n/a	N	n/a	Y	n/a	N	n/a	Y	n/a	N	Y	n/a	N	n/a	N
	Outstation Sites	Yes	n/a	N	n/a	N	n/a	N	n/a	N	n/a	N	Y	n/a	N	n/a	N
Payroll Deduction	Yes	n/a	N	n/a	Y	n/a	N	n/a	N	n/a	Y	N	n/a	N	n/a	N	
	Yes	n/a	N	n/a	Y	n/a	N	n/a	Y	n/a	N	Y	n/a	N	n/a	Y	
Penalty Wait Period for Non-Payment	Y or N	n/a	N	n/a	Y	n/a	N	n/a	Y	n/a	N	Y	n/a	N	n/a	Y	
	if Y, # of months	n/a	n/a	n/a	2	n/a	n/a	n/a	3	n/a	n/a	6	n/a	n/a	n/a	3	
Reporting Changes	Central Automated Phone System	Y or N	Y	Y	Y	Y	Y	N	N	N	N	N	Y	Y	N	N	
	E-mail	Y or N	Y	Y	N	Y	N	Y*	Y*	Y	N	N	N	N	N	N	
	Linked Customer Data	Y or N		N	Y	N	Y	N	N	N	Y	?	N	N	Y	Y	
	Mail-in	Y or N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	Online	Y or N	some	Y	Y	N	N	N	N	N	Y	Y	N	N	Y	Y	
Phone	Y or N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

NOTE: Changes made after August 2007 are in red text. Information is current as of 3/26/09.

(1) Can use online application

(2) By customer request

(3) December 2008 - Pre-populating only Select Plan for Women category (Family Planning Waiver).

(4) The closure date is not extended. However, at application or renewal, the individual may have an eligibility determination without a new application if they submit their information within 60 days.

(5) The only program that requires payment of a premium is Medical Assistance for Workers with Disabilities (MAWD). Premiums are due by the end of the month.

(6) Pre-populated renewal forms are currently used by 3 out of 8 contractors. We are currently in the process of requiring all contractors to use pre-populated renewal forms.

(7) May 2008 Policy Change - If the renewal process is completed within 60 days of closure, benefits are reinstated w/o lapse in coverage.



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