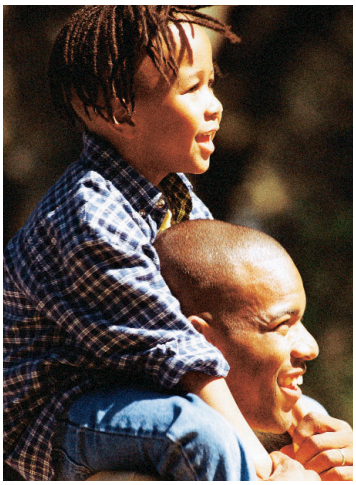
Covering Kids & Families Primer



UNDERSTANDING POLICY AND IMPROVING ELIGIBILITY SYSTEMS

PREPARED FOR

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SOUTHERN INSTITUTE ON CHILDREN AND FAMILIES

DECEMBER 2002

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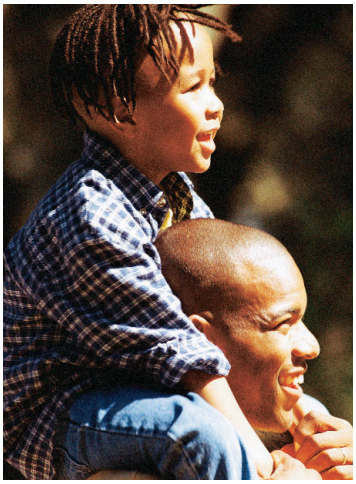

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DECEMBER 2002

BY

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INTRODUCTION

Covering Kids and Families (CKF) is a national initiative of The Robert Wood Johnson Foundation offering $55 million in grants to increase the number of eligible children and adults who are benefiting from federal and state health care coverage programs. Working through broad statewide and local coalitions, this four-year initiative will build on the work and experience of the Foundation's current Covering Kids initiative (1997-2002). CKF also will work with new eligible populations and seeks to build enduring national and regional capacity to carry on program activities beyond its funding period.

Covering Kids and Families Call for Proposals
The Robert Wood Johnson Foundation, May 2001

From 1998-2002, The Robert Wood Johnson Foundation (RWJF) Covering Kids (CK) initiative provided public and private organizations across the nation with invaluable learning and collaborative opportunities. CK coalitions in all states and the District of Columbia came together to design and implement outreach, simplification and coordination strategies to help more eligible uninsured children become enrolled in public health care coverage programs. CK had a greater capacity for obtaining results because a national network of information sharing and strategy development that facilitated relationships and even formal partnerships was developed.

The sustained commitment of RWJF led to the May 2001 announcement of a new four-year Covering Kids & Families (CKF) initiative.[1]

[1] For information on CKF awarded grants, please visit the web site at www.coveringkids.org.

COVERING KIDS AND FAMILIES GOALS

The CKF initiative is positioned to make significant progress toward the following three goals:

GOAL 1: Reduce the number of uninsured children (in all CKF-funded states) who are eligible for Medicaid or State Child Health Insurance Program (SCHIP) coverage but remain uninsured.

GOAL 2: Reduce the number of uninsured adults (in all CKF-funded states) who are eligible for Medicaid or SCHIP coverage but remain uninsured.

GOAL 3: Build knowledge, experience and capacity to achieve an enduring national and regional commitment to sustain beyond the grant period the enrollment and retention of children and adults in Medicaid or SCHIP.

The three strategies utilized during CK will continue to guide efforts by CKF coalitions to achieve the CKF goals. The three strategies must be addressed by all statewide and local CKF coalitions:

- Conduct and coordinate outreach programs;
- Simplify enrollment and renewal processes; and
- Coordinate existing health care coverage programs.

This paper focuses on the first two CKF goals, elaborates on the strategies, discusses some of the activities associated with each and identifies ways to ascertain whether statewide and local coalition efforts are successful.

MAKING A DIFFERENCE

The CKF goals one and two are not simply broad statements on reducing the number of uninsured children and adults. The goals focus on maximizing enrollment of uninsured children and adults who are eligible for but not covered by Medicaid or SCHIP. As was the case with Covering Kids, CKF is not an eligibility expansion initiative. CKF is designed to work within federal and state Medicaid and SCHIP income-eligibility levels.

In assessing whether the goals are being addressed, one of the first questions CKF coalitions should ask is, "**How will we know if we are making a difference?**" The most frequently used source for estimating and tracking the number of uninsured children and adults is the US Census Bureau's Current Population Survey (CPS), conducted in March of each year. The CPS provides estimates of uninsured children and adults for the nation and includes breakdowns by state. While steps have been taken in recent years to improve the CPS samples and survey instrument, many people in the field believe that the estimates for their states are not accurate and do not reflect local efforts. CPS data, however, are the most relied upon source for uninsured estimates.

For CKF coalitions, the issue of data selection for evaluating the effectiveness of their enrollment efforts can be resolved with a manageable alternative to CPS data. Statewide and local coalition efforts are directed at enrolling and retaining children and adults who are currently eligible for Medicaid and SCHIP. The best

measurement of overall difference made by CKF partners is the level of change observed in Medicaid and SCHIP caseloads. Given the current economy and lack of private insurance options for low-income families, a considerable reduction in the number of uninsured children and adults will require a significant increase in enrollment and retention of those currently eligible for Medicaid and SCHIP.

To determine whether a difference is being made, each statewide and local coalition can establish a running record of child and adult monthly caseloads for Medicaid and SCHIP. "Caseload" is an important term, and each statewide and local coalition should be aware of what it means in their state. Depending upon a state's data system, caseload could be a count of cases that may include multiple persons, such as parents and children within a family. Some states count individuals so that each case is an individual. Although there is no general preference, it is important to build knowledge about the state's data terminology and to ensure consistency in using either individuals or multiple persons in defining caseloads.

To reduce the verbiage, coalitions can say they want to undertake activities that will increase the Medicaid and SCHIP caseload. In its simplest form, caseloads are composed of two components: 1) decisions on applications, and 2) decisions on retaining covered children and adults. Caseloads can be increased when the number of applications approved increases and/or when the number of closures decreases. Below in Figure 1 is a simple equation that should serve as an overall guide.

Figure 1: Caseload Equation

Caseload (at beginning of the month)
\+ Applications Approved (during the month)
\- Cases Closed (during the month)

= Caseload (at beginning of next month)

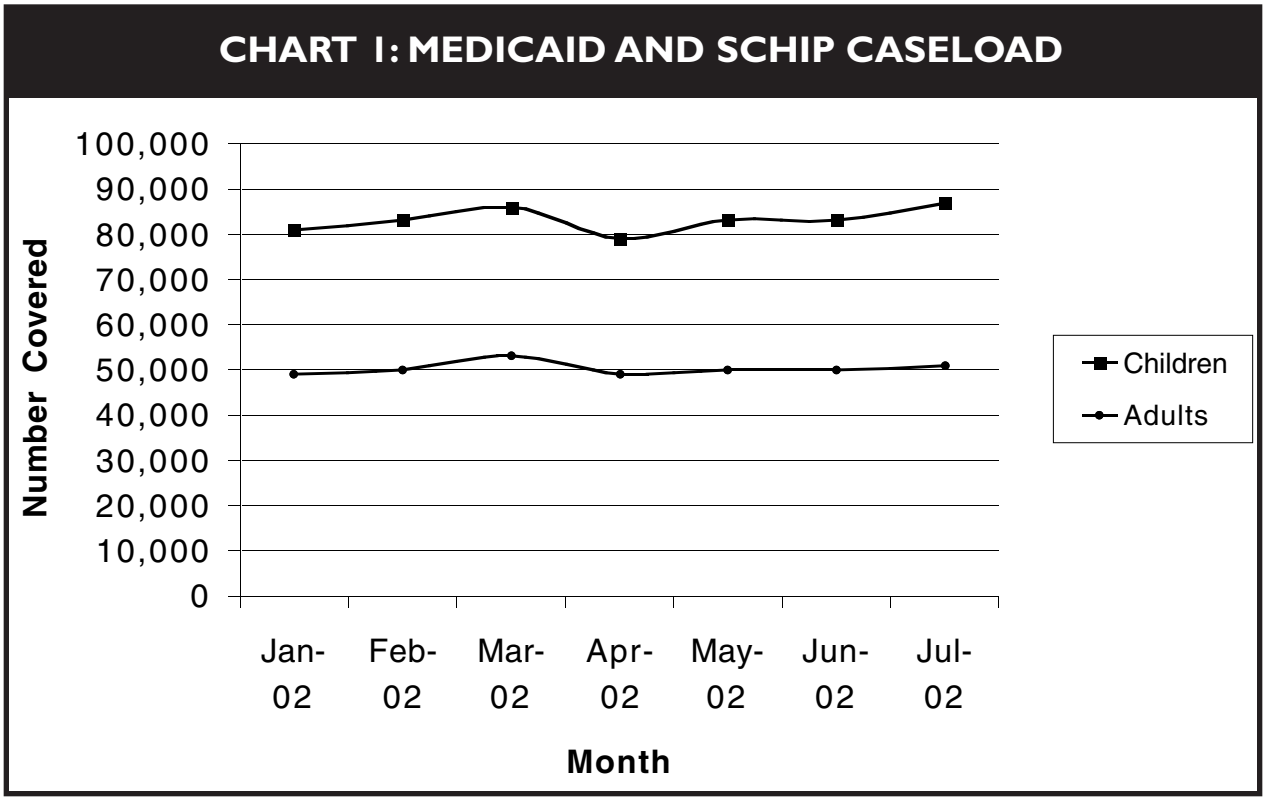
A fairly common area of confusion in reviewing eligibility data occurs when the data are labeled "number enrolled." This label is sometimes used to mean the number who were approved for coverage over a period of time, and other times it refers to a count of the number of children covered at a point in time. A good illustration of the difference is found in an analysis of SCHIP enrollment data. The analysis showed that a total of 4.6 million children were ever enrolled in SCHIP between October 2000 and September 2001, but only a total of 3.5 million children were enrolled in SCHIP during the month of December 2001.[2] Both numbers are valid. The former indicates a number of enrollees over a span of time while the latter indicates those that are enrolled at a specified point in time.

A CASELOAD NUMBER REFERS TO AN UNDUPLICATED COUNT OF THE NUMBER COVERED AT A POINT IN TIME. THE CASELOAD NUMBER REFLECTS THE NET CHANGE IN ENROLLMENT BY OFFSETTING APPLICATIONS APPROVED WITH CASES CLOSED.

A caseload number refers to an unduplicated count of the number covered at a point in time.

[2] Vernon K. Smith and David Rousseau, SCHIP Program Enrollment December 2001 Update (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, June 2002) p. 2-3.

CHART 1: MEDICAID AND SCHIP CASELOAD



The caseload number reflects the net change in enrollment by offsetting applications approved with cases closed. State and local eligibility office partners can be of significant assistance by providing caseload data on a monthly basis and helping coalition members understand the meaning of the data as they change over time. A run chart can be constructed by plotting the monthly caseload so that changes to the number of covered children and adults can be easily determined, as shown in Chart 1.

STRATEGIES

The CKF has adopted the three strategies of outreach, simplification and coordination as key to enrolling and retaining eligible children and adults. All statewide and local coalitions are required to implement activities within each of the three strategic areas. Significant reductions in eligible but uninsured children and adults will not occur without attention to all three strategic areas. Each strategic area will be discussed as it relates to the caseload equation set forth on page 4.

CONDUCT AND COORDINATE OUTREACH PROGRAMS

The ultimate reason for outreach is to generate applications from children and adults who are potentially eligible for Medicaid or SCHIP coverage. It is important to target messages to children and adults who fall within eligibility guidelines. The methods implemented to reach out to potentially eligible persons are quite varied

but, in general, relate to three primary activity areas:

- Awareness of Coverage
- Call to Action
- Application/Renewal Assistance

Awareness of Coverage

An important outreach activity is to increase awareness of the availability of coverage programs. Many families do not know that their children or the family may be eligible for coverage under Medicaid or SCHIP. Increasing awareness of the possibility of coverage among the potentially eligible population is a necessary step toward the generation of applications that can be approved. In addition, awareness-building activities should include members of the general population because they have contact with potentially eligible persons.

Call to Action

Awareness alone is not sufficient. Outreach strategies should include a call to action based on information regarding potential health care coverage. Coalitions should determine the action they want the potentially eligible population to take. For example, the Covering Kids Back-to-School Communications Campaign[3], administered by GMMB, encourages families with potentially eligible children to call a state or national hotline number to obtain more information about health care coverage.

During the Back-to-School 2001 Communications Campaign, there was an average increase of 147 percent in calls to target market hotlines during the campaign.[4] Evaluating the change in the volume of hotline calls will enable coalitions to determine the impact of the call to action. If, however, a state or local coalition launches a campaign intended to prompt families to submit a Medicaid or SCHIP application, the measure of success would be an increase in the number of applications submitted during and for several months following the campaign period.

Application/Renewal Assistance

For many families, awareness and an application in hand are not enough. Application assistance should be available by telephone and in-person with qualified assisters, including some with multilingual abilities, in a variety of locations that are easily accessible by families. In addition, home visits should be available upon request. For some families, individualized assistance is needed

[3]The Covering Kids Communications Campaign is administered by GMMB under the direction of The Robert Wood Johnson Foundation, and in cooperation with the Covering Kids and Families National Program Office.

[4]GMMB, "Back-to-School Synopsis of Achievements," prepared for Covering Kids Communications Boot Camp, April 22-24, 2002.

KIDS HEALTH INSURANCE WEEK IN HAWAI'I*

Hawai'i Covering Kids sponsored Kids Health Insurance Week from August 8-15, 2001, targeting children of working parents to get them enrolled in the state's free QUEST and Medicaid Fee-for-Service programs.

Awareness of Coverage

A broad-based group of partners, including the lieutenant governor and all four of the state's mayors, highlighted the need for health insurance by issuing proclamations, sponsoring outreach events and distributing information.

Hawai'i Covering Kids

- Was the focus of 14 radio and television interviews;
- Received coverage in 5 major newspaper articles; and
- Sponsored paid advertisements on 5 television stations, 21 radio stations, and 10 newspapers.

Call to Action

As a result of these awareness activities, 1,331 calls were made to the hotline, and 3,812 persons visited the Hawai'i Covering Kids web site during August.

Application/Renewal Assistance

In August, the state's Med-QUEST agency received 1,347 applications above the monthly average.

The campaign resulted in an additional 1,169 kids being covered by the state's Med-QUEST expanded programs.

*Barbara Luksch, *Kids Health Insurance Week: Our Successful Marketing and Media Outreach Campaign* (Honolulu, HI: Hawai'i Covering Kids, December 2001) p. 4.

to help the family complete and submit an application.

Assistance with completion of renewal forms at the end of the coverage period also should be provided for families. Assistance by telephone or in-person by qualified assisters in a variety of locations during non-traditional hours of operation is extremely important if families are to retain coverage. As stated previously, home visits should be available upon request.

As outlined above, coalitions should understand how their outreach activities are expected to

affect Medicaid and SCHIP caseloads. A critical factor is to focus on and generate applications from children and families who are potentially income-eligible. For example, are materials and ads worded to attract families who are likely to be approved? Developing strategies based on what is learned from demographic data is an effective way to improve targeting of outreach efforts. Are a target area's low-income uninsured children adolescents or preschoolers? What is the ethnic and cultural mix of families within the target area?

SIMPLIFY ENROLLMENT AND RENEWAL PROCESSES

Effective eligibility systems should provide coverage to children and adults who fall within eligibility guidelines. The purpose of simplification is to remove policy and procedural barriers that impede or prevent eligible children and adults from enrolling and retaining health care coverage.

Outreach results are diminished when applications are too difficult to complete and submit. An eligibility system that requires improvements is one that erroneously denies applications submitted on behalf of children and families who are, in fact, eligible. The same is true of eligibility systems that close or stop coverage for eligible children or eligible families. Eligibility systems are composed of three interactive parts: 1) automated eligibility systems; 2) processes; and 3) people.

During the eligibility determination period, any or all of the three interactive components can deny eligibility or stop coverage inappropriately. Attention to all three components is essential to the development of improved systems.

Automated Eligibility Systems

Many computer systems are programmed to make automated eligibility decisions and to stop coverage according to programming instructions

KANSAS IMPROVES ITS COMPUTER SYSTEM*

An example of a state department that took action to correct a problem is the Kansas Department of Social and Rehabilitation Services (SRS). A study of Medicaid and SCHIP covered children in Kansas found that even when continuous coverage is guaranteed for 12 months, coverage for a significant number of children was stopped prematurely. Only 73% of children remained covered at the end of 12 months. A major reason was that the computerized eligibility system had not been reprogrammed to implement the continuous coverage policy.

In March of 2000, Kansas reprogrammed its computer eligibility system in order to eliminate automatic redeterminations during the 12-month continuous coverage policy.

*R. Andrew Allison, Barbara J. LaClair, and Robert F. St. Peter, "Dynamics of HealthWave and Medicaid Enrollment: Into, Out of, and Between Two State Programs," Issue Brief, Number 11 (Topeka, KS: Kansas Institute of Health, March 2001) p. 3-4.

FOR MANY FAMILIES, AWARENESS AND AN APPLICATION IN HAND ARE NOT ENOUGH. APPLICATION ASSISTANCE SHOULD BE AVAILABLE BY TELEPHONE AND IN-PERSON WITH QUALIFIED ASSISTERS, INCLUDING SOME WITH MULTILINGUAL ABILITIES, IN A VARIETY OF LOCATIONS THAT ARE EASILY ACCESSIBLE BY FAMILIES.

without a case-by-case review by an eligibility worker prior to the computer action. The automated decisions to stop coverage should be carefully reviewed by reason for stopping coverage to ensure that eligible children and families do not lose coverage inappropriately.

Processes

There are two times when eligibility can be decided. The first time, which has received the most attention in recent years by CK initiatives, is related to entry or enrollment into Medicaid or SCHIP. The other time is when eligibility is reviewed during the coverage period to determine whether the child or adult continues to be eligible. Federal Medicaid and SCHIP rules require that a covered person's eligibility be reviewed at least once every 12 months. The timing of this review varies by state and is dependent upon state-specified coverage periods. States typically require families to report changes in their circumstances that occur during the coverage period within 10 days, such as a change in income or family size, so that eligibility can be reviewed. However, in states where the continuous eligibility option has been adopted, changes are not required to be reported during the coverage period.

Enrollment Into Medicaid and SCHIP

Simplification of policies and procedures relates directly to the number of applications approved in the caseload equation. Many states have adopted policies that simplified the application, eliminated asset tests, eliminated face-to-face interviews and allowed the applicant to self-declare citizenship, children's ages, and family income. The purpose of these types of policy changes is to remove barriers to completing the application process.

For each application submitted, there are three possible outcomes:

- The applicant withdraws the application;
- The application is approved; or
- The application is denied.

FIGURE 2: APPLICATION DECISION PROCESS

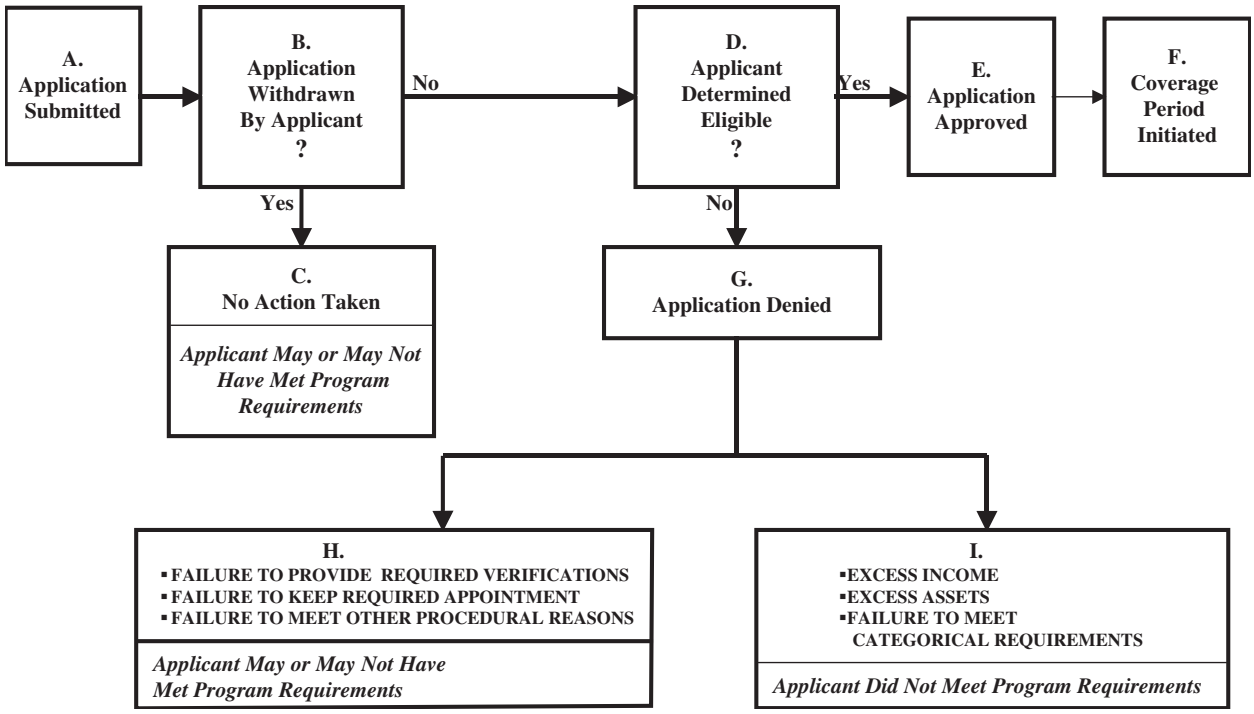


Figure 2 depicts the general sequence of eligibility decisions and outcomes. The precise wording of actions may vary by state.

Applications Withdrawn. At any time in the application decision process, an applicant can ask that the application be withdrawn and no further action taken. Coalitions should monitor the number of withdrawals to determine whether the system is somehow discouraging applicants from completing the application process.

Approvals. Approval is based upon a review of the completed Medicaid or SCHIP application and verification documents. A decision is then made that the applicant is eligible and coverage can be initiated.

Denials. The automated computer system or eligibility staff can deny applicants for a number of reasons. There are two types of denial reasons. The first is a denial of ineligible applicants because of excess income or excess assets or because of reasons related to other categorical eligibility requirements such as age.

The second type of denial is a procedural denial. A procedural denial is not the result of a decision that the applicant has excess income, excess assets or otherwise does not meet an eligibility criterion. The major reasons for

procedural denials are lack of required verification documents, failure to keep interview appointments, or failure to return information. It has been shown that denials of eligible applicants for procedural reasons could be avoided through simplification efforts.

Many states have attempted to eliminate or reduce procedural barriers in a variety of ways. Two common methods to reduce policy and procedural barriers are to eliminate a requirement to have face-to-face appointments and to reduce or eliminate certain verification documents. For example, the process for documenting the value of a vehicle is very time-consuming for workers and applicants. The vehicle test verification requirement is widely recognized as an unreasonable barrier to health care coverage for low-income families who need a vehicle in order to get to work and to access health care. States can eliminate the asset test for vehicles or allow families to declare the value of a vehicle. For children's coverage, almost all states have recognized the burden of a vehicle assets test and have eliminated this requirement.

MANY STATES HAVE ATTEMPTED TO ELIMINATE OR REDUCE PROCEDURAL BARRIERS IN A VARIETY OF WAYS. TWO COMMON METHODS TO REDUCE POLICY AND PROCEDURE BARRIERS ARE TO ELIMINATE A REQUIREMENT TO HAVE FACE-TO-FACE APPOINTMENTS AND TO REDUCE OR ELIMINATE CERTAIN VERIFICATION DOCUMENTS.

Review of Medicaid and SCHIP Eligibility

States have several options regarding how frequently within a 12-month period they can review eligibility. According to a state survey administered by the Center on Budget and Policy Priorities, as of January 2002, states had adopted the following policies related to renewal of child health coverage:

- Forty-two (42) states, including DC, review eligibility every 12 months for Medicaid and separate state SCHIP programs;
- Eight (8) states have chosen to review eligibility every six months for Medicaid or SCHIP; and
- One (1) state reviews eligibility for children covered by Medicaid every month.

Of the 42 states that review coverage every 12 months, 17 states have adopted a federal option to guarantee continuous Medicaid and SCHIP coverage of children for a full 12-month period.[5] In those states that do not guarantee continuous coverage, families are required to report any changes in family size or income within a few days so that eligibility can be reviewed. The simplified policy of renewal only at the end of a guaranteed continuous coverage period removes barriers for families and can eliminate a sizable administrative workload for eligibility staff.

According to a study by Mathematica Policy Research, Inc. the administrative costs associated with eligibility staff processing disenrollments, re-enrollments, and renewals ranged between 2 percent and 12 percent of overall Medicaid administrative costs during fiscal year 1995.[6]

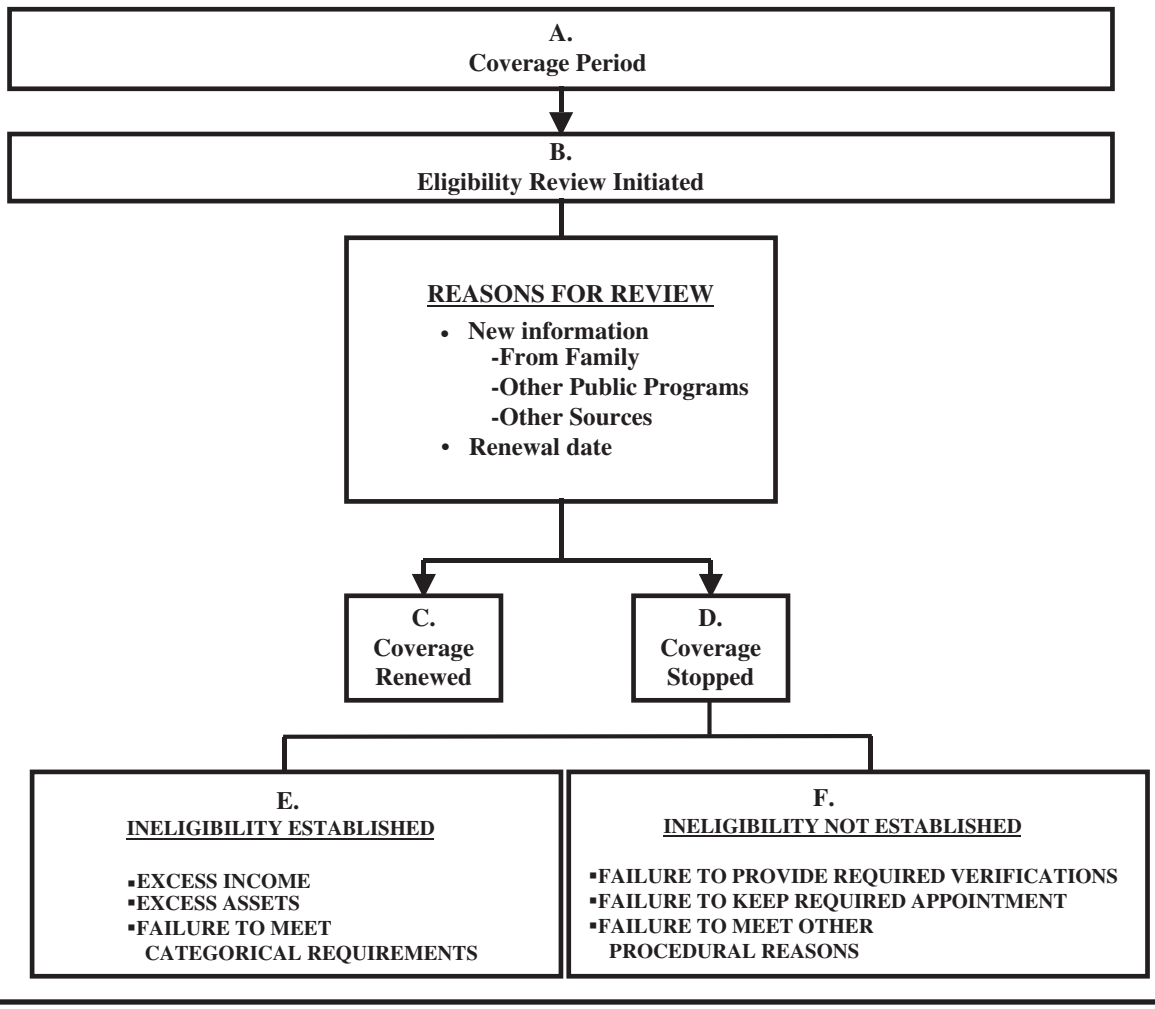
[5] Donna Cohen Ross and Laura Cox, Enrolling Children and Families in Health Coverage: The Promise of Doing More (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2002) p. 34.

[6] Carol Irvin, Deborah Peikes, Chris Trenholm, and Nazmul Khan, Discontinuous Coverage in Medicaid and the Implications of 12-Month Continuous Coverage for Children, Final Report (Cambridge, MA: Mathematica Policy Research Inc., October 24, 2001) p. 38.

Assessment of Eligibility During the Coverage Period. During the coverage period, assessment of eligibility should take place according to policy. Because the eligibility system is a complex interaction of automated eligibility systems, processes and people, coalitions should be diligent in monitoring how or whether approved policies are implemented in the computer system programming, in eligibility staff training, and in eligibility office procedures. Figure 3 illustrates how coverage can be inappropriately stopped during a coverage period.

Specified Renewal Period. Toward the end of a specified coverage period, families are notified in writing that action is needed in order to continue coverage. Families must update information, either by submitting income and other

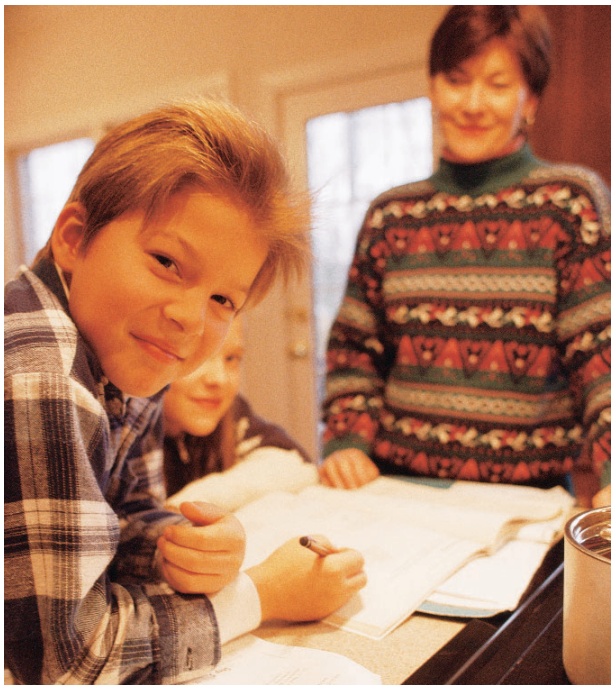
FIGURE 3: MEDICAID AND SCHIP ELIGIBILITY REVIEW PROCESS



verification documents or by self-declaring information required by the agency to renew eligibility. Some states send families preprinted forms that list family information related to program eligibility in order for a family to verify the accuracy of the information. Some states require that the form be signed and returned. In other states, if the information sent to the family is correct, the family need not return the form or contact eligibility staff.[7]

Based on a state's policies regarding the coverage renewal process, a decision is made to continue coverage or to stop coverage and close the case. The reasons for stopping coverage are very similar to the application denial reasons discussed above. The results are also similar in that far too many cases are closed due to inadequate information or procedural reasons, when in fact ineligibility has not been established.[8]

Coalitions should closely examine the reasons coverage is stopped. Coverage should be stopped only when ineligibility is established for all possible Medicaid coverage categories and SCHIP, based on eligibility criteria related to excess income, excess assets (if tested) or for reasons related to program eligibility requirements such as age. Case closures due to procedural reasons related to the renewal process rather than to program eligibility criteria should be examined fully to identify barriers that result in inappropriate closures and loss of health coverage. Elimination of renewal process barriers



reduces the number of children and families who have coverage stopped for procedural reasons.

Research conducted under the Child Health Insurance Research Initiative (CHIRI) found that Florida's passive renewal policy for SCHIP resulted in only 5 percent of children's cases being closed at renewal, compared to one-third to one-half of children in Kansas, Oregon, and New York where a passive renewal process was not used. Further, it was noted that up to one-quarter of children who were dropped at renewal from SCHIP programs in Kansas, Oregon, and New York returned two months later.[9] It is likely that those children were eligible at the time that coverage was stopped and should have maintained coverage.

[7] This process of sending families information that the agency has in its system and having families only contact the agency if there are updates to that information is called passive renewal.

[8] Supporting Families After Welfare Reform administrative reports. Supporting Families is a national program by The Robert Wood Johnson Foundation with leadership provided by the Southern Institute on Children and Families. Further information can be found at www.supportingfamilies.org.

[9] "The Consequences of States' Policies for SCHIP Disenrollment," was published in the June 2002 issue of Health Care Financing Review as part of a series of studies being done by the Child Health Insurance Research Initiative (CHIRI) project. CHIRI is jointly sponsored by the Agency for Healthcare Research and Quality (AHRQ), the David and Lucile Packard Foundation, and the Health Resources and Services Administration.

People

The third and perhaps most critical component in the eligibility system is people. It is the people who ultimately make the difference with implementation of policies and procedures. By putting policies into practice, people have the most powerful affect on enrollment and retention. Therefore, efforts to enroll and retain children and families in health care coverage programs must be collaborative to include eligibility staff, community representatives, and other key players. Each player must be aware of program rules and regulations.

...ONE REASON CHILDREN CONTINUE TO LOSE COVERAGE EARLY IS BECAUSE CASEWORKERS PREMATURELY REVIEW HEALTHWAVE AND MEDICAID ELIGIBILITY AS NEW INFORMATION IS RECEIVED FROM FAMILIES DURING THE GUARANTEED 12-MONTH COVERAGE PERIOD.

"What gets monitored–gets done!" By adopting this motto in the Charleston County, South Carolina, eligibility office, staff developed performance standards and measurement tools to improve eligibility outcomes. Their mantra, vocalized at their meetings, became "More Approvals Than Denials" and "In and Out in 30 Days." By focusing on the desired outcomes and putting simplification policies into practice, over time the eligibility unit achieved a fairly stable 95 percent approval rate (up from about 50 percent). The unit also started processing applications on a "same day/next day" basis.[10]

The Kansas HealthWave Evaluation Project performed research to determine why there was so much movement in, out of and between the state's HealthWave and Medicaid programs. After correcting an automated eligibility system programming problem that was erroneously stopping children's coverage prior to the end of the guaranteed 12-month period, the state still found that a large number of children were being dropped prematurely from both programs. The administering agency believes that one reason children continue to lose coverage early is because caseworkers prematurely review HealthWave and Medicaid eligibility as new information is received from families during the guaranteed 12-month coverage period.[11]

It was previously suggested that coalitions could develop run charts on changes to caseloads over time. Run charts also can be developed to track monthly the major factors of the caseload equation, application approvals and case closures in order to identify potential problems or barriers.

[10] Helen Thomas, "Using Data as a Supervisory Tool to Track Worker Performance," Presentation at Supporting Families After Welfare Reform 2001 Annual Meeting, Annapolis, MD, November 16, 2001.

[11] R. Andrew Allison, Barbara J. LaClair, and Robert F. St. Peter, "Dynamics of HealthWave and Medicaid Enrollment: Into, Out of, and Between Two State Programs," Issue Brief, Number 11 (Topeka, KS: Kansas Institute of Health, March 2001) p. 4.

COORDINATING EXISTING HEALTH CARE COVERAGE PROGRAMS

Coordination of coverage is a major CKF strategy. Coordination must occur among Medicaid eligibility categories and across Medicaid and SCHIP. CKF coalitions should examine how well the eligibility system is coordinated between the low-income family eligibility category, Section 1931, the Transitional Medical Assistance category, the poverty-related eligibility category for children and SCHIP in separate state programs. These categories are discussed below, and an excellent primer on these issues is a Covering Kids report titled, The Ins and Outs of Delinking: Promoting Medicaid Enrollment of Children Who Are Moving In and Out of the TANF System.[12]

The Medicaid program has a number of eligibility categories under which children and adults may be eligible. Each eligibility category has its own eligibility guidelines. The variation in the eligibility guidelines ranges from minor to major in how the guidelines set limits or definitions on age, functional ability, income, assets, marital status, living arrangements, number of hours worked, and more. Layered on top of "regular" Medicaid are separate state SCHIP programs and Medicaid and SCHIP waivers that allow states to develop different enrollment and renewal policies and procedures. Federal Medicaid guidelines require that eligibility opportunities be searched and ineligibility be established in each potential Medicaid eligibility category prior to denial or closure. Federal SCHIP law requires that ineligibility for Medicaid be established prior to approval for SCHIP coverage.[13]

Coverage is coordinated when it is seamless and variations between eligibility categories and programs are not apparent to applicants or to those with coverage. Coverage should be coordinated by the three interactive parts of the eligibility system rather than by the family so that the family need not receive notices of denial for every eligibility category for which the members were considered. The family should not have to know program details in order to apply for coverage, nor should decisions on coverage be delayed as information is transferred between programs.

When the system is not coordinated, loss of health care coverage can occur without the

[12] Cindy Mann, The Ins and Outs of Delinking: Promoting Medicaid Enrollment of Children Who Are Moving In and Out of the TANF System, (Columbia, SC: Covering Kids: A National Health Access Initiative for Low-Income Uninsured Children, March 1999).

[13] 42 CFR 435.930 (b) and 42 CFR 457.350.

eligibility system reviewing all possible avenues of coverage. For instance, families cannot be covered under an SCHIP program if they do not complete the Medicaid application process and are denied for procedural reasons. This lack of coordination within the Medicaid program and between Medicaid and SCHIP, however inadvertent, can constitute a violation of federal law.[14]

Medicaid Poverty-Related Children and Pregnant Women

The federal Medicaid law established mandatory and optional coverage groups. States are required to provide Medicaid coverage for some children and families who meet income criteria related to the Federal Poverty Level (FPL).[15] While states have flexibility in counting income and resources and setting eligibility levels, the following poverty level categories are mandatory populations for which states must provide coverage:

- Pregnant women, infants and children ages one through five whose family incomes are at or below 133 percent of the FPL;
- Children up to age 19 born after September 30, 1983, in families with incomes at or below 100 percent of the FPL.[16]

Section 1931

With the implementation of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, commonly referred to as welfare reform, Medicaid eligibility was delinked from eligibility for and receipt of cash assistance. Families with children can apply for Medicaid and, if they meet the eligibility requirements for a state, must be provided with Medicaid coverage. Families can qualify for Medicaid "…even if they do not apply for or are not eligible for cash assistance."[17] Under Section 1931 of the Social Security Act, states have the option to use less restrictive income and resource policies in order to expand the number of families who can become eligible for Medicaid. "For example, a State could disregard the difference between the July 16, 1996, AFDC (Aid to Families with Dependent Children) standard and 200 percent of the Federal poverty level effectively raising the income standard for families with children to 200 percent FPL."[18]

CKF coalitions must be aware of Medicaid eligibility guidelines under Section 1931 to assure that eligible families are enrolled and retain coverage as long as they meet the eligibility guidelines.

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[14] Timothy M. Westmoreland, "Dear State Medicaid Director Letter," (Baltimore, MD: Health Care Financing Administration, US Department of Health and Human Services, April 7, 2000). The Centers for Medicare and Medicaid Services (CMS) was formerly named Health Care Financing Administration (HCFA) and is a part of the US Department of Health & Human Services. CMS has federal administrative oversight of Medicare, Medicaid and SCHIP.

[15] The Federal Poverty Level, also known as the poverty guidelines, is used administratively to determine financial eligibility based on income and family size for certain federal programs. The US Department of Health and Human Services issues the poverty guidelines each year in the Federal Register. See Appendix A.

[16] "Medicaid Eligibility" (Baltimore, MD: Centers for Medicare & Medicaid Services, US Department of Health and Human Services) http://www.cms.hhs.gov/medicaid/eligibility/criteria.asp.

[17] Mann, 1999, p. 5.

[18] Continuing the Process: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage (Baltimore, MD; Centers for Medicare & Medicaid Services, US Department of Health and Human Services, August 2002) p. 28.

SIMPLIFICATION OF PROCESSES AND COORDINATION ACROSS ALL ELIGIBILITY CATEGORIES HELPS MORE ELIGIBLE CHILDREN TO BECOME ENROLLED AND RELIEVES OVERBURDENED ELIGIBILITY STAFF.

Transitional Medical Assistance

Transitional Medical Assistance (TMA) is provided to families with children who are ineligible for regular Medicaid due to earnings from work. Families must have received regular Medicaid at least three (3) of the previous six (6) months in order to be covered under TMA. Families who lose Medicaid due to child support payments also can receive TMA for four months. Loss of Medicaid under Section 1931, not the loss of welfare, "triggers" eligibility for TMA.[19] Families can receive up to 12 months of coverage under TMA.[20]

Authorization for TMA was scheduled to expire on September 30, 2002, and Congress is currently considering proposals to extend TMA as a part of the reauthorization of the Temporary Assistance to Needy Families (TANF) block grant.

State Child Health Insurance Program

States that have separate SCHIP programs must coordinate with Medicaid. The federal law, often described as "screen and enroll," requires that states screen children for Medicaid eligibility prior to enrollment in SCHIP. A child must be enrolled in Medicaid if found eligible. Coalitions should ensure that applications, policies, and processes for enrollment and renewal for Medicaid and SCHIP are brought into line with one another so that they do not confuse families and thus discourage enrollment and maintenance of coverage.

Private Coverage

In addition to coordination across public benefits programs, CKF coalitions also should develop strategies to work with private insurance providers. For example, some states continue to operate Caring Programs, which are collaborative efforts between Blue Cross/Blue Shield and private businesses, foundations and other funders. Those children and families who are found ineligible for public coverage would be provided information about private coverage alternatives. Linking families to affordable private insurance options will help to reduce the number of uninsured children and families.

Additionally, many low-income families who have access to employer coverage are unable to afford premiums for dependent coverage. In some states, if the child meets program eligibility requirements, state Medicaid and SCHIP programs will pay a portion of the employee's premium so that a private coverage program can cover the family. Thus, coordination across public and private coverage programs can help both parents and children to be insured.

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[19] Mann, 1999, p. 6.

[20] Families receive an initial six months of coverage through TMA. If a family's earnings stay below 185% of the poverty level after child care expenses are taken into account, the family can receive an additional six months of coverage. Six states have waivers that allow them to provide TMA for more than 12 months. Families that lose regular Medicaid because of receipt of child support may receive TMA for four months. "Transitional Medical Assistance (TMA): Medicaid Issue Update," (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2002) p. 1.

SIMPLIFICATION AND COORDINATION POLICY OPTIONS

Public and private partnerships, including CK coalitions, have made strides in simplifying and coordinating enrollment and renewal policies for Medicaid and SCHIP. For a discussion of eligibility issues that have impeded access to health care coverage, see the report, Southern Regional Initiative To Improve Access to Benefits For Low Income Families With Children.[21]

Simplification of the application and renewal processes and coordination across all eligibility categories helps more eligible children to become enrolled and relieves overburdened eligibility staff from all the dotted i's and crossed t's with which

THE CENTER FOR HEALTH LITERACY AND COMMUNICATION TECHNOLOGIES' CMS SIMPLIFICATION PROJECT

During 2001, the Centers for Medicare and Medicaid Services (CMS) contracted with The Center for Health Literacy and Communication Technologies at Maximus, Inc., to develop simplified model Medicaid, Medicaid/SCHIP, and Medicaid/Food Stamp/TANF applications, along with associated notices, that states could use to revise their applications and notices.

What Makes an Easy-to Read/Use Notice or Application?

In summary, The Center found that the following elements are key to creating notices and applications targeting low-literate consumers:

- Good organization of material, with logical flow from paragraph and page to page.
- A polite and respectful tone.
- Just a few key messages per page, so that consumers can absorb the essential information.
- Repetition of key messages.
- Simple vocabulary and common terms. When it's necessary to introduce new and difficult words, it is important to explain them using more familiar words.
- Clear, uncomplicated sentences.
- A frequently repeated and easy-to-find resource for help (a toll-free phone number, along with office hours, and availability of assistive devices).
- A clear and consistent design (without elaborate design elements that interfere with readability) and plenty of white space.
- Applications should have ample fill-in space, clearly delineated sections, "in place" instructions at the point where they are needed, and simple navigation.

**Information provided by Penny Lane, Project Manager, The Center for Health Literacy and Communication Technologies, Maximus, Inc. For sample application and notice language, see Appendix B.*

[21] Sarah C. Shuptrine, Vicki C. Grant and Genny G. McKenzie, Southern Regional Initiative to Improve Access to Benefits For Low Income Families With Children (Columbia, SC: Southern Institute on Children and Families, February, 1998), p. 37-52. The report can be found at www.kidsouth.org/reports/sriFeb98/index.html.

many have had to cope. Reducing the complexity of the eligibility process can and does relieve the incredible paperwork burden for families and eligibility staff, allowing eligibility staff to become part of the community's effort to help children.[22]

JOINT APPLICATION AND RENEWAL FORMS

Almost all states with Medicaid and separate state SCHIP programs utilize a joint application for purposes of administrative efficiency and to prevent families from having to complete a second application if they are found ineligible for one program. As of January 2002, 33 of the 35 states with separate SCHIP programs use joint applications. At the same time, only 21 states use joint renewal forms.[23]

FAMILY-FRIENDLY APPLICATIONS, RENEWAL FORMS AND NOTICES

Over the past few years, states have focused attention on simplifying applications for child health coverage, and while the review forms and notices also have been assessed, improvements to these forms have been implemented at a slower pace. Many states initially viewed a shortened form as synonymous with a simplified one. With greater understanding of all required forms and procedures, agencies and advocates began to think beyond the application to include all communication and verification forms.

Applications, renewal forms and notices should minimize the use of acronyms and legal jargon. Terminology and language should be written to communicate in simple terms, and formats should have plenty of "white space" to assist in comprehension. Lack of attention to simplification of these forms can create significant enrollment and renewal barriers for children and families and diminish the results of outreach efforts.

OUTSTATIONED ELIGIBILITY WORKERS AND APPLICATION ASSISTERS

Outstationed eligibility workers and application assisters allow families to obtain enrollment and renewal assistance without the need to go to a local welfare office. Federal law requires that states outstation Medicaid eligibility determination staff at Disproportionate Share Hospitals and Federally Qualified Health Clinics for determining eligibility for pregnant women and low-income children. States have the option to outstation eligibility staff at sites other than these, including children's hospitals and schools.

According to a "Dear State Medicaid Director Letter" from the Centers for Medicare and Medicaid Services, states that had outstationed eligibility staff beyond federal law and regulation requirements experienced "…increased enrollment, a higher level of staff satisfaction and lower turnover rates, and increased overall program satisfaction on the part of families and the provider community."[24]

Application assisters can help to simplify the application and renewal processes by providing families with one-on-one help completing

22 Sarah C. Shuptrine, "At the Crossroads: Achieving Health Insurance Coverage for Texas Children," (Austin, TX: Speech Given at a Statewide Outreach Conference, January 22, 2001).

23 Cohen Ross and Cox, Table 3, p. ii.

24 Timothy M. Westmoreland, "Dear State Medicaid Director Letter," (Baltimore, MD: Health Care Financing Administration, US Department of Health and Human Services, January 18, 2001) p. 1-2.

TABLE 1: DOCUMENTATION CHECKLIST		
Documentation Requirements for Applicants	**Federal Requirements to Provide Documentation**	**State Option to Allow Self-Declaration**
Immigration status for qualified aliens	X	
Citizenship		X
Income		X
Resources		X
Date of birth		X
Residency		X
Social Security Number		X
Child care expenses		X

Source: Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage, (Baltimore, MD: Centers for Medicare & Medicaid Services, US Department of Health and Human Services, August 2001).

applications. Application assistance sites can include community-based organizations, schools, Head Start facilities, child care centers, and sites operated by other community partners that families trust and with whom families can easily communicate. Some states have agreements with community partners to provide application assistance to families in exchange for monetary reimbursement.

Local eligibility agencies also can outstation eligibility staff to conduct outreach and to assist families in applying for health care coverage. Medicaid and SCHIP administrative funds can be used to fund local eligibility staff outreach and outstationing.

FACE-TO-FACE INTERVIEWS

Face-to-face interviews are not a federal requirement for enrollment or renewal.[25] Requiring families to have an in-person interview prior to enrollment or renewal can create significant barriers for families to enroll and retain Medicaid and SCHIP coverage. Lost wages and lack of transportation are the most cited barriers when a face-to-face interview is required for enrollment and renewal. States have utilized varied strategies, including removing the face-to-face interview requirement and allowing for mail-in applications and renewal forms.

[25] Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage, p. 8.

VERIFICATION

Requesting a long list of verification documents can be burdensome for families and eligibility staff and can result in a denial or loss of coverage even though the family may be eligible. For information on federal verification requirements see The Burden of Proof: How Much Is Too Much For Child Health Coverage.[26] The Burden of Proof report, produced by the Southern Institute on Children and Families in cooperation with CMS, is in the process of being updated and will be published in the near future.

Reducing eligibility errors often has been cited as a major reason to require verification. It should be noted that during the 1990s, Medicaid quality control error rates remained below the allowed 3 percent tolerance level.[27]

Federal law requires that immigration status documentation be provided for non-citizens for enrollment in Medicaid and SCHIP.[28] As of January

TABLE 2: ASSET TESTING FOR CHILDREN'S MEDICAID AND SEPARATE STATE SCHIP AS OF JANUARY 2002

States*	Assets Test for Medicaid	Assets Test for Separate SCHIP
Colorado	Require	Eliminated
Idaho	Require	N/A
Montana	Require	Eliminated
Nevada	Require	Eliminated
Oregon	Eliminated	Require
Texas	Require	Eliminated
Utah	Require	Eliminated

*Missouri has eliminated the asset test for children's "regular" Medicaid. Children in the Medicaid expansion group are subject to a "net worth" test of $250,000.

Source: CKF National Program Office display of data from Donna Cohen Ross and Laura Cox, Enrolling Children and Families in Health Coverage: The Promise of Doing More (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2002) p. 32-33.

[26] Sarah C. Shuptrine and Kristine Hartvigsen, The Burden of Proof: How Much is Too Much for Child Care Coverage? (Columbia, SC Southern Institute on Children and Families, December 1998). The report can be found at http://www.kidsouth.org/health/burden.html.

[27] Ibid, p. 18.

[28] "For CHIP, there are no verification requirements in the CHIP law (Title XXI of the Social Security Act) or elsewhere in the Social Security Act. However, the requirements for verification of citizenship or national status under PRWORA apply to CHIP…," Shuptrine and Hartvigsen, The Burden of Proof, p. 7.

2002, 13 states required no documentation for children applying for coverage other than for immigration status if applicable.[29] Table 1 on page 20 displays a list of federal documentation requirements for Medicaid.[30] It shows that commonly used verification documents are not required by the federal government.

ASSET TESTING

States have had the option of eliminating the asset test for low-income children applying for Medicaid since 1988.[31] Most states have taken advantage of this policy option and eliminated this barrier to enrollment and renewal. Very few states require an asset test for SCHIP.

Having an asset test can contribute to the overall administrative burden and costs to agencies. Table 2 on page 21 displays data on states that require assets testing for children's Medicaid and SCHIP programs.

Prior to 1996, only a few states had eliminated the asset test for adults for health care coverage. The passage of federal welfare reform in 1996 served as a catalyst for states to simplify the enrollment and renewal processes by eliminating the asset test for adult and family coverage categories under Medicaid. States can adopt eligibility methods under Section 1931 and Section 1902 (r)(2) that are less restrictive than regular Medicaid and would allow for the elimination of asset tests for low-income family, children and pregnant women categories.[32]

ENSURING A CONSISTENT SOURCE OF PAYMENT FOR A 12-MONTH PERIOD THROUGH GUARANTEED CONTINUOUS HEALTH CARE COVERAGE BRINGS STABILITY FOR BOTH THE FAMILY AND THE PROVIDERS. THIS STABILITY GREATLY ENHANCES THE CHILD'S CONTINUITY OF HEALTH CARE.

Recent research by the Kaiser Commission on Medicaid and the Uninsured showed that besides reducing verification burdens for families, the removal of the asset test has served to help eligibility staff save time and realize administrative savings. Further, of those states that participated in the study, "No state reported an increase in its Medicaid eligibility error rate due to the elimination of the asset test."[33]

CONTINUOUS ELIGIBILITY

The SCHIP legislation passed in 1997 changed Medicaid policy by allowing states the option to provide up to 12 months of guaranteed coverage to

[29] Cohen Ross and Cox, p. 10.

[30] Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage, (Baltimore, MD: Centers for Medicare & Medicaid Services, US Department of Health and Human Services, August 2001) p. 2.

[31] Vernon K. Smith, Eileen Ellis and Christina Chang, Eliminating the Medicaid Asset Test for Families: A Review of State Experiences (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, April 2001) p. 10-13. Section 1902 (r)(2) of the Social Security Act was enacted in the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360. Similar to Section 1931 authority for parents, Section 1902 (r)(2) enables states to use "less restrictive" methodologies to count assets for poverty-level children and certain other eligibility categories, allowing a relaxation of the asset test or its elimination altogether.

[32] Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage, p. 28-29.

[33] Smith, Ellis and Chang, p. 14.

children enrolled in Medicaid. This policy option is referred to as "continuous eligibility." Continuous eligibility means that children and families remain eligible for a specified period regardless of changes in family circumstances. States also can provide a continuous coverage period shorter than 12 months.

It should be noted that states could provide 12 months Medicaid or SCHIP coverage without stipulating that it is continuous; this means the child can lose coverage during the 12-month period. If coverage is not continuous, families are responsible for reporting within 10 days a change in family circumstances, such as a change in income, so that eligibility can be reviewed. Requiring families to report changes in circumstances can result in a termination of benefits for children who may become eligible again shortly after being terminated due to fluctuation of family income. The family will then have to reapply and go through the enrollment process for coverage. This practice of moving on and off of coverage is often referred to as "churning."[34]

Table 3 on page 24 shows the states that have adopted 12-month continuous coverage as a policy option for Medicaid and/or SCHIP.

Ensuring a consistent source of payment for a 12-month period through guaranteed continuous health care coverage brings stability for both the family and the providers. This stability greatly enhances the child's continuity of health care. For further details on state coverage periods, see the data charts in Appendix C of this report.

CHILD SUPPORT ENFORCEMENT

Child Support Enforcement procedures can pose barriers to child health coverage enrollment. Many eligibility agencies and custodial parents have misunderstood the policy that no child can be denied Medicaid coverage due to lack of cooperation on the part of an adult in paternity establishment.

In December 2000, HCFA issued guidance in a "Dear State Medicaid Director Letter" stating that, under federal law, a parent's cooperation in establishing paternity and providing third-party medical liability information cannot be required as a condition of eligibility on a child-only Medicaid application. Therefore, states are not required to ask about paternity or to seek cooperation in pursuing medical support when an application for Medicaid or a redetermination is performed on behalf of a child. There are no Child Support Enforcement requirements for SCHIP.[35]

PRESUMPTIVE ELIGIBILITY: COORDINATION OF TEMPORARY AND REGULAR COVERAGE

"Presumptive eligibility can increase entry points into the children's health coverage system, speed enrollment and eliminate gaps in coverage."[36] Presumptive eligibility is a process that allows for "qualified entities" to enroll families and pregnant women in health care coverage temporarily while families complete the formal application process. In 2000, Congress expanded the definition of "qualified entities" that are

[34] Churning can also be used to refer to those children who move between coverage under Medicaid and separate state SCHIP programs. If coordination is seamless, this movement between the two programs would not be apparent to the family. However, often eligible children lose coverage because of a lack of coordination.

[35] Timothy M. Westmoreland, "Dear State Medical Director Letter," (Baltimore, MD: Health Care Financing Administration, US Department of Health and Human Services, December 19, 2000) p. 3.

[36] Cohen Ross and Cox, p. 11.

TABLE 3: STATES THAT HAVE ADOPTED 12-MONTH CONTINUOUS COVERAGE FOR MEDICAID AND/OR SCHIP AS OF JANUARY 2002

STATES	MEDICAID	SCHIP
Alabama	✓	✓
Arizona		✓
California	✓	✓
Colorado		✓
Connecticut	✓	✓
Delaware		✓
Idaho	✓	✓
Illinois	✓	✓
Indiana	✓	✓
Iowa		✓
Kansas	✓	✓
Louisiana	✓	✓
Maine	✓	✓
Michigan		✓
Mississippi	✓	✓
Montana		✓
Nebraska	✓	✓
Nevada		✓
New Mexico	✓	✓
New York	✓	
North Carolina	✓	✓
North Dakota		✓
Pennsylvania		✓
South Carolina	✓	✓
Texas		✓
Utah		✓
Washington	✓	✓
West Virginia	✓	✓
Wyoming	✓	✓

Source: CKF National Program Office display of data from Donna Cohen Ross and Laura Cox, Enrolling Children and Families in Health Coverage: The Promise of Doing More (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2002) p. 34-35.

allowed to perform presumptive eligibility to include schools and eligibility determination agencies for Section 8 Housing, Medicaid, TANF, and SCHIP.[37]

The process for presumptive eligibility should be simple so that children and pregnant women who obtain temporary coverage under this policy are immediately enrolled in regular coverage for the entire length of a state's allowed coverage period. States have reported that training of staff at qualified entities and effective tracking of presumptively approved applications are key issues if the process for presumptive eligibility is to be successful.[38]

INCOME AND AGE ELIGIBILITY CRITERIA

Over the last 15 years, more opportunities for coverage have become available through federal Medicaid amendments and through the implementation of welfare reform and SCHIP. States have built upon several Medicaid eligibility categories and then layered separate state SCHIP programs on top. In many states, the result has been that children in the same family can be covered by different eligibility categories within Medicaid. Further, one sibling may be covered by Medicaid while another is covered by a separate state SCHIP program. State coalitions should examine the differences in age and income criteria and determine whether these differences present application and/or renewal barriers.[39]

CONCLUSION

Enacting policies to simplify and coordinate application and renewal systems is the first step in removing eligibility barriers that impede access to child and family health care coverage. Assuring that simplification and coordination policies actually are implemented at the local level is essential to fully achieve the goal of a family-friendly enrollment and retention system.

[37] Frank Fuentes, "Information Memorandum: Legislation on Presumptive Eligibility for Medicaid and Final Rules for State Child Health Insurance Program (SCHIP) and Medicaid Presumptive Eligibility," (Bethesda, MD: Administration for Children and Families, US Department of Health and Human Services, August 30, 2001).

[38] Cohen Ross and Cox, p. 11. (For details on states that have adopted presumptive eligibility as a policy option, see Appendix C.).

[39] Southern Regional Initiative To Improve Access to Benefits For Low Income Families With Children, p. 26.

RESOURCES

Organization	Web site Address
Center for Law and Social Policy (CLASP)	www.clasp.org
Center on Budget and Policy Priorities (CBPP)	www.cbpp.org
Centers for Medicare and Medicaid Services (CMS)	www.cms.hhs.gov
Child Health Insurance Research Initiative (CHIRI)	www.ahrq.gov/about/cods
Covering Kids and Covering Kids & Families	www.coveringkids.org
Health Management Associates	www.hlthmgt.com
Kaiser Commission on Medicaid and the Uninsured	www.kff.org
Mathematica Policy Research, Inc.	www.mathematica-mpr.com
Maximus, Inc., The Center for Health Literacy and Communications Technologies	www.maximus.com
National Academy for State Health Policy	www.nashp.org
National Conference for State Legislators	www.ncsl.gov
National Governors Association	www.nga.gov
National Immigration Law Center	www.nilc.org
Southern Institute on Children and Families	www.kidsouth.org
State Coverage Initiatives	www.statecoverage.net
State Policy Documentation Project	www.spdp.org
The Robert Wood Johnson Foundation, Covering the Uninsured	www.coveringtheuninsured.org
State Health Access Data Assistance Center	www.SHADAC.org
Supporting Families After Welfare Reform	www.supportingfamilies.org

APPENDICES

Appendix A
2002 Poverty Levels for the Contiguous United States, Alaska, and Hawaii

CONTIGUOUS UNITED STATES

FAMILY SIZE	50%	**100%**	125%	133%	150%	185%	200%
ONE	$4,430	**$8,860**	$11,075	$11,784	$13,290	$16,391	$17,720
TWO	$5,970	**$11,940**	$14,925	$15,880	$17,910	$22,089	$23,880
THREE	**$7,510**	**$15,020**	**$18,775**	**$19,977**	**$22,530**	**$27,787**	**$30,040**
FOUR	$9,050	**$18,100**	$22,625	$24,073	$27,150	$33,485	$36,200
FIVE	$10,590	**$21,180**	$26,475	$28,169	$31,770	$39,183	$42,360
SIX	$12,130	**$24,260**	$30,325	$32,266	$36,390	$44,881	$48,520
SEVEN	$13,670	**$27,340**	$34,175	$36,362	$41,010	$50,579	$54,680
EIGHT	$15,210	**$30,420**	$38,025	$40,459	$45,630	$56,277	$60,840

NOTE: FOR FAMILY UNITS WITH MORE THAN 8 MEMBERS, ADD $3,080 FOR EACH ADDITIONAL MEMBER.

ALASKA

FAMILY SIZE	50%	**100%**	125%	133%	150%	185%	200%
ONE	$5,540	**$11,080**	$13,850	$14,736	$16,620	$20,498	$22,160
TWO	$7,465	**$14,930**	$18,663	$19,857	$22,395	$27,621	$29,860
THREE	**$9,390**	**$18,780**	**$23,475**	**$24,977**	**$28,170**	**$34,743**	**$37,560**
FOUR	$11,315	**$22,630**	$28,288	$30,098	$33,945	$41,866	$45,260
FIVE	$13,240	**$26,480**	$33,100	$35,218	$39,720	$48,988	$52,960
SIX	$15,165	**$30,330**	$37,913	$40,339	$45,495	$56,111	$60,660
SEVEN	$17,090	**$34,180**	$42,725	$45,459	$51,270	$63,233	$68,360
EIGHT	$19,015	**$38,030**	$47,538	$50,580	$57,045	$70,356	$76,060

NOTE: FOR FAMILY UNITS WITH MORE THAN 8 MEMBERS, ADD $3,850 FOR EACH ADDITIONAL MEMBER.

HAWAII

FAMILY SIZE	50%	**100%**	125%	133%	150%	185%	200%
ONE	$5,100	**$10,200**	$12,750	$13,566	$15,300	$18,870	$20,400
TWO	$6,870	**$13,740**	$17,175	$18,274	$20,610	$25,419	$27,480
THREE	**$8,640**	**$17,280**	**$21,600**	**$22,982**	**$25,920**	**$31,968**	**$34,560**
FOUR	$10,410	**$20,820**	$26,025	$27,691	$31,230	$38,517	$41,640
FIVE	$12,180	**$24,360**	$30,450	$32,399	$36,540	$45,066	$48,720
SIX	$13,950	**$27,900**	$34,875	$37,107	$41,850	$51,615	$55,800
SEVEN	$15,720	**$31,440**	$39,300	$41,815	$47,160	$58,164	$62,880
EIGHT	$17,490	**$34,980**	$43,725	$46,523	$52,470	$64,713	$69,960

NOTE: FOR FAMILY UNITS WITH MORE THAN 8 MEMBERS, ADD $3,540 FOR EACH ADDITIONAL MEMBER.

Appendix B
Sample Application and Notice Language

The Center for Health Literacy and Communication Technologies, Maximus
www.cortidesignhost.com/maximus/chi/ourwork.asp

Application excerpt:
Before and after simplifying

Before

1. List the adults in this home starting with the person completing this application. Then only list and provide information on this form for adults who are: the parents of children under nineteen if their children are requesting medical assistance, women who are applying for pregnancy coverage and their spouses, a relative other than the parent caring for a child requesting assistance in their home only if that relative is also requesting medical assistance.

Name(first, middle, last)	Birthdate	Race* (choose code from list below)	Social Security Number*	Relationship to person completing application	Citizenship	Medical Wanted

* Completion of race, SSN, and citizenship information is optional for individuals not requesting assistance for themselves.
Race Codes: AI = American Indian W = White H = Hispanic A = Asian B = Black

After

B. Tell us about everyone else in your home who is applying for Medicaid and SCHIP. *There is room to write about more people on the next page.*

Person who is applying

First name: Middle initial: Last name: | Birth date *(month/day/year)*: | Age:

Is this person a U.S. citizen? **Yes** ☐ **No** ☐ | If this person is not a citizen, send a copy of his or her Alien card or an INS letter with this application. | Social Security Number:

Is this person pregnant? **Yes** ☐ **No** ☐ | Is this person in a special care facility? **Yes** ☐ **No** ☐ | Was this person treated for any health problems in the last 3 months? **Yes** ☐ **No** ☐ *If yes, Medicaid may help pay the bills.*

Does this person have other health insurance? **Yes** ☐ **No** ☐ *If yes, write name of insurance company:* | Does this person have a parent living in the home? **Yes** ☐ **No** ☐ *If yes, write the parent's name:*

Next Person who is applying

First name: Middle initial: Last name: | Birth date *(month/day/year)*: | Age:

Is this person a U.S. citizen? **Yes** ☐ **No** ☐ | If this person is not a citizen, send a copy of his or her Alien card or an INS letter with this application. | Social Security Number:

and so on...

Appendix B
Sample Application and Notice Language
Application Excerpts

continued from page 33

Notice excerpt: Before and after simplifying

Before

DEAR MARY SMITH:
WE HAVE REVIEWED YOUR ELIGIBILITY AND HAVE DETERMINED THAT YOU ARE PRESUMPTIVELY ELIGIBLE FOR MEDICAID FOR PREGNANT WOMEN. THE FOLLOWING INDIVIDUALS ARE MEMBERS OF THIS ASSISTANCE GROUP: MARY SMITH.
REASON: YOU ARE PREGNANT.

and so on...

After

Dear Mary Smith:

This letter is about Medicaid.
Thank you for filling out the Medicaid application in your doctor's office. You are approved to get Medicaid because you are pregnant.

You are approved to get Medicaid until we finish looking at your Medicaid application. Medicaid will pay until you get a letter saying that you cannot get Medicaid anymore. It is important for you to see your doctor for regular checkups.

and so on...

Handbook excerpt:

The Notices & Applications Handbook contains best practice guidelines to help states write, field test, and translate their Medicaid and SCHIP Notices and Applications. Here's an excerpt from the Handbook:

Guideline 6

Use simple ("unpacked") sentences, alone or combined.

Readers have a hard time understanding sentences that are packed with many messages.

Instead of this...

You have the right under the Fair Hearing Act to know the information contained in your credit file and to receive a free copy of your report if you request it no later than 60 days after you receive this notice, and you are the primary signature.

Try this...

You have the right:

- To know what information is in your file.
- To get a copy of your credit report.

If you want a copy of your credit report,

- Call our office at 1-800-123-1234, Monday to Friday, 8:30 a.m. to 5:00 p.m. The call is free.
- Call within 60 days after the date on this letter.

Appendix C
Child Health Coverage Data: State-by-State Eligibility Level, Enrollment Policies and Renewal

Donna Cohen Ross and Laura Cox, Enrolling Children and Families in Health Coverage: The Promise of Doing More, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2002), p.30-39

Table I

State Income Eligibility Guidelines for Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and SCHIP-funded Separate Child Health Insurance Programs[1]

(Percent of Federal Poverty Line)
January 2002

	Medicaid Infants (0-1)[2]	Medicaid Children (1-5)[2]	Medicaid Children (6-17)[3]	Medicaid Children (18-19)[3,4]	Separate State Program[5]
Alabama	133	133	100	100	200
Alaska	200	200	200	200	
Arizona *	140	133	100	100	200
Arkansas	200	200	200	200	
California	200	133	100	100	250
Colorado	133	133	100	43	185
Connecticut	185	185	185	185	300
Delaware *	200	133	100	100	200
District of Columbia	200	200	200	200	
Florida[6]	200	133	100	100	200
Georgia[7]	235	133	100	100	235
Hawaii	200	200	200	200	
Idaho	150	150	150	150	
Illinois[7]	200	133	133	133	185
Indiana	150	150	150	150	200
Iowa	200	133	133	133	200
Kansas	150	133	100	100	200
Kentucky	185	150	150	150	200
Louisiana *	200	200	200	200	
Maine[7]	200	150	150	150	200
Maryland *	200	200	200	200	300
Massachusetts[8,9]	200	150	150	150	200 (400+)
Michigan	185	150	150	150	200
Minnesota	280	275	275	275	
Mississippi	185	133	100	100	200
Missouri	300	300	300	300	
Montana	133	133	100	71	150
Nebraska	185	185	185	185	
Nevada	133	133	100	78	200
New Hampshire	300	185	185	185	300
New Jersey *	200	133	133	133	350
New Mexico	235	235	235	235	
New York[10]	200	133	133	133	250
North Carolina	185	133	100	100	200
North Dakota	133	133	100	100	140
Ohio	200	200	200	200	
Oklahoma	185	185	185	185	
Oregon	133	133	100	100	170
Pennsylvania[8]	185	133	100	46	200 (235)
Rhode Island	250	250	250	250	
South Carolina	185	150	150	150	
South Dakota *	140	140	140	140	200
Tennessee[8]	N/A	N/A	N/A	N/A	
Texas	185	133	100	100	200
Utah	133	133	100	100	200
Vermont[11]	300	300	300	300	300
Virginia *	133	133	100	100	200
Washington	200	200	200	200	250
West Virginia *	150	150	100	100	200
Wisconsin	185	185	185	185	
Wyoming *	133	133	100	100	133

* Indicates that a state has expanded eligibility in at least one of its children's health insurance programs since October 2000.

Appendix C
Child Health Coverage Data: State-by-State Eligibility Level, Enrollment Policies and Renewal

Notes for Table 1

1. The income eligibility guideline noted may refer to gross or net income depending on the state.

2. To be eligible in the infant category, a child has not yet reached his or her first birthday. To be eligible in the 1-5 category, the child is age 1 or older, but has not yet reached his or her sixth birthday. Minnesota covers children under age 2 in the infant category.

3. As required by federal law, states provide Medicaid to children age six or older who were born after September 30, 1983 and who have family incomes below 100 percent of the poverty line. By October 1, 2002 all poor children under age 19 will be covered. If the state covers children in this age group who have family incomes higher than 100 percent of the poverty line, or the state covers children born before September 30, 1983, thereby accelerating the phase-in period, it is noted in this column. States that have taken such steps have done so either through Medicaid statutory options or Medicaid waivers.

4. To be eligible in this category, a child is born before September 30, 1983 and has not yet reached his or her 19tth birthday. States are required to provide Medicaid coverage to these children if their family's income and resources are below AFDC standards in effect in their state in July 1996. States can modify those standards and expand eligibility under various statutory options.

5. The states listed use federal State Children's Health Insurance Program (SCHIP) funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may provide benefits similar to Medicaid or they may provide a limited benefit package. They also may impose premiums or other cost-sharing obligations on some or all families with eligible children.

6. Florida operates two SCHIP-funded separate programs. Healthy Kids covers children age 5 through 19, as well as younger siblings of enrolled children in some areas. Medi-Kids covers children birth through age 4.

7. Illinois and Maine covers infants in families with income at or below 200 percent of the federal poverty line who are born to mothers enrolled in Medicaid. Illinois covers other infants in families with income at or below 133 percent of the federal poverty line. Maine covers other infants in families with income at or below 185 percent of the federal poverty line. Georgia covers infants in families with income at or below 235 percent of the federal poverty line who are born to mothers enrolled in Medicaid. Georgia covers other infants in families with income at or below 185 percent of the federal poverty line.

8. Massachusetts and Pennsylvania provide state-financed coverage to children with incomes above SCHIP levels. Eligibility is shown in parentheses. Eligibility under the Tennessee waiver is based on the child's lack of insurance; there is no upper income limit.

9. Children between ages 1 and 19 in families with income between 150 and 200 percent of the federal poverty line will receive either slightly reduced MassHealth (Medicaid) benefits or assistance paying premiums for employer-based plans.

10. New York expanded Medicaid income eligibility guidelines to cover all children age 1 though 19 with family income at or below 133 percent of the federal poverty line. This change was implemented in April 2002.

11. Under Medicaid, uninsured children are covered up to 225 percent of the federal poverty line, and underinsured children are covered up to 300 percent of the federal poverty line. The expansion of coverage for underinsured children was achieved through an amendment to the state's Section 1115 waiver. Vermont covers uninsured children in families with income between 225 and 300 percent of the federal poverty line under a separate SCHIP program.

Appendix C
Child Health Coverage Data: State-by-State Eligibility Level, Enrollment Policies and Renewal

Table 2

Selected Simplified Enrollment Procedures in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and SCHIP-funded Separate Child Health Insurance Programs, January 2002

	Program	Joint Application[1]	Eliminated Face-to-Face Interview	Eliminated Asset Test	Presumptive Eligibility[2]
Total	Medicaid (51)*	N/A	47	45	9
	SCHIP (35) **	N/A	34	34	5
	Aligned Medicaid and Separate SCHIP ***	33	47	44	6
Alabama	Medicaid for Children[3]	•		•	
	Separate SCHIP		•	•	
Alaska	Medicaid for Children	N/A	•	•	
Arizona	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
• Arkansas	Medicaid for Children	N/A	•	•	
California	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Colorado	Medicaid for Children	•	•		
	Separate SCHIP		•	•	
Connecticut	Medicaid for Children	•	•	•	•
	Separate SCHIP		•	•	
Delaware	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
District of Columbia	Medicaid for Children	N/A	•	•	
Florida	Medicaid for Children[2,4]	•	•	•	•
	Separate SCHIP		•	•	
• Georgia	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Hawaii	Medicaid for Children	N/A	•	•	
Idaho	Medicaid for Children	N/A	•		
Illinois	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Indiana	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Iowa	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Kansas	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Kentucky	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Louisiana	Medicaid for Children	N/A	•	•	
Maine	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Maryland	Medicaid for Children	•	•	•	
•	Separate SCHIP		•	•	
Massachusetts	Medicaid for Children	•	•	•	•
	Separate SCHIP		•	•	•
Michigan	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	•
Minnesota	Medicaid for Children	N/A	•	•	
• Mississippi	Medicaid for Children[2]	•	•	•	•
•	Separate SCHIP[2]		•	•	•
Missouri	Medicaid for Children[5]	N/A	•	•	
• Montana	Medicaid for Children	•	•		
	Separate SCHIP		•	•	
Nebraska	Medicaid for Children	N/A	•	•	•
• Nevada	Medicaid for Children	•	•		
•	Separate SCHIP		•	•	
New Hampshire	Medicaid for Children	•	•	•	•
	Separate SCHIP		•	•	
New Jersey	Medicaid for Children	•	•	•	•
	Separate SCHIP		•	•	•
• New Mexico	Medicaid for Children	N/A	•	•	•
New York	Medicaid for Children[2,6]	•		•	•
	Separate SCHIP		•	•	•
North Carolina	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
• North Dakota	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Ohio	Medicaid for Children	N/A	•	•	
Oklahoma	Medicaid for Children	N/A	•	•	

Appendix C
Child Health Coverage Data: State-by-State Eligibility Level, Enrollment Policies and Renewal

Table 2 continued

	Program	Joint Application[1]	Eliminated Face-to-Face Interview	Eliminated Asset Test	Presumptive Eligibility[2]
Oregon	Medicaid for Children	•	•	•	
	Separate SCHIP		•		
Pennsylvania	Medicaid for Children[6]	•	•	•	
	Separate SCHIP		•	•	
Rhode Island	Medicaid for Children	N/A	•	•	
South Carolina	Medicaid for Children	N/A	•	•	
South Dakota	Medicaid for Children	•	•	•	
•	Separate SCHIP		•	•	
Tennessee	Medicaid for Children	N/A		•	
Texas •	Medicaid for Children	•	•		
	Separate SCHIP		•	•	
Utah	Medicaid for Children[3,7]				
	Separate SCHIP			•	
Vermont	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Virginia •	Medicaid for Children		•	•	
•	Separate SCHIP		•	•	
Washington	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
West Virginia •	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	
Wisconsin •	Medicaid for Children	N/A	•	•	
Wyoming •	Medicaid for Children	•	•	•	
	Separate SCHIP		•	•	

• •Indicates that a state has simplified one or more of its procedures or implemented a new program since October 2000.
• •Indicates that a state has rescinded one or more simplified procedures since October 2000.

* "Total Medicaid" indicates the number of states that have adopted a particular enrollment simplification strategy for their children's Medicaid program. All 50 states and the District of Columbia operate such programs.

** "Total Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy for their SCHIP-funded separate program. The following 35 states operate such programs: AL, AZ, CA, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, ME, MD, MA, MI, MS, MT, NV, NH, NJ, NY, NC, ND, OR, PA, SD, TX, UT, VT, VA, WA, WV, and WY. The remaining 15 states and DC use their SCHIP funds to expand Medicaid, exclusively.

*** "Aligned Medicaid & Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children's Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded Medicaid expansion program.

1. This column indicates whether a single application is used for children's Medicaid and the SCHIP-funded separate program, if the state operates one.

2. Under federal law, states may implement presumptive eligibility procedures in Medicaid and SCHIP-funded separate programs. Florida, Mississippi and New York (Medicaid) have yet to implement presumptive eligibility procedures. Presumptive eligibility procedures have been implemented in New York's SCHIP-funded separate program. In Michigan, a presumptive eligibility procedure has been developed for the state's SCHIP-funded separate program, however the procedure is optional and no health plan has chosen to use it.

3. These states require an interview for families applying for Medicaid for their children, however the interview may be conducted by telephone. In Alabama, the interview is usually done by telephone. In Utah, a face-to-face interview is required, but families are permitted to do the interview by telephone. In Utah, an interview also is required for the SCHIP-funded separate program.

4. Florida operates two SCHIP-funded separate programs. Healthy Kids covers children age 5 through 19, as well as younger siblings of enrolled children in some areas. Medi-Kids covers children birth through age 4.

5. Missouri has eliminated the asset test for children's "regular" Medicaid. Children in the Medicaid expansion group are subject to a "net worth" test of $250,000.

6. Pennsylvania uses Medicaid and SCHIP applications that solicit "common data elements" in collecting information for Medicaid and SCHIP, thus making Medicaid and SCHIP applications interchangeable.

7. Utah still counts assets in determining Medicaid eligibility for children over the age of 6.

Appendix C
Child Health Coverage Data: State-by-State Eligibility Level, Enrollment Policies and Renewal

Table 3

Selected Simplified Renewal Procedures in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and SCHIP-funded Separate Child Health Insurance Programs, January 2002

	Program	Frequency*** (months)	12-Month Continuous Eligibility	Eliminated Face-to-Face Interview	Joint Renewal Form[1]
Total	Medicaid (51)*	42•	18	48	N/A
	SCHIP (35) **	33•	23	34	N/A
	Aligned Medicaid and Separate SCHIP ***	42•	17	48	21
Alabama	• Medicaid for Children	12	•	•	•
	• Separate SCHIP	12	•	•	
Alaska	Medicaid for Children	6		•	N/A
Arizona	Medicaid for Children[2]	12		•	
	Separate SCHIP	12	•	•	
Arkansas	Medicaid for Children[3]	12		•	N/A
California	• Medicaid for Children	12	•	•	
	Separate SCHIP	12	•	•	
Colorado	Medicaid for Children[4]	12		•	
	Separate SCHIP	12	•	•	
Connecticut	• Medicaid for Children	12	•	•	•
	• Separate SCHIP	12	•	•	
Delaware	Medicaid for Children	12		•	•
	Separate SCHIP	12	•	•	
District of Columbia	Medicaid for Children	12		•	N/A
Florida	Medicaid for Children	12	• (under age 5)	•	
	Separate SCHIP[5]	6		•	
Georgia	• Medicaid for Children[6]	6		•	•
	• Separate SCHIP	12		•	
Hawaii	Medicaid for Children	12		•	N/A
Idaho	Medicaid for Children	12	•	•	N/A
Illinois	Medicaid for Children	12	•	•	
	Separate SCHIP	12	•	•	
Indiana	Medicaid for Children	12	•	•	•
	Separate SCHIP	12	•	•	
Iowa	Medicaid for Children	12		•	
	Separate SCHIP	12	•	•	
Kansas	Medicaid for Children	12	•	•	•
	Separate SCHIP	12	•	•	
Kentucky	• Medicaid for Children	12			•
	• Separate SCHIP	12			
Louisiana	Medicaid for Children	12	•	•	N/A
Maine	• Medicaid for Children	12	•	•	•
	• Separate SCHIP	12	•	•	
Maryland	Medicaid for Children	12		•	•
	• Separate SCHIP	12		•	
Massachusetts	Medicaid for Children	12		•	•
	Separate SCHIP	12		•	
Michigan	Medicaid for Children	12		•	
	Separate SCHIP	12	•	•	
Minnesota	Medicaid for Children[3]	6		•	N/A
Mississippi	Medicaid for Children	12	•	•	•
	Separate SCHIP	12	•	•	
Missouri	Medicaid for Children	12		•	N/A
Montana	• Medicaid for Children	12		•	
	Separate SCHIP	12	•	•	
Nebraska	Medicaid for Children	12	•	•	N/A
Nevada	Medicaid for Children	12		•	
	Separate SCHIP	12	•	•	
New Hampshire	Medicaid for Children	12		•	•
	Separate SCHIP	12		•	
New Jersey	Medicaid for Children[7]	12		•	•
	Separate SCHIP[7]	12		•	
New Mexico	Medicaid for Children	12	•	•	N/A
New York	Medicaid for Children[8]	12	•		•
	Separate SCHIP	12		•	
North Carolina	Medicaid for Children	12	•	•	•
	Separate SCHIP	12	•	•	
North Dakota	Medicaid for Children[9]	1 month		•	
	Separate SCHIP	12	•	•	
Ohio	Medicaid for Children[3]	12		•	N/A
Oklahoma	Medicaid for Children	6		•	N/A

Appendix C
Child Health Coverage Data: State-by-State Eligibility Level, Enrollment Policies and Renewal

Table 3 continued

	Program	Frequency*** (months)	12-Month Continuous Eligibility	Eliminated Face-to-Face Interview	Joint Renewal Form[1]
Oregon	Medicaid for Children	6		*	*
	Separate SCHIP	6		*	
Pennsylvania	Medicaid for Children	12		*	
	Separate SCHIP[10]	12	*	*	
Rhode Island	Medicaid for Children	12		*	N/A
South Carolina *	Medicaid for Children	12	*	*	N/A
South Dakota	Medicaid for Children	12		*	*
*	Separate SCHIP	12		*	
Tennessee	Medicaid for Children[3]	6			N/A
Texas *	Medicaid for Children	6		*	
	Separate SCHIP	12	*	*	
Utah	Medicaid for Children	12		*	
	Separate SCHIP	12	*	*	
Vermont *	Medicaid for Children	12		*	*
	Separate SCHIP	12		*	
Virginia *	Medicaid for Children	12		*	
*	Separate SCHIP	12		*	
Washington	Medicaid for Children	12	*	*	*
	Separate SCHIP	12	*	*	
West Virginia *	Medicaid for Children	12	*	*	*
*	Separate SCHIP	12	*	*	
Wisconsin *	Medicaid for Children[4]	12		*	N/A
Wyoming *	Medicaid for Children	12	*	*	*
*	Separate SCHIP	12	*	*	

* *Indicates that a state has simplified one or more of its procedures or implemented a new program since October 2000.

* *Indicates that a state has rescinded one or more simplified procedures since October 2000.

* "Total Medicaid" indicates the number of states that have adopted a particular enrollment simplification strategy for their children's Medicaid program. All 50 states and the District of Columbia operate such programs.

** "Total Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy for their SCHIP-funded separate program. The following 35 states operate such programs: AL, AZ, CA, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, ME, MD, MA, MI, MS, MT, NV, NH, NJ, NY, NC, ND, OR, PA, SD, TX, UT, VT, VA, WA, WV, and WY. The remaining 15 states and DC use their SCHIP funds to expand Medicaid, exclusively.

*** "Aligned Medicaid & Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children's Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded Medicaid expansion program.

* If the frequency of renewal is every 12 months, as opposed to six months or more frequently, the procedure is considered "simplified" for purposes of this table.

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1. This column indicates whether a single renewal form is used for children's Medicaid and the SCHIP-funded separate program, if the state operates one.

2. In Arizona, local offices may require families with children enrolled in Medicaid to complete a telephone interview at renewal.

3. In Arkansas, Minnesota, Ohio and Tennessee renewal procedures differ for families with children enrolled in Medicaid, depending on whether they are eligible under "regular" Medicaid or under expansions pursuant to Medicaid Section 1115 waivers or SCHIP-funded Medicaid expansions. In Minnesota and Tennessee, children who qualify under waiver programs can renew eligibility every 12 months, as opposed to every 6 months under "regular" Medicaid. In Arkansas and Ohio, children who qualify under expansion rules receive 12 months of continuous eligibility, as opposed to a 12 month renewal period in "regular" Medicaid. In Ohio, a waiver to continue this practice is pending.

4. In Colorado and Wisconsin, renewal procedures vary by county. In Wisconsin, county offices may require a face-to-face interview. Wisconsin has recently released a one-page renewal form that counties may use. If this form is used, no interview is required.

5. In Florida, all children covered under "regular" Medicaid have a 12 month renewal period. All children under age 5 enrolled in Medicaid receive 12 months of continuous eligibility. All children age 5 and older enrolled in Medicaid receive 6 months of continuous eligibility.

6. In Georgia, all families that apply for coverage using the joint Medicaid/SCHIP application receive a joint renewal form. Families that apply at the Medicaid office for Medicaid only receive a renewal form used to redetermine eligibility for TANF, Medicaid and food stamps.

7. In New Jersey, families of children who receive Medicaid or SCHIP can renew coverage using a joint renewal form issued by the central office. Families that qualify for other benefit programs, such as TANF or food stamps, must renew their children's coverage through their county office. County renewal procedures vary.

8. In New York, a contact with a community-based "facilitated enroller" will meet the face-to-face interview requirement. A joint application can be used with the "facilitated enroller" at renewal.

9. In North Dakota, families with children enrolled in Medicaid must report their income monthly. A full review of eligibility is done annually.

Appendix C
Child Health Coverage Data: State-by-State Eligibility Level, Enrollment Policies and Renewal

Table 4

Selected Verification Procedures: Self-Declaration of Income, Residency or Age in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and SCHIP-funded Separate Child Health Insurance Programs, January 2002

Program		Income	Residency	Child's Age
Total	Medicaid (51)*	13	43	45
	SCHIP (35) **	11	31	32
	Aligned Medicaid and Separate SCHIP ***	13	43	45
Alabama	Medicaid for Children		•	•
	Separate SCHIP	•	•	•
Alaska	Medicaid for Children		•	•
Arizona •	Medicaid for Children		•	•
	Separate SCHIP	•	•	•
Arkansas	Medicaid for Children	•	•	
California	Medicaid for Children			•
	Separate SCHIP[1]			•
Colorado	Medicaid for Children		•	•
	Separate SCHIP		•	•
Connecticut • •	Medicaid for Children	•	•	•
	Separate SCHIP	•	•	•
Delaware	Medicaid for Children[2]		•	•
	Separate SCHIP[2]		•	•
District of Columbia	Medicaid for Children			•
Florida	Medicaid for Children	•	•	•
	Separate SCHIP	•	•	•
Georgia	Medicaid for Children	•	•	•
	Separate SCHIP	•	•	•
Hawaii	Medicaid for Children		•	•
Idaho	Medicaid for Children	•	•	•
Illinois	Medicaid for Children		•	•
	Separate SCHIP		•	•
Indiana	Medicaid for Children		•	•
	Separate SCHIP		•	•
Iowa	Medicaid for Children		•	•
	Separate SCHIP		•	•
Kansas	Medicaid for Children		•	•
	Separate SCHIP		•	•
Kentucky • •	Medicaid for Children		•	•
	Separate SCHIP		•	•
Louisiana	Medicaid for Children		•	•
Maine	Medicaid for Children		•	•
	Separate SCHIP		•	•
Maryland	Medicaid for Children	•	•	•
	Separate SCHIP	•	•	•
Massachusetts	Medicaid for Children		•	•
	Separate SCHIP		•	•
Michigan	Medicaid for Children	•	•	•
	Separate SCHIP	•	•	•
Minnesota	Medicaid for Children[3]		•	•
Mississippi • •	Medicaid for Children[4]	•	•	•
	Separate SCHIP[4]	•	•	•
Missouri	Medicaid for Children[5]		•	•
Montana	Medicaid for Children[1]		•	•
	Separate SCHIP		•	•
Nebraska	Medicaid for Children		•	•
Nevada	Medicaid for Children			•
	Separate SCHIP		•	•
New Hampshire	Medicaid for Children			
	Separate SCHIP			
New Jersey	Medicaid for Children		•	
	Separate SCHIP		•	
New Mexico	Medicaid for Children		•	
New York	Medicaid for Children			
	Separate SCHIP			
North Carolina	Medicaid for Children		•	•
	Separate SCHIP		•	•
North Dakota	Medicaid for Children		•	•
	Separate SCHIP		•	•
Ohio	Medicaid for Children		•	•
Oklahoma	Medicaid for Children	•	•	•
Oregon	Medicaid for Children			•
	Separate SCHIP			•

Appendix C
Child Health Coverage Data: State-by-State Eligibility Level, Enrollment Policies and Renewal

Table 4 continued

Program		Income	Residency	Child's Age
Pennsylvania	Medicaid for Children		*	*
	Separate SCHIP		*	*
Rhode Island	Medicaid for Children		*	*
South Carolina	Medicaid for Children		*	*
South Dakota	Medicaid for Children		*	*
	Separate SCHIP		*	*
Tennessee	Medicaid for Children[6]			*
Texas	Medicaid for Children			*
	Separate SCHIP		*	*
Utah	Medicaid for Children		*	*
	Separate SCHIP		*	*
Vermont	Medicaid for Children	*	*	*
	Separate SCHIP	*	*	*
Virginia	Medicaid for Children		*	
	Separate SCHIP		*	*
Washington	Medicaid for Children	*	*	*
	Separate SCHIP	*	*	*
West Virginia	Medicaid for Children		*	*
	Separate SCHIP		*	*
Wisconsin *	Medicaid for Children	*	*	*
Wyoming *	Medicaid for Children	*	*	*
	Separate SCHIP	*	*	*

* • Indicates that a state has implemented self-declaration of income since October 2000.

* • Indicates that a state has eliminated self-declaration of income since October 2000.

* "Total Medicaid" indicates the number of states that have adopted a particular enrollment simplification strategy for their children's Medicaid program. All 50 states and the District of Columbia operate such programs.

** "Total Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy for their SCHIP-funded separate program. The following 35 states operate such programs: AL, AZ, CA, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, ME, MD, MA, MI, MS, MT, NV, NH, NJ, NY, NC, ND, OR, PA, SD, TX, UT, VT, VA, WA, WV, and WY. The remaining 15 states and DC use their SCHIP funds to expand Medicaid, exclusively.

*** "Aligned Medicaid & Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children's Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded Medicaid expansion program.

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1. In California, families must submit birth certificates for children applying for SCHIP. In Montana, families must submit birth certificates for children applying for Medicaid. In both states, birth certificates are used to verify citizenship.

2. In Delaware, families must verify the birth dates of newborns.

3. Minnesota has adopted self-declaration of income for its Medicaid and Medicaid expansion programs, but procedures have not yet been implemented.

4. Mississippi requires families to provide either a parent's Social Security number or verification of income.

5. In Missouri, income verification is requested only when this information is not available from other sources, such as employment security or the food stamp program.

6. In Tennessee, applicants for the expansion program may self-declare all family information. No verification is required.

Appendix C
Child Health Coverage Data: State-by-State Eligibility Level, Enrollment Policies and Renewal

Table 5

Presumptive Eligibility in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and SCHIP-funded Separate Child Health Insurance Programs
January 2002

State	Presumptive Eligibility in Medicaid	Presumptive Eligibility in Separate SCHIP Program	One-step Application[1]	Qualified Entities
Connecticut	Yes	No	No	Community health centers, school-based health centers and Head Start programs
Florida[2]	Yes	No	Not yet determined	Not yet determined
Massachusetts[3]	Yes	Yes	Yes	MassHealth Enrollment Center
Michigan[4]	No	Yes	Yes	Health plans
Mississippi[5]	Yes	Yes	Yes (slightly modified)	Community health centers, disproportionate share hospitals and health departments
Nebraska	Yes	N/A	Yes	Community health centers and outpatient hospitals
New Hampshire[6]	Yes	No	Yes	Health care providers, WIC, Head Start programs, agencies that determine eligibility for subsidized child care, community-based organizations, Title V programs and Title X programs
New Jersey	Yes	Yes, for children in families with income below 200 percent of the federal poverty line	No	Health departments, community health centers and hospitals
New Mexico	Yes	N/A	Yes	Health departments, Indian Health Service programs, Head Start programs, schools and agencies that determine eligibility for subsidized child care
New York[2]	Yes	Yes	Yes (SCHIP) Not yet determined (Medicaid)	Health plans (SCHIP) Not yet determined (Medicaid)

1. This column indicates whether the application used to determine presumptive eligibility also can be used to make a final eligibility determination.

2. In Florida and New York, presumptive eligibility procedures have not yet been implemented in Medicaid.

3. Presumptive eligibility in Massachusetts differs from the process elsewhere, pursuant to the state's Section 1115 waiver. Under this procedure, all applications received at the central enrollment center that do not include the necessary verification are reviewed for presumptive eligibility. If a family's declared income is at or below 200 percent of the federal poverty line, and the child for whom the family is seeking coverage does not have other health insurance coverage, the child is determined to be presumptively eligible.

4. In Michigan, a presumptive eligibility procedure has been developed for the state's SCHIP-funded separate program, however the procedure is optional and no health plan has chosen to use it.

5. In Mississippi, presumptive eligibility procedures have not yet been implemented.

6. New Hampshire plans to revise its presumptive eligibility procedures to make the process more efficient. Under the new procedures, which will allow the state to track presumptive eligibility approval rates, community health centers and hospitals will be permitted to be qualified entities. Other entities that may have done presumptive eligibility determinations in the past may be designated as application assistance sites.

Appendix C
Child Health Coverage Data: State-by-State Eligibility Level, Enrollment Policies and Renewal

Table 6

Length of Time a Child is Required to Be Uninsured Prior to Enrolling in Children's Health Coverage*

	Length of Waiting Period[1] (in months)	
	At Implementation	January 2002
Alabama[2]	3	3
Alaska	12	12
Arizona	6	3
Arkansas	12	6
California	3	3
Colorado	3	3
Connecticut	6	2
Delaware	6	6
District of Columbia	*None*	*None*
Florida	*None*	*None*
Georgia	3	3
Hawaii	*None*	*None*
Idaho	*None*	*None*
Illinois	3	3
Indiana	3	3
Iowa	6	6
Kansas	6	*None*
Kentucky[3]	6	6
Louisiana	3	*None*
Maine	3	3
Maryland[3]	6	6
Massachusetts	*None*	*None*
Michigan	6	6
Minnesota	4	4
Mississippi	6	*None*
Missouri	6	6
Montana	3	3
Nebraska	*None*	*None*
Nevada	6	6
New Hampshire	6	6
New Jersey	12	6
New Mexico	12	*None*
New York	*None*	*None*
North Carolina	2	2
North Dakota	6	6
Ohio	*None*	*None*
Oklahoma	*None*	*None*
Oregon	6	6
Pennsylvania	*None*	*None*
Rhode Island	4	*None*
South Carolina	*None*	*None*
South Dakota	3	3
Tennessee	*None*	*None*
Texas[2]	3	3
Utah	3	3
Vermont	*None*	*None*
Virginia	12	6
Washington	4	4
West Virginia	6	6
Wisconsin	3	3
Wyoming	1	1

* **States in bold** have SCHIP-funded separate programs and may operate SCHIP-funded Medicaid expansions as well. States not in bold are SCHIP-funded Medicaid expansions.

1. These columns indicate the length of time a child is required to be uninsured before he or she is able to enroll in the SCHIP-funded program.

2. In Alabama and Texas, the waiting period is 90 days.

3. In Kentucky and Maryland, the waiting periods noted are used in both the SCHIP-funded Medicaid expansion and the SCHIP-funded separate program.

MISSION STATEMENT

The Southern Institute on Children and Families is an independent, non-profit public policy organization founded in 1990. It endeavors to improve opportunities for children and families in the South with a focus on disadvantaged children. Through special projects and surveys, the Southern Institute on Children and Families spotlights health, education, social and economic issues of regional significance. It works to encourage public/private-sector collaboration on behalf of children and families and seeks to remove bureaucratic and other barriers that restrict access to needed benefits and services. The Southern Institute on Children and Families is funded through grants and contributions.

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