Promising practices from the nation's single largest effort to insure eligible children and adults through public health coverage

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Covering Kids & Families **National Program Office**
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Acknowledgements

The Southern Institute on Children and Families extends appreciation to the Robert Wood Johnson Foundation (RWJF) for its leadership in envisioning and generously supporting *Covering Kids & Families* and its predecessor *Covering Kids*. Through resources provided by RWJF, a cadre of individuals and organizations across the nation has built knowledge and capacity to improve access to Medicaid and State Children's Health Insurance Program (SCHIP) health coverage.

This report outlines promising practices implemented by *Covering Kids & Families* projects at the statewide and local levels from 2001-2007. This report would not have been possible without the creative minds, innovative work and commitment of the *Covering Kids & Families* statewide and local projects and coalitions across America. The many accomplishments of statewide and local *Covering Kids & Families* projects in all 50 states and the District of Columbia provided ample material from which to select documented promising practices in outreach, simplification of eligibility policies and procedures and coordination of public health coverage. The Southern Institute also extends appreciation to the Medicaid and SCHIP state, local and federal officials who provided valuable contributions to the work of the *Covering Kids & Families* coalitions and the eligibility process improvement collaboratives.

About This Report

Judi Cramer, *Covering Kids & Families* Regional Coordinator, served as the Promising Practices Project Director. She led the planning and development of the report, coordinated the efforts of the Southern Institute staff and consultants and provided the overall management of the project under the leadership of Dr. Nancy Pursley, *Covering Kids & Families* Deputy Director for Program Operations. Judi Cramer, Sondra Gardetto and Denise Crouch, *Covering Kids & Families* Regional Coordinators, researched statewide and local project data, identified and reviewed effective activities and participated in the selection processes. Michael Stafford, Administrative Assistant, supported all phases of the project, and Jill Shirey, Program Assistant, assisted with proofing and distribution of the report.

Dr. Vicki Grant, Southern Institute on Children and Families Vice President for Process Improvement, and Laura Heller, Deputy Director of the Process Improvement Center, led development of the *Covering Kids & Families* Eligibility Process Improvement Collaborative section of this report.

Nicole Ravenell, *Covering Kids & Families* Deputy Director for Policy and Southern Institute Vice President for Operations, Dr. Kathryn Luchok, Policy and Research Director, LaCrystal Jackson, Policy and Research Analyst and Glenn Mainwaring, Policy and Research Program Assistant, provided the Medicaid and SCHIP data. Beth Shine, Southern Institute Communications Director, facilitated editing, proofing and report production.

Southern Institute staff were assisted by a team of consultants in producing this *Covering Kids & Families* Promising Practices Report. Ann Bacharach, Pennsylvania statewide *Covering Kids & Families* coordinator and member of the Pennsylvania *Covering Kids & Families* Eligibility Process Improvement Collaborative team, researched and provided the descriptive data for the outreach, simplification and coordination promising practices. Michele Wallace, member of the Oregon statewide *Covering Kids & Families* coalition and member of the Oregon *Covering Kids & Families* Eligibility Process Improvement Collaborative team, provided research for the eligibility process improvement collaborative efforts. Dr. Carol Baron, former lead of Virginia's statewide *Covering Kids* project and member of the Virginia statewide *Covering Kids & Families* coalition, researched data, organized and designed the format and served as the primary writer for the report.

Sarah Shuptrine, National Program Office Director for *Covering Kids & Families* and Southern Institute President and CEO, provided overall direction and guidance for the project.

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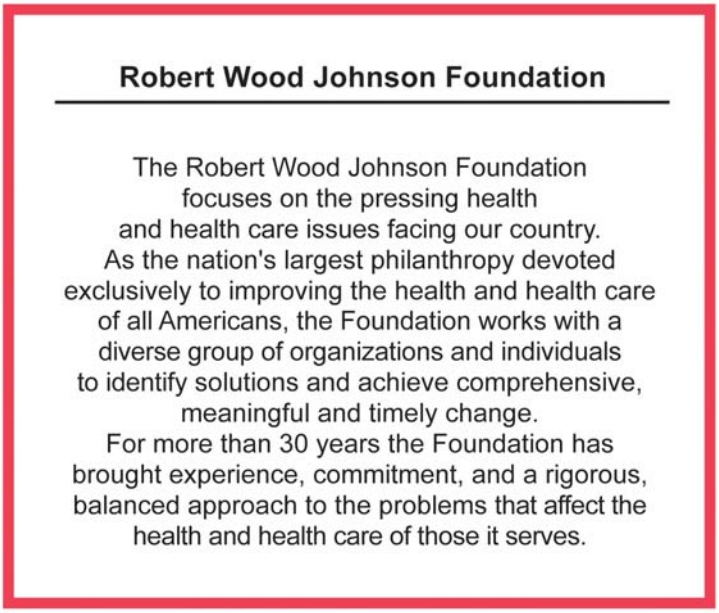
Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation (RWJF) is the nation's largest philanthropy devoted to improving health and health care. RWJF supports training, education, research and projects that demonstrate effective ways to deliver health services, especially for the most vulnerable among us.



RWJF envisioned and provided the financial support for *Covering Kids* (1997-2002) and *Covering Kids & Families* (2001-2007). The first initiative, *Covering Kids*, was a national program to help states and local communities increase the number of children who benefit from public health insurance coverage programs. RWJF was concerned about the millions of uninsured children who were eligible for Medicaid, but were not enrolled, and envisioned *Covering Kids* prior to passage of the federal Balanced Budget Act of 1997 that created the State Children's Health Insurance Program (SCHIP). SCHIP provided an additional $24 billion in federal resources over ten years to help states expand health care coverage to the nation's uninsured children. The RWJF Board of Trustees originally authorized a $13 million *Covering Kids* program in July 1997 to run in 15 states for three years. The following year in response to the high number of applications for funding and the new opportunities created by SCHIP to enroll even more children in health coverage programs, the authorization was increased to $43 million, and the program was extended to all 50 states and the District of Columbia. The Southern Institute on Children and Families was designated as the *Covering Kids* National Program Office to provide leadership and direction for the initiative.

RWJF also authorized more than $26 million in a nationwide *Covering Kids* communications campaign beginning in 2000 to increase the visibility and understanding of existing government programs that provide health coverage to eligible children. GMMB, a social marketing firm based in Washington, DC conducted the campaign. GMMB worked in collaboration with the Southern Institute to provide communications technical assistance to *Covering Kids* projects, including the design of attractive research-based outreach materials and toolkits for all statewide and local projects. Working in conjunction with *Covering Kids* statewide and local projects, the communications team conducted annual Back-to-School campaigns that generated considerable television, radio and print coverage and significantly increased calls to a federal nationwide hotline that linked callers to state eligibility offices in their state of residence.

In May 2001, the RWJF Board of Trustees authorized $65 million for the second initiative called *Covering Kids & Families.* Again, RWJF asked the Southern Institute to serve as the National Program Office to provide leadership and direction for the initiative. *Covering Kids & Families* operated in 50 states and the District of Columbia, and retained a focus on its

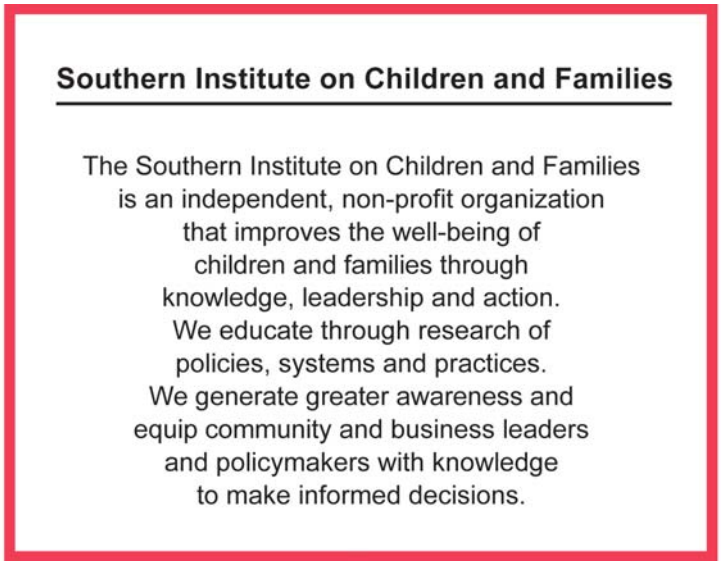
predecessor's three key strategies of outreach, simplifying enrollment and renewal policies and practices and coordinating eligibility policies and procedures among existing health care coverage programs. *Covering Kids & Families* expanded the target population from children only to encompass both children and adults. In addition, *Covering Kids & Families* focused on building knowledge, experience and capacity for sustainability.

In 2000, RWJF initiated the *Supporting Families After Welfare Reform: Access to Medicaid, SCHIP and Food Stamps* program, which developed a process improvement approach to examining Medicaid and SCHIP enrollment barriers and testing reforms to identify strategies that could be adopted by counties and states. The Southern Institute was designated as the *Supporting Families* National Program Office. Two *Covering Kids & Families* Eligibility Process Improvement Collaboratives were later led by *Supporting Families* staff at the Southern Institute.

As part of the *Covering Kids & Families* program, RWJF included the Access Initiative for local projects to improve access to health care services after enrollment in Medicaid and SCHIP. The initiative was directed by the Center for Health Care Strategies, Inc. (CHCS) and implemented in 2003. It documented barriers that impeded access to health care and then developed and tested strategies to improve access to health care services in the project communities. More information about the Access Initiative can be found at the CHCS Web site (http://www.chcs.org).

Southern Institute on Children and Families

The Southern Institute on Children and Families is an independent, non-profit organization that improves the well-being of children and families through knowledge, leadership and action. The Southern Institute works with federal, state and local leaders and businesses to tackle critical issues facing lower-income families and children and turns that knowledge into effective solutions that improve opportunities and change lives.



The Southern Institute has provided leadership and direction as the National Program Office for three Robert Wood Johnson Foundation initiatives: *Covering Kids* (1997-2002), followed by *Supporting Families After Welfare Reform: Access to Medicaid, SCHIP and Food Stamps* (2000-2003) and *Covering Kids & Families* (2001-2007).

The Southern Institute released groundbreaking research on improving access to Medicaid coverage for lower-income children and adults in the early to mid 1990's,[1] which resulted in federal and state eligibility policy and process reforms and paved the way for removal of public health coverage eligibility barriers across the nation. This research formed the foundation for the outreach, simplification and coordination action strategies that have guided *Covering Kids* and *Covering Kids & Families*.

The Southern Institute works with public and private sector organizations across the nation on issues related to its mission. The Southern Institute works with organizations to improve the effectiveness, efficiency and responsiveness of public programs through research and policy analysis, eligibility process improvement, technical assistance and coalition consultation services. A special area of focus for the Southern Institute is 17 southern states and the District of Columbia, a region of the nation that faces difficult challenges in improving health, education and economic opportunities for lower-income families and children.

Letter From the National Program Office Director

Of the approximately 46.6 million Americans who are uninsured, more than eight million are children. The majority of these children are in lower-income families with one or more full-time workers. Almost three-fourths of these uninsured children are eligible for, but not enrolled in free or low-cost health coverage available in every state through Medicaid and the State Children's Health Insurance Program (SCHIP). While progress has been made, many families are still unaware of public coverage opportunities. Also, many families encounter procedural barriers that impede their efforts to enroll their children initially or to renew their coverage.

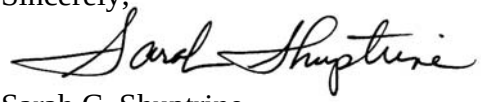
Since its inception in 1990, a core mission of the Southern Institute on Children and Families has been to design and implement effective outreach to inform families about available coverage and to create a family-friendly application and renewal process. With support from the Robert Wood Johnson Foundation (RWJF) over the past ten years, the Southern Institute has directed three dynamic initiatives through which statewide and local projects across the nation improved access to Medicaid and SCHIP for eligible, uninsured children and adults. We started in 1997 with *Covering Kids* and focused on enrolling eligible children. We built upon these efforts in 2000 through *Supporting Families After Welfare Reform*, focusing on families leaving welfare. And in 2001, *Covering Kids & Families* was initiated with an expanded focus to improve access to coverage for uninsured adults as well as children.

Over the past six years, the creative and persistent endeavors of *Covering Kids & Families* statewide and local coalitions in all 50 states and the District of Columbia contributed to a decline in the number of uninsured children. This decrease in the number of uninsured children occurred at the same time the number of uninsured adults steadily increased. This is cause for celebration, but the job is not done.

Covering Kids & Families comes to a close in April 2007, but I am pleased to report most statewide and many of the local coalitions have obtained or are seeking the resources to sustain their efforts. This is a testament to the commitment of the dedicated individuals and organizations that compose the coalitions which have led outreach, simplification and coordination initiatives in their states and communities. *Covering Kids & Families* leaves behind a treasure of effective approaches to achieve results in community and statewide outreach, simplification of eligibility policies and processes and coordination across Medicaid and SCHIP programs.

This Promising Practices Report illustrates many of the creative and collaborative ways *Covering Kids & Families* coalitions worked to break down barriers to public health coverage for lower-income children and adults. Thanks to the commitment of so many across the nation, this report won't simply be one that catalogues past achievements. Rather the report will serve as a resource to sustaining and building upon the *Covering Kids & Families* legacy to see that every child and adult eligible for Medicaid or SCHIP are given the opportunity that health coverage bestows.

Sincerely,



Sarah C. Shuptrine
Director, *Covering Kids & Families* National Program Office
President and CEO, Southern Institute on Children and Families

Background

Uninsured Americans are often forced to forego or delay needed medical care, suffer from more illnesses and sometimes die as a result of not having health coverage. Affordability is a major factor. Health insurance is unaffordable for millions of lower-income individuals and families. Even if a health plan is offered through their employer, the cost often places family health coverage out of the employees' reach. The consequences of being uninsured are considerable:

- Uninsured Americans are four times more likely to require avoidable hospitalizations and emergency hospital care.[2]
- Uninsured women receive fewer prenatal services.
- Uninsured newborns are more likely to be low birth weight or to die.[3]
- Uninsured children are 70 percent more likely not to receive care for common conditions like ear infections.
- Uninsured children are 30 percent less likely to receive medical attention for injuries.[4]
- Over one quarter (25.6 percent) of children who are uninsured for all or part of the year do not receive any medical care, compared to 12.3 percent of children who are insured all year.
- Among children uninsured for all or part of the year, 35 percent do not have a personal doctor or nurse. This is significantly higher than among children insured all year at 13.5 percent.[5]

The scope of the uninsured problem is large. In 2005, 46.6 million persons were without health coverage in America. The number of children without coverage is estimated at 8.3 million. In almost all states, lower-income, uninsured adults have few or no options to obtain coverage. For children in lower-income families, however, national and state policies have been enacted to provide public health coverage that significantly improves their access to preventive and primary health care. Yet seven out of 10 uninsured American children are eligible for free or low-cost health coverage through either Medicaid or the State Children's Health Insurance Program (SCHIP), but are not enrolled. Enrolling those eligible for public coverage is an important part of the solution for the uninsured, and there is data to show that it makes a difference for children:

- Almost one quarter (24.1 percent) of uninsured children have no usual source of care, compared to 6.1 percent of children covered by Medicaid.
- Approximately eight percent (8.3 percent) of uninsured children do not receive or postpone care, compared to 2.5 percent of those on Medicaid.
- Children with Medicaid are 26 percent more likely than uninsured children to have a well-child visit.[6]

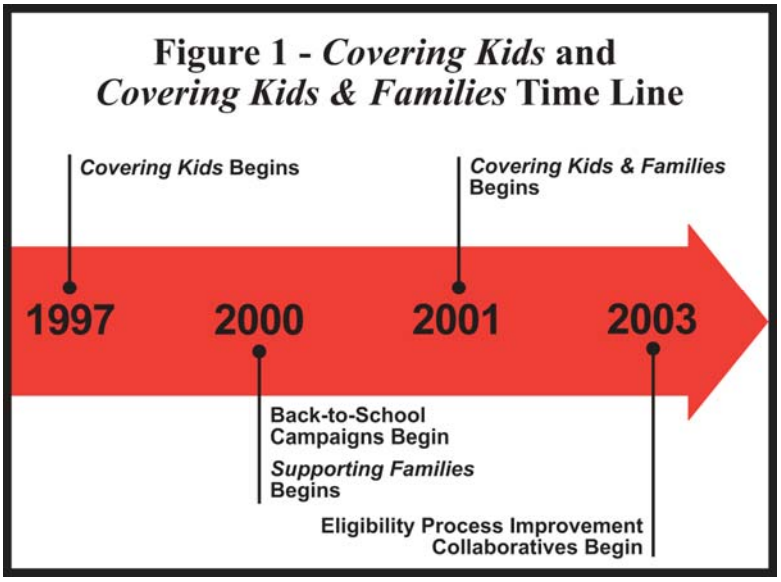
As noted above, millions of children are eligible for Medicaid and SCHIP, but are not enrolled. The reasons are diverse and deep-rooted. Numerous barriers to enrollment have been documented:

- The sense of social stigma that families attach to receiving Medicaid

- Parents and other caretakers erroneously believing they have to be receiving cash assistance, known as "welfare," for their children to be eligible for Medicaid
- Lower-income parents not applying for Medicaid or other health coverage programs because they are unaware such coverage exists, or mistakenly believe their children will not qualify
- Parents finding the Medicaid application process complex and burdensome
- Uncoordinated children's coverage programs in some states, resulting in missed opportunities to enroll eligible children into appropriate programs
- Differing rules and regulations across programs that create confusion
- Antiquated databases mistakenly dropping thousands of children from the rosters, leading many parents to be confused and discouraged[7]

As the enrollment track record of the Medicaid program has demonstrated, enacting policies that provide health coverage opportunities does not necessarily guarantee that eligible children will be enrolled.[8] In 1997, it became evident to the Robert Wood Johnson Foundation (RWJF) that a national program to find eligible children, simplify the application process and coordinate existing coverage programs could increase the number of children who benefited from enrollment in Medicaid. SCHIP was enacted in the summer of 1997 and provided additional opportunities for children in lower-income families to gain access to health coverage.

The *Covering Kids* initiative was authorized by RWJF in 1997. From 1997-2002, *Covering Kids* through outreach, simplification and coordination strategies served as a change agent and encouraged a fundamental shift in perceptions of the Medicaid program – from a welfare program to a health insurance program with a new consumer focus. The *Covering Kids* initiative created coalitions of individuals and organizations in each state knowledgeable about Medicaid and SCHIP eligibility to an extent that would not have been possible without *Covering Kids*.



The work of *Covering Kids* statewide and local coalitions was significantly enhanced by a communications campaign funded by RWJF and led by GMMB, a Washington, DC social marketing firm. A major focus of the communication effort was the award-winning annual Back-to-School campaigns,[9] which were a coordinated effort with statewide and local coalitions.

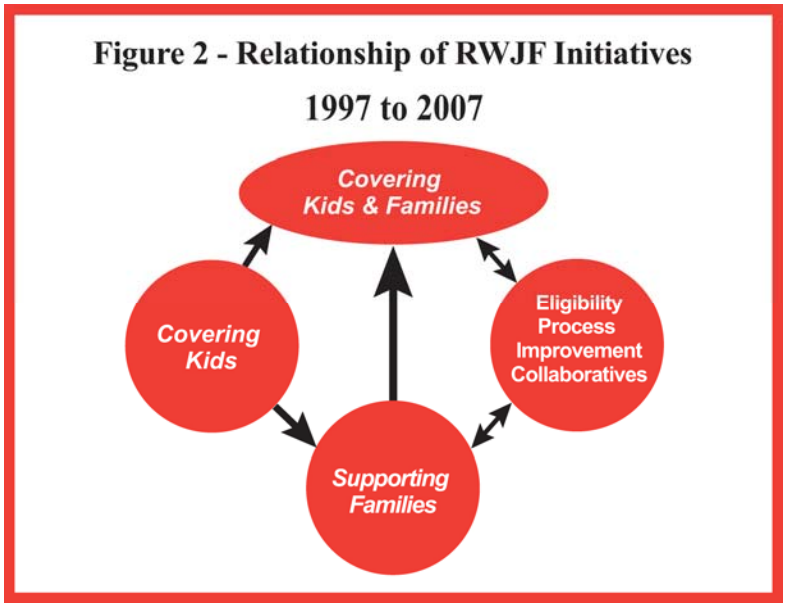
RWJF funded a separate but related initiative, *Supporting Families After Welfare Reform: Access to Medicaid, SCHIP and Food Stamps.* Concerns over policy and system issues that may have contributed to declines in Medicaid and Food Stamp Program enrollment led to a decision by RWJF to support a new $6.8 million grant program

implemented in 2000. *Supporting Families* was a joint initiative of RWJF, the United States Department of Health and Human Services and the United States Department of Agriculture. The purpose of *Supporting Families* was to help states or large counties solve problems in eligibility processes that make it difficult for lower-income families to access or retain Medicaid, SCHIP or Food Stamp benefits, particularly families moving from welfare to work.

The success of the *Covering Kids* initiative led to the May 2001 announcement of the *Covering Kids & Families* initiative, the third RWJF initiative focused on increasing the number of eligible but uninsured people who benefit from public health coverage programs. Working through statewide and local coalitions, *Covering Kids & Families* built on the work and experience of *Covering Kids*. Many states expanded their health coverage programs to include parents and other adults who work in jobs that either do not provide health care coverage for their employees or do not offer coverage that is affordable. The *Covering Kids & Families* initiative is discussed more fully in the next section of this report.

In 2003, RWJF announced a special opportunity for statewide *Covering Kids & Families* projects to participate in the *Covering Kids & Families* Eligibility Process Improvement Collaborative directed by Southern Institute staff. This collaborative was designed to capitalize on lessons learned from the *Supporting Families* initiative while focusing on improvements related to the goals and strategies of *Covering Kids & Families*. The success of the first collaborative led to the second *Covering Kids & Families* Eligibility Process Improvement Collaborative in 2005. A total of 27 states participated in these collaboratives.

Covering Kids, *Covering Kids & Families*, *Supporting Families* and the *Covering Kids & Families* Eligibility Process Improvement Collaboratives informed each other and incorporated successful strategies across programs. Figure 2 shows the relationship of the initiatives. The *Covering Kids & Families* Eligibility Process Improvement Collaboratives provided *Covering Kids & Families* statewide and local projects with the opportunity to learn about and apply a data-driven approach referred to as the Model for Improvement,[10] which is described in the Eligibility Process Improvement Collaboratives section of this report.



A comparison of public health coverage policies, processes and requirements between 1997 and 2007 documents the progress that has been made. Prior to the inception of *Covering Kids* in 1997, the eligibility environment was not considered to be family-friendly. In 1997, it was typical for lower-income families to be unaware that Medicaid was available to children in working families. It was also typical for community organizations and providers to think that families had to be on welfare in order to access Medicaid coverage for their children. The application process was primarily the province of

government. Families frequently described the Medicaid application process as "demeaning." There were little to no outreach and awareness activities, and it was rare to find outreach materials with welcoming messages, understandable text and attractive appearances.[11]

In 1997, state and local eligibility agencies were directed to focus primarily on reducing eligibility errors that resulted in ineligible individuals receiving Medicaid coverage. Less attention was given to inappropriate denials and closures of families eligible for Medicaid. Very little application assistance was being provided by non-government organizations. Few individuals outside of government had a working knowledge of eligibility barriers and strategies to remove them. The burden was placed on the applicant to produce all information requested by an eligibility worker. It was a "You go and get it and bring it to me system."

In 1997, 15 states had an asset test for child health coverage. An asset test is particularly counterproductive public policy because it penalizes families who have managed to build the assets they need to get and keep jobs, access health care and be prepared for an economic downturn or national emergency. In 1997, 22 states had a face-to-face interview requirement at application. The face-to-face interview requirement makes it necessary for a family member to travel to an eligibility office, usually during regular business hours. For hourly wage workers this requirement often results in missed work hours and lost pay.

In 1997, 10.6 million American children were estimated to be uninsured. Five million of these children were estimated to be eligible for Medicaid and thus were needlessly uninsured.[12] The good news in 1997 was the passage of the federal SCHIP, which provided much needed additional resources to allow states to cover more uninsured children in lower-income working families.[13]

Today, as a result of the leadership of statewide and local *Covering Kids & Families* coalitions, there is a cadre of people across the nation with knowledge and skills to be effective at identifying and removing Medicaid and SCHIP application and renewal barriers. Today, many public and private entities are involved in assisting Medicaid and SCHIP applicants – enrollment is no longer just a government responsibility. State eligibility agencies have become valuable partners in efforts to reduce the number of uninsured children who are eligible for, but not enrolled in Medicaid or SCHIP.

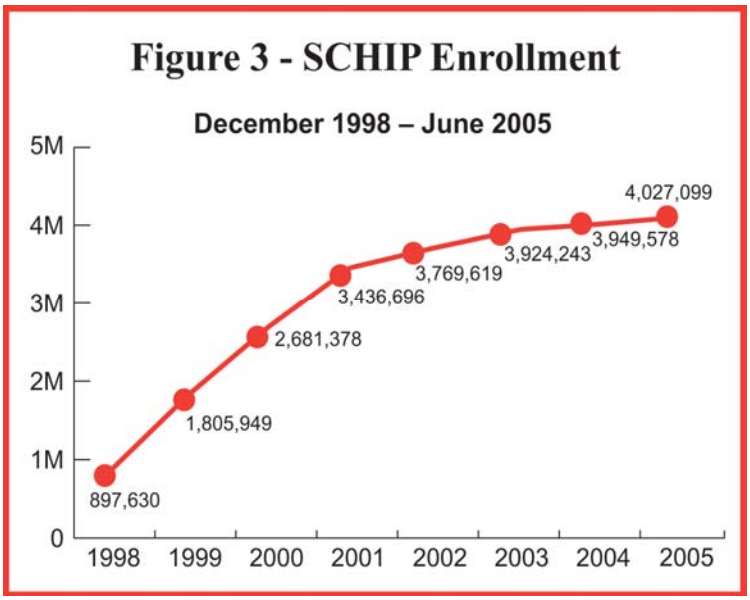
Today, the application process is far more accessible. Applications are available at many more community sites. States are allowing applications to be filed by mail and many allow applications online. Most states have made similar improvements to the renewal process. There are state 1-800 numbers, as well as the national toll-free 1-877-KIDS-NOW number that routes callers to their state of residence for eligibility information and assistance. For the most part, families experience a more dignified application and renewal process, a goal that required a reduction in the verification requirements that were unnecessary for determination of health coverage eligibility.

In 2006, the number of states with an asset test had been reduced from 15 to five, and only five states required a face-to-face interview compared to 22 in 1997. An important measure of the impact of the simplification of the application process is the increased enrollment in Medicaid and SCHIP. Since the initiation of SCHIP, enrollment in the program has increased over 340 percent from 897,630 in December 1998 to 4,027,099 in June 2005 as shown in Figure 3.[14] A more dignified and simplified application process also allowed those children who were

eligible for Medicaid, but uninsured to obtain coverage. States' data indicate for every child enrolled in SCHIP, one or more children are enrolled in Medicaid.[15]

There has been steady growth in SCHIP enrollment for the 50 states and the District of Columbia (December 1998 to June 2005) as displayed in Appendix A. Medicaid enrollment for families, children and pregnant women is only reported for 44 states and is included in Appendix B. While the number of uninsured children in America has decreased since 1997, the lack of nationwide Medicaid data limits the ability to report quantitative data on the impact of the work done over the course of the *Covering Kids* and *Covering Kids & Families* initiatives to identify and enroll those eligible for Medicaid.

The *Covering Kids* and *Covering Kids & Families* initiatives helped transform today's Medicaid and SCHIP programs. Resources provided by RWJF and the hard work and commitment of the statewide and local *Covering Kids & Families* coalitions have made a significant difference in the lives of millions of children and adults who otherwise would still be in the ranks of the uninsured. The efforts of the statewide and local coalition members and other partners have resulted in real policy and procedural changes that help facilitate the enrollment and retention of eligible children and adults in Medicaid and SCHIP.



While the *Covering Kids & Families* grants are phasing out, the leadership continues through the sustained commitment of the individuals and organizations that worked together during the grant period. In most states, the statewide coalitions plan to continue their efforts and are playing a crucial role as part of the interconnected fiber of the public health insurance system for lower-income children and adults.

Today, helping eligible children and adults gain access to Medicaid and SCHIP is recognized as "good public policy." It is cost effective, promotes child development, opens opportunities for children to perform better in school and it supports working parents who don't earn enough to pay for health coverage on their own.

Still, there is more work to be done. There remain millions of lower-income children and adults who are eligible but not enrolled in Medicaid or SCHIP coverage. The creative and effective outreach, simplification and coordination strategies employed by *Covering Kids & Families* are the key to sustainability and the enduring legacy of the initiative. These strategies are the practices that hold the promise for continued progress toward the goal of enrolling and retaining all eligible children and adults in Medicaid and SCHIP.

This Promising Practices Report provides information on a variety of approaches to reduce the number of children and adults who are eligible for, but not enrolled in Medicaid and SCHIP. The report is a hands-on resource to help inform current and future initiatives aimed at improving access to Medicaid and SCHIP for lower-income children and adults. Key players continue to be Medicaid and SCHIP administrators, federal, state and local policymakers, health care providers, advocates, schools, businesses and community leaders. Leadership and sustained commitment to maintaining and building on the gains of *Covering Kids* and *Covering Kids & Families* will assure continued progress. These "promising practices" are representative of the *Covering Kids & Families* legacy.

Covering Kids & Families

From 1997 to 2002, *Covering Kids* coalitions across the country worked to identify and enroll uninsured children who were eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). During this period, a number of states expanded their health coverage programs to include eligible parents and other adults who work in jobs that either do not provide health care coverage benefits for their employees or do not provide coverage that is affordable. In response to the need to continue support for coalitions working to enroll uninsured children in Medicaid and SCHIP and to assist uninsured, eligible adults, the Robert Wood Johnson Foundation (RWJF) launched *Covering Kids & Families* in 2001. The *Covering Kids & Families* initiative includes a mix of new statewide and local project partners and former *Covering Kids* statewide and local lead organizations.

A National Advisory Committee appointed by RWJF made recommendations on applications from 50 states and the District of Columbia. Awards were made in phases during the application review process. Ultimately, awards were made to 45 states and the District of Columbia. The maximum grant per state was $1 million for a four-year period, with the stipulation that the statewide project provide matching funds equal to or exceeding 50 percent of the total four-year allocation. The intent of the match requirement was to help projects look beyond the RWJF resources and start early in planning for sustainability after *Covering Kids & Families*.

The five remaining states received smaller grants referred to as *Covering Kids & Families* Liaison awards. As part of the *Covering Kids & Families* initiative, the liaison projects focused on increasing the number of eligible children and adults enrolled in Medicaid and SCHIP. The liaison projects were responsible for: conducting statewide communication campaigns; convening annual statewide meetings of stakeholders; and attending *Covering Kids & Families* regional and national meetings.

Goals, Strategies and Results

Covering Kids & Families is results oriented, with the desired end result clear – enrollment and retention of eligible lower-income children and adults in Medicaid or SCHIP. *Covering Kids & Families* builds the knowledge and practice of effective and efficient approaches for reaching eligible children and adults, for simplifying the enrollment and renewal processes and for coordinating policies and procedures across health coverage programs. The *Covering Kids & Families* initiative has three goals:

Goal 1. Reduce the number of uninsured children who are eligible for Medicaid or SCHIP coverage but remain uninsured.

Goal 2. Reduce the number of uninsured adults 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.

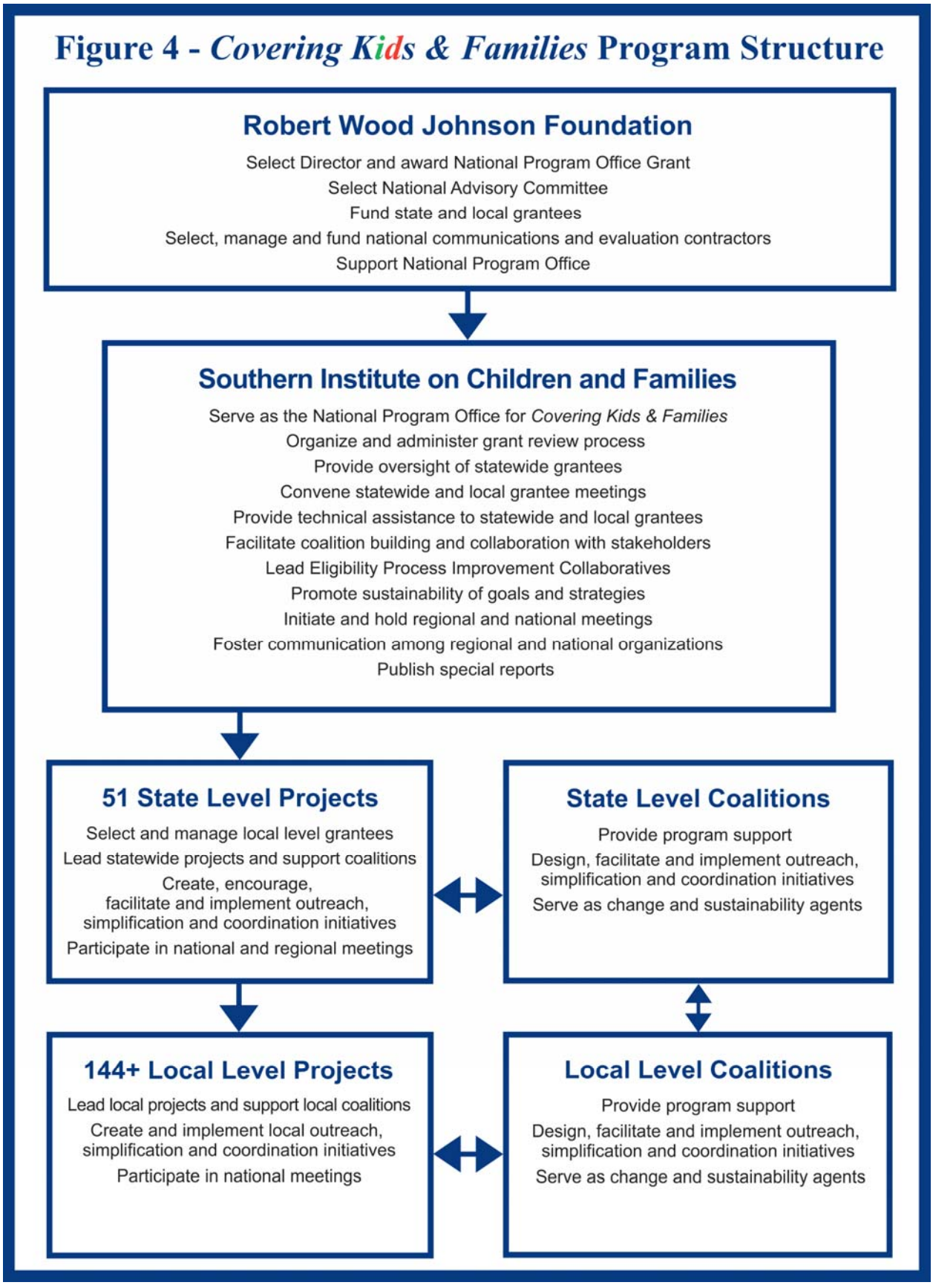
To accomplish the goals, *Covering Kids & Families* statewide and local projects focus on three strategies to reduce the number of uninsured children and adults who are eligible for Medicaid and SCHIP, but are not enrolled:

- Outreach to eligible, uninsured children and adults;
- Simplification of burdensome eligibility policies and practices; and
- Coordination of eligibility policies and procedures among different coverage programs.

Program Structure

The *Covering Kids & Families* program structure includes four entities: RWJF; the Southern Institute (National Program Office); the statewide and local projects; and the statewide and local coalitions. A detailed description of the roles of each of the four entities appears in Figure 4.

Figure 4 - *Covering Kids & Families* Program Structure



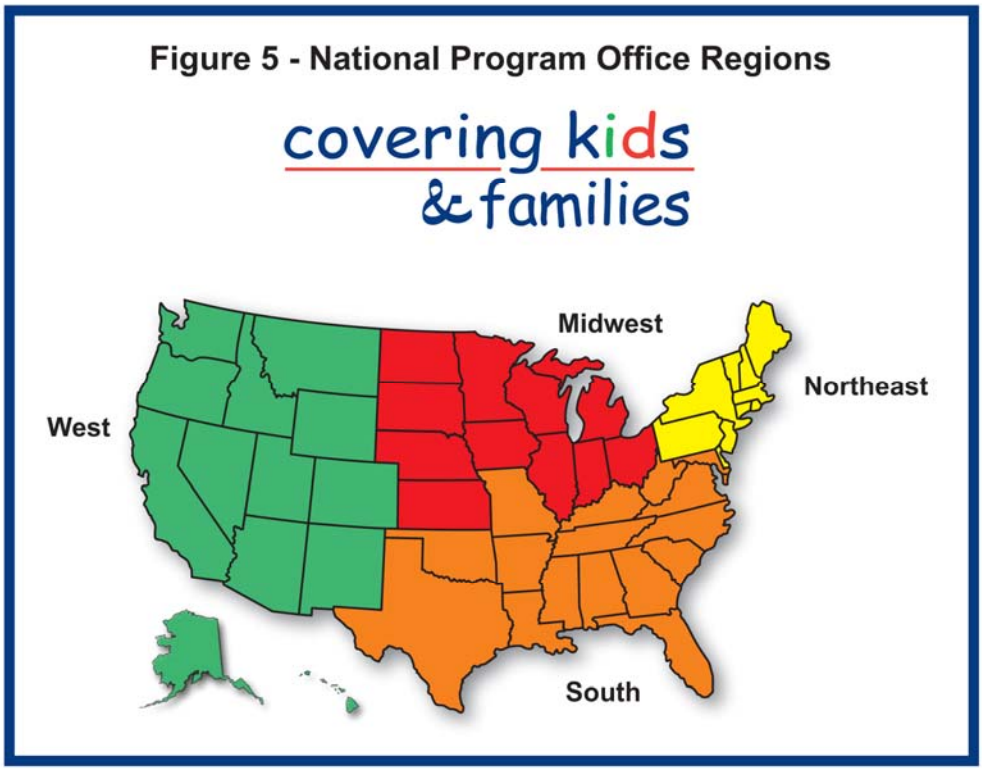
Robert Wood Johnson Foundation

RWJF inspired the program with its vision and funding; selected the National Program Director and National Advisory Committee; and made the final decision on awards to the statewide project organizations. RWJF has direct oversight over the National Program Office, provides overall financial oversight and manages the communications and evaluation contractors.

Southern Institute on Children and Families

As the National Program Office, the Southern Institute has responsibility for overall program leadership and direction and provides oversight of state level projects. The Southern Institute also provides policy expertise, training and technical assistance for state and local level projects, conducts site visits, prepares special reports, convenes national and regional meetings, and leads the Eligibility Process Improvement Collaboratives. The Southern Institute created *Covering Kids & Families* regions, as illustrated in Figure 5 below, and assigned Regional Coordinators for each region. Appendix C lists the states in each region.

Figure 5 - National Program Office Regions

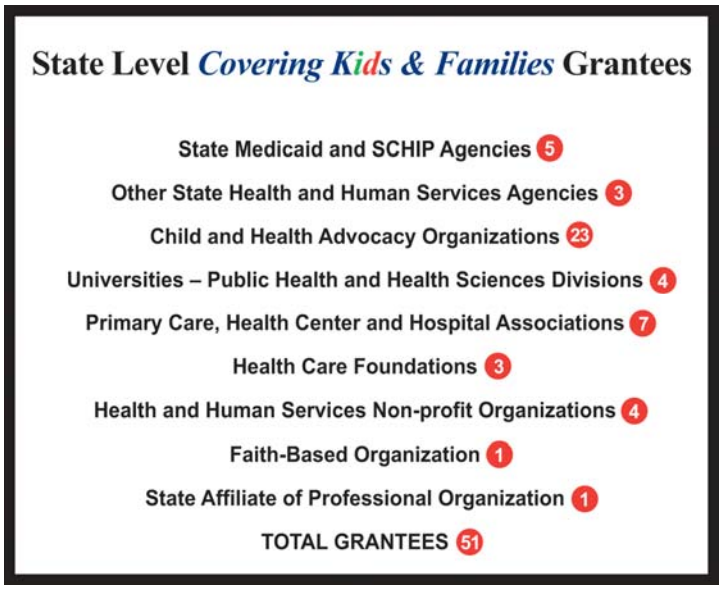


The Southern Institute convened national and regional meetings for the projects to share their experiences and learn more about strategies to accomplish the *Covering Kids & Families* goals. Regional meetings gave *Covering Kids & Families* projects the opportunity to work one-on-one with state and federal Medicaid and SCHIP officials from their respective regions of the United States. The Southern Institute also hosted seminars and national conference calls, such as the "Building and Sustaining Effective Coalitions Seminar" and the national conference call on "Successful Renewal Strategies." In addition, the Southern Institute builds knowledge through special reports and through its *Covering Kids & Families* Announcement and Talk Listservs. A list of health coverage related reports is available online at http://www.thesoutherninstitute.org/.

State and Local Level Projects

Lead organizations for the *Covering Kids & Families* statewide projects (grantees) include a variety of organizations interested in health care coverage for lower-income children and families. Statewide projects develop and support coalitions to address the *Covering Kids & Families* goals. An important outcome for the statewide projects has been the development of sustainable relationships and initiatives that will endure after *Covering Kids & Families*.

Statewide projects are responsible for selecting and managing local level projects. The more than 140 local projects focus on outreach, simplification and coordination at the local level. Similar to the statewide projects, the local projects represent a wide range of community and local groups interested in promoting health coverage for lower-income children and families. Local projects focus on their local communities and support their local coalitions. A list of the statewide and local *Covering Kids & Families* project lead organizations is provided in Appendix D.



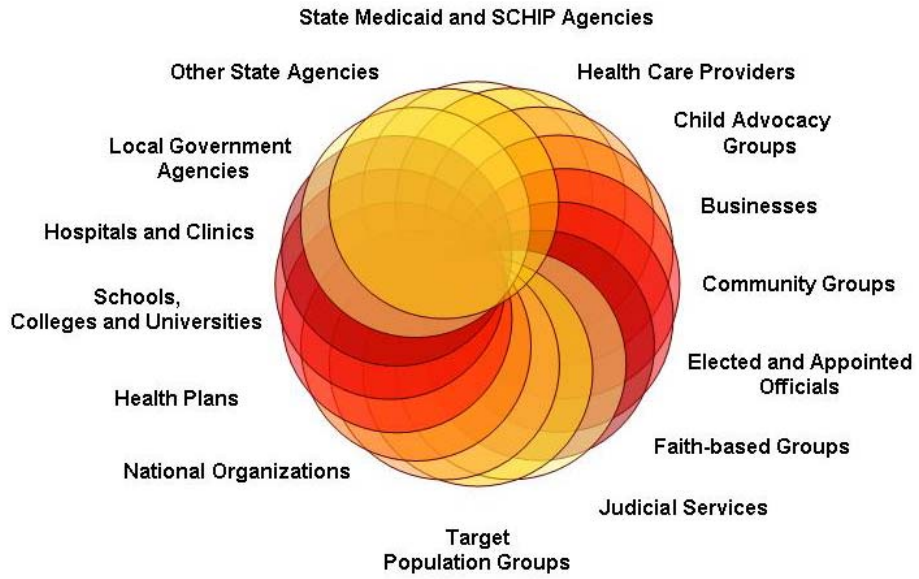
State and Local Coalitions

Statewide and local projects are guided by coalitions that represent a diverse national network of more than 5,500 member organizations as illustrated in Figure 6 on the next page. The coalitions are responsible for designing and implementing outreach, simplification and coordination initiatives and serve as change and sustainability agents. The coalitions work to ensure that eligible children and adults are insured through Medicaid or SCHIP. Each year statewide and local coalitions plan and

implement creative activities in partnership with the RWJF national Back-to-School Campaign to raise awareness and promote enrollment of eligible children and adults in Medicaid and SCHIP.

Through broad representation and active leadership, the statewide and local coalitions have the capacity to galvanize members to achieve public and private sector action on behalf of uninsured lower-income children and adults.

Figure 6 – State and Local Coalition Membership



The Future

Covering Kids & Families projects and coalitions across the nation have been instrumental in reforming eligibility policies and practices and establishing networks and collaboratives to carry the legacy forward and sustain the efforts in the long term. Some initiatives are particularly noteworthy and well-documented and these promising practices are summarized in this report.

Covering Kids & Families grants were time-bound, but the work of the projects and their coalitions is not. Sustaining the effort is in the hands of these projects and coalition members, and they are well prepared to continue to provide leadership on into the future.

Promising Practices Overview

The premise of this report is promising practices demonstrated in one state have the potential to work elsewhere with effective leadership, "how to" information and adequate resources. This Promising Practices Report serves as a resource of potentially replicable initiatives that can lead toward improvements and positive outcomes in other domains.

The *Covering Kids & Families* statewide and local projects have experienced an extraordinary opportunity to improve access to Medicaid and State Children's Health Insurance Program (SCHIP) coverage for eligible children and adults through effective outreach, simplification and coordination strategies. This Promising Practices Report shows how the *Covering Kids & Families* projects reached out to the uninsured through effective media and outreach campaigns, through successful partnerships and linkages, through creative use of the Internet and technology and through broad-based coalitions for planning and implementing enrollment initiatives. The report also highlights effective ways to simplify the enrollment and renewal processes through joint applications, ex parte review, electronic systems and reducing income verification, as well as ways for aligning Medicaid and SCHIP. The promising practices accomplish the following:

- Demonstrate positive results, e.g., outcome data, program change, policy innovation;
- Demonstrate a significant level of impact, e.g., increased enrollment, positive customer satisfaction survey results, "ready-to-process" Medicaid and SCHIP applications and increased renewal notice responses;
- Show potential for replication; and
- Demonstrate a significant level of involvement by *Covering Kids & Families* statewide or local coalitions and projects.

The promising practices are presented in two sections. The first section highlights 31 promising practices from statewide and local *Covering Kids & Families* projects. The second section highlights three significant improvement efforts from the *Covering Kids & Families* Eligibility Process Improvement Collaboratives.

To select the promising practices, staff at the Southern Institute on Children and Families conducted an extensive review of *Covering Kids & Families* project reports and other available reports, including the statewide and local *Covering Kids & Families* online project reports, final *Covering Kids & Families* narrative reports, annual bibliographies, National Program Office site visit letters, annual meeting presentations and interviews with key persons where necessary. After the extensive review of information about practices of potential interest, the *Covering Kids & Families* Regional Coordinators with support from independent contractors collected more in-depth information about each of the potential promising practices. Practices selected for the final review demonstrated results that made policy or system improvements, increased knowledge, added to conventional wisdom and/or had the capacity to galvanize others to action. After a final round of information gathering and review, the Southern Institute staff made the final selection of practices to highlight in this report. Together the promising practices tell an impressive story of the innovative strategies that *Covering Kids & Families* projects used to reduce the number of children and adults who are eligible for but not enrolled in Medicaid and SCHIP. They are not a full census of the effective strategies generated by *Covering Kids & Families* project staff and

coalitions, but rather they represent the broad range of approaches of the *Covering Kids & Families* initiative.

The 31 statewide and local *Covering Kids & Families* project promising practices highlighted in the first section are shown in Appendix E. These promising practices represent both statewide and local projects, led by a full range of agencies and groups from 25 states. The generic terminology of Medicaid and SCHIP is used throughout this report, but many states have their own names for SCHIP and/or children's Medicaid. Appendix E shows the state names for Medicaid and SCHIP programs.

The process improvement efforts of three teams from the *Covering Kids & Families* Eligibility Process Improvement Collaboratives in the second section highlight the Model for Improvement, including the Plan, Do, Study, Act (PDSA) Cycle. The three initiatives described demonstrate practical application of the Model for Improvement.

The promising practices are presented in a user-friendly format that facilitates consideration of replication in other states or local areas. Each promising practice is introduced with a brief explanation followed by: 1) a description of the activity and its focus; 2) the outcomes describing what was achieved as a result of the activity; 3) resources utilized; 4) key partners engaged; 5) lessons learned; and 6) contact information for the promising practice. In the first section, the promising practices are grouped according to the Outreach, Simplification and Coordination strategies. The improvement strategies in the *Covering Kids & Families* Eligibility Process Improvement section highlight the PDSA Cycle.

The lessons learned from *Covering Kids* informed the *Covering Kids & Families* initiative. As the *Covering Kids & Families* initiative comes to an end in 2007, the lessons learned from *Covering Kids & Families* likewise will inform future endeavors. The promising practices in this report are intended to assist Medicaid and SCHIP officials, federal, state and local policymakers, health care providers, schools, businesses, child advocates, Medicaid and SCHIP eligibility workers, legal service workers and others invested in ensuring health coverage for lower-income children and families.

Statewide and Local Project/Coalition Promising Practices

Outreach

Outreach brings the Medicaid and State Children's Health Insurance Program (SCHIP) application process to the eligible population. Distance, time, health, cultural and language barriers prevent many eligible families and children from engaging in a face-to-face interview at a Medicaid or SCHIP eligibility office. Outreach means bringing the application process closer to their health care providers, homes, work and everyday lives. Outreach means reaching out from the eligibility offices to the broader community. Outreach also means making the eligible population aware of the health coverage available through Medicaid and SCHIP and increasing their knowledge about eligibility criteria and how to apply. Media and information campaigns are tools for reaching out to eligible but uninsured children and adults.

Covering Kids & Families has played a critical role in developing and implementing effective outreach approaches to identify and enroll eligible children and adults in Medicaid and SCHIP. The statewide and local *Covering Kids & Families* coalitions have been creative in designing and implementing effective activities and approaches to reach eligible children and adults through partnerships at the state and local levels. In addition, statewide and local *Covering Kids & Families* coalitions have provided leadership in training thousands of community-based organizations on their states' outreach, eligibility criteria and application requirements. The coalitions have worked with community entities to institutionalize outreach efforts to reach eligible children and adults with whom they interface through their organizations.

The 18 promising practices outlined in this section represent the wide range of possible approaches to outreach. Some of the practices focused on establishing partnerships. Others worked on getting the word out. Some focused on the initial application, and others focused on the renewal process. Some utilized automated systems to facilitate outreach. Other outreach promising practices focused on geographic areas or special populations and circumstances. They all shared one factor – they reached out to achieve the goal of increased Medicaid and SCHIP enrollment for eligible children and adults.

Partnering With Local Eligibility Office Through an Enrollment Coordinators Work Group

PROMISING PRACTICE	Hold bi-weekly Medicaid and SCHIP enrollment coordinators meetings to facilitate **outreach** and **simplify** processes by discussing enrollments, barriers, educational activities and other relevant topics. Communication between outreach workers and the local eligibility office resulted in shared common goals, improved accuracy of the applications submitted and increased enrollment and renewals.
DESCRIPTION	The Enrollment Coordinators Work Group is facilitated by the staff of the Indiana local *Covering Kids & Families* project, St. Joseph County Coalition. Medicaid and SCHIP enrollment coordinators are located at various sites within the community, such as medical centers, hospitals, Head Start and local agencies. For example, the enrollment center coordinators come from the St. Joseph Regional Medical Center, Memorial Hospital, Family and Children Center, Health Department, Indiana Health Center, Head Start Early Childhood Program and the Department of Family and Children. Bi-weekly meetings were held bringing together all of the community-based enrollment center coordinators and the benefits advocates from the county Medicaid and SCHIP eligibility office, the Division of Family Resources (DFR). The meetings facilitated collaborative work on Medicaid and SCHIP enrollment and renewal issues or challenges. For example, strategies were discussed on piloting with the local DFR office a renewal campaign called "If it's Blue, it's Time to Renew," where renewal notices are sent in a blue envelope to be easily identified. The Enrollment Coordinators also documented stories, collected enrollment center data and reviewed county data reports to identify barriers to enrollment and renewals as a result of the negative impact of the elimination of continuous eligibility. The Enrollment Coordinators gave information back to the statewide *Covering Kids & Families* coalition to facilitate advocating for reinstating continuous eligibility. The Enrollment Coordinators also provided monthly data to the coalition on the number of applications received, denied and approved in a month. This important data allowed outreach to be tailored to strengthen certain areas in the community and provided an avenue for identifying other procedural or policy barriers on a regular basis. The DFR representative also provided feedback and training to the enrollment coordinators regarding the status and quality of applications submitted.

OUTCOMES	▪ The Enrollment Coordinators Work Group:
	  ▫ Allows partners to understand the issues each enrollment center faces and gives everyone an opportunity to express perspectives and to offer possible improvements on the application and renewal process.
	  ▫ Gives the coalition a chance to coordinate outreach activities.
	▪ Processing time of new applications decreased from an average of 30 days to less than 10 days. Quality of applications continues to be maintained.
	▪ Ideas and suggestions to simplify the application and renewal process were given directly to the DFR office based on customer feedback received at the community-based enrollment sites.

RESOURCES	▪ Partners from the community-based enrollment sites ▪ Partners in the local eligibility office, including the director and eligibility staff ▪ Meeting space ▪ Staff to organize the meetings, agendas and follow-up tasks and maintain membership lists and contact information ▪ A skilled facilitator viewed as objective by members of the group
ACTION STEPS	▪ Establish a meeting site. ▪ Convene the Work Group to establish goals and schedules. ▪ Hold regular meetings and present information to the coalition. ▪ Follow up on ideas generated at the meetings.
KEY PARTNERS	▪ Enrollment Coordinators from the St. Joseph Regional Medical Center, Memorial Hospital, Family and Children Center, Health Department, Indiana Health Center, Head Start and the Department of Family and Children provided feedback on the consumer perspective of the application process and regular data on the number of applications they assisted in completing, the number approved and the number denied each month. ▪ The DFR representative provided training on the application process and feedback on the status and quality of the applications completed.
LESSONS LEARNED	▪ The partnership gives everyone a chance to get actively engaged in outreach activities for enrolling new individuals into the program and assisting families with renewing their coverage. ▪ The partnership gives enrollment centers an avenue for sharing information with the DFR on barriers to enrolling and renewing coverage and discussing possible solutions. ▪ Once established, the success of the group's endeavor provided the momentum to continue. ▪ Leadership from the local eligibility office and an effective facilitator who was seen as "objective" by the members of the work group were important aspects of establishing and continuing this work group.

CONTACT INFORMATION	**Project**	United Way of St. Joseph County, Inc. Local *Covering Kids & Families* Project South Bend, Indiana
	Contact	Doranna Byrd Phone: 574-236-1049 Email: dbyrd@ckfindiana.org
	Web site	http://ckfindiana.org/st_joseph/

Tracking Outreach Outcomes	
PROMISING PRACTICE	Develop an **outreach** database to document the work of the statewide *Covering Kids & Families* project, identifying barriers encountered by families seeking coverage and tracking trends. The outreach database facilitated the Medicaid and SCHIP enrollment process and identified barriers.
DESCRIPTION	The Connecticut statewide *Covering Kids & Families* project, Connecticut Voices for Children, engaged an outside consultant to develop an ACCESS database to track Medicaid and SCHIP outreach outcomes and another consultant to maintain the database. The Connecticut *Covering Kids & Families* Automated Client Tracking System (ACTS) was a valuable tool in identifying barriers to enrollment. The system tracks outreach efforts, automatically triggers follow-up on cases and reports on cases in which families encountered eligibility barriers. This tracking system was used by the Hartford HUSKY Outreach Project and the two local *Covering Kids & Families* projects, Bridgeport/Stratford – Bridgeport Child Advocacy Coalition and East of the River HUSKY Collaborative. Staff from the statewide and local *Covering Kids & Families* projects was trained to use laptop computers to collect the data. The three local project sites had the ability to track all cases and their associated calls. Data collected for ACTS included case status, case outcomes, case demographics (family characteristics, language and ethnicity), client contacts, how clients heard about the project, reasons for client contact, actions taken by the local projects to assist clients, agencies to which staff refer clients for assistance and/or for advocacy on behalf of the client and barriers experienced by families in application or renewal processes. The ACTS database is capable of linking a client to an agency, outreach event or family, tracking outreach materials used at events, generating reports by the geographic area and generating mailing lists/labels for family and agency contacts. Other reports broken down by site delineated reasons for calls, enrollment status, and barriers encountered. The reports made it possible to tally the number of adults and children enrolled, renewed, pending and denied as well as those who did not apply due to immigration status. The tracking system also allowed community staff to maintain renewal date information in order to remind families of renewal requirements.
OUTCOMES	▪ ACTS reports showed that applications for pregnant women were not always processed in a timely manner, with some taking up to 45 days. This issue was raised with state partners and a new process of identifying pregnant women applications was developed reducing the processing time to 10 days or less. ▪ ACTS reports opened dialogue about children losing coverage when a child moves from Medicaid and SCHIP and presumptive eligibility for pregnant women. ▪ ACTS reports showed that local *Covering Kids & Families* project staff enrolled or renewed coverage for 910 children and 263 adults in one year.

OUTCOMES (continued)	▪ 156 enrollment and renewal issues were identified, with social service system barriers the most frequently cited. ▪ The database also proved helpful in identifying families who became eligible once policy changes affecting immigrants were implemented.
RESOURCES	▪ State or private investment in the ACCESS database ▪ Collaboration and data sharing between the public program agencies and the data collection and analysis agency ▪ Training for project staff on how to implement the data collection ▪ Portable laptop computers ▪ Regular assessment and analysis of the data collected
ACTION STEPS	▪ Secure funding and other resources to develop an outreach database. ▪ Develop the outreach database. ▪ Test the database at local project sites. ▪ Collect data and provide feedback on the enrollment process and barriers.
KEY PARTNERS	▪ Carey Consulting developed the ACCESS database. ▪ Maximus Inc. maintained the ACCESS database. ▪ Hartford HUSKY Outreach Project served as a test site.
LESSONS LEARNED	▪ The success of the tracking system stemmed from the collaborative team approach with the local *Covering Kids & Families* project staff and the consultants in developing and implementing this system. ▪ The quarterly coding meetings in which cases, problems encountered and trends were discussed ensured that the tracking system could collect the information needed to document the identified changes and new issues.

CONTACT INFORMATION	**Project**	Connecticut Voices For Children Statewide *Covering Kids & Families* Project Connecticut
	Contact	Sharon Langer Phone: 860-548-1661 Email: slanger@ctkidslink.org
	Web site	http://www.ctkidslink.org/covering.html

Spreading the Word Through Frequently Asked Questions

PROMISING PRACTICE	Develop **outreach** materials and enrollment information on Medicaid and SCHIP tailored to specific professional and community constituencies, thereby encouraging a systems approach to enrollment and renewal. The information is organized as frequently asked questions (FAQs), posted on a Web site, and updated as needed.
DESCRIPTION	Working through existing professional organizations to educate members about Medicaid and SCHIP, the North Carolina statewide *Covering Kids & Families* project, North Carolina Pediatric Society Foundation, developed and distributed FAQs educational materials tailored to a variety of constituencies. By tailoring the FAQs to specific constituencies, a systems approach to Medicaid and SCHIP enrollment and renewal was encouraged. Some FAQs were developed by the North Carolina Healthy Start Foundation and these were supplemented with "in-house" FAQs. The FAQs are posted on the Web site of the statewide *Covering Kids & Families* project with links for specific constituencies for helpful information about North Carolina's Medicaid and SCHIP programs. The constituencies include child care providers, child care health consultants, child care resource & referral agencies, medical practice managers, religious leaders, public school superintendents and principals, human resource managers, teachers and department of social service employees. In addition to the FAQs, "electronic note cards" are also distributed and posted at the Web site providing regular updates on program changes, outreach strategies and successful messaging. The electronic note cards contain up to 3 messages in both English and Spanish. The FAQs explicitly articulate how income eligibility guidelines for subsidized child care and Medicaid cohere and address the following questions: ▫ What is Health Check/Health Choice (Medicaid and SCHIP)? ▫ Why should children enroll? ▫ What are the income eligibility guidelines? ▫ Can an unemployed parent apply? ▫ How does a family apply for children's health insurance? ▫ What happens to the application? ▫ Is there a charge for children's health insurance? ▫ How can the constituency promote children's health insurance? Outreach to diverse groups led to invitations for the statewide *Covering Kids & Families* project staff to present information on children's health coverage at professional meetings throughout the state, furthering the partnership with professional groups.

OUTCOMES	▪ The North Carolina Association of County Directors of Social Services (DSS) sent the DSS constituency FAQ out to all directors. Directors also received an electronic note that they could customize with local contact information and use in training of child care workers at child care facilities that accept subsidies. ▪ These materials are widely utilized – 3,000 FAQ handouts were distributed to early education groups and 425 handouts were sent to social services and health care groups.
RESOURCES	▪ Relationships with diverse provider groups ▪ An understanding of the roles of management and line staff in the area of health care, pharmacy, schools, faith-based organizations and child care ▪ Staff to create the FAQs and post them on the Web ▪ Outreach to groups to make constituencies aware of the FAQs
ACTION STEPS	▪ Develop FAQs and electronic notes materials with assistance from partners and tailor them specifically to each constituency. ▪ Post FAQs and electronic notes on Web site. ▪ Maintain the FAQs and electronic notes. ▪ Distribute the FAQs and electronic notes as appropriate.
KEY PARTNERS	▪ Professional organizations provided information and did outreach. ▪ North Carolina Healthy Start Foundation developed some of the FAQs.
LESSONS LEARNED	▪ The versatile FAQs simplified the process of tailoring outreach to specific constituencies. The customized FAQ is a tool that complements those generally available from state sources. Local agencies can further customize the document to meet particular needs.

CONTACT INFORMATION	**Project**	North Carolina Pediatric Society Foundation Statewide *Covering Kids & Families* Project North Carolina
	Contact	Steve Shore Phone: 919-839-1156 Email: ssncps@attglobal.net
	Web site	http://www.ncpeds.org

Sending a Unified Marketing Message	
PROMISING PRACTICE	"Brand" the name of the children's Medicaid and SCHIP program statewide through television ads and other media to support **outreach** efforts. Following the media campaign there was a significant increase in applicants reporting television ads as their source of information about the health coverage program.
DESCRIPTION	The Virginia statewide *Covering Kids & Families* project, the Virginia Health Care Foundation, worked to develop a unified, effective message campaign through a collaborative partnership among key stakeholders. The Virginia statewide *Covering Kids & Families* coalition formed a partnership with Anthem (managed care organization) and the Department of Medical Assistance Services (Medicaid and SCHIP office) to share their resources to support and lead this major initiative. The media campaign reinforced the FAMIS (Virginia's children's Medicaid and SCHIP program) label and addressed questions regarding who is qualified, how to apply and the importance of having FAMIS health care coverage. The emphasis was on providing clear and accurate information about the program. Initially, research was conducted to identify the diverse, eligible populations. A survey was completed by the Value, Access and Utilization Task Force of the statewide *Covering Kids & Families* coalition. Based on survey results, four population groupings were identified: 1) 14 percent of the parents do not value health insurance and do not want help from the government; 2) 30 percent of the parents manage their income and family responsibilities well enough to pay for their children's health insurance; 3) 33 percent of the parents value what government programs can do for their families; and 4) 23 percent of parents feel a lot of financial pressure and are not sure how to get the health insurance they want and need for their children. As a result of the research, the campaign developed a plan to use parents from Group 3 (parents who value government programs made available for their families) to speak to the parents in Group 4 (parents who are under financial pressure and not sure how to access health insurance for their children). A statewide search was conducted to identify a spokesperson from among Group 3 respondents to be the "messenger" in the media campaign. The campaign was launched with a new public service television advertisement, flyers and the Governor's press conference introducing "Julia," a parent of children enrolled in FAMIS, as the spokesperson.
OUTCOMES	▪ With the synergy created through this collaboration the outcomes and end products were far greater than any one of the groups would have been able to produce. ▪ The message campaign was successful as demonstrated by a 167 percent increase in applicants reporting television ads as their source of information about the FAMIS program.

RESOURCES	▪ Leadership and capacity to galvanize as a coalition ▪ Expertise to conduct and analyze market research about the target audience ▪ Strong relationships with key stakeholders ▪ Credibility and strong relationships with key state Medicaid and SCHIP officials ▪ Strong knowledge of state and federal program rules and regulations ▪ Financial resources to develop and produce the advertising campaign materials for TV, radio and print media
ACTION STEPS	▪ Form partnerships and develop working relationship with Medicaid and SCHIP agency. ▪ Conduct market research. ▪ Based on the research, develop the advertising campaign. ▪ Identify a spokesperson to be the "messenger" in the media campaign. ▪ Launch the media campaign. ▪ Collect data.
KEY PARTNERS	▪ Medicaid and SCHIP officials contributed financial resources and program expertise. ▪ Managed Care Organization contributed financial and other resources. ▪ TV and radio media partners aired public service announcements.
LESSONS LEARNED	▪ Surveying the target audiences is an effective method to identify appropriate messaging approaches. ▪ Launching the campaign at the Governor's press conference garnered earned media with a particular focus on the new spokesperson.

CONTACT INFORMATION	**Project**	Virginia Health Care Foundation Statewide *Covering Kids & Families* Project Virginia
	Contact	Judith Cash Phone: 804-828-5804 Email: judith@vhcf.org
	Web site	http://www.vhcf.org

Enrolling the Uninsured Through Health Provider Partnerships	
PROMISING PRACTICE	Conduct Medicaid and SCHIP **outreach** to uninsured people seeking health care services at Kahuku Hospital, including emergency room (ER) patients and uninsured hospital patients by establishing inreach and outreach services at a hospital setting. The services increased enrollment in Medicaid and SCHIP and saved the hospital significant dollars.
DESCRIPTION	The Hawai'i *Covering Kids & Families* local project, Kahuku Hospital, designed innovative strategies for rural hospital inreach and outreach to address enrollment barriers in the community. The local *Covering Kids & Families* project inreach worker assisted uninsured ER or hospital patients with completing Medicaid and SCHIP applications. The completed and signed application was faxed by the receptionist the same day to the Hawai'i Department of Human Services office to protect the application's submission date. The next business day the local *Covering Kids & Families* project outreach worker contacted the customer for additional information. The inreach worker also checked a daily list to identify hospital patients without insurance. The local *Covering Kids & Families* project inreach worker assisted the potentially eligible patients in completing Medicaid and SCHIP applications. The worker also assisted mothers in enrolling their newborn infants into the appropriate health coverage program. The hospital then provided the delivery verification for newborns automatically to the Hawai'i Department of Human Services Med-QUEST (Medicaid and SCHIP) Division. The outreach worker also partnered with local obstetricians, gynecologists and family practitioners to help pregnant women and their newborns get coverage.
OUTCOMES	▪ Over the four-year *Covering Kids & Families* grant the efforts of the local project to enroll uninsured individuals accessing services at the Kahuku Hospital contributed to decreasing the number of uninsured in the community and saving the hospital a total of $1,065,916 that was billed for Medicaid and SCHIP services. ▪ The ER enrollment process has improved efficiency in streamlining Medicaid and SCHIP applications for follow-up by the outreach and inreach workers.
RESOURCES	▪ Hospital partners ▪ Hospital administrators to support the use of staff for application assistance ▪ Partnership with Medicaid and SCHIP staff ▪ Staff capacity to assist patients through the application process ▪ Systems to identify and track patients in need of assistance ▪ Training for hospital staff working in the billing department and emergency room

ACTION STEPS	▪ Establish a working relationship with hospital administrators and emergency room staff. ▪ Identify outreach and inreach workers. ▪ Meet with outreach and inreach workers and hospital billing department staff to discuss the Medicaid and SCHIP application process. ▪ Establish a procedure for making referrals with the hospital's emergency room receptionists. ▪ Collect data for feedback.
KEY PARTNERS	▪ Hospital administrators and staff facilitated the referral system. ▪ Local obstetricians, gynecologists and family practice physicians facilitated contact with patients needing Medicaid and SCHIP application assistance.
LESSONS LEARNED	▪ Working with the billing department and emergency room staff helped simplify the Medicaid and SCHIP application process for patients. ▪ Billable services were recouped for eligible patients because they immediately applied for Medicaid and SCHIP.

CONTACT INFORMATION	**Project**	Kahuku Hospital Local *Covering Kids & Families* Project Kahuku, Hawai'i
	Contact	Michelle Malufau Phone: 808-387-9217 Email: mmalufau@hotmail.com
	Web site	N/A

Increasing Enrollment Through Emergency Rooms	
PROMISING PRACTICE	**Outreach** to children treated in hospital emergency rooms (ER) using a **simplified** application and enrollment process for Medicaid and SCHIP health care coverage. The project established effective and timely ER enrollment procedures.
DESCRIPTION	The North Carolina local *Covering Kids & Families* project, the Buncombe County Department of Social Services (DSS), implemented a hospital ER enrollment initiative at two Mission Health, Inc. hospitals in Asheville, NC – Memorial and St. Joseph. The local *Covering Kids & Families* project team worked with a "champion" from within Mission Health corporation to make the business case for the collaboration. Any parent or guardian of an uninsured child treated at Memorial or St. Joseph hospital was offered the opportunity to apply for Medicaid and SCHIP at the time of discharge. It was unrealistic to expect hospital staff to complete the entire application with the family prior to leaving the ER. Therefore, the "bare bones" application was taken at the hospital ER. The ER staff completed the highlighted mandated questions on the regular state application. The mandated questions included the name of the child, birth date and sex as well as an address and phone number with the name and birth date of the parent or guardian and their relationship to the child. The application also needed the parent/guardian's signature and the date of the application. This "bare bones" version of the application was then forwarded to the Buncombe County DSS Outreach Worker stationed at the hospital. The DSS Hospital Outreach Worker sent the signed application to a call-center Medicaid and SCHIP Outreach Coordinator who followed up with a call to the family at a convenient time (either day or night) to complete the rest of the application. The Outreach Coordinator then forwarded the application to the Buncombe County DSS Eligibility Worker for processing. The Outreach Coordinator trained the ER staff on the completion of the application. It is critical to protect the date the child is seen in the ER so the hospital bill will be paid and ongoing Medicaid and SCHIP coverage is initiated. The DSS Hospital Outreach Worker receives the application on the date of service so that the date of the ER visit can be protected.

OUTCOMES	▪ The number of applications received from the hospital ERs increased:
	  □ 10/01/05 through 09/30/06 – Eighty applications were received, or 2.4 percent of all applications with a location identifier.
	  □ 07/01/06 through 11/17/06 – Forty-nine applications were received, or 4.3 percent of all applications with a location identifier.
	▪ The process was well received by hospitals and seen as a financial benefit.
	▪ The process has resulted in more complete/accurate applications.
	▪ The success of the program led to institutionalization of the initiative in the ER.

RESOURCES	▪ A corporate/hospital administrative person to serve as a "champion" for the project ▪ Staff to build and nurture the relationships between DSS and the hospital ER ▪ A simplified Medicaid and SCHIP application mechanism to preserve the application date as the date of service ▪ ER staff to provide intake and DSS staff to provide follow up client contact
ACTION STEPS	▪ Establish collaborative partnerships with hospitals. ▪ Identify hospital ER partners able to complete the first step of the Medicaid and SCHIP application with families. ▪ Verify the capacity of DSS eligibility staff to complete the remainder of the application over the phone. ▪ Monitor the outcomes of this enrollment simplification for families.
KEY PARTNERS	▪ The Mission hospitals' staff devised strategies to help families apply for coverage at ER discharge and forwarded the applications to the DSS office.
LESSONS LEARNED	▪ Persistence is needed in approaching the hospital leadership and finding the person within the hospital who can act as a "champion" for the project. ▪ Making a business case helped assure the hospital staff that the project was in their financial interest. ▪ The simplified application used at the hospital resulted in cooperation by the ER staff.

CONTACT INFORMATION	**Project**	Buncombe County Department of Social Services Local *Covering Kids & Families* Project Asheville, North Carolina
	Contact	Jim Holland Phone: 828-250-5531 Email: jim.holland@buncombecounty.org
	Web site	http://www.buncombecounty.org

Reaching Pregnant Women and Children Through Health Clinics	
PROMISING PRACTICE	Conduct an **outreach** and awareness campaign to enroll pregnant women, particularly Hispanic women in Medicaid. Over 5,000 pregnant women enrolled into the Oklahoma Medicaid program.
DESCRIPTION	The Oklahoma statewide *Covering Kids & Families* project led an outreach and awareness campaign to enroll eligible pregnant women in Medicaid. The primary outreach focus was to Hispanic pregnant women, particularly with the Oklahoma City local *Covering Kids & Families* project. Effective strategies included educating and providing technical assistance to medical professionals, conducting a media campaign and facilitating outreach activities. Refer to Appendix F for information on eligibility criteria related to health coverage of pregnant women. Variety Health Center, the Oklahoma City local *Covering Kids & Families* project, used the Promotora program model for enrolling eligible Hispanic women and their children. The Promotora program is a health information initiative from the Baylor University School of Nursing. The Variety Health Center's Promotora program was a trusted source for Medicaid and SCHIP information and application assistance to the Hispanic population. Through a collaborative cost-sharing partnership with the Oklahoma Department of Human Services, the local project was able to place an outstationed Promotora eligibility worker onsite at the Variety Health Center to assist and enroll eligible women from the Hispanic community. The outstationed Promotora eligibility worker was an employee of the state Medicaid and SCHIP agency. The state employee status of the outstationed Promotora eligibility worker gave access to the state's Medicaid and SCHIP computerized system to enter application data and determine eligibility onsite for the applicants. The health center developed a tracking system to follow up on application outcomes. To support community outreach, the statewide *Covering Kids & Families* project also worked with corporate organizations such as McDonald's, Babies"R"Us and a local television station to promote the importance of helping pregnant women, Hispanics and other eligible families to access health coverage. The statewide lead agency was also awarded a Healthy Beginnings grant that the project was able to leverage as match funds in support of their *Covering Kids & Families* goals and objectives. The Healthy Beginnings campaign piloted Medicaid outreach strategies to pregnant women at four sites across Oklahoma, including the Oklahoma City area and a Promotora program's translation of a comprehensive prenatal brochure into Spanish. In 2003, the Healthy Beginnings Campaign developed a media campaign, including bus and bus bench transit ads, op-eds, radio and television public service announcements with a focus on reaching minority populations. Op-editorials to El Nacional and El Latino newspapers were disseminated to various local minority newspapers that focus on reaching these populations with the Healthy Beginnings message. The successful collaborative partnership with the state Medicaid and SCHIP agency (Oklahoma Health Care Authority) was replicated by the Northeast Oklahoma local *Covering Kids & Families* project. Local Oklahoma City *Covering Kids & Families* project staff trained the Northeast Oklahoma staff.

OUTCOMES	▪ Over a two-year period, the Oklahoma City local *Covering Kids & Families* project enrolled 12,850 pregnant women into the Oklahoma Medicaid program. ▪ In 2004, the Outreach Campaign received over $40,800 worth of pro-bono air time promoting the Campaign.
RESOURCES	▪ Training in the Promotora program ▪ Culturally competent, Spanish speaking staff from the Hispanic community for the Promotora program ▪ Capacity to engage community-based organizations and health care providers in outreach and enrollment tactics ▪ Staff to provide training ▪ Funding for staff and development and distribution of education/promotional materials ▪ Capacity to engage business in outreach activities ▪ Partnership with local media
ACTION STEPS	▪ Engage community-based organizations and health care providers in outreach and enrollment tactics for the minority communities. ▪ Provide training and translate materials. ▪ Fund staff and the development and distribution of materials. ▪ Partner with local media.
KEY PARTNERS	▪ Variety Health Center's Promotora program outreached to the Hispanic community and translated a variety of materials into Spanish. ▪ Business partners supported the outreach effort and relationships with health care provider organizations to promote the importance of helping pregnant women access health coverage.
LESSONS LEARNED	▪ Many direct service agencies and providers have a better understanding of the Medicaid eligibility procedures because of the Healthy Beginnings Campaign and many minority pregnant women have a better understanding of the importance of prenatal care and seek prenatal services.

CONTACT INFORMATION	**Project**	Oklahoma Institute for Child Advocacy Statewide *Covering Kids & Families* Project Oklahoma
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Reaching Uninsured Families Through the School Lunch Program

PROMISING PRACTICE	Expand existing partnerships with school health and school lunch programs by matching Medicaid, SCHIP and school lunch current enrollment lists to identify potentially eligible children and do **outreach** to enroll them into public health coverage programs. The matched enrollment lists resulted in increased enrollment.
DESCRIPTION	In response to 2004 Congressional legislation mandating that all schools participating in the National School Lunch Program do direct verification matches with the Food Stamp Program and TANF, the St. Joseph County local *Covering Kids & Families* project tested a matching system that could then be implemented across the state. The Indiana Department of Education (DOE) Nutrition Director, a statewide *Covering Kids & Families* coalition member, volunteered to work with the local project to pilot test the direct verification match process and then implement the process statewide. The Indiana Family and Social Services Administration (FSSA) Medicaid Office matched the Medicaid and SCHIP and school lunch program enrollment lists to identify children not enrolled in health coverage. Contact information was provided by the schools, and families were contacted via phone or mail to help them apply for Medicaid and SCHIP. The data also provided an opportunity to remind those currently enrolled to renew their coverage. The statewide *Covering Kids & Families* coalition provided direction and ideas to the local *Covering Kids & Families* coalitions (Allen County, Cass/Fulton County, Delaware County, Lake County, Marion County/Central Indiana, and St. Joseph County) for implementing outreach and enrollment strategies through schools. The statewide coalition developed a toolkit based on the experiences of the local *Covering Kids & Families* projects. They also identified barriers in the school lunch outreach process and worked with FSSA to refine the process. The local *Covering Kids & Families* coalitions encouraged school districts to participate in the matching process and to join the *Covering Kids & Families* coalitions. Local *Covering Kids & Families* staff worked with school superintendents, school nurses and counselors to establish an initial partnership that grew significantly over time through additional activities such as outreach during Back-to-School nights and participation in Back-to-School community events. In some instances, memoranda of understanding with school districts were signed to build further on the partnerships. School districts provided the local *Covering Kids & Families* coalitions with lists of children eligible for free or reduced price school meals and the local *Covering Kids & Families* staff provided follow-up contact with families to encourage them to apply for Medicaid and SCHIP.
OUTCOMES	▪ This process made a significant difference in raising awareness about Medicaid and SCHIP and increasing enrollment during the beginning of each school year. ▪ Enrollment trends during the first months of the school year showed increases by as much as 20 percent. ▪ Local *Covering Kids & Families* projects receive referrals throughout the school year from school nurses, aides or other school health personnel to assist with getting uninsured children covered.

RESOURCES	▪ Strong partnership with state Education and Medicaid and SCHIP departments to implement innovative strategies to utilize the Congressional amendment to reach uninsured children through the school lunch program ▪ State level capacity to match health coverage enrollment data with school lunch enrollment data ▪ Coalition infrastructure to support strategy development to be implemented at the local level ▪ Local coalition partnerships with school districts ▪ Local outreach staff to make connections with targeted school districts to provide outreach to identified families and build relationships with local enrollment centers
ACTION STEPS	▪ Establish a strong relationship with state Education and Medicaid and SCHIP agencies. ▪ Match school lunch program and Medicaid and SCHIP enrollment data. ▪ Develop reports identifying uninsured children by local school districts. ▪ Outreach to the families of uninsured, eligible children. ▪ Provide feedback on the process and Medicaid and SCHIP enrollment outcomes.
KEY PARTNERS	▪ FSSA provided the data match between the school lunch program and Medicaid and SCHIP to identify eligible but not enrolled children. ▪ School superintendents and administrators and key staff (Nutrition Directors, Nurses, Counselors and Social Workers) partnered with local *Covering Kids & Families* projects and community-based enrollment centers to assist with reaching potentially eligible, uninsured children.
LESSONS LEARNED	▪ The initial activities with school districts built relationships and led to additional activities. When outreach staff reached families who were already enrolled, they were reminded to renew their coverage. ▪ Enrollment centers found that it usually took a family receiving up to four types of notices/advertisements before they applied for health coverage benefits. However, the main notices that prompted the parents to initiate the application process came from the school lunch program data match.

CONTACT INFORMATION	**Project**	Health and Hospital Corporation of Marion County Local *Covering Kids & Families* Project Indianapolis, Indiana
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Institutionalizing School Outreach	
PROMISING PRACTICE	Identify uninsured school children through a link of the school enrollment and Medicaid rolls and conduct Medicaid and SCHIP **outreach** to uninsured students. Several thousand uninsured children were reached through this process.
DESCRIPTION	The local *Covering Kids & Families* project, Baltimore HealthCare Access, Inc. worked with the Baltimore School Health Program to identify uninsured students and to provide enrollment assistance to students eligible for Medicaid and SCHIP. Baltimore HealthCare Access, Inc. is an agency of the Baltimore City Health Department (BCHD). This relationship allowed the local project to easily form a partnership with the Baltimore School Health Program. An important component of this effort was a match of Medicaid and SCHIP rolls and Baltimore City School enrollment. Baltimore City Schools Third Party billing office provided the database of student enrollment and the Maryland Department of Human Resources ran a 'match' with the Medicaid and SCHIP rolls. Baltimore local *Covering Kids & Families* project staff provided Medicaid and SCHIP training for school health staff to provide application assistance. The local project staff also conducted outreach through school health offices and school-based health centers and followed up with outreach and assistance with enrollment and renewal applications. Once students with "unknown" insurance status were identified through the database match the Baltimore project staff provided manpower to conduct follow-up and outreach through phone contacts and home visits. The local *Covering Kids & Families* project also provided incentives to the Baltimore City Health Department's School Health Program for distribution to students upon return of a completed School Health Card. Incentives varied by age group and ranged from mini radios for teens to key chains, silly putty and pencils for elementary school-age children. Through another partnership with Enhancing Neighborhood Action by Local Empowerment (ENABLE), the Baltimore local *Covering Kids & Families* project facilitated placement of AmeriCorps Community Health Workers in selected schools through the BCHD School Health Program. The AmeriCorps workers were trained by ENABLE, conducted follow-up, outreach, application assistance and annual renewal of coverage with students and their families eligible for or enrolled in Medicaid and SCHIP. With ENABLE AmeriCorps Community Health Workers in the Baltimore Schools, the Baltimore local *Covering Kids & Families* project was able to provide day-to-day onsite management of the project and build towards a sustainable effort.
OUTCOMES	▪ The fiscal year 2003 objective was to enroll 3,000 applicants through the Baltimore schools. Actual fiscal year 2003 enrollment data from the school outreach partnership was 3,829. Application assistance was provided to 2,000 clients for 2005.

RESOURCES	▪ The capacity to conduct an automated match between the school district database of students and the state's Medicaid and SCHIP enrollment database ▪ Staff to conduct the follow-up contact with families of students identified with "unknown" insurance status, to complete applications and verification requirements and to provide help in retaining coverage ▪ Tracking process to assess the results and status of the follow-up contacts
ACTION STEPS	▪ Identify appropriate party to run the data match. ▪ Run the data match of school children to the Medicaid and SCHIP rolls. ▪ Train school staff and AmeriCorps workers on outreach and enrollment assistance. ▪ Follow up on applications.
KEY PARTNERS	▪ School district staff provided the data match, lists of children with "unknown" insurance status and contact information. ▪ Baltimore City Schools Third Party billing office provided the database of student enrollment. ▪ Maryland Department of Human Resources ran a 'match' with the Medicaid and SCHIP rolls. ▪ AmeriCorps Community Health Workers conducted the follow-up contact, application and renewal support as well as project management.
LESSONS LEARNED	▪ Many of these parents are working adults and it is difficult to complete home visits during the day. The Baltimore local *Covering Kids & Families* school health advocate adjusted work hours to attempt to reach working families in the evening. ▪ Coordination between the local *Covering Kids & Families* project staff, ENABLE and the School Health Division of the BCHD greatly increased the ability of ENABLE to assist within the school system. ▪ Partnerships were the key to success and were mutually beneficial. ▪ Access to data was critical to target effective outreach for enrollment/renewal. ▪ Incentives played a role in encouraging return of the school health card.

CONTACT INFORMATION	**Project**	Baltimore HealthCare Access, Inc. Local *Covering Kids & Families* Project Baltimore, Maryland
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Identifying Eligible Children With School Lunch Application Data Match

PROMISING PRACTICE	Collaborate with school districts to **outreach** to children receiving free or reduced cost school lunches through the National School Lunch Program. The result of the collaborative effort was increased enrollment for the school lunch population and a blueprint for a sustainable Medicaid and SCHIP initiative.
DESCRIPTION	The Utah statewide *Covering Kids & Families* project, Voices for Utah Children, in collaboration with the local *Covering Kids & Families* projects (Salt Lake City and Granite school districts) worked with the Utah State Office of Education on Child Nutrition to link school lunch program data with the state's health coverage data. Data linking enabled the state to identify school lunch program families not currently receiving health coverage through Utah's Medicaid and SCHIP programs. To facilitate the link, statewide *Covering Kids & Families* project staff assisted in revising the wording on the school lunch program application. Local *Covering Kids & Families* project staff used the merged databases to facilitate timely outreach to the targeted population. The local *Covering Kids & Families* projects developed programs to facilitate outreach to eligible families through the school systems. The Salt Lake City local *Covering Kids & Families* project worked with the school district Webmaster to create a system that tracked Medicaid and SCHIP enrollment information, enabling the school district to provide timely notice of open enrollment periods. The project also sent screening letters to potentially eligible families who participate in the school lunch program. Eligible families interested in obtaining health coverage through the state returned the screening letter to the school and a Family Involvement Assistant followed up with the family. Family Involvement Assistants are school district employees assigned to each school who are trained in the Medicaid and SCHIP application and enrollment assistance process. They contact families in their school community, introduce them to Medicaid and SCHIP and provide application assistance. The Granite School District local *Covering Kids & Families* project developed and implemented the Referral System Model. In this model, district professionals – teachers, psychologists, principals, nurses, social workers and secretaries – were trained to make a referral for an uninsured child. The referral was assigned to Family Involvement Assistants for follow-up and application assistance. Local project staff also distributed information on the link in the school secretaries' training for the Granite and Salt Lake City districts. The local Salt Lake City *Covering Kids & Families* project staff also provided input on new student information software packages being considered for use by the district to ensure the selected package could automatically link school lunch enrollment information with student health insurance coverage information.
OUTCOMES	▪ An innovative data merging process helped identify and enroll uninsured, eligible children in Medicaid and SCHIP. ▪ The data linking and referral systems were successful in the two school districts and the processes were expanded to additional school districts in the state.

OUTCOMES (continued)	▪ Twenty-five Utah school districts participated in training and six established referral programs similar to the Granite and Salt Lake City school districts. ▪ Through the Granite School District Referral Model System, 1,100 referrals were made during the 2004-05 school year and 77 percent of the referrals resulted in health coverage enrollments.
RESOURCES	▪ Partnerships with Medicaid and SCHIP agencies and school officials ▪ A data system capable of matching Medicaid and SCHIP data with school district data ▪ School district staff to implement the data link and to make appropriate referrals for Medicaid and SCHIP enrollment assistance ▪ Trained volunteers/staff to follow up with families to provide assistance
ACTION STEPS	▪ Make contacts with state health coverage and school lunch program agencies. ▪ Make adjustments to the school lunch program information system to simplify database linking. ▪ Link the state health coverage and school lunch program data. ▪ Identify a "champion" in each school district to move the project forward. ▪ Establish a mechanism for delivering the data match to school districts and/or outreach agencies and organizations. ▪ Train school district staff or other volunteers to provide application assistance. ▪ Set up and use a referral system to provide enrollment assistance.
KEY PARTNERS	▪ The Office of Education on Children Nutrition and Department of Health Medicaid and SCHIP officials managed the data. ▪ School district officials provided leadership support for the referral and application assistance. ▪ Salt Lake City School District Technology Director played a key role in linking the school lunch program system to the Department of Health's system.
LESSONS LEARNED	▪ The data linking process is possible and provides for targeted outreach. ▪ Changing/simplifying the wording on the free or reduced school meal program application helped facilitate the link. ▪ The Referral Model System involves the school community in an efficient and effective manner. ▪ The Family Involvement Assistants are integral to outreach.

CONTACT INFORMATION	**Project**	Voices for Utah Children Statewide *Covering Kids & Families* Project Utah
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Partnering With Native American Organizations

PROMISING PRACTICE	Develop collaborative relationships within the Native American community to do **outreach** and increase enrollment in Medicaid and SCHIP. The initiative led to a large percent increase in Native Americans enrolled in Medicaid and SCHIP.
DESCRIPTION	The North Dakota statewide *Covering Kids & Families* project, Dakota Medical Foundation/Dakota Medical Charities, collected data and documented the need to address the issues of eligible but uninsured Native American children. The state *Covering Kids & Families* project director met individually with Native American leaders to foster a collaborative partnership. The partnership with the Native American population was initially facilitated through the community and technical colleges. The collaborative effort with the Rural Response Coalition (a faith-based group) opened the door further to the Native American community on the Standing Rock Reservation. A new committee was formed with the statewide *Covering Kids & Families* coalition members and representatives of each tribe to design the best approach to encourage outreach and enrollment on all the North Dakota Native American reservations. The most promising collaboration was through the elementary and secondary school systems. Progress was made also by identifying and informing the people that work with youth on the reservation. For instance, the Turtle Mountain Boys and Girls Club showed an interest in enrolling Native American children into Medicaid and SCHIP coverage programs because of emphasis on prevention and on treatment of drug dependency on the reservation. The statewide *Covering Kids & Families* project staff made presentations to a variety of interest groups. Presentations at the North Dakota Indian Educators conference, the Native American Ministries, the Native American Outreach Center and the Tribal Colleges meetings raised awareness about Native American Medicaid and SCHIP enrollment. At these meetings statewide *Covering Kids & Families* project staff gained the commitment to work collaboratively and to conduct specific outreach activities aimed at increasing Native American enrollment. The statewide *Covering Kids & Families* coalition members provided guidance and technical assistance for developing the *Covering Kids & Families* Reaching American Indian and Alaska Native Families Outreach Toolkit. The outreach marketing campaign encouraged applications and the implementation of the state's new VISION computer system made the increased enrollments possible. The applications were processed using the VISION system according to the eligibility guidelines for Medicaid, SCHIP or North Dakota's BlueCross BlueShield Caring for Children Program.
OUTCOMES	▪ Native American enrollment increased in SCHIP by 120 percent and in Medicaid by two percent between July 2005 and March 2006. ▪ In comparison, there was a 50 percent increase in overall SCHIP enrollment for the same time period.

RESOURCES	▪ A trusting relationship with multiple organizations serving the Native American population and with the tribes themselves ▪ Culturally competent outreach materials ▪ Eligibility workers and an enrollment system to handle the increased Medicaid and SCHIP participation ▪ Staff to collect data on the impact of the efforts on enrollment
ACTION STEPS	▪ Establish working relationship in the Native American community. ▪ Develop marketing materials. ▪ Conduct marketing campaign through organizations serving the community. ▪ Collect data and provide feedback on the results of the outreach efforts.
KEY PARTNERS	▪ Native American tribal leaders collaborated on the outreach initiatives. ▪ A "champion" to facilitate collaboration. A statewide *Covering Kids & Families* coalition member, the Executive Director of the Indian Affairs Commission, facilitated convening a task force to educate and train Native Americans through the technical and community colleges in North Dakota. ▪ Agencies and organizations working with Native American youth provided Medicaid and SCHIP enrollment information to their families. ▪ Native American education organizations provided Back-to-School materials to their students and teachers.
LESSONS LEARNED	▪ Collaboration with the tribes was challenging. The tribes were reluctant to release data on the number of uninsured to the statewide *Covering Kids & Families* coalition even though they regularly shared data they collected as public information with other entities. Building trusting relationships and collaborative partnerships over time expanded opportunities to reach the Native American children and families. ▪ The loss of some enrollees while gaining new enrollees was an issue identified though the outreach initiatives, which may indicate eligible children are failing to maintain continuous coverage.

CONTACT INFORMATION	**Project**	Dakota Medical Foundation/Dakota Medical Charities Statewide *Covering Kids & Families* Project North Dakota
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Establishing Business Partnerships	
PROMISING PRACTICE	Engage business partners through a lunch meeting to **outreach** to their customers and employees. The meeting resulted in a commitment for Medicaid and SCHIP enrollment outreach at several of the businesses in the local area.
DESCRIPTION	The local *Covering Kids & Families* project, Children's Coalition for Northeast Louisiana, hosted a lunch meeting of human resources directors for the major businesses in the region surrounding Monroe, LA to learn about outreach for health coverage. Twenty-nine businesses were represented at the meeting and five businesses subsequently launched enrollment events for their employees. A state representative, who is a champion for the local *Covering Kids & Families* coalition, played a key role in facilitating the arrangements. A local restaurant that was not usually open for lunch agreed to host the meeting and donate lunch for the participants. Letters of invitation were sent to 38 businesses, and human resources directors from 29 businesses attended, representing a total employee base of 16,800. The local *Covering Kids & Families* project prepared information binders for each of the business' human resources departments. The binder was printed on card stock to allow it to be used by the human resources director as a stand-up flip presentation. The binders included detailed information on the state's Medicaid and SCHIP program and another program for pregnant women (LaMOMS), contact information for the local *Covering Kids & Families* coalition, the state and local Department of Health and Hospitals (DHH), promotional items, applications and brochure holders. At the lunch meeting the *Covering Kids & Families* and DHH staff made a formal presentation on the programs followed by a question and answer period. The business representatives were asked to commit to any or all of the following: 1) holding an enrollment event at their business; 2) placing applications and information onsite, e.g., in break rooms; 3) including applications and information in employment packets; and 4) allowing *Covering Kids & Families* staff to speak to their employees.
OUTCOMES	▪ Twenty-nine representatives of local businesses heard a presentation on Medicaid, SCHIP and LaMOMS and received information binders. ▪ Twelve hundred University of Louisiana employees attended a presentation on Medicaid and SCHIP. Applications were distributed at the event. ▪ Three hundred employees at Pine Valley Foods, Inc. were invited to an application and enrollment event. ▪ The human resources staff at WillStaff, a worldwide staffing company, was trained on Medicaid and SCHIP and the 500 employees received application/pay-check inserts. ▪ The human resources staff at the Ouachita Parish Schools (2,500 employees) received training on Medicaid and SCHIP and each school identified an individual to train to assist parents with completing the application. ▪ The human resources staff at Chase, a bank with 1,700 employees, was trained on Medicaid and SCHIP and "lunch and learn" sessions were planned.

OUTCOMES (continued)	▪ Close to 8,000 applications were delivered by DHH staff to 16 other businesses.
RESOURCES	▪ Outreach materials tailored for a business audience ▪ Staff capacity to deliver the outreach event, engage state representative(s), make restaurant arrangements, contact human resources directors and follow up on training and information requests ▪ Willing business partners or a "champion" such as the state representative who can help enlist the involvement of the local business community
ACTION STEPS	▪ Enlist help of leader (legislative, business, community). ▪ Make arrangements for the meeting/lunch. ▪ Prepare the presentation and materials for distribution. ▪ Decide on what you want the businesses to do. ▪ Hold the lunch meeting. ▪ Provide follow-up contact to each business to secure commitments and plan for events.
KEY PARTNERS	▪ State representative (champion) helped get the businesses involved. ▪ Business partners and their human resources staff participated in the lunch meeting and performed outreach. ▪ DHH participated in the lunch meeting. ▪ Outback Steak House restaurant provided the lunch.
LESSONS LEARNED	▪ Engaging the help of entities that have formal consistent contact with the potentially eligible population is efficient and effective. ▪ Businesses have a vested interest in learning about and conducting outreach to their employees. There was a great interest in LaMOMS by the business community as many do not offer maternity coverage for their employees, and if they do, the coverage includes a high deductible. To promote awareness of LaMOMS, the *Covering Kids & Families* coalition offers a new section for expectant moms at their community outreach events. ▪ Encouraging interest and action from the business community is facilitated by a leading legislative, business or community volunteer.

CONTACT INFORMATION	**Project**	Children's Coalition for Northeast Louisiana Local *Covering Kids & Families* Project Monroe, Louisiana
	Contact	Denise Calhoun Phone: 318-323-8775 E-mail: dcalhoun@childrenscoalition.org
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Organizing Business Outreach	
PROMISING PRACTICE	Collaborate with a local grocery store chain to facilitate citywide **outreach** to families with eligible Medicaid and SCHIP children through enrollment events at the stores. This initiative reached almost 18,000 eligible, uninsured children.
DESCRIPTION	The Texas local *Covering Kids & Families* project, Children's Defense Fund of Houston, in Houston (Harris County), TX collaborated with Fiesta Mart, Inc. to facilitate citywide Medicaid and SCHIP outreach drives, reaching close to 18,000 eligible, uninsured children. The one-day campaigns occurred twice a year during the Back-to-School communications campaign and on Valentine's Day. During each one-day outreach event application assistance was provided at 10 to 15 Fiesta locations throughout Houston and Harris County. Community-based outreach organizations managed the initiative at individual stores. More than 200 volunteers representing the local *Covering Kids & Families* coalition, including the Texas Department of Human Services Children's Medicaid Program, the Harris County Hospital District, AARP, the Better Business Bureau, local health and social service programs and area high school, college and medical students supported the sign-up events. Over 100 volunteers were recruited and trained to provide onsite application assistance at the Fiesta stores for each of the 14 outreach events. The outreach drives were led by extensive upfront media, particularly with the Spanish media, promoting the outreach events and informing parents what documents they needed to bring with them to enroll their children at the outreach events. Fiesta Mart, Inc. corporate offices arranged the sign-up locations in their stores and provided promotional information in their marketing circulars. Fiesta hosted and sponsored press conferences, publicized enrollment drives in its store circular and provided their mascot for press events and enrollment activities. The Fiesta outreach events were also supported by a general targeted media blitz about health care coverage for lower-income families. The broader media campaigns were supported by other local project partners, including funding from the Michael and Susan Dell Foundation. Local *Covering Kids & Families* project staff also participated in the advertising campaigns by making public service announcements, participating in public media interviews and working with an extensive array of media partnerships.
OUTCOMES	▪ By the end of 2006, 14 Fiesta outreach events had been conducted assisting close to 9,000 families and 18,000 children in applying for health care coverage. ▪ Based on the success of the Fiesta drives, the local *Covering Kids & Families* project was able to expand outreach to other local partnerships, including McDonald's, and to statewide business partnerships. ▪ The success of the Fiesta drives motivated the local project staff and coalition members to develop an extensive outreach agenda with other businesses, schools and the faith community.

RESOURCES	▪ Strong buy-in from Fiesta Mart, Inc., including providing store space, putting announcements in the Fiesta circulars and using the mascot to publicize events ▪ Staff to provide program oversight, nurture the business partnership, recruit and train volunteers, publicize the events, inform parents about what documents to bring and maintain a working relationship with community-based organizations ▪ Volunteers willing to be trained and to assist families with the application ▪ A broad media campaign to support the message
ACTION STEPS	▪ Develop media and business partnerships. ▪ Identify community-based groups to take the lead for each outreach site. ▪ Train volunteers to work at outreach sites and to provide application assistance. ▪ Publicize the outreach event. ▪ Hold the outreach event. ▪ Follow up on the outcomes of the events to measure the number of families reached and enrolled in Medicaid and SCHIP.
KEY PARTNERS	▪ Fiesta Mart, Inc. provided promotional materials in their flyers and provided space at the stores. ▪ Eligibility workers completed Medicaid and SCHIP enrollments. ▪ Michael and Susan Dell Foundation funded the broad media campaign. ▪ Community and school-based volunteers provided assistance with the Medicaid and SCHIP applications at the enrollment events.
LESSONS LEARNED	▪ Strong buy-in from Fiesta Mart, Inc. was critical to the success of the project. ▪ Development of media relationships enabled an effective media campaign that helped raise awareness. ▪ Specific announcements in the Fiesta supermarket circular, as well as English and Spanish language public service announcements building up to the outreach drives, helped more families learn about health coverage. ▪ The outreach drives helped create and develop instrumental public and private sector partnerships vital to sustaining outreach initiatives. ▪ Coalition members made the outreach drives more inclusive by providing application assistance in Chinese, Spanish, Urdu and Vietnamese through translators.

CONTACT INFORMATION	**Project**	Children's Defense Fund Texas – Houston Local *Covering Kids & Families* Project Houston, Texas
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Partnering With One-Stop Career Center	
PROMISING PRACTICE	Conduct **outreach** through the human resources departments of local businesses and the Rhode Island One-Stop Career Centers to individuals in employment transition and unemployed workers and their families for Medicaid and SCHIP health care coverage. This outreach initiative was institutionalized by working through an established entity such as the One-Stop Career Centers.
DESCRIPTION	The Rhode Island statewide *Covering Kids & Families* project, Rhode Island Kids Count, partnered with netWORKri, Rhode Island's One-Stop Career Center System, to conduct Medicaid and SCHIP outreach to individuals in employment transition and unemployed workers and their families. The One-Stop Career Center System works in partnership with the Rhode Island Department of Labor and Training. The netWORKri centers match jobseekers and employers through quality employment programs and services. The outreach initiative started in the Providence netWORKri center and spread to the other five netWORKri centers – Pawtuckett, Wakefield, West Warwick, Woonsocket and East Bay (Warren). Rhode Island's One-Stop Career Centers provide general information on Medicaid and SCHIP and refer individuals in employment transition, such as those laid off or about to be unemployed through business closings, to a statewide *Covering Kids & Families* project Outreach Worker for application assistance. The Outreach Worker also became a vital member of the One-Stop Career Center's rapid response team, providing information and training to local businesses; providing health coverage information to workers who were losing employment due to lay offs or plant or business closings; and providing application assistance to individuals and families. The netWORKri One-Stop centers also provided Medicaid and SCHIP health coverage information to uninsured individuals who visited or called the One-Stop Career Centers seeking unemployment benefits or prospective employment. Flyers with Medicaid and SCHIP information were also placed in as many as 17,000 unemployment checks making certain that families that lose private health coverage are aware of the public benefits available to them.
OUTCOMES	▪ The netWORKri staff incorporated questions related to health coverage into the One-Stop Web site information and as part of the initial screening tool. ▪ The netWORKri sites continue to provide applications and information to individuals and families using their services. ▪ The netWORKri staff makes referrals to the state's toll-free information line and provides contact information for family resource counselors within the community.
RESOURCES	▪ State-sponsored One-Stop job training and employment sites to provide information about available health coverage and screening for eligibility ▪ Project staff to provide application assistance to eligible individuals and families

ACTION STEPS	▪ Establish a working relationship with the state or local One-Stop Career Center. ▪ Train receptionists or other workers at One-Stop Career Centers to screen people for health coverage needs and to refer them for Medicaid and SCHIP application assistance. ▪ Identify project staff to serve as a member of a rapid response team that visits local companies that are laying off workers to educate them about health coverage options. ▪ Encourage One-Stop Career Centers to institutionalize the health coverage information in their service package.
KEY PARTNERS	▪ netWORKri (One-Stop Career Centers), part of the Rhode Island Department of Labor and Training, provided general information on Medicaid and SCHIP and referred individuals in employment transition to outreach workers. ▪ Businesses provided health coverage information to workers.
LESSONS LEARNED	▪ Institutionalize information dissemination by working with an established and funded related service entity, such as the publicly funded One-Stop Career Centers. ▪ Incorporate health insurance screening at the point-of entry (front desk) for all clients applying for One-Stop services. ▪ Working with rapid response teams was a fruitful way to capture soon-to-be unemployed workers who were often unfamiliar with benefits available to them through the public health coverage programs.

CONTACT INFORMATION	**Project**	Rhode Island KIDS COUNT Statewide *Covering Kids & Families* Project Rhode Island
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	Web site	http://www.rikidscount.org

Building Faith-based Partnerships	
PROMISING PRACTICE	Build a broad-scale partnership with the faith-based community to do **outreach** for Medicaid and SCHIP enrollment. The partnerships resulted in successful annual faith-based media and enrollment campaigns.
DESCRIPTION	The Illinois statewide *Covering Kids & Families* project, Illinois Maternal and Child Health Coalition, worked collaboratively with the faith community to reach out to uninsured children and families across the state. The coalition met with faith leaders and developed outreach and enrollment strategies and produced a toolkit for faith and community organizations. They also began an initiative called "Faith, Health and Unity" Month. During this month, the statewide and local *Covering Kids & Families* coalitions organize a public awareness campaign that includes a media initiative and a congregation information campaign. The public awareness campaign begins with an interfaith breakfast and a press conference. Each year planning for the event begins at least six months before the campaign kicks off. Coalition members disseminate the "Faith, Health and Unity" toolkits. The toolkit contains a cover letter explaining the campaign, bulletin and pulpit announcements, pre-designed flyers to insert into newsletters, talking points about embracing good health that can be incorporated into a sermon, flyers, posters, Medicaid and SCHIP enrollment applications, an outreach material order form and a participation form that is used to match congregations with Medicaid and SCHIP outreach partners. The toolkits are also used to recruit faith-based members to the statewide *Covering Kids & Families* coalition, to recruit and train faith-based members to become Medicaid and SCHIP application assistors and to gather faith-based family stories. The wide reach of the local *Covering Kids & Families* Chicago/Cook County Coalition and the local *Covering Kids & Families* 217 Coalition helped broaden facilitation of the faith-based initiative. The *Covering Kids & Families* 217 Coalition is a diverse group, made up of state agencies, school districts, health providers, faith leaders and businesses working together in seventeen counties within the 217 area code throughout Central Illinois.

OUTCOMES	▪ Barriers to enrollment were eliminated.
	▪ Faith-based partnerships were built.
	▪ Over a four-year time period the coalitions:
	  □ Distributed 3,100 toolkits and 25,000 brochures;
	  □ Held four press events with a total of 240 religious leaders participating;
	  □ Hosted onsite outreach activities with 220 congregations participating;
	  □ Engaged participation of members from the Christian, Jewish, Muslim and Buddhist faith communities; and
	  □ Increased Medicaid and SCHIP enrollments by an average of 8,000 children and 3,400 parents in the months following the annual campaigns.
	▪ This initiative earned support and recognition from the Governor's office.

RESOURCES	▪ Staffing to recruit congregations, build the media campaign, organize the kick-off breakfast and create the faith-based outreach toolkit ▪ Toolkits printed and distributed
ACTION STEPS	▪ Create collaborative partnerships with faith-based organizations, state officials, media and businesses. ▪ Develop and update toolkits as needed. ▪ Conduct mass mailings to faith-based organizations. ▪ Conduct one-on-one presentations to faith-based organizations. ▪ Conduct presentations and enrollments at faith-based conferences. ▪ Brand an annual event. ▪ Collect statistics and data.
KEY PARTNERS	▪ *Covering Kids & Families* Coalition members with faith-based connections served as entry points to specific churches, synagogues or mosques. ▪ Congregation staff members worked to include material in bulletins, hang posters, write sermons and recruit congregation members to become Medicaid and SCHIP application assistors.
LESSONS LEARNED	▪ Plan and start the campaign early. Faith communities need time to get buy-in from their leadership before acting. ▪ Some congregations may have health ministries, which can be supportive of outreach efforts. ▪ Start with coalition members who are active in their congregations.

CONTACT INFORMATION	**Project**	Illinois Maternal and Child Health Coalition Statewide *Covering Kids & Families* Project Illinois
	Contact	Laura Leon Phone: 312-491-8161 Email: lleon@ilmaternal.org
	Web site	http://www.ilmaternal.org/CoveringKidsIL.index.htm

Accessing Coverage in Remote Areas Through Computer Video Systems

PROMISING PRACTICE	Streamline the application process by linking clients at remote **outreach** sites directly to a case worker at the county eligibility offices for "face-to-face" interviews or for applying for or renewing Medicaid and SCHIP coverage. The video conference eliminated transportation barriers.
DESCRIPTION	The Minnesota local *Covering Kids & Families* project, Beltrami/Cass County, implemented a video conferencing link to a case worker at the Cass County Health and Human Services office for clients applying for Medicaid and SCHIP through an outreach worker. The local *Covering Kids & Families* project is a partnership with the Bemidji Area Indian Health Service and the Ojibwe Tribal Health Division. The local *Covering Kids & Families* project outreach worker rotates to various locations throughout the two counties to provide one-on-one outreach and assistance to families in need of health care coverage, focusing on the needs of Native Americans. The local *Covering Kids & Families* project secured match funds and convinced the Cass County eligibility office to develop a remote video access project called V-Link. V-Link video and computer equipment was installed in five of the outreach sites in Cass County and at the county eligibility office. V-Link is a real-time video conferencing system for clients to network directly to the county offices for a remote consultation and application assistance of their Medicaid and SCHIP applications and renewals. The outreach worker assists families through V-Link access at schools, community organizations and health fairs. Through V-Link the outreach worker is also able to connect clients with a Food Stamp case worker to complete the Food Stamp application. V-Link also motivated other local *Covering Kids & Families* coalition partners to do outreach using the V-Link system. V-Link installation was supported by grants from two technology company foundations (approximately $4,000). The county office used existing DSL and Internet access. Installation at the outreach sites costs about $1,000 per site.
OUTCOMES	▪ After installing the V-Link system at the first outreach site, more than 60 clients were served directly by the V-Link system in the first ten months. Installation at a second site doubled this number and also provided access for veterans unable to physically apply at the county office. The other three sites experienced a similar increase in clients served after installation of V-Link. ▪ Anecdotal information shows that families are able to receive benefits sooner and do not experience the loss in wages that they would sustain if they had to take time off from their jobs to apply in person at the county office. ▪ Cass County has also eliminated some travel time for their staff and the applications are being processed in less time. ▪ The V-Link system also allows for greater coordination between Medicaid, SCHIP and the Food Stamp Program because families are able to apply for these programs in one video encounter. ▪ County administrators have committed to growing and maintaining the V-Link system.

RESOURCES	▪ Computer video links to provide real time visual contact between the customer and the eligibility office to meet the interview requirement ▪ Policies and procedures to support the video contact as fulfilling the "face-to-face" interview when required for Medicaid, SCHIP and other public benefit programs ▪ Outreach workers to provide application assistance
ACTION STEPS	▪ Establish working relationship with Medicaid and SCHIP local agency. ▪ Secure funds. ▪ Establish and staff outreach centers. ▪ Develop policies and procedures that take advantage of video conferencing. ▪ Install V-Link or other video conferencing system. ▪ Train case workers and outreach staff to use the video conferencing system. ▪ Advertise available service through local media.
KEY PARTNERS	▪ Cass County Health and Human Services eligibility staff used V-Link to complete Medicaid and SCHIP applications from remote sites. ▪ Minnesota Department of Human Services eligibility staff collaborated with the County staff and local *Covering Kids & Families* project to develop this method of meeting the interview requirement.
LESSONS LEARNED	▪ Long distances between eligible families and the local eligibility office, a lack of transportation and other physical barriers to accessing the eligibility office require creative problem solving. The V-Link system solved the problem for many families.

CONTACT INFORMATION	**Project**	Beltrami (Bemidji Area Indian Health Service) Local *Covering Kids & Families* Project Walker, Minnesota
	Contact	Joel Stokka Phone: 218-760-1026 Email: jstokka@mail.com
	Web site	http://www.ihs.gov/FacilitiesServices/AreaOffices/Bemidji/Bem.asp

Conducting an Enrollment Campaign for Open Enrollment Period	
PROMISING PRACTICE	Make eligible families aware of the first 30-day enrollment period following an 18-month enrollment freeze by maximizing the efforts of local agencies in **outreach** and application assistance by developing and implementing an outreach communications strategy that included business partnerships. The enrollment campaign brought in over 90,000 applications in the 30-day period.
DESCRIPTION	Florida provided only 30 days notice of a 30-day open SCHIP enrollment period after an 18-month freeze on applications. The Florida statewide *Covering Kids & Families* coalition, led by the statewide project, the Lawton and Rhea Chiles Center at the University of South Florida, organized a statewide initiative that focused on four key areas: media, business organizations, community organizations and state agencies. The Florida Healthy Kids Corporation and a media consultant successfully conducted a huge media blitz. Businesses also played an important role in outreach. Walgreen pharmacies printed enrollment information on all prescriptions, Wal-Mart provided open enrollment information at their pharmacies; utility companies sent flyer inserts with their billings; health plan providers, HealthEase and Staywell, printed and shipped SCHIP application forms to local community organizations, Amerigroup Florida coordinated area health outreach fairs and the Florida State Hispanic Chamber of Commerce reached 80,000 small Latino businesses. Since the open enrollment period was only 30 days, it was critical that partners work together on a statewide basis and eliminate duplication of efforts. The statewide *Covering Kids & Families* project staff called each coalition member individually and asked what they could do to enroll as many children as possible and how they could commit to working to accomplish the target. A lot of time and energy was spent working with the coalition members to assess their resources. Coalition members were kept engaged in the process and they responded in-kind. This resulted in a strong team effort to target eligible children. The Florida statewide *Covering Kids & Families* project staff provided training for community-based organizations and strong support of individual organizations' needs. The Florida SCHIP Community Coordinators worked very closely with their community partners and the media to inform the families they serve about the open enrollment period. Through a conference call, Community Coordinators began to work on their open enrollment plans. With support from "Gearing Up" workshops, Coordinators developed regional communications plans and were trained on the processes and rules for the open enrollment period. The local *Covering Kids & Families* projects – Health Care District of Palm Beach County, The Public Health Trust of Dade County, Northeast Florida Coalition and Panhandle Area Health Network – continued to partner with their local Sheriff's and Fire Rescue squads to reach eligible families.
OUTCOMES	▪ Over 90,000 applications were received during the 30-day period. This was a record number for Florida.

RESOURCES	▪ Coalition leadership and capacity to galvanize participation to respond quickly to a need/issue ▪ Partnerships with Medicaid, SCHIP and other key state agencies ▪ Communications partners ▪ Local community partners ▪ Collaboration with statewide and local business partners ▪ Procedures to identify and respond quickly to problems in handling mass numbers of applications
ACTION STEPS	▪ Plan an emergency media and enrollment blitz. ▪ Ask for full involvement of coalition members. ▪ Delegate appropriate activities to all parties. ▪ Stay in communication and give support and feedback to partners.
KEY PARTNERS	▪ A media consultant assisted the Florida Healthy Kids Corporation to implement a media blitz. ▪ The coordinator for research programs at the Institute for Child Health Policy managed the media contract and provided data on the outcomes of the enrollment period. ▪ Florida Healthy Kids Corporation provided training for Community Coordinators and leadership on the enrollment period. ▪ Local KidCare Community Coordinators worked very closely with their community partners and the media to inform the families they serve about the open enrollment period and completed applications for more than 90,000 children.
LESSONS LEARNED	▪ Establishing credibility and ensuring a true collaborative process was the key to success for the Florida statewide *Covering Kids & Families* coalition. ▪ The network of community organizations, businesses and other significant partners developed through the *Covering Kids & Families* coalition efforts made it possible to implement and organize an effective outreach campaign for the open enrollment period.

CONTACT INFORMATION	**Project**	Lawton and Rhea Chiles Center, University of South Florida Statewide *Covering Kids & Families* Project Florida
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Responding to a Hurricane Disaster Through Outreach	
PROMISING PRACTICE	Create a health care coverage-focused disaster response toolkit to do **outreach** to families who have lost employment due to a disaster. These toolkits also assisted disaster-relief organizations and state agencies. Develop a shortened Medicaid and SCHIP application to simplify the enrollment process for temporary coverage. The goal was to make Medicaid and SCHIP health care coverage easily accessible to families adversely affected by a natural disaster.
DESCRIPTION	After Hurricane Ivan in 2004, the Alabama local *Covering Kids & Families* project managed by the Mobile County Department of Public Health, quickly responded. Their Covering the Uninsured Coalition developed a toolkit to address the need for public health benefits by families physically and economically displaced by hurricanes, floods or other natural disasters. The goal was to provide easy and rapid access to public benefits programs, especially Medicaid for children of families experiencing displacement due to the disaster. As part of the hurricane response coordination effort, the local *Covering Kids & Families* project met with Volunteer Mobile and the influx of disaster recovery assistance programs from all levels of government to provide them with information and training on available health coverage programs. Staff time was used to coordinate the toolkit distribution and to meet with a wide range of disaster recovery service providers and state agencies. When Hurricane Katrina hit in 2005, the disaster response toolkits were ready to assist the recovery workers. Also, the Alabama Medicaid Agency and the Alabama Department of Public Health (DPH), the statewide *Covering Kids & Families* project, worked with the Centers for Medicare and Medicaid Services to develop a new procedure for handling Medicaid and SCHIP. The plan they created included a shortened (two-page) application which can be used for children applying for both programs as well as adults applying for temporary Medicaid coverage. The local *Covering Kids & Families* projects worked closely with Medicaid to ensure that the "short" application forms for enrollment were available at disaster relief sites. Sites visited included community and civic centers, shelters, FEMA locations, businesses and local government agencies. The local *Covering Kids & Families* projects monitored local school enrollment spikes indicating displaced families and targeted outreach efforts to reach them. They also worked in unusual sites, including a trailer based in the local state park to make their services more accessible. The Alabama DPH also garnered earned media through a press release distributed by the Public Health Information Officer from the Department of Homeland Security to promote child health coverage for displaced families (due to hurricanes, etc.). The local *Covering Kids & Families* projects also met with the Alabama Department of Human Resources staff to discuss how child health coverage information could be distributed during emergency food stamp distribution.

OUTCOMES	▪ More than 3,000 copies of disaster response toolkits including Medicaid and SCHIP applications/information were provided. ▪ The disaster response toolkit is a model for other states and localities to replicate and use in response to disasters. ▪ State and local coalition members and partners followed up with application assistance at community sites.
RESOURCES	▪ Partners from the disaster assistance organizations, state agencies and local community-based organizations ▪ Advanced planning and staff time to develop the toolkits, press releases and working relationships ▪ State program decision makers who can address policy issues as they arise ▪ Materials developed for outreach activities in non-disaster settings combined with additional customized information for disaster situations
ACTION STEPS	▪ Develop a toolkit for families that includes information on available public health coverage programs and additional materials that address the aftermath of natural disasters. ▪ Meet with disaster recovery assistance programs from all levels of government to provide them with information and training on available health coverage programs. ▪ Work with state agency staff to develop and implement a shortened application for temporary coverage.
KEY PARTNERS	▪ Alabama Department of Health provided materials and worked to simplify the application process for the disaster regions. ▪ Long-Term Recovery Project and Project Rebound provided access to families experiencing physical and economic displacement. ▪ Volunteer Mobile coordinated the influx of disaster recovery agencies and provided additional outlets for the toolkits and other information. ▪ Local disaster recovery agencies were willing to work creatively to provide information and to colocate benefits assistance access points.
LESSONS LEARNED	▪ Engaging an expert Public Information Officer to help design and disseminate the child health coverage "post-disaster" message is invaluable. ▪ Having disaster response toolkits prepared in advance of Hurricane Katrina enabled swift outreach response.

CONTACT INFORMATION	**Project**	Alabama Department of Public Health Statewide *Covering Kids & Families* Project Alabama
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Simplification

Simplification of the eligibility policies and the application and renewal procedures is essential to enroll and retain children and adults in public health coverage programs for which they are eligible under program criteria. Simplification removes policy and procedural barriers that impede or prevent eligible children and adults from enrolling and retaining health care coverage. Simplification of the eligibility rules and the application and renewal processes also eases the workload of the often overburdened case workers at state and county eligibility agencies. Simplification measures have been implemented in most states and the District of Columbia in a manner that protects program integrity.

The *Covering Kids & Families* projects, in collaboration with their state partners, have made great strides in simplifying their Medicaid and State Children's Health Insurance Program (SCHIP) enrollment and renewal policies and procedures. The list of possible ways to simplify the Medicaid and SCHIP policies and procedures to facilitate enrollment is long. Removing policy barriers is one approach. Eliminating asset tests, eliminating the face-to-face interview requirement, eliminating unnecessary document verification and implementing presumptive eligibility are techniques for simplifying the process through policy changes. For example, a presumptive eligibility policy permits children to be enrolled temporarily in Medicaid and SCHIP if they appear eligible while the family completes the application process. This allows children to receive prompt attention to their health needs and allows providers to be reimbursed for delivering needed care. See Appendix G for additional information on simplification enrollment and renewal trends in children's health coverage programs. Other ways to simplify the Medicaid and SCHIP enrollment process include improving customer service, improving work flow, automating systems, changing the work environment and/or improving communication across systems and workers. Many states have adopted joint Medicaid and SCHIP applications. Joint applications are not just a matter of putting the applications on the same Web site or on the same paper, but ensuring the process remains user-friendly with enrollment policies that do not create barriers. Simplification starts with the initial application, but the renewal process also creates barriers to Medicaid and SCHIP eligibility that need to be addressed.

Eleven (11) simplification promising practices are presented below. Some approaches institutionalized the simplification improvement process by establishing an overall policy framework and ongoing work groups focused on simplification. Other simplification promising practices focused on making changes to existing joint Medicaid and SCHIP applications and developing joint applications for Medicaid and other public benefit programs. Document verification policies were part of several of the application simplifications. Some focused on combining simplification and outreach and other simplification promising practices focused on renewals. All strategies achieved policy and/or process reforms to improve access to enrollment and renewal of coverage through Medicaid and SCHIP.

Developing a Framework for Outreach, Enrollment and Retention	
PROMISING PRACTICE	Create a blueprint for Medicaid and SCHIP **outreach**, by **simplifying** enrollment and retention strategies based on local experience integrating and coordinating county programs with state-sponsored health coverage programs. The blueprint continues to serve as a guide to ensure linkages are made between state and county children's coverage programs.
DESCRIPTION	The California statewide *Covering Kids & Families* project, Community Health Councils, Inc., convened a work group of county experts from Local Children's Health Initiatives to seek information on local practices in conducting Medicaid and SCHIP outreach, enrollment and retention. Local Children's Health Initiatives exist in many California localities and are supported by a mix of public and private foundation funds to cultivate new public-private partnerships for children's health care coverage. The statewide *Covering Kids & Families* project developed a "Keeping You Covered" database for organizations to track outreach, enrollment, retention and utilization activities for Medicaid and SCHIP programs. In addition to the four local *Covering Kids & Families* projects, at least three other organizations used the tracking database in their work. Based on the information and data gathered from work group members, the work group developed a policy framework for outreach, enrollment, retention and utilization for children and families. The statewide *Covering Kids & Families* coalition, with more than 50 active members, provided a vehicle for disseminating the information. The formal Policy Framework for Outreach, Enrollment, Retention and Utilization for Health Care Coverage in California (Policy Framework) was prepared as a guide for the state and counties. The Policy Framework outlined standards and guidelines rooted in the goal of creating an environment, systems and procedures that ensured the enrollment, continuous retention and appropriate utilization of health care coverage for all children and families in Los Angeles. The standards advanced and assumed adoption of a comprehensive case management model based upon the principle of "no wrong door" that seeks to reduce barriers to eligibility systems. The Policy Framework describes standards and guidelines to adopt to provide the highly specialized and professional services that maximize access to quality and affordable health care coverage. The Policy Framework guide included local strategies and practices as examples. The statewide *Covering Kids & Families* project staff also collaborated with the California Welfare Directors Association and the Western Center on Law and Poverty to support their Medical Care Committee's efforts to improve Medicaid and SCHIP enrollment and retention. Project staff also met with the California State Department of Health Services, the Managed Risk Medical Insurance Board and the California First 5 Children and Families Commission to discuss the Policy Framework.
OUTCOMES	▪ The Administration proposed $72.2 million to support enrollment, renewal and retention in Medicaid and SCHIP, modeling some of the proposed recommendations and lessons learned featured in the Policy Framework.

RESOURCES	▪ Local advocates and community-based organizations engaged in outreach, enrollment and retention efforts ▪ Staff to convene a meeting of the groups to share best practices and lessons learned ▪ Staff to write a set of policy recommendations based on the shared strategies ▪ Relationships with key program staff and other stakeholders to provide a venue to review the recommendations ▪ Staff time and expertise to cultivate and maintain these relationships and to collect, analyze and report on best practices
ACTION STEPS	▪ Develop a partnership with organizations engaged in outreach, enrollment, retention and utilization activities. ▪ Hold meetings for partners. ▪ Develop and share a database to track Medicaid and SCHIP outreach, enrollment, retention and utilization activities. ▪ Convene a work group to develop a policy framework. ▪ Distribute the policy framework through work group members.
KEY PARTNERS	▪ Local Children's Health Initiatives, Consumers Union, California Welfare Directors Association and the Western Center on Law and Poverty participated in development of the Policy Framework. ▪ California State Department of Health Services, the Managed Risk Medical Insurance Board and the California First 5 Children and Families Commission provided input and feedback on the Policy Framework.
LESSONS LEARNED	▪ The collaborative work to develop a broad spectrum plan facilitated effective Medicaid and SCHIP outreach.

CONTACT INFORMATION	**Project**	Community Health Councils, Inc. Statewide *Covering Kids & Families* Project California
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	Web site	http://www.chc-inc.org

Facilitating an Enrollment Work Group	
PROMISING PRACTICE	Create a work group to conduct community monitoring of the Medicaid and SCHIP application and mail-in renewal processes and to identify and document trends, barriers, issues or problems within enrollment systems with the goal of **simplifying** the process. Several key policies and procedures were changed based on the monitoring resulting in increased efficiency and effectiveness in enrollment and renewal efforts.
DESCRIPTION	The New York City local *Covering Kids & Families* project, New York City Leadership Group (Children's Defense Fund), created a Facilitated Enrollment Work Group to monitor the Medicaid and SCHIP (Family Health Plus and Child Health Plus) enrollment and renewal process. New York City is one of more than 40 Facilitated Enrollment sites across the state that through an agreement with the New York State Health Department are empowered to conduct the face-to-face interview portion of the Medicaid and SCHIP applications. The Facilitated Enrollment Work Group (Work Group) was formed to monitor enrollment processes in New York City. There was a similar Work Group at the state level. New York City local *Covering Kids & Families* project staff served on both work groups. The community monitoring work was effective at identifying and documenting issues, problems and trends within New York's public health insurance programs. Monitoring covered processing delays and problems, appropriate eligibility determinations, transitions between Medicaid and SCHIP programs, health plan enrollment, documentation requirements and other issues. The information gathered was presented at meetings with state and local officials and policymakers. The New York City local *Covering Kids & Families* project staff met bi-monthly with the Work Group and quarterly with the statewide *Covering Kids & Families* project, the New York Department of Health staff and the Deputy Commissioner of the Medicaid program. The information shared at the meetings was used to identify the source of the issue, to present findings to appropriate government officials and to work with government partners to develop systemic solutions to better enable eligible families to get and keep their Medicaid and SCHIP coverage for children. Issues presented to the New York State Health Department included clarifications on how children are to transition between Medicaid and SCHIP programs, implementation of new policies (self attestation of resources and implementation of asset test), health plan protocols and the need for better electronic reporting from the Facilitated Enrollment Agencies. Issues presented to the New York City Human Resources Administration (the local Medicaid and SCHIP agency) included protocol issues related to the implementation of self attestation of resources, mail-in renewal issues (documentation requirements, how case corrections are handled, transfers between programs, delays in the receipt of determinations), delays in the processing of SCHIP and split applications as well as incorrect program enrollment, e.g., SCHIP eligible clients put into Medicaid. Issues related to pregnant women and program selection and adding newborns were also raised.

OUTCOMES	▪ The Work Group monitoring and reporting process identified loss of enrollment and health plan enrollment problems and assessed the impact of new Human Resources Administration policies. ▪ The monitoring and reporting process created a venue to raise and address the issues encountered by Facilitated Enrollment Agencies. The Work Group's experience was representative of the larger picture and by addressing their issues the local *Covering Kids & Families* project was able to effect policy and protocol changes that affected the larger Medicaid and SCHIP populations. ▪ Problems were identified with mail-in renewals such as delays in the timely processing of renewals, a lack of determinations on renewals, enrollment into the wrong program, impact of changes on renewal forms, processing issues such as adding or combining cases and returned cases.
RESOURCES	▪ Staff to organize bi-monthly meetings, track issues raised and document them ▪ Agencies and organizations engaged in enrollment and renewal activities ▪ Relationships and credibility with state Medicaid and SCHIP program staff ▪ A meeting place
ACTION STEPS	▪ Organize bi-monthly meetings of the Work Group to obtain regular feedback on the enrollment and renewal process. ▪ Organize quarterly meetings with the statewide *Covering Kids & Families* project staff, including the Deputy Commissioner of the Medicaid program, to address the issues identified. ▪ Maintain relationships with the Work Group and key Medicaid and SCHIP staff.
KEY PARTNERS	▪ The deputy commissioners for Medicaid and for Planning, Policy and Resource Development at the New York Department of Health consulted with the local *Covering Kids & Families* project staff on implementation of new processes and policies and addressed the recommendations of the Work Group. ▪ Facilitated Enrollment Agencies processed Medicaid and SCHIP applications.
LESSONS LEARNED	▪ Facilitated enrollers needed clarification about submission protocols. ▪ A similar strategy could be accomplished using a group of community agencies engaged in enrollment and renewal activities.

CONTACT INFORMATION	**Project**	New York City Leadership Group (Children's Defense Fund) Local *Covering Kids & Families* Project New York, New York
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Redesigning and Simplifying a Joint Medicaid and SCHIP Application

PROMISING PRACTICE	Redesign joint Medicaid and SCHIP application by deleting the outdated Medicaid asset information, correcting other outdated information and clarifying confusing language. The revised application **simplified** the application process and is more user-friendly.
DESCRIPTION	The Colorado statewide *Covering Kids & Families* project, Colorado Community Health Network, worked with state agency partners to redesign the joint Medicaid and SCHIP application by deleting Medicaid asset information since it is no longer part of eligibility determination, correcting outdated information and clarifying confusing language. Over time, the statewide *Covering Kids & Families* project established a strong data collection mechanism to document the barriers to obtaining health coverage for children and pregnant women. Based on information from the dataset the statewide *Covering Kids & Families* project provided concrete recommendations on how to overcome those barriers through a revised joint Medicaid and SCHIP application. Funding was appropriated in a 2006 Colorado House Bill to revise the application making it more user-friendly. The Department of Health Care Policy and Financing formed a committee with representation from the statewide *Covering Kids & Families* project, ACS (the Colorado Medical Assistance Fiscal Agent), MAXIMUS (contractor for Medicaid enrollment in Colorado), Medicaid and SCHIP staff and county representatives to review and revise the current application. Statewide *Covering Kids & Families* project representatives were the only non-state staff or contractor invited to participate on the redesign committee. Coalition members who provide Medicaid and SCHIP outreach provided suggestions for changing the application to the statewide *Covering Kids & Families* project representatives who in turn, presented these suggestions to the redesign committee. Project representatives met several times with the coalition members to keep them informed of the progress with the redesign. National health literacy experts provided technical assistance on the application design to ensure that the form and instructions were easy to read and understand.
OUTCOMES	▪ A draft revised application was developed. ▪ A literacy review of the redesigned joint application was being completed by the state. It is being tested before being released statewide.
RESOURCES	▪ Staff to organize the collection of substantial and credible data from local entities to demonstrate barriers to enrollment ▪ Staff to analyze and report on the data ▪ Relationships with state program staff with whom to share the data ▪ An opportunity for redesign as a result of state policy decisions ▪ Community-based organizations to provide additional input based on contact with consumers ▪ Staff capacity to attend meetings and make recommendations to state staff

ACTION STEPS	▪ Develop and maintain a Medicaid and SCHIP enrollment database. ▪ Analyze and report to Medicaid and SCHIP agency on enrollment barriers based on information from database. ▪ Develop a working relationship with state policymakers and Medicaid and SCHIP eligibility staff. ▪ Meet with state officials to review the current application process and to make recommendations for improvements. ▪ Pilot test the revised application before distributing statewide.
KEY PARTNERS	▪ Colorado Department of Health Policy and Financing (Medicaid and SCHIP) staff invited the statewide *Covering Kids & Families* project staff to join the work group redesigning the application.
LESSONS LEARNED	▪ Data collection over time can serve as a strong platform for developing new strategies to overcome the barriers identified. ▪ Building strong working relationships with key Medicaid and SCHIP policymakers and staff leads to collaborative opportunities.

CONTACT INFORMATION	**Project**	Colorado Community Health Network Statewide *Covering Kids & Families* Project Colorado
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Simplifying the Application Process Through a Joint Medicaid, SCHIP and Food Stamp Application

PROMISING PRACTICE	Create an interagency team for developing a joint application and enrollment process for Medicaid, SCHIP and Food Stamp Program benefits to eliminate duplication of effort for both families and eligibility staff and to **simplify** and expedite the enrollment process. The project was very well-received by the local eligibility office workers and was expanded to other counties.
DESCRIPTION	The North Carolina local *Covering Kids & Families* project, Buncombe County Department of Social Services (Asheville area), worked in collaboration with the county's Food Stamp Program to successfully develop and institute a combined Medicaid, SCHIP and Food Stamp application for children's health coverage. In North Carolina Medicaid, SCHIP and the Food Stamp Program are supervised at the state level under the umbrella agency, the North Carolina Department of Health and Human Services, and administered at the local level under the local departments of social services. Enrollment in the Food Stamp Program and the Medicaid and SCHIP programs is processed through two different divisions of the local social service agency – Food Assistance and Medical Assistance. Thus, a joint application meant coordinating across divisions as well as merging the actual "paperwork." When families renewed their Food Stamp benefits, the Food Assistance worker at the local DSS checked the Medicaid and SCHIP status of the children in the system. If the system showed that the children were not enrolled in Medicaid and SCHIP, the case was assigned to a Food Stamp and Medicaid team. The teams were comprised of one Food Stamp Program worker and one Medicaid worker. Since the Food Stamp Program worker normally receives proof of income at the time of application, the Medicaid and SCHIP portion of the combined application was ready to process immediately using the same income verification gathered in the Food Stamp Program application process. The new process was first tested with one Food Stamp and Medicaid team. The test was successful and therefore all Food Stamp Program workers were trained to take the application and partnered with Medicaid and SCHIP workers to process applications as a team.
OUTCOMES	▪ During the period April – September 2005, the local social service office took 196 combined applications. One third of the families completing combined applications originally came to DSS only to renew food stamp benefits. ▪ Application approval time for the two programs was reduced from two weeks to less than a week. Food Stamp Program workers reported the process took an additional 15 to 30 minutes, but the Medicaid and SCHIP workers' processing time was so greatly reduced that most applications were approved within 24 to 48 hours. ▪ Case workers were very satisfied with the combined application and were enthusiastic about the simplicity of the combined application process.

OUTCOMES (continued)	▪ Customers were called to evaluate their response to the combined application process and they were very positive and enthusiastic about the process. ▪ Based on the success of this promising practice: □ Adult Medicaid is now developing a combined application with the Food Stamp Program. □ *Covering Kids & Families* local project staff trained other county offices in the state for replication of the joint Food Stamp and Medicaid application process.
RESOURCES	▪ Collaboration from the local eligibility office and its eligibility staff in the Food Stamp Program, Medicaid and SCHIP
ACTION STEPS	▪ Develop a unified, coordinated single application for the Food Stamp Program, Medicaid and SCHIP for enrolling children and adults. ▪ Pilot test with a Food Stamp Program and Medicaid and SCHIP worker. ▪ Train Food Stamp Program and Medicaid and SCHIP workers on the joint application. ▪ Choose worker teams. ▪ Process the joint applications. ▪ Follow up with workers and customers to assess satisfaction with the new application and process.
KEY PARTNERS	▪ Eligibility office leadership approved, planned and coordinated the initiative. ▪ Eligibility office staff implemented the joint application process.
LESSONS LEARNED	▪ The combined Medicaid, SCHIP and Food Stamp Program application has been an unqualified success; the Medicaid and Food Stamp team process reduces duplication for both the worker and the family applying.

CONTACT INFORMATION	**Project**	Buncombe County Department of Social Services Local *Covering Kids & Families* Project Asheville, North Carolina
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Combining Enrollment of Medicaid and Food Stamp Benefits

PROMISING PRACTICE	Test and provide feedback on the design and implementation of an ACCESS electronic application to **simplify** enrollment in Medicaid, SCHIP and the Food Stamp Program. This partnership led to a simplified accessible enrollment process.
DESCRIPTION	In 2003 the Wisconsin Department of Health and Family Services (WDHFS) received a United States Department of Agriculture (USDA) grant to build a Web-based electronic application tool to connect lower-income consumers directly to Medicaid, SCHIP and Food Stamp Program benefits. The statewide *Covering Kids & Families* project, the University of Wisconsin Extension, joined the state's Income Maintenance Advisory Committee to work with the WDHFS agency to develop and enhance the electronic application tool – ACCESS. At each stage of ACCESS development, *Covering Kids & Families* statewide and local project staff was involved in testing and implementing the system, providing feedback and recommendations and designing brochures and printed materials. ACCESS incorporates a screening tool that can be completed in 15 minutes and provides information on an applicant's eligibility and "next steps" for applying. Initially ACCESS only provided information and a mechanism for asking questions about the public benefit programs. In 2005 the program was expanded to include a "check my benefits" tool for current enrollees. In 2006 the system expanded to a full service application system enabling consumers to apply for benefits, report changes in their status and obtain information about their benefits directly from this system. ACCESS also provides information on the status of pending applications and any additional information needed from the applicant to complete the application process.
OUTCOMES	▪ In the first 11 months of operation that ACCESS was available, 30,466 people visited the Web site: □ Seven out of eight visitors who started an eligibility survey completed the form. □ Ninety-two percent of those who completed the survey were potentially eligible for at least one benefit program. □ Five percent of all people requesting assistance at local agencies said they had used ACCESS before coming in to apply. □ One percent of Web site visits were to the Spanish language site. ▪ As of August 2006: □ 105,303 people began a session through the "Am I Eligible" screening tool. □ 82,546 completed a session. □ 79,166 were found eligible for at least one of the public benefits programs. □ 9,176 people began an online application. □ 5,753 online applications were submitted. □ At least 4,000 of the completed online applications were for a family Medicaid program. □ 20,126 people who filed paper applications reported using the screening tool prior to filling out the application.

RESOURCES	▪ State capacity (including funding) to develop and implement an online tool to screen and enroll individuals and families into Medicaid, SCHIP and the Food Stamp Program ▪ Cross-agency collaboration for enrollment in multiple programs ▪ Community enrollment partners capable and supportive of testing out the system and providing feedback and recommended improvements based on customer suggestions ▪ Collaborative relationships between *Covering Kids & Families* coalition members and the state Medicaid department
ACTION STEPS	▪ Obtain support and funding for an online integrated application system. ▪ Develop a cross-agency collaborative approach for enrollment. ▪ Enlist coalition members to test and give feedback on the system. ▪ Track usage and application outcomes.
KEY PARTNERS	▪ *Covering Kids & Families* statewide coalition members on Wisconsin's Income Maintenance Advisory Committee worked with the state agency to develop and enhance the application tool. ▪ WDHFS (Wisconsin's Food Stamp Program) received a grant to build the Web-based application tool and facilitated the Web site development. ▪ Wisconsin Division of Healthcare Financing (Medicaid and SCHIP agency) collaborated on the project.
LESSONS LEARNED	▪ Collaborating with other enrollment and outreach efforts maximizes results. ▪ Collaborating with all partners and receiving feedback from customers at the test sites made the implementation of the ACCESS program a success in simplifying the enrollment process for Wisconsin families. ▪ As online applications increased, mail-in applications decreased; suggesting people may be using the online system as an alternative to the mail-in application.

CONTACT INFORMATION	**Project**	University of Wisconsin-Madison School of Human Ecology Statewide *Covering Kids & Families* Project Wisconsin
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Employing Presumptive Eligibility to Implement an Electronic Application System	
PROMISING PRACTICE	Partner with state Medicaid and SCHIP agency to develop an online application system that **simplifies** the enrollment process making **outreach** to uninsured children easier. The simplified electronic application made the process more efficient and provided access to isolated populations.
DESCRIPTION	The Michigan statewide *Covering Kids & Families* project, Michigan Public Health Institute, worked to develop an online Medicaid and SCHIP application system in partnership with the Michigan Department of Community Health (MDCH). The online application incorporates Michigan's presumptive eligibility policy, making Medicaid and SCHIP enrollment easier, faster and more user-friendly. Presumptive eligibility policy permits children to be enrolled temporarily in Medicaid and SCHIP if they appear eligible while the family completes the application process. The system was tested at seven pilot sites. Local *Covering Kids & Families* projects (Detroit/Wayne County Child Health Care Coalition, Catholic Social Services of the Upper Peninsula, Michigan Center for Rural Health and Muskegon Community Health Project) worked with the pilot sites to provide feedback on what did and did not work. During the development of the system the statewide *Covering Kids & Families* coalition raised issues related to the notification letter and the slow issuance of recipient identification numbers. The coalition also developed strategies to promote the electronic application at all outreach events. The MDCH developed an interactive training module for agencies and providers, offered provider education via information booths at statewide conferences, established outstationed workers throughout the community authorized to process the Medicaid and SCHIP applications and created a resource list of facilities available to provide application assistance. The electronic application makes it possible for families to apply from their own home and helps outreach workers assist clients who do not have access to the Internet. Clients can call the community-based outreach workers who then use the electronic application to relay the client's information. The accessibility of the electronic application also attracts new outreach partners, such as hospital staff. The online application takes about 25 minutes to complete and is available to anyone with access to the Internet. The electronic application prompts for missing or incorrect information, ensuring that all applications are complete upon submission and provides immediate eligibility feedback (approval, denial, instructions). Since Michigan policy recognizes presumptive eligibility, the applicant's eligibility is determined in two to three minutes real-time, provided the information entered is complete. Michigan requires a signature to be submitted, so applicants must print the signature page and mail the signed page to the program within five days of completing the online application. The state provides presumptive eligibility to applicants for two months. If the child is SCHIP eligible, the premium payment must be received to continue eligibility. In Michigan, SCHIP has a passive renewal process; staff sends the pre-populated renewal form to current enrollees for their review if changes are needed. Medicaid enrollees must submit a new paper application for re-determination. The online application reaches the state agencies quickly and eliminates mail delays.

OUTCOMES	▪ The electronic application maximizes the advantages of the self-declaration, presumptive eligibility and no face-to-face interview policies. ▪ The electronic application provides access to isolated populations and reduces the fear of stigma by making the process more private. ▪ The application is processed and determination is made within five minutes. ▪ Administrative costs (staffing, paperwork, postage) are reduced. ▪ Client satisfaction surveys are consistently favorable. ▪ Post-eligibility audits show an error rate of less than two percent with the simplification policies.
RESOURCES	▪ Partnership with Medicaid and SCHIP administrations ▪ State government commitment to developing and implementing an electronic application, including the funding ▪ Supportive policies, including e-signature capacity, presumptive eligibility, self-declaration of income and passive renewal ▪ Internet access and the ability to create and maintain a network application that is publicly accessible and securely interfaces with a state database ▪ Community partners network for outreach (including hospitals, health departments and community action agencies)
ACTION STEPS	▪ Develop an online application that incorporates presumptive eligibility. ▪ Pilot test the application and provide feedback. ▪ Make appropriate adjustments to the system. ▪ Promote the electronic application at outreach events.
KEY PARTNERS	▪ State Medicaid and SCHIP agency officials provide leadership and oversight in the development and implementation of the electronic application. ▪ Community partners network for outreach.
LESSONS LEARNED	▪ Simplified policies joined with the automated system made it possible for widely disbursed community-based outreach workers to efficiently and effectively enroll eligible uninsured children in Medicaid and SCHIP.

CONTACT INFORMATION	**Project**	Michigan Public Health Institute Statewide *Covering Kids & Families* Project Michigan
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Engaging Hospitals in Simplifying the Application Process	
PROMISING PRACTICE	Implement and pilot test in a hospital setting a **simplified** one-page Medicaid and SCHIP application that was initially used for outreach to children receiving free or reduced price meals through the National School Lunch Program. A list of simplification recommendations that helped increase Medicaid and SCHIP applications and enrollment resulted from the test.
DESCRIPTION	The New Jersey Assembly passed legislation allowing New Jersey Family Care to create a one-page express application to be used primarily as part of special outreach through the National School Lunch Program applications. Based on the positive pilot test of the simplified application in a school setting, partnerships were formed to test the application in a hospital setting. Partnerships were created between New Jersey Family Care, the New Jersey statewide *Covering Kids & Families* project, Health Research & Educational Trust (HRET) of New Jersey and five hospitals to test the use of the one-page express application at hospital locations. HRET worked with the New Jersey Hospital Association to test the one-page form in a hospital setting, to train hospital staff on Medicaid and SCHIP application processes and to provide technical expertise in the first enrollment event and in subsequent enrollment events that followed the pilot tests. Hospitals were selected based on high charity care expenditures. Hospital staff was trained to provide application assistance. A critical aspect of this express application was reliance on presumptive eligibility based on the applicant's self-declaration of income. At renewal time in one year, they were asked to provide required proof if the state was not able to verify their income through the existing databases. As a trusted partner, HRET acted as a liaison between the hospitals, the statewide *Covering Kids & Families* coalition members and the state agency, providing feedback on the express application form and offering assistance with evaluation of special efforts using this form. Evaluation of this process led to other simplification suggestions. HRET staff worked with coalition members to develop a list of potential simplifications to streamline the Medicaid and SCHIP application and renewal processes and procedures and shared that information with state administrative and legislative officials.
OUTCOMES	▪ The hospital project resulted in a suggestion that the presumptive eligibility application be combined with a separate HMO selection form. This suggestion was accepted and a new one-page application was designed. ▪ Based on the success of this effort, additional community agencies used the same one-page application form and self-declaration to enhance their outreach and enrollment efforts. ▪ Based on this project, the one-page application was implemented statewide including an HMO selection, eliminating the need for a separate form.

RESOURCES	▪ Enabling legislation creating a mandate for the one-page form and the option for self-declaration of income with retrospective verification ▪ A partnership with the hospital staff to provide training and technical assistance for Medicaid and SCHIP enrollment processes ▪ Staff to maintain the relationship with the hospitals and to follow up on the results
ACTION STEPS	▪ Use a simplified application designed for another setting. ▪ Expand the program to families seen in another setting, such as hospitals. ▪ Train hospital personnel to assist with and complete the express applications. ▪ Plan enrollment event and obtain endorsement for the event from the New Jersey Hospital Association. ▪ Hold an outreach event at hospitals using the one-page express application. ▪ Collect feedback and outcome data.
KEY PARTNERS	▪ Legislative leaders and lobbyists pushed and passed the required legislation. ▪ New Jersey Family Care staff conducted the pilot. ▪ Hospitals held enrollment events.
LESSONS LEARNED	▪ The presumptive eligibility application and simplified enrollment process helped community agency partners to successfully assist families, increasing applications and enrollment in health coverage programs.

CONTACT INFORMATION	**Project**	Health Research & Educational Trust of New Jersey Statewide *Covering Kids & Families* Project New Jersey
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Implementing Express Renewal to Improve Renewal and Retention	
PROMISING PRACTICE	Create and test a pilot to expand and **simplify** Medicaid and SCHIP renewal access processes to retain more eligible families in health coverage programs. The pilot test led to a more comprehensive automation of the Medicaid and SCHIP enrollment process.
DESCRIPTION	The Massachusetts statewide *Covering Kids & Families* project, Health Care for All, in partnership with the Massachusetts Office of Health and Human Services, Division of Medical Assistance (DMA) designed and pilot tested an Express Renewal project that allowed Medicaid and SCHIP families to renew their coverage at local health care provider community-based sites. Funding to conduct the pilot test was provided by the Centers for Medicare and Medicaid Services. Direction for the Express Renewal project was provided by a DMA team led by the Assistant Commissioner. The statewide *Covering Kids & Families* project and the local *Covering Kids & Families* projects (Lower/Outer Cape Cod, Everett and Springfield) provided pilot test sites, technical assistance and consumer input. The DMA provided renewal information to test sites. This program allowed Medicaid and SCHIP participants, during a point-of-service event, to initiate a process to advance their eligibility renewal date for a full 12 months. Participating providers engaged eligible Medicaid and SCHIP enrollees in completing an abbreviated certification of their status and their continuing responsibilities to provide the DMA with information concerning changes in their status and income. Enrollees eligible to participate were those whose circumstances (i.e., income level) had not changed since their last determination (either at the time of the original application or the most recent renewal) and were within 30 to 180 days of their next scheduled renewal. If the enrollees met these conditions they were given the opportunity to complete a one-page form and their coverage was renewed for an additional 12 months provided that they met the Medicaid and SCHIP eligibility requirements. Statewide implementation of Express Renewal was delayed due to the state's development of the more comprehensive virtual gateway/online application system in Massachusetts. As a part of the Express Renewal demonstration project the state partners started development of an extensive Web-based application for the Massachusetts Health Renewal process. This new system addressed the operational difficulties encountered in the Express Renewal demonstration project.
OUTCOMES	▪ Initial results showed that 42 percent of the Express Renewal applications submitted had coverage extended for another 12 months. ▪ DMA was able to collect updated member demographics for their database. ▪ Express Renewal requests that did not result in extension of coverage lacked available information on renewal dates and/or were for clients who did not fit the Express Renewal parameters.

OUTCOMES (continued)	▪ The Express Renewal pilot clearly confirmed the utility of a simplified renewal process for individuals and families who experience no significant changes in their eligibility demographics. However, the implementation of this practice on a statewide scale could not be supported by the existing automated systems, thus implementation of the Express Renewal project statewide was delayed while the state built its electronic application known as the Virtual Gateway.
RESOURCES	▪ Funding for the pilot test ▪ State Medicaid and SCHIP agency to partner in addressing renewal simplification issues through policy and processing revisions ▪ Consumer advocates and providers to provide pilot test sites, input on consumer issues and technical assistance where necessary ▪ Internet and computer infrastructure to connect local community-based sites to the application/renewal system ▪ Training for pilot staff
ACTION STEPS	▪ Develop partnership with state Medicaid and SCHIP agency. ▪ Develop automated system. ▪ Establish test sites. ▪ Establish feedback mechanisms.
KEY PARTNERS	▪ Leadership from Massachusetts Office of Health and Human Services, Division of Medical Assistance provided direction for the project team.
LESSONS LEARNED	▪ The results were both encouraging and instructive. ▪ This type of project requires a refined level of computer technology to work effectively. ▪ Providers need to be educated about the process and the benefit to their practice.

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Using Simplified Phone Reviews to Improve Renewal and Retention

PROMISING PRACTICE	Arkansas created a reminder system and used a **simplified** telephone renewal interview to help families maintain their children's health coverage through Medicaid and SCHIP and avoid having to re-apply. This simplified renewal process resulted in saving time for the family and case worker and helped the families maintain continuous health coverage.
DESCRIPTION	A team of statewide and local *Covering Kids & Families* project staff and state Medicaid and SCHIP officials examined the data on families who failed to renew their children's health coverage at the end of the initial enrollment period. The data revealed that many families who lost coverage were re-entering as new enrollees. Case worker time needed for enrolling families is usually greater than the time needed to renew coverage. In addition, during the period between losing and re-gaining coverage the families may experience higher health care costs. With a goal of reducing the number of case closures due to failure to return reenrollment forms, Arkansas instituted policy and process revisions that simplified the renewal process by conducting telephone interviews that ask five (5) essential questions that can be answered very quickly. The questions address changes in household composition, income, child care, other health insurance, and the name of the child's primary care physician. Initially using staff from the local *Covering Kids & Families* project, Poplar House, Arkansas tested a practice where an outreach worker made reminder calls and conducted telephone renewal interviews with families who had not returned their annual renewal form for Medicaid and SCHIP. A key element in the success of this effort was the family's rapid response in returning calls based on the voice mail messages they received about renewing their health care coverage. When a voice message was left reminding families to call and renew their coverage, the call back number left on the message was set up to be answered immediately so that families did not have to wait or try calling more than once in order to maintain their children's coverage. This telephone renewal process began as a pilot in one county in January 2004. Once established as a successful tactic, this renewal process was expanded to three additional counties using local eligibility case workers for further testing. By January 2005, the telephone renewal process was expanded to an entire region and in July 2005, this process was expanded statewide.
OUTCOMES	▪ Clients have been receptive to the simplified telephone renewal process. Very few have declined to complete their renewal by phone. ▪ The Arkansas Department of Health and Human Services (DHHS) has been able to complete the annual renewal over the telephone for 30 percent of families who had not returned the printed renewal form.

RESOURCES	▪ Data on the number of mailed Medicaid and SCHIP renewal forms that were not returned ▪ Support from the Arkansas DHHS to utilize phone interviews for annual renewals for Medicaid and SCHIP ▪ Funds to implement and operate a telephone system that would be answered at all times ▪ Partnership with the Arkansas DHHS to develop a simplified renewal interview process/form to be completed by telephone and submitted without a client's signature ▪ Clinic staff to make calls during and after business hours and leave a pager number if the parent could not be reached
ACTION STEPS	▪ Implement policy and procedural changes that allow renewal of coverage without a signature and telephone contact to obtain information. ▪ Create and implement a standard set of questions that obtain the information necessary to make a determination of continued eligibility. ▪ Track renewal responses to identify those who are due to renew but have not responded. ▪ Make outbound calls to remind families about renewal. ▪ Leverage families' responses to the outbound call into completed renewals using the standard set of questions.
KEY PARTNERS	▪ Director of County Operations for Arkansas DHHS facilitated the review of renewals and the new process.
LESSONS LEARNED	▪ Reminder calls and telephone interviews can assist families in maintaining coverage. ▪ Five essential questions can sufficiently obtain the information necessary to make a determination of continued eligibility.

CONTACT INFORMATION	**Project**	Arkansas Advocates for Children & Families Statewide *Covering Kids & Families* Project Arkansas
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Tracking Enrollment and Renewal Trends	
PROMISING PRACTICE	Collect, analyze and report on Medicaid and SCHIP application, enrollment and renewal data to distribute to key partners for **simplifying** the enrollment and renewal processes. The data reports led to important simplification and **outreach** efforts and provided the basis for advocating for policy and procedural changes.
DESCRIPTION	The Indiana statewide *Covering Kids & Families* project, Health and Hospital Corporation of Marion County, focused on gathering, analyzing and sharing Medicaid and SCHIP participant characteristic data related to outreach and renewal outcomes. The data was gathered on the statewide level, but the statewide coalition also worked with each local *Covering Kids & Families* project (Allen County, Cass/Fulton County, Delaware County, Lake County, Marion County/Central Indiana and St. Joseph County) to gather and analyze data in response to local needs and conditions. The statewide *Covering Kids & Families* project made arrangements through the Indiana Family and Social Services Administration (FSSA) to receive Medicaid and SCHIP enrollment data. The agreement provided for monthly data reports by region, county, zip code, age and assistance group category for all children enrolled in Medicaid and SCHIP. In return, the statewide *Covering Kids & Families* project provided summaries of the information to statewide coalition committees, the statewide and local *Covering Kids & Families* coalition partners and local eligibility office partners to monitor enrollment trends and progress. All data sharing respected the need to maintain confidentiality. For example, the Managed Care Organizations saw data on their clients and aggregate data for other enrollees. In return, the Managed Care Organizations shared their aggregate data from their records with the statewide *Covering Kids & Families* project. After receiving feedback from local *Covering Kids & Families* coalitions, the statewide *Covering Kids & Families* project developed a system for distributing state data, county and zip code data and charts of enrollment by age. Data was shared with local *Covering Kids & Families* coalitions for targeting specific regions for billboard advertising, school outreach, events and other outreach efforts. State trends were also shared at all *Covering Kids & Families* committee meetings. Data shared illustrated the negative impact of eliminating the continuous eligibility policy and the barriers in accessing and maintaining health coverage.
OUTCOMES	▪ Response from all users of the data reports was positive and enthusiastic. Previous to these reports there was no access to monthly data reports to track performance or identify issues. Even local eligibility offices that had access to the data lacked resources to aggregate or compare trends beyond their own county. ▪ Statewide, the database led to raised awareness about Medicaid and SCHIP enrollment and retention issues. ▪ Local *Covering Kids & Families* coalitions gained understanding of the data and used it effectively for planning and coordinating outreach.

OUTCOMES (continued)	▪ The data reports made it possible: □ For FSSA to create a statewide renewal taskforce to address six strategies to improve the re-determination process. FSSA worked with *Covering Kids & Families* and other partners to implement these strategies. □ To focus attention on the early childhood outreach efforts. □ To gather and analyze data on School Lunch Program outreach efforts thus helping to implement new streamlined processes. □ To conduct training on processing issues within local eligibility offices that produced unreliable and misleading data. □ To provide a basis for advocacy for simplification of Medicaid and SCHIP. For example, Indiana eliminated 12-month continuous eligibility in July 2002. The data mining efforts helped to understand and document unintended consequences of this policy change and thereby provided a foundation for discussion about reinstating this important policy. □ To realize the need to work more closely with the Indiana Rural Health Association and early childhood agencies.
RESOURCES	▪ A strong relationship with the state eligibility agency that allows the sharing of Medicaid and SCHIP data with an entity outside government ▪ The capacity to credibly aggregate and analyze the data to produce reliable tracking information ▪ Staff to advocate for changes based on the data reports
ACTION STEPS	▪ Develop a strong working relationship with the state Medicaid and SCHIP eligibility agency. ▪ Set up and implement a data sharing mechanism. ▪ Produce and distribute data reports. ▪ Use the information in the data reports to advocate for simplified processes.
KEY PARTNERS	▪ FSSA collected the raw data on applications, enrollment and renewals and shared the information with the statewide *Covering Kids & Families* project.
LESSONS LEARNED	▪ Summaries of enrollment trends were critical to proving the retention issues in Indiana to the Medicaid Oversight Committee, resulting in agreement to the proposal to review the reinstatement of 12-month continuous eligibility.

CONTACT INFORMATION	**Project**	Health and Hospital Corporation of Marion County Statewide *Covering Kids & Families* Project Indiana
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Reducing Income Verification for Enrollment	
PROMISING PRACTICE	Form an advocacy policy work group to **simplify** the Medicaid and SCHIP application process by eliminating the income verification requirement and by implementing self-declaration of income or alternatively reducing the amount of verification to one pay stub. The group successfully achieved modification of the income verification policy.
DESCRIPTION	The Illinois statewide *Covering Kids & Families* project, Illinois Maternal and Child Health Coalition, formed a policy work group to address the Medicaid and SCHIP denial rate issue. The group collected data on the number of Illinois families denied coverage or renewal due to "procedural reasons." A significant number of "denials for procedural reasons" was due to lack of income verification. The policy work group created a policy paper on reducing income verification and implementing self-declaration of income and distributed the paper to state officials, administrators, coalition members and legislators to educate them on the issues. Although the state was not ready to eliminate income verification completely, income verification requirements were reduced from 30 days of income documentation to one pay stub. Also, day care expense documentation was changed to self-declaration.
OUTCOMES	▪ Denials for enrollment due to failure to provide income documentation dropped from 17.6 percent in November 2003 to less than 10 percent in May 2004. ▪ Cancellations at renewal due to failure to provide income documentation within the SCHIP unit dropped from 14 percent in November 2003 to 4.3 percent in May 2004. ▪ Income verification simplification also positively impacted application processing time and error rates did not increase.
RESOURCES	▪ Access to state Medicaid and SCHIP enrollment data ▪ Local entities that can provide information on the barriers faced and test innovative solutions on a small scale ▪ Supportive state decision makers and program staff to join in the development and testing of new strategies and tactics ▪ Training for local eligibility office Medicaid and SCHIP staff on the new procedures ▪ Staff capacity to develop a policy paper and to present the recommendations to key state Medicaid and SCHIP program staff

ACTION STEPS	▪ Form a work group. ▪ Collect Medicaid and SCHIP enrollment data. ▪ Write a policy paper to educate key state personnel and legislators. ▪ Support testing and feedback of the Medicaid and SCHIP enrollment process changes. ▪ Report on outcomes.
KEY PARTNERS	▪ Staff from the Illinois Department of Human Services implemented the simplification to one pay stub at enrollment and renewal. ▪ Statewide and local eligibility staff provided data relevant to the income verification barriers.
LESSONS LEARNED	▪ The implementation of one pay stub was well-received by state program staff but did not relieve concerns about moving to self-declaration of income. ▪ Participation with the *Covering Kids & Families* Eligibility Policy Group was helpful in preparing the coalition to advocate with the new administration for policy improvements.

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Coordination

Effective coordination between Medicaid and the State Children's Health Insurance Program (SCHIP) and among various Medicaid categories helps facilitate a smooth transition of children and adults from one program category to another, preventing gaps in health coverage. Transitions are needed when family circumstances change, such as a change in family composition or income. When public programs are coordinated, continuity of health coverage is maintained and state and local eligibility offices experience increased productivity and administrative cost savings.

Covering Kids & Families projects worked with their Medicaid and SCHIP state partners to coordinate across programs, reducing complexity for both applicants and eligibility agencies. States aligned verification requirements, developed a joint application and renewal form, established one common program name and promoted both Medicaid and SCHIP in their marketing and outreach campaigns.

Coordination challenges are greater in states that have separate SCHIP programs. Most states have implemented coordination measures at application, but in many states additional actions are needed to effectively coordinate renewals across Medicaid and SCHIP. States that chose to expand Medicaid rather than create a separate SCHIP program helped to alleviate coordination barriers, but these states still experience coordination challenges among Medicaid eligibility categories. Coordination across Medicaid eligibility categories includes smooth transitions between the lower-income family eligibility category, the Transitional Medical Assistance category and the poverty-related eligibility category for children. Each Medicaid eligibility category has its own eligibility guidelines. The variation in 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. Medicaid guidelines require that eligibility opportunities be searched and ineligibility be established in each potential Medicaid eligibility category prior to denial or closure.[16] Federal SCHIP law requires that ineligibility for Medicaid be established prior to approval for SCHIP coverage.[17]

Coverage is coordinated when it is seamless and variations between eligibility categories and programs are transparent to families. Coverage is achieved when the three interactive parts of the eligibility system (automated systems, processes and eligibility determination staff) are coordinated. When coverage is coordinated, application and renewal decisions are not delayed as information is transferred between coverage programs. When coverage is coordinated individual denial notices are not sent to the family for every eligibility category for which the family members were considered. When the system is not coordinated, loss of health care coverage can occur, resulting in loss of access to health care.

The two promising practices described below demonstrate effective approaches to coordination – implementing an electronic referral system between Medicaid and SCHIP programs and improving retention and coordination through ex parte renewal.

Implementing Electronic Referral System Between Medicaid and SCHIP	
PROMISING PRACTICE	Implement an electronic referral system within the state that allows **coordination** between Medicaid and SCHIP in the joint application process, thus keeping children from losing coverage.
DESCRIPTION	Data collected by the Iowa statewide *Covering Kids & Families* project, the Iowa Department of Human Services (DHS), showed that: 1) children who lost Medicaid eligibility were not being referred to SCHIP for review; 2) children had breaks in coverage because referrals were not made; and 3) children were falling out of the system. DHS is the agency that administers Medicaid and SCHIP in Iowa. The Iowa statewide *Covering Kids & Families* coalition presented data to the DHS director, making a case for an electronic Medicaid and SCHIP referral process. The information shared showed why the change should be made, the savings that would be achieved and what efficiencies would be gained. The members of the coalition also worked to get broad support for the electronic renewal system, a particularly essential step because resources from other areas needed to be redirected in order to implement the electronic renewal system. The coalition also included those affected by the change – eligibility workers, clients and advocates. The collaborative team, consisting of statewide *Covering Kids & Families* staff and Medicaid and SCHIP administrators, worked on developing an automated referral process that was added to the Medicaid computer system. Previously, income maintenance workers were required to copy and fax forms to make the referral. The team tested a new notice of decision, an email reminder for the income maintenance worker to make the referral and management reports for the supervisors to be implemented with the system. Data was collected continuously on the referrals throughout the state. Team members conducted statewide training for income maintenance workers on their role in making referrals and on the new automated system. Additionally, the team reviewed monthly data and developed new goals to continue the project based on the data review. Iowa's DHS also restructured so that the SCHIP Administrator covered eligibility for both Medicaid and SCHIP. This reorganization allowed eligibility changes to occur more rapidly and simultaneously in the two programs.
OUTCOMES	▪ Average monthly referrals have steadily increased from 369 to 703, resulting in decreasing the number of applications and renewals denied for failure to comply, while also increasing enrollment in Medicaid and SCHIP. ▪ The change in management for Medicaid and SCHIP allows eligibility changes to occur more rapidly within Medicaid and also allows changes to occur simultaneously in the two programs. ▪ Implementation of the automated referral resulted in about a 200 percent increase in referrals from December 2003 to December 2004.

RESOURCES	▪ Collaborative partnership with state Medicaid and SCHIP administration ▪ An eligibility agency willing to embark on an electronic referral process ▪ Sufficient state budget funding to invest in the necessary computer hardware and software ▪ Training for state eligibility staff
ACTION STEPS	▪ Document the need for an electronic referral system. ▪ Establish a working relationship with key Medicaid and SCHIP decision makers. ▪ Make a data-informed case to appropriate leaders for an electronic referral system. ▪ Collaborate on the electronic referral system design and provide feedback. ▪ Use data from the system to refine the referral and enrollment process.
KEY PARTNERS	▪ Iowa Department of Public Health provided the Medicaid component of the referral process. ▪ Center for Healthy Communities provided the consumer perspective and tested materials with consumers.
LESSONS LEARNED	▪ The data-informed updates at the SCHIP Board Meetings helped the statewide *Covering Kids & Families* project establish a trusting relationship and contributed to serious consideration of the recommendations. ▪ Setting realistic goals maintained the credibility of the effort. ▪ The automated referral system reflects positively on Medicaid and SCHIP because the enhanced coordination between the programs results in more families having a positive experience with the programs. ▪ The automated referral system lightens the workload on income maintenance workers who are now available to spend more time assisting families through the application process.

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Utilizing Ex Parte Review to Improve Retention and Coordination	
PROMISING PRACTICE	Improve Medicaid and SCHIP enrollment and retention rates by implementing ex parte review for families. Ex parte review **coordinated** and **simplified** the Medicaid and SCHIP application and renewal processes for the eligibility worker and the families.
DESCRIPTION	The Louisiana statewide *Covering Kids & Families* project, Agenda for Children, in collaboration with the Louisiana Department of Health and Hospitals (LDHH) implemented ex parte review for a variety of verification requirements. An ex parte review process is one in which the agency relies upon information obtained from sources other than the client. Those sources are other state agencies, case file records, etc. Ex parte review began with citizenship, household composition and Louisiana residency in 2000. Voluntary child support through ex parte review was added in 2001 and age in 2002. Federal direction through State Medicaid Director letters posted at the United States Department of Health and Human Services Centers for Medicare and Medicaid Web site gave the initial impetus to re-think operations and procedures. A global shift in philosophy within the LDHH was essential to moving the overall improvement process forward. LDHH eligibility offices underwent a "radical" shift in processing procedures to rely on outside sources rather than the client to provide confirmation of information supplied in applying for or renewing Medicaid or SCHIP coverage. The LDHH ex parte review process relies on data available to Medicaid workers from the state's computer systems to verify eligibility. This process enhances coordination at renewal and simplifies the renewal process for both the eligibility worker and the client. Case workers participated in training that shifted their work focus from an emphasis on quality control and thorough documentation to an emphasis on "reasonable certainty" and thorough efforts to obtain verification from outside sources. Maintaining enrollment through ex parte verification was seen as cost-effective and time-saving for the case worker. The LDHH was a vital partner in the Louisiana statewide *Covering Kids & Families* coalition. The coalition played a key role in the implementation of the ex parte review by acting as the communication and networking mechanism among key state agencies, consumer advocates and health care provider organizations. The outside data sources included other benefits such as TANF, the Food Stamp Program and Supplemental Security Income. System improvements to allow communication between programs were the foundation for changes in processing. Ex parte review is cost effective and efficient. The case worker does not have to issue new cards or notices because both Medicaid and SCHIP are under one name, LaCHIP, and families are automatically transitioned to the appropriate program. When the family's circumstances change (i.e., income level), the ex parte process enables the case worker to seamlessly transition the case between programs.

OUTCOMES	▪ The use of ex parte review gives LDHH the ability to manage average caseloads of 1,174 per Medicaid Analyst. ▪ SCHIP application denials for procedural reasons fell to less than half a percent and Medicaid procedural closures at renewal dropped to an eight percent statewide average. ▪ Ex parte renewals now account for 60 percent of Medicaid children. ▪ Ex parte reviews resulted in continuing increases in enrollment for both Medicaid and SCHIP. ▪ The average processing time for Pregnant Woman applications was reduced from 19 calendar days to fewer than five calendar days. This achievement involved changes to verification policy, with LDHH no longer requiring medical verification of pregnancy and due date for outstationed case workers.
RESOURCES	▪ State data systems capable of sharing information across programs ▪ Training for case workers on obtaining data from the systems available before asking clients for verification ▪ Trusting relationships among key agencies and reliable input from consumer advocates ▪ Data on renewal outcomes and effect on productivity of state workers
ACTION STEPS	▪ Get guidance on ex parte reviews from the experience of other states. ▪ Develop a systems plan for obtaining ex parte reviews. ▪ Train eligibility workers on ex parte review processes. ▪ Implement, test, provide feedback and modify the process.
KEY PARTNERS	▪ The Medicaid Deputy Director provided leadership, encouragement, ideas and motivation to lead this effort from the top. ▪ Local eligibility office management adapted their work as necessary, and contributed process and procedural ideas to test and implement ex parte review.
LESSONS LEARNED	▪ Ongoing reviews of existing policies and procedures should be conducted to identify both unintended consequences and best practices. ▪ "Best practices" need to be identified, documented and shared with other offices. Good renewal outcomes deserve acknowledgement and recognition. ▪ Empowerment of local eligibility offices in designing ongoing process improvement strategies, sharing of "best practices" among local offices and recognition of success are all critical factors.

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Covering Kids & Families Eligibility Process Improvement Collaboratives

Two *Covering Kids & Families* Eligibility Process Improvement Collaboratives were offered to *Covering Kids & Families* projects to build their capacity to maximize the efficiency and effectiveness of the enrollment and retention process of eligible but uninsured adults and children. The collaboratives were designed to accelerate the process for attaining and sustaining the above goal. Participating in the collaborative allowed teams to share and learn as a part of a larger community that included representatives from other states dealing with similar issues and with experts in the field of Medicaid and the State Children's Health Insurance Program (SCHIP).

In early 2000 declines in Medicaid and Food Stamp Program enrollment of adults and children were believed to be the result of welfare reform policy changes and the de-linking of Temporary Assistance for Needy Families (TANF) and Medicaid. While reducing dependence on government benefits was an acknowledged goal of welfare reform, an unintended consequence was the loss of health coverage by thousands of eligible families.[18]

The de-linking resulted in the eligibility process becoming more confusing and therefore children and adults who were potentially eligible for Medicaid and SCHIP were failing to begin or complete the eligibility process. To enroll and retain eligible persons required systems changes to the eligibility process and making changes that resulted in improvements, not just changes, required a well thought-out plan in conjunction with testing and follow-up.

Recognizing the need for system changes to the eligibility process, the Robert Wood Johnson Foundation (RWJF) funded *Supporting Families After Welfare Reform: Access to Medicaid, SCHIP and Food Stamps* in partnership with the United States Department of Health and Human Services and the United States Department of Agriculture. *Supporting Families* focused on helping states and large counties solve problems in eligibility processes that made it difficult for lower-income families to access or retain Medicaid, SCHIP and food stamp benefits. Eight states and four large counties received grants to participate in this initiative.

The Southern Institute on Children and Families provided leadership and guidance by:

- Providing technical assistance for projects in how to use eligibility and enrollment data to improve their systems;
- Holding workshops for projects on the barriers in state and local eligibility and enrollment processes;
- Providing technical assistance to help states identify opportunities in their systems for significant improvements;
- Providing resources to implement proposed solutions; and
- Offering a blueprint for providing technical assistance on building a collaborative process.

When initial efforts to improve the eligibility processes for Medicaid and SCHIP did not generate the desired results for *Supporting Families*, the Southern Institute adopted a blueprint for building a collaborative process called the Breakthrough Series Collaborative, which is based on the Institute for Healthcare Improvement model. In this model a collaborative is a group of teams working toward a common goal, using each other as a resource for learning by sharing

ideas and experiences. Teams test specific improvement strategies that have proven to be successful in addressing the area of concern for the teams.

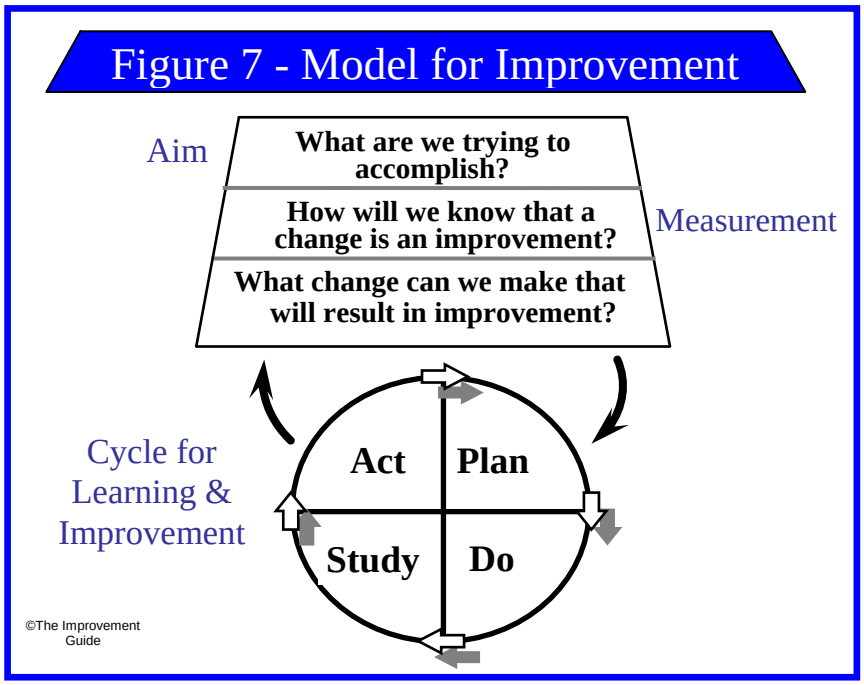
The *Supporting Families* Collaborative focused on "Maximizing the Enrollment and Retention of Adults and Children in Medicaid and SCHIP." The Food Stamp Program eligibility process was a secondary focus for several collaborative teams. Collaborative activities included:

- Identifying gaps between the ideal processes and practices and the actual processes and practices;
- Using measurement strategies to track changes; and
- Participating in a series of learning and sharing activities, with group learning sessions followed by action periods supported by conference calls, site visits and technical assistance facilitating implementation based on learning.

The ideas and learning that flowed from the *Supporting Families* Collaborative stimulated interest in testing ideas and achieving desired results in the broader context of the *Covering Kids & Families* projects. The *Covering Kids & Families* Eligibility Process Improvement Collaboratives were developed as a result of the success of the *Supporting Families* Collaborative. *Covering Kids & Families* Eligibility Process Improvement Collaborative teams identified opportunities for improvement in the Medicaid and SCHIP enrollment and renewal processes utilizing the Model for Improvement as the primary improvement methodology.[19] Strategies were developed, tested and analyzed to gauge the impact of the strategy on the process prior to implementation. Through the *Covering Kids & Families* collaboratives' efforts, many states streamlined Medicaid and SCHIP processes to achieve more efficient performance.

The ultimate goal of measuring the eligibility process is to learn about the performance of the system and to implement improvements. The knowledge gained by measuring the processes serves as feedback for developing changes that lead to improvements throughout the system. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* provides a framework[20] for making changes to processes that will lead to improvements. The Model for Improvement is depicted in Figure 7. Three basic questions form the foundation of the model:

- *What are we trying to accomplish?* This is the aim statement for the improvement.
- *How will we know that a change is an improvement?* Measures are established to record the results of the change.
- *What change can we make that will result in an improvement?* Testing cycles are used to learn the results and make continuous improvements.



The Plan, Do, Study, Act (PDSA) Cycle for learning and improvement develops, tests and analyzes changes that may lead to improvements. The Model for Improvement uses small-scale testing to quickly gain knowledge of the potential impact of process changes. Testing is part of the continuous process of planning, doing, studying, acting and planning again. During continuous testing, data is collected over time to build knowledge sequentially, which provides confirmation of the impact of a tested strategy, good or bad. Testing increases confidence that a change will result in improvement and lowers risks related to the impact the change will have on the system.

The steps in the PDSA Cycle lay the groundwork for continual learning and improvement:

Plan: What are the objectives and what are the question(s) to ask? What results are predicted and why? What are the overall implementation and testing procedures? What data will be collected? Who will do what, where and when?

Do: Carry out the plan, document problems and unexpected observations and begin to analyze the data.

Study: Complete the data analysis, compare data findings to the predictions and summarize what is learned.

Act: Should the change be adopted and implemented, or abandoned? Should the change be adapted and tested in another cycle? The PDSA Cycle can be repeated as often as necessary.

The Improvement Strategies Guide provided the collaborative teams with change concepts and strategies[21] that have been proven to be effective or shown promise when addressing specific problems. Table 1 shows the improvement concepts and strategies from the Improvement Guide that *Covering Kids & Families* and *Supporting Families* state and local projects had the opportunity to test in their efforts to maximize the efficiency and effectiveness

of Medicaid and SCHIP enrollment processes. By definition the enrollment process has several interdependent components: people, process, policy, automated systems and work environments. An adjustment in one component can change the dynamics in other components. For example, changes in policy can change the interface with customers, procedures, automation and even the office environment. It is expected that many strategies offered in the Guide will likely require modifications to best fit the environment of the team testing or utilizing the change.

Table 1 – Improvement Concepts and Strategies

IMPROVEMENT CONCEPT	IMPROVEMENT STRATEGY
Improve Customer Service	▪ Improve legibility of notices ▪ Simplify and improve the way customers provide information ▪ Minimize requirements for multiple interviews ▪ Develop electronic applications and renewals ▪ Provide staff and resources to assist with the application process ▪ Have scheduled appointments and allow walk-ins ▪ Reduce wait time for customer assistance ▪ Simplify appointment types and scheduling ▪ Use bilingual workers to follow up and assist customers ▪ Listen to customers ▪ Ask customers if there is anything else you can do to help ▪ Coach customers to use services ▪ Focus on the outcome to a customer ▪ Focus on making the customer eligible ▪ Update customers on status of application during review
Improve Work Flow	▪ Match staffing to needs ▪ Use variable work schedules ▪ Synchronize eligibility periods ▪ Make Medicaid eligibility decision first ▪ Do tasks in parallel ▪ Minimize handoffs and bottlenecks ▪ Take and send application, rather than refer to another office ▪ Use automation ▪ Outstation eligibility workers ▪ Work down backlog ▪ Standardize procedures across programs ▪ Triage applications ▪ Eliminate logs

Table 1 – Improvement Concepts and Strategies (continued)	
IMPROVEMENT CONCEPT	**IMPROVEMENT STRATEGY**
Improve Policy	▪ Eliminate unnecessary verification ▪ Determine ineligibility for all categories prior to denial/closure ▪ Eliminate requests for child support enforcement on application and renewal forms ▪ Adopt 12-month continuous eligibility for children ▪ Maintain eligibility coverage when families move from county to county within a state ▪ Eliminate asset tests ▪ Eliminate face-to-face interview requirements at application and at renewal ▪ Follow-up with customers prior to closure/denial ▪ Standardize policies across programs ▪ Use ex parte review sources
Automation and Error Proofing	▪ Use reminders for eligibility workers and customers ▪ Restrict case closures or denials prior to peer or supervisory review ▪ Remove auto denials or closure options ▪ Develop audit reviews
Change Work Environment and Communications	▪ Give people access to information ▪ Give workers online manuals ▪ Provide access to other computer systems ▪ Give workers information on their performance indicators ▪ Use proper measurements ▪ Provide training ▪ Colocate eligibility workers

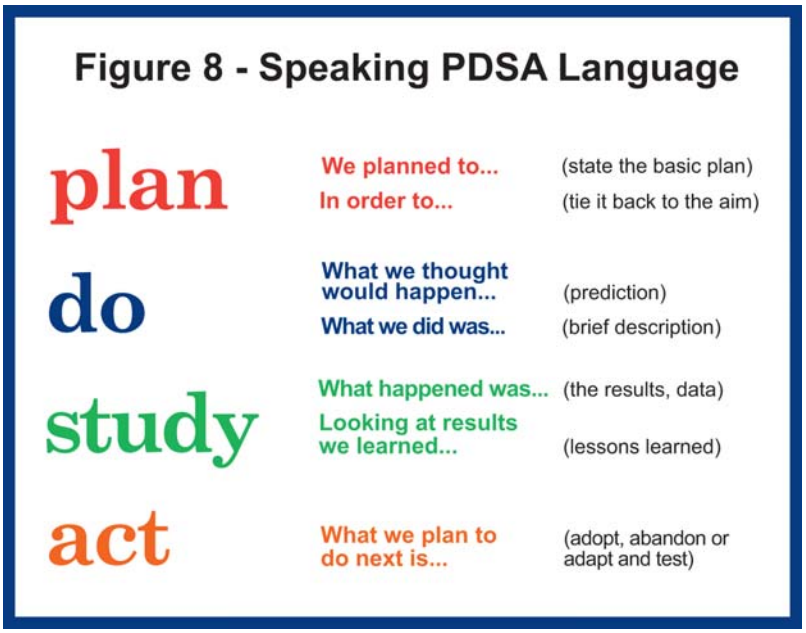
The work of the *Covering Kids & Families* Collaboratives was not about change for the sake of change, but rather based on the philosophy that "while all changes do not lead to improvement, all improvement requires change."[22] The work of the *Covering Kids & Families* Collaboratives was a search for effective changes with a focus on simplification, outreach and coordination strategies.

Covering Kids & Families Collaborative teams tested and implemented improvements in Medicaid and SCHIP eligibility processes, relying on the improvement methodologies taught during their participation in the collaborative. The teams identified the steps of their eligibility process and asked questions such as:

- Is this step in the process necessary?
- Can steps be combined with others?
- Can the sequence change to improve the workflow?
- Can the location change where the step is completed?
- Can a step be reassigned?

After reviewing their process and identifying potential areas where changes could be made, teams utilized the strategies in Table 1 and other ideas as a basis for developing tests of change.

The process improvement efforts of three teams from the *Covering Kids & Families* Collaboratives are presented to illustrate the positive results that come from active participation in a collaborative and use of the Model for Improvement. These teams fully embraced the use of the collaboratives and the PDSA Cycle.



The PDSA actions of the three teams cover different process components, but use the same proven process improvement approaches to achieving their goals. The Iowa statewide *Covering Kids & Families* project and its coalition, working to improve communication with clients and outreach workers, tested a system that focused on the people, automated system and work environment components of the enrollment processes. The Oregon statewide *Covering Kids & Families* project and its coalition focused on the people and process components of enrollment processes, looking at the causes of long delays in application processing. The Pennsylvania statewide *Covering Kids & Families* project and its coalition focused on the automated system, people, process and work environment components of the overall system to achieve a greater rate of completed applications from the online interface. What the teams did, who did it, why they did it, how they did it, what they learned and how others can learn from their experience follows.

Eligibility Process Improvement Collaboratives

Team Efforts

Improving Coordination Between Medicaid and SCHIP Through an Automated Referral System	
PROMISING PRACTICE	Through the *Covering Kids & Families* Eligibility Process Improvement Collaborative, Iowa tested processes to improve notification communications and automate the Medicaid and SCHIP referral process to improve coordination between the two coverage programs. The new process resulted in a significant increase in referrals and decrease in denials.
DESCRIPTION	The Iowa *Covering Kids & Families* Collaborative team used the Process Improvement Collaborative Model for Improvement to develop a customer-friendly system for improving enrollment notices, the referral process and training of eligibility workers on referring clients between Medicaid and SCHIP. In addition to the improvements, the Iowa Medicaid and SCHIP agency learned how to use the PDSA approach to make other improvements within their agency. The Iowa *Covering Kids & Families* Collaborative team, a partnership between the Iowa statewide *Covering Kids & Families* coalition, the Iowa Department of Human Services and the Iowa Department of Public Health, focused on making the transition between Medicaid and SCHIP seamless for the client. Data showed that children were losing coverage without being referred to another program for eligibility screening. Using the PDSA model, the Iowa Collaborative team developed strategies for creating improved notices and a system request to automate the referral process that would generate an automatic referral and email message reminders to the eligibility worker. PLAN – The Iowa Department of Human Services was planning to implement several potential changes over a one-year period that included: 1) online applications to be implemented about six months into the project, 2) automatic referral system between Medicaid and SCHIP to be implemented six months later and 3) full implementation of online applications scheduled to be available within 12 months. To support these plans, the Iowa Collaborative team coordinated their goals with the state's plans. The overall goal of the Iowa Collaborative team was to create seamless coverage for clients moving between public health coverage programs. Specifically, the aim was to: 1) eliminate barriers to enrollment, 2) increase the number of renewal approvals, 3) increase the approvals of new applications and 4) decrease Medicaid and SCHIP enrollment cancellations and denials for failure to comply with renewal and application verification requirements. The Iowa Collaborative team developed an aim statement based on data that indicated only 40 percent of the SCHIP denials were referred to Medicaid. They had no data regarding the Medicaid denials for excess income referred to SCHIP. The strategies developed to address the aim were based on the results of a survey of outreach coordinators and a survey of eligibility workers regarding the referral process. Two areas of concern identified were confusing correspondence and lack of worker knowledge of the referral requirement. The Iowa Collaborative team designed tests addressing these two areas. In addition, the Iowa Collaborative team designed a test around implementing an electronic referral system.

DESCRIPTION (continued)	DO – After initial planning, the Iowa Collaborative team: ▪ Reviewed processes customers use to enroll in public health coverage programs; ▪ Held client focus groups to identify application/notification language and forms that were barriers to health coverage; ▪ Reviewed the automated referral processes; ▪ Trained staff on the online application system; ▪ Tested staff for their understanding of the automated referral system; and ▪ Created feedback loops with the outreach staff for a proactive approach to identifying potential barriers and creating solutions. Existing staff conducted the focus groups and rewrote/redesigned the form and letter. Information gathered from the review processes was communicated to state Medicaid and SCHIP officials. STUDY – Program or system changes were tested in small venues before transitioning the changes to the rest of the office and geographic area and state. For example, client focus groups reviewed notices, provided feedback on readability and the type of language that would make the Medicaid and SCHIP application easier to understand. Outreach worker focus groups were conducted to gather information for simplifying the application process. This information was critical to developing a customer-friendly online application. The focus group process was used throughout the testing cycle. The study of the referral rate between Medicaid and SCHIP focused on automating the referral process between the two programs. The goal was to automate the referral system between Medicaid and SCHIP so that data could be transmitted electronically and increase referral rates. The automated referral process was tested with four in-house testers, four field testers and the third-party administrator. The automated reminder email was tested for clarity and effectiveness with eligibility workers. ACT – After several iterations of the email message, the automated email was implemented statewide in July 2004. Eligibility workers received training on the referral requirement, which increased the knowledge level of workers and therefore increased referrals. The communication system established with outreach workers was continued to gather information about issues with the referral system to identify problems or barriers.

OUTCOMES	▪ July 2004 data showed a 72 percent increase from the previous six months in referrals from Medicaid to SCHIP. An assessment of data from August 2003 to August 2004 showed a 227 percent increase in referrals from Medicaid to SCHIP. ▪ Training workers improved the referral process between programs resulting in increased referrals. ▪ Denials decreased by 4.4 percent. ▪ Denial for failure to comply dropped from 57 percent of all denials to 47 percent. ▪ The automatic referral system eliminated data entry errors. ▪ Improved notices reduced confusion for clients and saved administrative resources. ▪ Fifty percent of applications and referrals were sent electronically when the system became available. ▪ The Iowa Department of Human Services has used small-scale testing and process review within other program areas such as payment accuracy in the Food Stamp Program and Child Welfare Collaboration. A full-time improvement manager has been hired within the organization to manage and coordinate improvement activities throughout the organization. ▪ The Department of Human Services trained all policy staff and incorporated the Plan, Do, Study, Act process into new policy development across the Department of Health and Work Supports. ▪ As more clients continued in Medicaid, training identified a desire to create specialized case eligibility to be sure eligibility is done correctly. Staff supported this change and specialized Medicaid caseloads were implemented, thereby creating more accuracy and familiarity with program requirements and the referral process for SCHIP. ▪ The Iowa Collaborative team was awarded the Golden Dome Award, which is the Governor's Statewide Employee Recognition Award. The award recognizes outstanding contributions of teams (supported by measurable results) in state government.
RESOURCES	▪ Medicaid and SCHIP agency leadership and commitment to the Eligibility Process Improvement Collaborative ▪ Staff to use the Model for Improvement and PDSA Cycles ▪ Access to enrollment/eligibility data ▪ Automated Medicaid and SCHIP referral system

KEY PARTNERS	▪ Iowa Department of Public Health provided leadership, collected anecdotal data and gathered information from the statewide *Covering Kids & Families* coalition. ▪ Iowa Department of Human Services provided leadership and committed to exploring process improvements and implementing changes. ▪ Center for Healthy Communities conducted focus groups and gathered information.
LESSONS LEARNED	▪ Partnerships with state departments, local county health and visiting nurse services helped create fresh perspective for review of processes and documents. ▪ The ability to replicate small-scale testing was easier to accomplish with a Bureau Chief for the Department on the team who was able to share successes and best practices with other members of the department's executive staff.

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Streamlining Medicaid and SCHIP Application Process With Lean Thinking	
PROMISING PRACTICE	During the *Covering Kids & Families* Eligibility Process Improvement Collaborative, the Oregon Collaborative team applied lean thinking concepts to the Oregon Medicaid and SCHIP application process. The initiative successfully met the goal of simplifying the process and reducing the processing time for completing eligibility determinations.
DESCRIPTION	The Medicaid and SCHIP eligibility processing center was not meeting the state's Medicaid eligibility determination time line policy requirements and customer service standards. The application determination process was taking as long as 22 days to complete. Complaint calls and administrative hearings were at a high volume. Staff was working mandatory overtime and the workloads had become unmanageable. PLAN – The Oregon Collaborative team decided to review and study the current processing steps to determine eligibility. Using the Eligibility Process Improvement Collaborative and the Model for Improvement, the Oregon Collaborative team applied the lean thinking principles to simplify the eligibility determination process and reduce the processing time for completing eligibility determinations. Lean principles are about getting the right things to the right place, at the right time, in the right quantity while minimizing waste and being flexible and open to change. The lean process requires a culture change in which eligibility determination workers have an understanding of the "right thing, right place, right time and right quantity" concepts and embrace the changes in practice so that they own the process. DO – The existing eligibility determination process was reviewed and recommendations were made. Medicaid eligibility staff completed a work flow chart analysis to determine the steps and time involved to make an eligibility determination for an application. The analysis identified 72 steps in the determination process from the receipt of the application to the determination of eligibility for benefits. STUDY – During a three day workshop, the team analyzed the work flow data, identified non-value added steps and designed a simplified eligibility determination process to test. Analysis of the work flow chart data identified numerous duplicate steps, which resulted in inefficient use of staff time and lengthened the determination process. ACT – A team of Medicaid and SCHIP management and staff tested the new simplified process for completing eligibility determinations. The team continued to test the simplified eligibility determination process using the PDSA Cycle.

OUTCOMES	▪ The number of steps in the determination process was reduced from 72 to eight as a result of implementing the redesigned eligibility determination process. ▪ The redesigned eligibility process was aligned with policy requirements and customer service expectations. ▪ The application decision timeline was reduced from 22 to four days. ▪ The number of complaint calls and administrative hearings was reduced. ▪ Staff overtime costs were reduced from $27,000 per month to $0.
RESOURCES	▪ Leadership support and commitment from the Medicaid and SCHIP eligibility determination agency ▪ Lean thinking process improvement training ▪ Available eligibility determination staff to participate in the work flow analysis ▪ Application processing data
ACTION STEPS	▪ Secure eligibility determination management support of the effort. ▪ Complete a work flow analysis of the eligibility process to determine the steps of the process and the time to complete each step. ▪ Establish a team to analyze the data captured through the work flow study and develop a simplified eligibility determination process. ▪ Use the PDSA Cycle to test changes that lead to improvement. ▪ Communicate with staff to keep them informed and committed to the project.
KEY PARTNERS	▪ Oregon Department of Human Services provided leadership and the capacity to implement the procedural changes. ▪ Medicaid and SCHIP eligibility determination management and staff completed the workflow analysis and implemented the eligibility processing changes.
LESSONS LEARNED	▪ Communication is critical throughout the process to keep Medicaid and SCHIP eligibility management and staff apprised of what is being done, why there is a need to change the process and how the goals of the project support the mission of the organization. ▪ The work flow chart is an effective tool to identify duplication and potential barriers in a process.

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Using a Web-based Application System to Support Simplification Efforts	
PROMISING PRACTICE	Through the *Covering Kids & Families* Eligibility Process Improvement Collaborative, Pennsylvania tested a simplified process where the Healthy Babies Healthy Kids Helpline staff takes application information by telephone, enters the data and submits the application through COMPASS, the state's web-based application system. The test led to statewide adoption of the Helpline application assistance.
DESCRIPTION	A team of state program officials, state contractors and statewide *Covering Kids & Families* leadership tested the potential for leveraging the online application into an application assistance opportunity through Pennsylvania's toll-free Helpline number. PLAN – The goal was to connect families calling the Helpline for information to a direct means of application assistance through COMPASS, the state's web-based application system. Callers to the Helpline seeking information on health coverage were offered the opportunity to apply for health coverage over the telephone rather than receiving a mailed paper application for the family to complete on their own. DO – The new Helpline-assisted COMPASS approach to Medicaid and SCHIP applications was tested in one county with people who called the Helpline asking for health coverage information. A small sample of people who called the Helpline for Medicaid and SCHIP information received the application assistance from the Helpline through the web-based COMPASS. Helpline staff took applications over the telephone, submitted them through COMPASS and tracked the outcomes. The outcomes from the Helpline-assisted web-based application were then compared to the application outcomes for callers who received the usual Helpline service – a paper application mailed to them to complete and submit. Several small-scale tests were conducted to remove barriers to effective application processing. STUDY – Both online and paper applications were tracked for comparison. The analysis showed a significantly higher rate of completed and submitted applications for those who applied through the telephone/COMPASS process than those who received a paper application. The online applications were found to be more complete and ready for processing, thereby reducing processing time. ACT – During testing it was discovered that the follow through for mailing the application signature page to applicants who submitted online applications was inconsistent. Adjustments were made to the COMPASS system to address the issue of requiring a signature page and a copy of the application for the applicant. A decision was made to centralize the mailing of the signature page to ensure completion. Other inconsistencies in the application approval process between Medicaid and SCHIP were identified and addressed during the project. The telephone application process took about 10 to 15 minutes to complete and did not create a backlog of calls at the Helpline number. Based on the positive outcomes of the small-scale testing, the telephone application assistance was spread statewide, making it available to any caller accessing the Helpline number.

OUTCOMES	▪ The Department of Insurance expanded the Helpline contract to provide the option for telephone application assistance for Medicaid and SCHIP to all individuals calling the toll-free number. ▪ The Department of Insurance further expanded the process to include telephone renewal for individuals who called the Helpline number seeking assistance with renewal forms. ▪ The Helpline staff began making reminder calls to families who had less than 30 days to renew their children's coverage in an effort to take their renewal information over the telephone to maintain the family's health care coverage. The majority of families completed the application in one telephone call.
RESOURCES	▪ Electronic web-based application system ▪ Statewide toll-free Helpline ▪ Trained staff for telephone application assistance through a Helpline number ▪ Literacy-tested, understandable script for telephone counselors ▪ Enrollment and tracking data for analysis
ACTION STEPS	▪ Develop and test a script for telephone counselors to use during application assistance opportunities. ▪ Test and track telephone applications entered into COMPASS system as compared to paper applications provided to families to complete and submit. ▪ Study data to identify issues and make adjustments to the process as needed. ▪ Spread the offer of telephone application assistance to all Helpline callers.
KEY PARTNERS	▪ Medicaid officials provided leadership and the capacity for decision making as policy and system issues arose. ▪ Outreach director with the Department of Insurance provided data. ▪ Helpline director trained and monitored staff and project tests. ▪ COMPASS system technology staff tracked applications.
LESSONS LEARNED	▪ An unexpected consequence of the project was the morale boost it provided to the Helpline staff that assisted families calling the Helpline number. ▪ Tracking the applications during the project identified a gap in how the COMPASS system processed the signature page for applicants to complete. To correct this gap, the mailing of the signature page was centralized to insure timely and accurate completion of the signature page.

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Appendices

Appendix A
Total SCHIP Enrollment in 50 States and the District of Columbia
(December 1998 to June 2005)

Total SCHIP Enrollment in 50 States and the District of Columbia
(December 1998 to June 2005)

Monthly Enrollment

State	Type*	Dec 1998	Dec 1999	Dec 2000	Dec 2001	Dec 2002	Dec 2003	Dec 2004	Jun 2005
United States	-	**897,630**	**1,805,949**	**2,681,378**	**3,436,696**	**3,769,619**	**3,924,243**	**3,949,578**	**4,027,099**
Alabama	S	22,102	33,638	32,915	46,971	55,423	58,696	62,817	64,342
Alaska	M	-	7,346	9,882	12,152	14,158	11,666	11,078	11,366
Arizona	S	3,710	27,765	41,501	54,917	49,985	50,721	48,061	50,638
Arkansas	M	341	1,021	1,498	1,686	-	-	-	61,102
California	C	66,482	230,820	388,790	542,283	637,666	722,901	771,283	816,406
Colorado	S	11,704	23,013	28,120	38,228	48,500	49,978	38,189	40,696
Connecticut	S	5,524	9,088	10,572	12,458	13,436	13,906	14,685	15,696
Delaware	C	-	2,510	3,823	3,502	4,515	4,751	4,413	4,360
District of Columbia	M	569	2,187	3,178	2,554	3,786	3,720	4,379	4,573
Florida	C	56,265	124,763	188,364	221,388	283,079	319,477	271,946	203,983
Georgia	S	213	56,116	106,574	150,330	171,702	196,615	211,857	228,801
Hawai'i	M	-	-	3,854	7,190	8,886	10,907	13,719	14,108
Idaho	C	2,937	4,728	9,150	11,940	11,197	11,237	12,884	13,787
Illinois	C	24,897	47,020	61,123	70,953	76,928	92,144	122,711	135,984
Indiana	C	24,982	34,656	45,572	48,814	55,800	61,577	71,401	68,939
Iowa	C	7,004	12,677	18,013	24,488	26,487	30,701	33,553	34,913
Kansas	S	-	15,206	19,148	24,138	29,918	31,012	34,169	34,611
Kentucky	C	5,188	28,068	52,653	50,486	50,340	51,381	49,638	49,377
Louisiana	M	3,741	26,649	40,551	69,906	81,077	94,799	106,091	107,914
Maine	C	4,490	8,147	9,519	11,595	12,864	13,085	14,436	13,989
Maryland	C	35,757	62,893	82,065	96,581	109,827	89,574	90,852	95,018
Massachusetts	C	28,146	52,508	60,854	53,130	56,429	61,968	57,450	65,289
Michigan	C	16,044	32,464	42,293	52,736	47,224	53,767	50,789	56,195
Minnesota	C	8	4	16	12	8	2,039	2,206	2,122
Mississippi	S	8,276	11,191	30,827	49,608	53,937	61,159	67,015	68,068
Missouri	M	23,998	54,306	70,888	77,811	81,707	89,811	94,457	93,730
Montana	S	-	2,458	9,700	9,500	9,540	10,626	10,929	10,908
Nebraska	M	3,525	6,204	6,921	9,602	18,918	22,659	23,697	23,132
Nevada	S	2,782	7,573	14,241	22,240	25,361	24,914	26,375	28,836
New Hampshire	C	11	2,169	3,468	4,340	5,928	6,431	6,752	7,022
New Jersey	C	22,733	55,430	76,749	87,839	93,477	97,940	102,765	115,222
New Mexico	M	-	2,395	6,174	9,085	11,170	11,393	12,076	10,647
New York	C	270,683	425,025	529,149	538,108	513,764	457,317	452,938	426,529
North Carolina	S	17,887	55,723	72,024	64,815	89,446	104,923	122,613	130,467
North Dakota	C	79	1,026	2,225	2,659	3,104	3,495	3,671	4,136
Ohio	M	35,300	45,103	66,649	83,741	121,058	128,602	136,849	122,796
Oklahoma	M	15,523	32,503	37,000	40,707	43,217	46,110	54,905	54,427
Oregon	S	10,336	14,118	16,617	18,436	19,748	20,473	24,254	25,014
Pennsylvania	S	68,376	87,592	104,326	118,047	125,424	137,429	134,160	136,511
Rhode Island	C	2,981	6,978	10,619	12,179	9,847	10,955	11,842	11,756

South Carolina	M	38,006	43,773	44,392	47,680	42,395	45,534	51,469	52,561
South Dakota	C	1,405	2,789	5,545	7,689	9,020	9,595	10,466	10,610
Tennessee		13,603	16,805	12,873	6,320	-	-	-	-
Texas	S	35,477	28,513	200,290	492,803	500,567	438,164	335,751	326,473
Utah	S	4,390	13,745	20,389	26,427	26,318	27,943	24,021	28,268
Vermont	S	406	1,632	2,485	3,058	3,278	2,911	3,418	2,992
Virginia	C	1,420	19,569	29,967	36,091	46,611	56,258	68,524	73,187
Washington	S	-	-	3,522	6,169	7,569	9,206	13,585	12,956
West Virginia	S	329	8,935	15,653	20,593	21,348	22,790	24,283	24,515
Wisconsin	M	-	17,107	26,178	29,661	34,445	37,839	30,302	28,006
Wyoming	S	-	-	2,479	3,050	3,187	3,144	3,854	4,121

NOTES:
* SCHIP program classification as of June 2005. M = Medicaid Expansion Program (12) S = Separate Program (19) C = Combined Program (20)

This state-provided enrollment data are "point-in-time" counts of enrollment, reflecting the number of children and adults enrolled in SCHIP programs in each state in the indicated month as reported in SCHIP enrollment reports for 2004 and 2005 referenced below. "Point-in-time" data differ from an "ever-enrolled, for any length of time" count of enrollees, such as in reports issued by the federal Centers for Medicare and Medicaid Services (CMS).

SOURCES:
Smith, Vernon K., PhD, David M. Rousseau, MPH and Molly O'Malley, MPP. *SCHIP Program Enrollment: December 2003 UPDATE*. The Kaiser Commission on Medicaid and the Uninsured. Washington, DC. July 2004.

Smith, Vernon K., PhD and David M. Rousseau, MPH. *SCHIP Enrollment in 50 States: December 2004 Data Update*. The Kaiser Commission on Medicaid and the Uninsured. Washington, DC. September 2005.

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Appendix B
Families, Children and Pregnant Women Enrollment in 44 States
(June 1997 to June 2005)

Families, Children and Pregnant Women Enrollment in 44 States (June 1997 to June 2005)

	Monthly Enrollment in Thousands											Percent Change				
State	Jun 1997	Jun 1998	Jun 1999	Jun 2000	Jun 2001	Jun 2002	Jun 2003	Jun 2004	Dec 2004	Jun 2005	*Jun 97 to Jun 05*	Jun 97 to Jun 99 Avg	Jun 99 to Jun 01 Avg	Jun 01 to Jun 03 Avg	Jun 03 to Jun 04	Jun 04 to Jun 05
Alabama	282.0	287.5	299.5	308.2	338.0	371.5	387.0	405.1	405.6	413.5	*131.4*	3.1%	6.3%	7.0%	4.7%	2.1%
Alaska	53.0	49.8	54.7	57.6	59.3	61.5	65.5	67.1	66.1	67.9	*14.9*	1.9%	4.1%	5.1%	2.4%	1.2%
Arizona	311.3	281.3	286.6	322.9	377.1	537.3	656.2	667.2	740.3	740.0	*428.7*	-3.9%	14.7%	32.3%	1.7%	10.9%
Arkansas	138.7	165.3	180.5	195.3	236.6	276.7	265.4	287.7	301.9	302.7	*164.0*	14.2%	14.7%	6.4%	8.4%	5.2%
California	3,878.6	3,673.9	3,717.7	3,689.0	4,080.5	4,572.6	4,788.9	4,766.7	4,783.8	4,797.8	*919.2*	-2.0%	4.9%	8.4%	-0.5%	0.7%
Colorado	159.5	148.8	151.9	170.7	188.5	214.8	244.9	285.3	317.1	311.3	*151.8*	-2.3%	11.4%	14.0%	16.5%	9.1%
Connecticut	220.0	218.7	228.4	229.5	240.9	281.0	275.9	307.4	311.3	307.2	*87.2*	1.9%	2.7%	7.4%	11.4%	-0.1%
Florida	927.3	848.8	871.3	992.4	1,121.7	1,255.6	1,320.7	1,392.9	1,425.8	1,472.7	*545.5*	-2.9%	13.5%	8.6%	5.5%	5.7%
Georgia	669.0	642.6	631.2	616.5	697.3	816.3	912.7	984.4	1,028.0	1,035.2	*366.2*	-2.9%	5.4%	14.4%	7.9%	5.2%
Hawaii	129.7	127.1	122.8	114.1	124.0	124.8	132.0	138.7	144.1	146.0	*16.3*	-2.7%	0.8%	3.2%	5.1%	5.3%
Idaho	59.7	58.4	56.1	71.4	90.6	101.2	111.2	117.9	123.8	122.6	*62.9*	-3.1%	27.1%	10.8%	6.0%	3.9%
Illinois	948.5	892.1	858.7	919.7	966.9	982.5	1,076.1	1,152.0	1,216.2	1,249.6	*301.1*	-4.8%	6.1%	5.6%	7.1%	8.5%
Indiana	306.4	308.5	359.8	408.6	462.3	507.6	516.1	549.1	554.4	564.9	*258.5*	8.7%	13.4%	5.7%	6.4%	2.9%
Iowa	131.5	122.3	113.9	113.9	135.7	151.5	165.3	176.3	179.6	182.5	*51.0*	-6.9%	9.6%	10.4%	6.7%	3.5%
Kansas	119.7	104.8	112.5	122.4	133.8	144.4	157.6	175.3	176.0	184.6	*64.8*	-2.6%	9.1%	8.5%	11.3%	5.3%
Kentucky	311.2	298.2	291.9	316.3	347.8	361.5	397.5	398.0	402.2	406.3	*95.1*	-3.1%	9.2%	6.9%	0.1%	2.1%
Louisiana	328.6	322.4	354.5	417.1	496.3	590.4	657.1	713.3	734.9	752.5	*423.9*	4.0%	18.3%	15.1%	8.6%	5.5%
Maine	99.2	97.3	97.9	99.3	109.2	123.8	145.2	153.8	157.8	159.7	*60.6*	-0.6%	5.7%	15.4%	5.9%	3.9%
Maryland	300.5	274.1	259.8	276.8	294.8	310.1	315.6	342.3	345.3	348.3	*47.8*	-7.0%	6.5%	3.5%	8.5%	1.8%
Michigan	795.9	784.2	726.9	712.0	772.8	865.5	934.7	999.6	1,020.6	1,044.9	*249.0*	-4.4%	3.2%	10.0%	6.9%	4.5%
Minnesota	342.7	315.3	333.5	336.2	364.3	369.2	407.2	416.4	417.1	426.6	*84.0*	-1.1%	4.6%	5.8%	2.2%	2.5%
Mississippi	223.4	197.2	216.0	256.1	343.5	364.3	369.3	362.4	372.8	373.2	*149.8*	-1.1%	26.3%	3.7%	-1.9%	3.0%
Missouri	406.5	399.4	445.8	489.3	556.0	594.1	634.6	645.2	653.2	639.3	*232.8*	4.9%	11.7%	6.8%	1.7%	-0.9%
Nebraska	104.3	111.2	124.9	133.2	144.2	155.1	123.1	130.3	127.9	124.8	*20.5*	9.5%	7.4%	-6.5%	5.8%	-4.2%
Nevada	62.7	66.1	65.2	70.1	83.3	113.9	122.1	125.3	126.8	124.6	*61.8*	2.0%	13.2%	22.0%	2.6%	-0.6%
New Hampshire	59.9	57.2	60.5	59.7	61.2	68.2	74.1	77.6	78.1	79.7	*19.8*	0.6%	0.7%	10.0%	4.8%	2.7%
New Jersey	423.8	394.8	379.0	391.6	487.4	546.7	541.8	536.7	532.2	530.6	*106.8*	-5.4%	13.9%	5.6%	-0.9%	-1.1%
New Mexico	194.5	198.0	214.2	223.7	238.0	272.9	292.6	308.2	302.0	287.9	*93.3*	5.0%	5.4%	10.9%	5.3%	-6.6%
New York	2,037.4	1,921.0	1,829.0	1,805.3	1,910.3	2,385.6	2,684.2	2,945.5	3,010.4	3,085.9	*1,048.5*	-5.3%	2.3%	18.7%	9.7%	4.8%
North Carolina	523.0	504.2	503.4	538.0	628.1	672.4	714.3	743.2	748.8	756.5	*233.5*	-1.9%	11.8%	6.6%	4.0%	1.8%
North Dakota	29.7	27.0	27.8	27.7	28.5	32.3	37.7	36.2	36.1	36.0	*6.3*	-3.1%	1.3%	15.0%	-3.8%	-0.7%
Ohio	761.3	727.7	670.8	716.8	877.0	1,002.4	1,052.1	1,114.0	1,144.2	1,169.8	*408.5*	-6.1%	14.6%	9.6%	5.9%	5.0%
Oklahoma	176.3	203.7	222.3	261.8	287.6	316.3	323.9	341.4	341.1	348.2	*171.9*	12.3%	13.8%	6.2%	5.4%	2.0%
Oregon	244.9	244.9	244.3	236.3	226.1	236.4	227.0	242.5	240.7	245.7	*0.8*	-0.1%	-3.8%	0.3%	6.8%	1.3%
Rhode Island	73.0	75.0	82.3	94.7	99.6	105.1	110.1	115.1	114.7	113.7	*40.7*	6.2%	10.1%	5.1%	4.5%	-1.2%
South Carolina	230.8	278.3	283.9	354.6	414.1	480.2	489.6	465.5	463.0	462.1	*231.3*	11.3%	20.8%	9.0%	-4.9%	-0.7%
South Dakota	39.0	40.1	45.2	48.7	54.1	58.7	62.4	65.0	65.4	66.5	*27.5*	7.8%	9.4%	7.4%	4.2%	2.3%
Texas	1,447.1	1,297.7	1,239.0	1,271.9	1,354.2	1,687.9	2,023.2	2,134.6	2,191.3	2,187.3	*740.2*	-7.4%	4.6%	22.3%	5.5%	2.5%
Utah	94.5	95.3	93.1	91.7	95.8	107.7	122.6	135.5	136.6	141.0	*46.5*	-0.7%	1.5%	13.1%	10.4%	4.1%
Vermont	64.2	63.8	66.1	67.1	69.2	71.4	72.6	72.6	71.8	71.1	*6.9*	1.5%	2.3%	2.4%	-0.1%	-2.1%
Virginia	336.6	315.7	304.7	292.1	290.3	308.0	342.3	391.6	400.8	416.5	*79.9*	-4.8%	-2.4%	8.6%	14.4%	6.4%
Washington	578.7	562.6	552.3	628.2	603.8	635.9	652.7	615.6	607.4	628.4	*49.7*	-2.3%	4.9%	4.0%	-5.7%	2.1%
Wisconsin	258.4	234.9	229.7	295.2	326.8	388.1	427.7	459.1	469.0	476.1	*217.7*	-5.6%	19.6%	14.5%	7.3%	3.7%
Wyoming	23.0	23.5	22.7	24.5	29.1	38.0	43.0	44.8	45.3	45.9	*22.8*	-0.6%	13.3%	21.9%	4.4%	2.3%
Total	**18,906.0**	**18,060.5**	**18,032.1**	**18,868.2**	**20,846.5**	**23,661.5**	**25,475.9**	**26,604.5**	**27,131.5**	**27,447.5**	***8,541.4***	**-2.3%**	**7.6%**	**10.6%**	**4.4%**	**3.2%**

SOURCE:
Compiled by Health Management Associates from State Medicaid enrollment reports for the Kaiser Commission on Medicaid and the Uninsured. *Medicaid Enrollment in 50 States* (December 2006): 10.

Appendix C
Covering Kids & Families National Program Office Regions

Covering Kids & Families National Program Office Regions

Midwestern Region
Illinois
Indiana
Iowa
Kansas
Michigan
Minnesota
Nebraska
North Dakota
Ohio
South Dakota
Wisconsin

Northeastern Region
Connecticut
Delaware
Maine
Massachusetts
New Hampshire
New Jersey
New York
Pennsylvania
Rhode Island
Vermont

Southern Region
Alabama
Arkansas
District of Columbia
Florida
Georgia
Kentucky
Louisiana
Maryland
Mississippi
Missouri
North Carolina
Oklahoma
South Carolina
Tennessee
Texas
Virginia
West Virginia

Western Region
Alaska
Arizona
California
Colorado
Hawai'i
Idaho
Montana
Nevada
New Mexico
Oregon
Utah
Washington
Wyoming

Appendix D
Statewide and Local *Covering Kids & Families* Projects

Statewide and Local *Covering Kids & Families* Projects

State	Statewide Project Lead Organization	Local Project Lead Organizations
Alabama	Alabama Department of Public Health, Montgomery	▪ Jefferson County Department of Public Health – Birmingham ▪ Mobile County Department of Public Health – Mobile
Alaska	Alaska Native Tribal Health Consortium, Anchorage	▪ Alaska Primary Care Association – Anchorage ▪ Southcentral Foundation – Anchorage
Arizona	Children's Action Alliance, Phoenix	▪ El Rio Health Center – Tucson ▪ Phoenix Day Child and Family Learning Center – Phoenix ▪ Yuma County Health Department – Yuma
Arkansas	Arkansas Advocates for Children & Families, Little Rock	▪ Community Health Network Crittenden Memorial Hospital – West Memphis ▪ Healthy Connections, Inc. – Mena ▪ Our Children First Coalition – Texarkana ▪ Poplar House Clinic – Rogers ▪ St. Bernard's Medical Center – Jonesboro
California	Community Health Councils, Inc., Los Angeles	▪ Commission – Multicultural Community Alliance –Fresno ▪ Fresno County Economic Opportunities – Fresno ▪ North Coast Clinics Networks – Eureka ▪ Riverside County Medi-Cal Outreach Coalition – Riverside ▪ Sutter Lakeside Community Services – Lakeport
Colorado	Colorado Community Health Network, Denver	▪ Denver Health Community Voices – Denver ▪ Hilltop Community Resources, Inc. – Grand Junction ▪ Pueblo Coalition for the Medically Underserved – Pueblo
Connecticut	Connecticut Voices for Children, Hartford	▪ Bridgeport Child Advocacy Coalition – Bridgeport ▪ Eastern Connecticut Health Network – Manchester
Delaware	Medical Society of Delaware, Inc., Houston	▪ Delaware Chapter of the American Academy of Pediatrics – Wilmington ▪ Delaware Foundation for Medical Services – Houston
District of Columbia	DC Action for Children, Washington	▪ Bread for the City ▪ Washington Child Development Council

State	Statewide Project Lead Organization	Local Project Lead Organizations
Florida	Lawton and Rhea Chiles Center, University of South Florida, Tampa	▪ Health Care District of Palm Beach County – West Palm Beach ▪ Northeast Florida Coalition – Jacksonville ▪ Panhandle Area Health Network – Marianna ▪ Public Health Trust of Dade County/Jackson Health System – Miami
Georgia	Georgia Department of Community Health, Atlanta	▪ Clarke County Department of Family and Children Services – Athens ▪ Columbus Regional Healthcare Systems – Columbus ▪ Healthy Mothers Healthy Babies – Atlanta ▪ Medical College of Georgia – Augusta ▪ Southeast Health District – Waycross
Hawai'i	Hawai'i Primary Care Association, Honolulu	▪ Kahuku Hospital – Kahuku ▪ Ho'ola Lahui Hawai'i – Lihu'e
Idaho	Mountain States Group, Inc., Boise	▪ Kootenai Medical Center – Coeur d'Alene ▪ Madison Memorial Hospital – Rexburg ▪ Terry Reilly Health Services Center – Boise
Illinois	Illinois Maternal and Child Health Coalition, Chicago	▪ Campaign for Better Health Care – Champaign ▪ North Center Health District Council – Chicago ▪ Westside Health Partnership – Chicago
Indiana	Health and Hospital Corporation of Marion County, Indianapolis	▪ Area Five Agency on Aging and Community Services – Logansport ▪ Health and Hospital Corporation of Marion County – Indianapolis ▪ Lake County Minority Health Coalition – Gary ▪ Neighborhood Health Clinics, Inc. – Fort Wayne ▪ Open Door/BMH Health Center – Muncie ▪ United Way of St. Joseph County – South Bend
Iowa	Iowa Department of Public Health, Des Moines	▪ Community Health Services of Marion County – Knoxville ▪ Visiting Nurse Services – Des Moines
Kansas	Kansas Children's Service League, Lenexa	*Liaison Project*
Kentucky	University of Kentucky, Lexington	▪ Clover Fork Clinic – Evarts ▪ Partners for Healthy Louisville – Louisville

State	Statewide Project Lead Organization	Local Project Lead Organizations
Louisiana	Agenda for Children, New Orleans	▪ Children's Coalition for Northeast Louisiana – Monroe ▪ CHRISTUS St. Francis Cabrini Hospital – Alexandria ▪ Family Road of Greater Baton Rouge – Baton Rouge
Maine	Maine Primary Care Association, Augusta	▪ Penquis Community Action Program – Bangor ▪ Regional Medical Center at Lubec – Lubec
Maryland	University of Maryland, Baltimore	▪ Baltimore HealthCare Access, Inc. – Baltimore ▪ Eastern Shore Area Health Education Center – Cambridge ▪ Medical Care Community Partnership – Forestville ▪ Western Maryland Area Health Education Center – Cumberland
Massachusetts	Health Care For All, Boston	▪ Joint Committee for Children's Health Care – Everett ▪ Outer Cape Health Services – Orleans ▪ Springfield Department of Health & Human Services – Springfield
Michigan	Michigan Public Health Institute, Okemos	▪ Catholic Social Services of the Upper Peninsula – Marquette ▪ Detroit/Wayne County Child Health Care Coalition – Dearborn ▪ Michigan Center for Rural Health – East Lansing ▪ Muskegon Community Health Project – Muskegon
Minnesota	Children's Defense Fund – Minnesota, St. Paul	▪ Beltrami (Bemidji Area Indian Health Service) – Walker ▪ New Families Center – Minneapolis ▪ Olmsted County Human Services – Rochester ▪ Portico Healthnet – St. Paul
Mississippi	Mississippi Division of Medicaid, Jackson	▪ Hinds County Health Alliance – Jackson ▪ Mississippi Forum on Children and Families – Jackson
Missouri	Missouri Primary Care Association, Jefferson City	▪ Area Resources for Community & Human Services – St. Louis ▪ Greater Kansas City Local Investment Commission – Kansas City ▪ Washington County Community – 2000 Partnership – Potosi

State	Statewide Project Lead Organization	Local Project Lead Organizations
Montana	Healthy Mothers, Healthy Babies: The Montana Coalition, Helena	*Liaison Project*
Nebraska	Voices for Children in Nebraska, Omaha	▪ Elkhorn Logan Valley Public Health Department – Wisner ▪ Hope Medical Outreach – Omaha
Nevada	Nevada Health and Human Services, Carson City	▪ Clark County Health District – Las Vegas ▪ United Way of Northern Nevada – Minden
New Hampshire	New Hampshire Healthy Kids, Concord	▪ Child Health Services – Manchester ▪ HUB Family Resource Center – Dover
New Jersey	Health Research & Educational Trust of New Jersey, Princeton	▪ Gateway Maternal & Child Health Consortium – Newark ▪ Hudson Prenatal Consortium – Jersey City ▪ Kids Corporation – Newark ▪ Southern New Jersey Perinatal Cooperative – Pennsauken
New Mexico	New Mexico Voices for Children and Families, Albuquerque	▪ Community Action Agency of Southern New Mexico – Las Cruces ▪ Boys and Girls Club of Santa Fe – Santa Fe ▪ New Mexico Primary Care Association – Albuquerque ▪ Torrence County, DBA Torrence Health Council – Moriatry ▪ San Juan County Partnership – Farmington ▪ Valencia County Youth Development Inc. – Los Lunas
New York	New York State Department of Health, Albany	▪ Children's Defense Fund – New York – New York City ▪ Children's Defense Fund – New York – Albany
North Carolina	North Carolina Pediatric Society Foundation, Raleigh	▪ Buncombe County Department of Social Services – Asheville ▪ Moore County Chamber of Commerce – Southern Pines ▪ New Hanover County Partnership for Children – Wilmington
North Dakota	Dakota Medical Foundation/ Dakota Medical Charities, Fargo	▪ Cass County Department of Social Services – Fargo ▪ Dakota Medical Foundation – Fargo
Ohio	Children's Defense Fund – Ohio, Columbus	▪ Legal Aid Society of Greater Cincinnati – Cincinnati ▪ Neighborhood Health Association – Toledo
Oklahoma	Oklahoma Institute for Child Advocacy, Oklahoma City	▪ Northeastern Oklahoma Community Health Centers – Hulbert ▪ Variety Health Center – Oklahoma City

State	Statewide Project Lead Organization	Local Project Lead Organizations
Oregon	Oregon Health Action Campaign, Salem	▪ Health Network for Rural Schools – La Grande ▪ Lincoln County Coalition – Newport ▪ Outside In – Portland ▪ Rogue Valley Community Health Center – Medford
Pennsylvania	Pennsylvania Partnerships for Children, Harrisburg	▪ Consumer Health Coalition – Pittsburgh ▪ Cornerstone Care – Greensboro ▪ Philadelphia Citizens for Children and Youth – Philadelphia ▪ Wellspan Health System – York
Rhode Island	Rhode Island KIDS COUNT, Providence	▪ netWORKri – Pawtucket Progresso Latino – Central Falls ▪ St. Joseph Health Services of Rhode Island – Providence
South Carolina	South Carolina Hospital Association, Columbia	*Liaison Project*
South Dakota	Community HealthCare Association of the Dakotas, Inc., Sioux Falls	*Liaison Project*
Tennessee	Tennessee Voices for Children, Nashville	▪ Memphis-Shelby County Health Department – Memphis ▪ Prospect, Inc. – Lebanon
Texas	Texas Association of Community Health Centers, Inc., Austin	▪ Children's Defense Fund of Texas – Houston ▪ Migrant Health Promotion – Progreso
Utah	Voices for Utah Children, Salt Lake City	▪ Granite School District – Salt Lake City ▪ Salt Lake City School District – Salt Lake City
Vermont	Vermont Department of Health, Burlington	*Liaison Project*
Virginia	Virginia Health Care Foundation, Richmond	▪ Consortium for Infant and Child Health – Norfolk ▪ Radford University FAMIS Outreach Project – Radford ▪ United Way-Thomas Jefferson – Charlottesville
Washington	Washington Health Foundation, Seattle	▪ CHOICE – Olympia ▪ Clark County Health District – Vancouver ▪ Northeast Tri-Counties Health Improvement Partnership – Colville ▪ Yakima Neighborhood Health Services – Yakima

State	Statewide Project Lead Organization	Local Project Lead Organizations
West Virginia	West Virginia Council of Churches, Charleston	▪ Minnie Hamilton Health Care Center – Grantsville ▪ Nicholas County Empowerment Corporation-Starting Points – Richwood ▪ United Way of Central West Virginia – Charleston
Wisconsin	University of Wisconsin-Madison School of Human Ecology, Madison	▪ ABC for Health – Madison ▪ Community Advocates – Milwaukee ▪ La Crosse County Health Department – La Crosse
Wyoming	Wyoming Department of Health, Cheyenne	▪ Boys and Girls Club of Northern Arapaho Tribe – Riverton ▪ Laramie County Community Partnership – Cheyenne ▪ Johnson County Community Resource Center – Buffalo ▪ Natrona County Human Services Commission – Casper ▪ Washakie County Public Health – Worland

Appendix E
Promising Practices by Strategy, Project, Organization and State

Promising Practices by Strategy,

Promising Practice	Strategy	Project Level
Partnering with Local Eligibility Office Through an Enrollment Coordinators Work Group	Outreach – Local Eligibility Office	Local
Tracking Outreach Outcomes	Outreach – Community-wide	Both
Spreading the Word Through Frequently Asked Questions	Outreach – Community-wide	State
Sending a Unified Marketing Message	Outreach – Community-wide	State
Enrolling the Uninsured Through Health Provider Partnerships	Outreach – Hospitals/Clinics	Local
Increasing Enrollment Through Emergency Rooms	Outreach – Hospitals/Clinics	Local
Reaching Pregnant Women and Children Through Health Clinics	Outreach – Hospitals/Clinics	Both
Reaching Uninsured Families Through the School Lunch Program	Outreach – Schools and Colleges	Local
Institutionalizing School Outreach	Outreach – Schools and Colleges	Local
Identifying Eligible Children With School Lunch Application Data Match	Outreach – Schools and Colleges	Both
Partnering With Native American Organizations	Outreach – Schools and Colleges	State
Establishing Business Partnerships	Outreach – Businesses	Local
Organizing Business Outreach	Outreach – Businesses	Local
Partnering With One-Stop Career Center	Outreach – Businesses	State
Building Faith-based Partnerships	Outreach – Faith-based	State

Project, Organization and State

Name of Lead Organization	Type of Lead Organization	State	State Medicaid and SCHIP Names
United Way of St. Joseph County, Inc.	Local Area United Way	Indiana	Hoosier Healthwise
Connecticut Voices for Children	Child and Health Advocacy Organization	Connecticut	HUSKY A/HUSKY B
North Carolina Pediatric Society Foundation	State Affiliate of Professional Organization	North Carolina	Health Check/NC Health Choice for Children
Virginia Health Care Foundation	Health Care Foundation	Virginia	FAMIS/FAMIS Plus
Kahuku Hospital	Hospital and Health Care Center	Hawai'i	Med-QUEST
Buncombe County Department of Social Services	District, County and City Public Health Agency	North Carolina	Health Check/NC Health Choice for Children
Oklahoma Institute for Child Advocacy	Child and Health Advocacy Organization	Oklahoma	SoonerCare
Health and Hospital Corporation of Marion County	Hospital and Health Care Center	Indiana	Hoosier Healthwise
Baltimore HealthCare Access, Inc.	Local Area Child and Health Advocacy Organization	Maryland	Maryland Children's Health Program (MCHP)/MCHP Premium
Voices for Utah Children	Child and Health Advocacy Organization	Utah	Medicaid/Children's Health Insurance Program (CHIP)
Dakota Medical Foundation/Dakota Medical Charities	Health Care Foundation	North Dakota	Medicaid/Healthy Steps Program
Children's Coalition for Northeast Louisiana	Local Area Child and Health Advocacy Organization	Louisiana	LaCHIP
Children's Defense Fund Texas – Houston	Local Area Child and Health Advocacy Organization	Texas	Medicaid/Children's Health Insurance Program (CHIP)
Rhode Island KIDS COUNT	Child and Health Advocacy Organization	Rhode Island	Rite Care
Illinois Maternal and Child Health Coalition	Child and Health Advocacy Organization	Illinois	All Kids

Promising Practices by Strategy,

Promising Practice	Strategy	Project Level
Accessing Coverage in Remote Areas Through Computer Video Systems	Outreach – Rural Areas	Local
Conducting an Enrollment Campaign for Open Enrollment Period	Outreach – Special Circumstances	State
Responding to a Hurricane Disaster Through Outreach	Outreach – Special Circumstances	Both
Developing a Framework for Outreach, Enrollment and Retention	Simplification	State
Facilitating an Enrollment Work Group	Simplification	Local
Redesigning and Simplifying a Joint Medicaid and SCHIP Application	Simplification	State
Simplifying the Application Process Through a Joint Medicaid, SCHIP and Food Stamp Application	Simplification	Local
Combining Enrollment of Medicaid and Food Stamp Benefits	Simplification	Both
Employing Presumptive Eligibility to Implement an Electronic Application System	Simplification	State
Engaging Hospitals in Simplifying the Application Process	Simplification	State
Implementing Express Renewal to Improve Renewal and Retention	Simplification	Both
Using Simplified Phone Reviews to Improve Renewal and Retention	Simplification	Local
Tracking Enrollment and Renewal Trends	Simplification	Both
Reducing Income Verification for Enrollment	Simplification	State
Implementing Electronic Referral System Between Medicaid and SCHIP	Coordination	State
Utilizing Ex Parte Review to Improve Retention and Coordination	Coordination	State

Project, Organization and State

Name of Lead Organization	Type of Lead Organization	State	State Medicaid and SCHIP Names
Bemidji Area Indian Health Service	Local Area Child and Health Advocacy Organization	Minnesota	Medical Assistance/ MinnesotaCare/General Assistance Medical Care
Lawton and Rhea Chiles Center, University of South Florida	University – Public Health and Health Sciences Division	Florida	Florida KidCare
Alabama Department of Public Health	State Health and Human Services Agency	Alabama	Medicaid/All Kids
Community Health Councils, Inc.	Child and Health Advocacy Organization	California	Medi-Cal/Healthy Families
Children's Defense Fund – New York	Local Area Child and Health Advocacy Organization	New York	Child Health Plus A/Child Health Plus B
Colorado Community Health Network	Primary Care, Health Center and Hospital Association	Colorado	Medicaid/Child Health Plan Plus (CHP+)
Buncombe County Department of Social Services	District, County and City Public Health Agency	North Carolina	Health Check/NC Health Choice for Children
University of Wisconsin-Madison, School of Human Ecology	University – Public Health and Health Sciences Division	Wisconsin	Healthy Start/Badger Care
Michigan Public Health Institute	Child and Health Advocacy Organization	Michigan	Healthy Kids/MIChild
Health Research & Educational Trust of New Jersey	Primary Care, Health Center and Hospital Association	New Jersey	NJ Family Care
Health Care For All	Child and Health Advocacy Organization	Massachusetts	MassHealth
Arkansas Advocates for Children & Families	Child and Health Advocacy Organization	Arkansas	ARKids A/ARKids B
Health and Hospital Corporation of Marion County	Primary Care, Health Center and Hospital Association	Indiana	Hoosier Healthwise
Illinois Maternal and Child Health Coalition	Child and Health Advocacy Organization	Illinois	All Kids
Iowa Department of Public Health	State Health and Human Services Agency	Iowa	Medicaid/*hawk-i*
Agenda for Children	Child and Health Advocacy Organization	Louisiana	LaCHIP

Appendix F
Selected Eligibility Criteria Related to Health Coverage of Pregnant Women By Number of States

Selected Eligibility Criteria Related to Health Coverage of Pregnant Women By Number of States

Pregnant Women Income Eligibility (2003 to 2006)				
Income Eligibility Level (% of Federal Poverty Level)	**2003**	**2004**	**2005**	**2006**
133%	11	9	9	8
150%	4	4	5	4
166%	0	0	0	1
175%	0	2	1	1
185%	19	20	19	20
200%	12	12	12	12
200% (300%)[1]	1	1	2	2
235%	1	0	0	0
250%	1	1	1	1
250% (300%)[2]	1	0	0	0
250% (350%)[3]	0	1	1	1
275%	1	1	1	1

Pregnant Women Asset Criteria (2003 to 2006)				
Criteria	**2003**	**2004**	**2005**	**2006**
No Asset Test	44	45	45	44
Asset Test	7	6	6	7

Pregnant Women Presumptive Eligibility Criteria (2003 to 2006)				
Criteria	**2003**	**2004**	**2005**	**2006**
Presumptive Eligibility	29	29	30	31
No Presumptive Eligibility	22	22	21	20

Unborn Child Option for SCHIP Coverage to the Unborn Children of Pregnant Women (2005 to 2006)				
Option	**2003**	**2004**	**2005**	**2006**
Unborn Child Option	-	-	9	11
No Unborn Child Option	-	-	42	40

NOTES:
1. In California, the Access for Infants and Mothers (AIM) program is available to pregnant women with income between 201 and 300 percent of the federal poverty line. In Iowa, pregnant women with income between 200 and 300 percent of the federal poverty line with high medical expenses can "spend down" to qualify for the state's waiver program.

2. In Rhode Island in 2003, Medicaid income eligibility level for pregnant women was 250 percent of the federal poverty line. There was also a state-funded program for women with income between 251 and 300 percent of the federal poverty line. The state-funded coverage required that pregnant women pay the full cost of the premium.

3. Effective 2004, Rhode Island's Medicaid income eligibility guideline for pregnant women is 250 percent of the federal poverty line. There is also a state-funded program for women with income between 251 and 350 percent of the federal poverty line. Under this program, which requires a premium, the state funds the cost of labor and delivery only.

SOURCES (these tables were adapted from the following reports):
Cohen Ross, Donna and Laura Cox. *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge*. Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. Washington, DC. July 2003.

Cohen Ross, Donna and Laura Cox. *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*. Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. Washington, DC. October 2004.

Cohen Ross, Donna and Laura Cox. *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families*. Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. Washington, DC. October 2005.

Cohen Ross, Donna, Laura Cox and Caryn Marks. *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*. Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. Washington, DC. January 2007.

Appendix G
Expanding Eligibility and Simplifying Enrollment and Renewal: Trends in Children's Health Coverage Programs (July 1997 to July 2006)

Expanding Eligibility and Simplifying Enrollment and Renewal: Trends in Children's Health Coverage Programs (July 1997 to July 2006)

State Strategies	Jul 1997[1]	Nov 1998[2]	Jul 2000[2]	Jan 2002[2]	Apr 2003[2]	Jul 2004[2]	Jul 2005[2]	Jul 2006[2]
Total number of children's health coverage programs								
Medicaid for Children	51	51	51	51	51	51	51	51
SCHIP	N/A	19	32	35	35	36	36	36
Coverage offered to children under age 19 in families with income at or below 200% of Federal Poverty Level	6[3]	22	36	40	39	39	41	41
Joint application for Medicaid and SCHIP	N/A	N/C	28	33	34	34	34	33
Asset test not required								
Medicaid for Children	36	40	42	45	45	46	47	47
SCHIP	N/A	17	31	34	34	33	33	34
Face-to-face interview at enrollment not required								
Medicaid for Children	22[4]	33[5]	40	47	46	45	45	46
SCHIP	N/A	N/C	31	34	33	33	33	33
Presumptive eligibility for children								
Medicaid for Children	O/N	6	8	9	7	8	9	9
SCHIP	N/A	N/C	4	5	4	6	6	6
Income verification not required								
Medicaid for Children	N/C	N/C	10	13	12	10	9	9
SCHIP	N/A	N/C	7	11	11	10	9	10
Face-to-face interview at renewal not required								
Medicaid for Children	N/C	N/C	43	48	49	48	48	48
SCHIP	N/A	N/C	32	34	35	35	35	35
12-month continuous eligibility for children								
Medicaid for Children	O/N	10	14	18	15	15	17	16
SCHIP	N/A	N/C	22	23	21	21	24	25
Implemented enrollment freeze								
Medicaid for Children	N/C	N/C	N/C	0	1[6]	1[7]	1	1
SCHIP	N/A	N/C	N/C	3	2	7	3[8]	1[9]

N/A = Not Applicable **N/C = Not Collected** **O/N = Option Not Available**

NOTES:
The numbers in this table reflect the net change in actions taken by states from year to year. Specific strategies may be adopted and retracted by several states during a given year. Data from years 1999 and 2001 were not provided in the report from which this table was derived.

1. These data reflect states' eligibility expansions and use of simplification strategies for children's Medicaid (poverty level groups).
2. These data reflect states' eligibility expansions and use of simplification strategies for children's Medicaid (poverty level groups) and SCHIP-funded separate programs, as indicated.
3. In addition, two (2) states, Massachusetts and New York, financed children's health coverage to this income level using state funds only.
4. Seven (7) states still required telephone interviews; face-to-face interviews were left to county discretion in one (1) state.
5. Thirty-three (33) states had eliminated the face-to-face interview for children applying for Medicaid. Six (6) states eliminated the face-to-face interview only for families using the joint Medicaid and SCHIP application to apply for coverage. No data was collected specifically about separate SCHIP programs.
6. In Tennessee, enrollment was closed to some but not all children eligible under the state's Medicaid waiver program.
7. In Tennessee, enrollment was closed to some but not all children eligible under the state's Medicaid waiver program. In Massachusetts, there was a waiting list for state-financed coverage.
8. The three (3) states that froze enrollment in SCHIP at some time between July 2004 and July 2005 had all reopened enrollment by July 2005.
9. Utah froze enrollment in SCHIP as of September 2006.

SOURCE:
Cohen Ross, Donna, Laura Cox and Caryn Marks. *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006.* Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. Washington, DC. January 2007.

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[9] In 2002, the Advertising Research foundation awarded the Robert Wood Johnson Foundation the David Ogilvy Award, the highest honor in market research in the United States, for the research conducted for the communications campaign by Wirthlin Worldwide and Arkin. The campaign itself has been cited as a model in two advertising textbooks. George E. Belch and others, *Advertising and Promotion: An Integrated Marketing Communications Perspective, 6th edition* (New York: McGraw-Hill, April 23, 2003); William F. Arens, *Contemporary Advertising, 9th edition* (New York: McGraw-Hill/Irwin Series in Marketing, November 14, 2003).

[10] Gerald J. Langley and others, *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (San Francisco: Jossey-Bass, 1996).

[11] Sarah C. Shuptrine and Associates, *Assessment of the Medicaid Eligibility Process in Chatham County, Georgia* (prepared for Memorial Medical Center, June 1991).

[12] Eileen R. Ellis, Vernon K. Smith, PhD and David M. Rousseau, MPH, *Medicaid Enrollment in 50 States: June 2004 Data Update* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, September 2005).

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