The Supporting Families Story

The Movement Toward Quality Improvement

Supporting Families After Welfare Reform

Southern Institute
ON CHILDREN & FAMILIES

Columbia, South Carolina

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PREFACE

In counties and states throughout our country, eligibility agency workers assemble with the common goal of assisting families in need of Medicaid/State Children's Health Insurance Program (SCHIP) and Food Stamp benefits. This assistance contributes to the well-being of the families and prevents them from suffering unnecessary hardship. However, there are many eligible families who are not receiving services.

Amid concerns that a decline in Medicaid/ SCHIP and Food Stamp enrollments was a result of process and policy issues, the *Supporting Families After Welfare Reform: Access to Medicaid, SCHIP and Food Stamps* grant program was created by The Robert Wood Johnson Foundation in 2000 to address problems in the eligibility process. Teams from a cross section of county and state agencies were invited to apply for grants that would enable their participation, and a National Program Office (NPO) was established to provide guidance and leadership. The Southern Institute on Children and Families serves as the NPO.

In April 2002 the *Supporting Families* staff participated in a seminar on collaborative learning and process improvement presented by the Institute for Healthcare Improvement (IHI). The decision was made to adapt the IHI model for technical assistance with the *Supporting Families* grantees. Using the knowledge gained from working with state and county agencies involved in serving Medicaid/ SCHIP and Food Stamp recipients and applicants, the *Supporting Families* staff produced a blueprint for a collaborative process derived from the IHI methodology, but more structured to the needs of *Supporting Families* grantees. Eligibility issues were identified and a curriculum was established to support a collaborative environment that would promote knowledge sharing and problem solving.

Throughout the course of the Supporting Families Breakthrough Series Collaborative the grantees participated in conference calls, learning sessions, one-on-one calls, site visits and online collaboration through a dedicated website. This publication is a record of collaborative participants' efforts, from changes that yielded no improvement to promising strategies that generated measurable improvement in retention at their test sites. It is a story of dedication and hard work. It is a story of collaboration between teams separated by great distances. But, most of all, it is a story of success.

THIS PUBLICATION IS A RECORD OF COLLABORATIVE PARTICIPANTS' EFFORTS, FROM CHANGES THAT YIELDED NO IMPROVEMENT TO PROMISING STRATEGIES THAT GENERATED MEASURABLE IMPROVEMENT IN RETENTION AT THEIR TEST SITES. IT IS A STORY OF DEDICATION AND HARD WORK. IT IS A STORY OF COLLABORATION BETWEEN TEAMS SEPARATED BY GREAT DISTANCES. BUT, MOST OF ALL, IT IS A STORY OF SUCCESS.

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The Supporting Families Story has been created based on the experiences and recommendations of all who participated in the *Supporting Families After Welfare Reform* Breakthrough Series (BTS) Collaborative. This includes the state and county organizations working with Medicaid and SCHIP issues, as well as faculty and staff from the Southern Institute on Children and Families, Maximus – The Center for Health Literacy and Communication Technologies, Associates in Process Improvement and the Centers for Medicare and Medicaid Services (CMS).

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AGENCIES IN BOLD ARE *SUPPORTING FAMILIES* GRANTEES WITH THE EXCEPTION OF WASHINGTON HEALTH FOUNDATION, A *COVERING KIDS & FAMILIES* GRANTEE PARTICIPANT

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INTRODUCTION TO THE COLLABORATIVE PROCESS

Concerns over policy and systems issues resulting in declines in Medicaid and Food Stamp enrollment led to a decision by The Robert Wood Johnson Foundation to support a new $6.8 million competitive grant program implemented in 2000. The program, *Supporting Families After Welfare Reform: Access to Medicaid, SCHIP and Food Stamps*, was a joint initiative of the Foundation, the United States Department of Health and Human Services and the United States Department of Agriculture. The Southern Institute on Children and Families was chosen to serve as the National Program Office (NPO) for the program.

In 2000 the declines in Medicaid and Food Stamp 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.

The purpose of *Supporting Families After Welfare Reform* was to help states or large counties solve problems in eligibility processes that made it difficult for low-income families to access or retain Medicaid, SCHIP or Food Stamps, particularly families moving from welfare to work. The program included:

- Technical assistance for states and counties in developing and using eligibility and enrollment data to improve their systems
- Workshops for states and counties on the barriers in state and local eligibility and enrollment processes
- Technical assistance to help states diagnose where opportunities for significant improvements exist in their eligibility process and to develop plans of action
- Resources to states and counties to implement proposed solutions

The Foundation issued a Call for Proposals in February 2000, with applications due to the Southern Institute by May 1. *Supporting Families* application workshops were offered in conjunction with *Covering Kids* Regional Meetings in Savannah, GA; Albuquerque, NM and Philadelphia, PA. In addition, the Southern Institute held a national application conference call in March 2000.

The Southern Institute received a total of 19 applications from 18 states and 1 large county. The *Supporting Families* National Advisory Committee (NAC) reviewed the applications. Between July and November, representatives from the NAC, The Robert Wood Johnson Foundation and the Southern Institute conducted 11 pre-award site visits.

Two kinds of grants were awarded in the *Supporting Families* program. Diagnostic grants were awarded to help projects extract performance reports from state/county eligibility systems and identify key measures of effectiveness in enrolling and retaining families. Diagnostic grants of $75,000 each were awarded to Alabama, Connecticut, Delaware, Minnesota, Cuyahoga County (Ohio) and South Carolina. Maine received technical assistance but not a monetary grant. Implementation grants to help projects implement plans to solve enrollment problems were awarded to Georgia and New Jersey.

During 2000 a major responsibility of the NPO was the development of content for training workshops to address barriers to participation and improvements in the eligibility processes. To assist with this process the Southern Institute contracted with MCGiX, a consulting firm based in Cleveland, Ohio.

Policy experts were invited to attend two work group meetings facilitated by MCGiX in July and August 2000. Using information derived from the work group meetings, MCGiX worked with staff from the Southern Institute to develop two training instruments for grantees: *The Program Diagnostic Tool* and the *Tool Kit for State Policy Writers and Decision-Makers*. The first provided a logical process for diagnosis of problems in eligibility programs. The second served as a policy and procedural resource providing federal policies and information on points within eligibility systems where the risk of losing eligible recipients existed. The materials were available in hard copy and on CD. A third document was developed for use by technical assistance consultants in leading grantees through the diagnostic process.

In February 2001 the NPO held two training sessions for grantees in San Antonio, Texas. In addition to *Supporting Families* Project Directors, representatives from state Medicaid, SCHIP, TANF, Food Stamp and Information Systems divisions were invited to participate in the training sessions to foster relationships and build teamwork needed at the state and local levels to realize program goals.

Technical assistance to grantees was delivered using a traditional consulting model. Consulting teams made up of subject matter experts in Food Stamp, Medicaid and SCHIP policy, along with NPO staff, made 15 total visits to individual grantee sites in addition to regular conference calls that included project consultants, grantees and NPO staff members.

In September 2001 the Foundation provided a special grant opportunity and invited counties with more than one million residents to apply for *Supporting Families* funding. Six proposals were received, and after pre-award site visits, grants were awarded to Los Angeles and San Bernardino Counties in California and Nassau County, New York.

Early in 2002 the NPO and Foundation staff began evaluating the existing model for technical assistance. Foundation officers recommended that the NPO evaluate a methodology being used by the Institute for Healthcare Improvement called the Breakthrough Series Collaborative. In April 2002 staff from the NPO attended a seminar on the principles of collaborative learning and process improvement. The decision was made to adapt this model for on-going technical assistance with *Supporting Families* grantees.

WHAT IS A COLLABORATIVE?

A collaborative is a group of teams that are 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. In a formal collaborative, teams have access to each other, faculty members (who are experts in the topic field) and the collaborative leadership who helps maintain focus on the overall goal of the collaborative.

SUPPORTING FAMILIES BREAKTHROUGH SERIES COLLABORATIVE FRAMEWORK

The framework consists of the people and the content necessary to develop strategies that will enable process improvement. This includes the faculty, participants, infrastructure and curriculum administered to maximize the success of teams through knowledge sharing and group learning. A key part of the framework involves using measurement strategies to track changes.

Further discussions on measurement are reviewed in the next section entitled, *Improving the Eligibility Process.*

COLLABORATIVE TOPIC AND TEAMS

The topic chosen for the *Supporting Families* Collaborative was based on strategies included in the implementation proposals from *Supporting Families* grantees. This broad range of strategies was used to create the collaborative topic: "Maximizing the Enrollment and Retention of Adults and Children in Medicaid and SCHIP." This topic was chosen because there was an identified gap between the ideal processes and practices and those actually in use. The *Supporting Families* grantees identified problems in eligibility policies, processes and/or practices that were preventing eligible children and families from enrolling and staying enrolled in Medicaid and SCHIP. The grantees participated in an informational conference call that discussed the collaborative approach as a means to getting rapid and sustainable results.

COLLABORATIVE FACULTY

The faculty served as leaders, teachers and consultants for the Collaborative. They played a key role at each learning session, both as presenters and as advisors. They participated in all conference calls and were available to assist teams on a one-on-one basis, if needed. Faculty members for the *Supporting Families* Collaborative were chosen based on the needs of the teams, the topic chosen for the Collaborative and the strategies identified in the implementation grants.

A number of the grantees indicated plans to revise notices and Penny Lane, writer and researcher, was recruited because of her work with Maximus – The Center for Health Literacy and Communication Technologies. Cheryl Camillo, Health Insurance Specialist with CMS, was recruited because of her federal policy knowledge in Medicaid and SCHIP. Many of the teams indicated the need to simplify policies and procedures.

Ron Moen, consultant with Associates in Process Improvement, has extensive knowledge in the Model for Improvement and managing a collaborative. He served as a consultant to guide the teams through the improvement methodology and as a faculty member.

The *Supporting Families* NPO staff served as Collaborative chair, director, coordinator and improvement advisor. Members included Vicki Grant, Nancy Gantt, Laura Heller, Melissa Ray and Ken Miracle.

Covering Kids & Families NPO staff served in an advisory capacity because of their federal and state policy knowledge and experience with identifying promising practices. Members included Nicole Ravenell, Policy and Research Director; Dorothy Stamper, Regional Coordinator; and Glenn Mainwaring, Administrative Assistant.

COLLABORATIVE CHARTER AND IMPROVEMENT STRATEGIES

A major part of the planning for the Collaborative was the development of the Collaborative Charter and Improvement Strategies package. A collaborative charter is the informational foundation and guiding document for the teams. It included the Collaborative topic, the problem statement, mission, goals, methods for achieving the goals and expectations for the faculty and the Collaborative teams. The *Supporting Families* NPO Collaborative leadership developed the Charter and the Improvement Strategies with input from faculty and advisory team members (See *Supporting Families* Breakthrough Series Collaborative Charter at the end of this section).

The Improvement Strategies provided teams with

concepts proven to be effective in addressing the problems identified by the Collaborative teams. The concepts and strategies could be tested and modified to fit the organizational framework of the team. The Improvement Strategies also included sites where strategies had been implemented. This provided teams with a potential resource to contact regarding their testing and implementation of a strategy. The *Supporting Families* NPO developed the strategies based on the list of change concepts outlined in *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*.[1] The package was developed to ensure that it included concepts and strategies to best assist teams in meeting their goals (See *Improvement Strategies*).

After the framework had been established, Collaborative teams and faculty participated in specific learning and sharing activities that took place throughout the life of the Collaborative. A collaborative can last for up to 13 months or longer. The *Supporting Families* Breakthrough Series Collaborative was introduced in August 2002 with the distribution of the pre-work material. The first Learning Session (LS 1) was held in September 2002 in Tempe, AZ.

Learning Session 2 (LS 2) was held in New Orleans, LA, in November 2002 and Learning Session 3 (LS 3) was held in Charleston, SC, in May 2003. The action period between Learning Sessions included regular conference calls and technical assistance site visits.

COMPONENTS OF THE COLLABORATIVE

What is involved in the collaborative process for the participating teams and faculty? How do they get where they want to be and how does the collaborative get them there rapidly? The components of the collaborative provide guidance on the actual activities involved in the collaborative.

COLLABORATIVE PRE-WORK PACKAGE

The *Supporting Families* Breakthrough Series Collaborative was officially launched with the distribution of the pre-work package in August 2002, approximately four weeks prior to the first learning session. The package provided the teams and faculty with general information about the Collaborative, such as the background on the Collaborative, learning sessions, schedule for the learning sessions and the core measures. It also included registration materials for LS 1. Teams were provided with a copy of the Collaborative Charter, a list of the Collaborative leadership team members and the activities to be completed by the teams prior to the first learning session.

The activities included forming a team and defining the role of each team member, defining the team goal or aim statement and creating a storyboard. It also included the plans for how the teams would measure the progress on reaching the goal. This included collecting data on the core measures for the four months prior to the Collaborative (See *Improving the Eligibility Process*). The core measures were defined and a template for monthly reporting was included in the pre-work package. The Collaborative leadership hosted a conference call with the teams after the pre-work package was distributed to address any issues or concerns teams had after reviewing the pre-work material. Teams were advised to contact the *Supporting Families* NPO if there were other concerns or issues after the call or if they needed assistance in completing the pre-work assignments.

COLLABORATIVE LEARNING SESSION 1

In a collaborative, teams are required to attend and participate in three learning sessions. Learning sessions are meetings where teams are provided information on the collaborative approach, the method of improvement to be utilized to reach the goal of the collaborative and presentations by experts in the field to show how specific strategies can be used to get the desired results.

Learning Session 1 for the *Supporting Families* Breakthrough Series Collaborative was held one month after the distribution of the pre-work. This learning session provided background information on why the collaborative approach was chosen to assist teams in reaching their goals. Teams were introduced to the Model for Improvement and the collaborative approach. An overview of the Improvement Strategies was given, and plenary sessions provided information on some areas of interest identified in *Supporting Families* grantee proposals. Those areas included writing for the customer and federal Medicaid and SCHIP simplification strategies. A motivational speaker, Dick Richards, discussed creative thinking in a session called "Artful Work."

COLLABORATIVE WEBSITE

To assist the collaborative process, the NPO created a private website, the *Supporting Families* Breakthrough Series Collaborative extranet, to serve as an online community for the participants. The extranet was protected by password and separated from the *Supporting Families* public website. This private website provided a single resource point for all information concerning the collaborative and served as a network to connect all the participants. The website included announcements and news about upcoming conference calls and meetings. Collaborative forms, useful files and documents presented by other teams or speakers at the learning sessions were also a part of the website.

Since teams were located in multiple states and time zones, the website served as a common area that was always accessible. It provided a location for the Collaborative participants to be able to review what occurred on a call, at a meeting or get information presented during a call they may have missed. The website was constantly updated with the latest information and served as the current record of the state of the Collaborative.

Collaborative participants used various methods for Internet access, including very slow modem accounts. In consideration of the limitations in access, and in order to optimize the online collaborative experience, the website was constructed in a manner that focused on delivery of information rather than its presentation. The website also was designed to comply with accessibility guidelines established by the World Wide Web Consortium Web Accessibility Initiative and Section 508, enacted by Congress to ensure that electronic and information technology is accessible to people with disabilities.

COLLABORATIVE ACTION PERIOD 1

The time between learning sessions is called an action period. An action period is the time teams use for developing tests, analyzing those tests and making the necessary adjustments to make a strategy more appropriate for their environment.

Supporting Families Action Period 1 asked each team to develop and perform a test using Plan-Do-Study-Act (PDSA) cycles and apply the test to a strategy from the Improvement Strategies. The results were to be reported within two weeks using the PDSA form posted on the extranet. Teams were to use the data report template posted on the website to report monthly data on core measures. *Supporting Families* Collaborative leadership held scheduled conference calls with all Collaborative teams. These calls allowed teams to report on their progress or

tests they were running, as well as discuss any problems they may have had. Conference calls were held to discuss and address special issues such as internal audit issues and customer and worker satisfaction issues. Teams were to submit a monthly team leader report highlighting their activities.

Teams were to use the website for reporting the monthly data and for submitting their monthly team leader reports. Some teams had difficulty with the report format. A conference call was held specifically to address reporting issues. Reporting was redesigned so teams could submit data and team leader reports in any format, and the Collaborative leadership would reformat for the website. It also was noted that the small-scale tests being run would not reflect changes in the data for the core measures. Teams were asked to submit data for their test site based on the tests performed at that site.

COLLABORATIVE LEARNING SESSION 2

The *Supporting Families* Breakthrough Series Collaborative leadership developed the agenda for LS 2 based on recommendations the Collaborative teams provided on evaluations after LS 1 and from conference call suggestions during Action Period 1. This session included presenters who could provide relevant examples of the implementation strategies that could lead to improvement in their offices. Some strategies included allowing mail-in applications, eliminating face-to-face interview requirements, eliminating asset tests and implementing 12-month continuous eligibility for children. This session provided the teams with examples of how utilizing the Improvement Strategies can generate improvements in the Medicaid and SCHIP enrollment and renewal process. The sessions also continued to provide information on the Model for Improvement (testing and implementation and introduction to spread) and the collaborative process. Teams began to present results of their tests and talk about any barriers they encountered.

COLLABORATIVE ACTION PERIOD 2

The Action Period between LS 2 and LS 3 was primarily the same as Action Period 1. The exception was that during Action Period 2 faculty began making site visits to provide technical assistance to help teams in the development of PDSA cycles using small scale testing. The purpose of the site visits was to address any barriers to testing and implementation. Regularly scheduled conference calls where the teams provided verbal updates on their testing strategies and the results were held.

COLLABORATIVE LEARNING SESSION 3

Teams that actively participate in a collaborative by testing, communicating, sharing and staying focused on the outcome are usually successful. At the end of the collaborative, team success is measured in the ability to answer the following questions:

- What were you trying to accomplish?
- How do you know that a change generated an improvement?
- What changes did you make that resulted in improvement?

The agenda for LS 3 was designed for more team participation. Teams were encouraged to bring a senior leader to LS 3 where team accomplishments were highlighted. Presenters shared additional information on how to help with the implementation of specific strategies. The teams were still testing and had become familiar enough with each other to share information and ask questions.

The *Supporting Families* Collaborative ran approximately nine months.

CONCLUSION

The *Supporting Families* Breakthrough Series Collaborative teams tested strategies that generated an improvement in their retention data at their test sites. A breakdown of the results of those tests can be found in *Team Activities and Accomplishments*.

[1]Gerald J. Langley, Kevin M. Nolan, Thomas P. Nolan, Clifford L. Norman, and Lloyd P. Provost, *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (San Francisco: Jossey-Bass, 1996).

Supporting Families Breakthrough Series Collaborative Charter

TOPIC: MAXIMIZING ENROLLMENT AND RETENTION OF ADULTS AND CHILDREN IN MEDICAID AND SCHIP

PROBLEM STATEMENT

Many families are inappropriately denied Medicaid and SCHIP benefits at application or their coverage is inappropriately stopped at review or during the eligibility period. Most of the original *Supporting Families* grantees found that nearly half of the denials and closures in Medicaid and SCHIP were due to procedural reasons. Coverage can be stopped for technical reasons such as a lack of coordination across state eligibility systems. This lack of coordination could be between automated systems that determine eligibility for different programs. It can also be the result of a variation of how county eligibility offices implement state policies. Further, eligibility requirements for families receiving Temporary Assistance for Needy Families (TANF) and/or Food Stamps can result in a negative effect on Medicaid and SCHIP coverage. Some families' TANF benefits are stopped due to time limits or at their own request. These families can have coverage stopped without a determination of their potential for continued eligibility for health care coverage programs. To achieve significant improvements in the enrollment and retention of adults and children, changes need to be made in the policies, practices and procedures, which account for nearly half of the denials and closures in Medicaid and SCHIP.

MISSION

In this Collaborative the mission is to achieve breakthrough improvements to systems that will significantly increase the enrollment and retention of adults and children who are eligible for Medicaid and SCHIP. The mission also will include the development of a means to share initial learning and results and to expand the implementation of improvements county and statewide.

The Collaborative leadership will help each team achieve this mission as well as each team's specific aims.

GOAL

The goal of the Collaborative is to maximize enrollment and retention of adults and children in Medicaid, SCHIP and Food Stamps (where applicable) by improving county and state eligibility processes.

METHODS

Each team is expected to develop specific goals relating to maximizing enrollment and retention of uninsured children and adults in their county or state. Participating teams will utilize a package of changes that has been identified and proven effective by other organizations and experts. Teams should begin by working with a specific county, region, unit or worker with the intent of spreading the tested and demonstrated improvements throughout the county or state.

Teams will attend three learning sessions that will provide for team learning and feedback and promote collaboration between teams to assist in reaching their goals. They will share knowledge and experiences to learn from other teams which practices have been successful and which practices have not been successful. Ongoing communication between teams and Collaborative leadership will take place while grantees are learning and running small-scale tests of the change ideas. This approach will utilize the effective improvement model known as Plan-Do-Study-Act (PDSA).

Teams will use process and outcome measurement strategies to assess progress towards achieving the Collaborative goals. They will be expected to collect data that relates to their aim at least monthly and to plot these data over time to assess the impact of any changes. The teams also will be expected to report their PDSA cycles as they occur.

The Collaborative leadership will assist teams in capitalizing on the learning and improvements from the focused project by coaching team members to develop a system for spreading improvements.

EXPECTATIONS

The Collaborative faculty/National Program Office will:

- Provide practice ideas and change concepts on improvement in enrollment and retention of uninsured adults and children, which have been successfully implemented by others
- Be readily available to teams for coaching and general guidance
- Provide communication strategies to keep the teams connected for shared learning
- Assess progress and provide feedback to teams
- Assist teams in identifying barriers to change and problem-solve solutions
- Plan and conduct three learning sessions

Teams are expected to:

- Complete pre-work activities to prepare for the first learning session
- Attend learning sessions and carry the change concepts back to adapt for testing and implementation
- Utilize PDSA cycles in processes and systems that lead to improvements
- Define team goals, measures and breakthrough targets
- Share information with the Collaborative in monthly narrative reports and at learning sessions
- Utilize the Collaborative as a strategic means of implementing part or all of the *Supporting Families* grant
- Serve as a resource for future collaboratives

IMPROVING THE ELIGIBILITY PROCESS

In 2002 Medicaid provided coverage to 47 million children, adults (primarily working parents), seniors and persons with disabilities.[1] During 2002 SCHIP provided coverage to approximately 5.3 million children.

Eligibility systems for Medicaid and SCHIP have significant societal value due to the tremendous impact on the lives of millions of children, adults and families. These systems are expected to be accurate – enabling eligible children and adults to obtain health coverage in an effective manner and withholding benefits from those who do not qualify.

Recently, difficult decisions have been faced in the budget process. Publicly funded programs and processes, such as the eligibility process for Medicaid and SCHIP coverage, have been scrutinized for ineffectiveness and inefficiency. Despite federal quality control data to show otherwise, a recent argument in public debate has questioned whether the eligibility process is allowing ineligible persons to receive public health coverage, thereby driving up the costs for these programs. Administrators have often been unable to provide specific information on how many eligible children and adults are denied coverage and, conversely, how many ineligible children and adults are approved for coverage. As a result, measures on the eligibility system are necessary to improve the accuracy of eligibility decision making.

WHO ADMINISTERS MEDICAID AND SCHIP?

Executive and legislative policy makers define who is eligible and who is not eligible for public health coverage. Additionally, policy makers define the amount of premiums and co-payments according to the family income level. Administrators must design systems and processes to facilitate accurate decision making by staff that must put these definitions into operation each day.

Administration of the eligibility process for Medicaid and SCHIP is a major undertaking for states and counties. The eligibility decision-making process is a system of inputs and outputs. The inputs to the system are numerous and include factors such as the effectiveness of the automated computer system, the complexity of the many detailed policies, worker skills and training, resources available to workers and the personal record-keeping ability of applicants. In many offices, administrators are very familiar with the inputs but have much less information about the outputs or the accuracy of eligibility decision making. Only by reviewing outcomes over time can improvements to effectiveness and efficiency be judiciously developed and implemented.

Inaccurate decisions have consequences that need to be prevented. Accuracy rates deserve attention to assure public health coverage is provided only to persons who are truly eligible. Similarly,

public trust is diminished and the system loses credibility when ineligible persons are provided coverage and eligible persons are denied coverage.

WHAT ARE THE ERRORS IN AN ELIGIBILITY SYSTEM?

As the following table shows, accuracy of an office decision on eligibility is defined in relationship to the actual status of a person's qualifications for eligibility. Accurate decisions sort out eligible persons from ineligible persons as shown in quadrants #1 and #4. Inaccurate decisions displayed in quadrant #2 occur when the office approves coverage when the child or adult is not eligible. These decisions are the primary focus of the Medicaid Quality Control system and can result in federal financial sanctions if the federal error rate is exceeded. Quadrant #3 errors result in health coverage being denied to eligible children and adults. No federal financial sanctions are applied to states for these errors. Such mistakes can cause these families to lose opportunities for covered preventive and primary care, as well as become uncompensated care costs for providers and other public health services agencies.

		CHILD OR ADULT	
		ELIGIBLE	NOT ELIGIBLE
OFFICE DECISION	DETERMINED ELIGIBLE	1 ACCURATE DECISION	2 INACCURATE DECISION
	DETERMINED NOT ELIGIBLE	3 INACCURATE DECISION	4 ACCURATE DECISION

WHAT IS THE ELIGIBILITY SYSTEM ACCURACY RATE?

The example below illustrates what can be learned by determining the accuracy of eligibility decisions on a set of 100 cases.

		CHILD OR ADULT		
	100 CASES	ELIGIBLE (87 Eligible)	NOT ELIGIBLE (13 Not Eligible)	ACCURACY RATE
OFFICE DECISION	DETERMINED ELIGIBLE (70 Approved)	1 ACCURATE DECISION (69 Cases)	2 INACCURATE DECISION (1 Case)	99%
	DETERMINED NOT ELIGIBLE (30 Denied)	3 INACCURATE DECISION (18 Cases)	4 ACCURATE DECISION (12 Cases)	40%
	ACCURACY RATE	79%	92%	81%

The overall accuracy rate of office decisions was 81 percent. Almost one in every five decisions on eligibility was in error and there is room for significant improvement.

Of the 70 decisions to approve coverage, 99 percent of the decisions were accurate.

Of the 30 decisions to deny coverage, 40 percent of the decisions were accurate. What was different in the eligibility process that caused 60 percent of the denial decisions to be inaccurate?

Of the 87 eligible applicants, 79 percent were accurately approved for coverage and 21 percent were inaccurately denied.

Of the 13 not eligible applicants, 8 percent were inaccurately approved and 92 percent were accurately denied coverage.

BASIC MEASUREMENTS

The eligibility system within a state or local office should be designed to produce accurate decisions. Accuracy of eligibility decisions should be measured. If the accuracy rate is lower than desired, improvements can be made.

There are eight basic measures of the eligibility process that can be reviewed and plotted over time. These measures are as follows:

BASIC MEASUREMENTS OF AN ELIGIBILITY SYSTEM

M1: APPLICATION RECEIVED	Number of applications received in the month
M2: PERCENT APPROVALS	100 X approvals in the month ÷ total application decisions made in the month
M3: PERCENT DENIALS	100 X denials in the month ÷ total application decisions made in the month
M4: DENIALS BY REASON	100 X denials by reason ÷ total denials
M5: PERCENT CLOSURES	100 X closures in the month ÷ cases at the beginning of the month + approvals in month
M6: CLOSURES BY REASON	100 X closures by reason ÷ total closures
M7: PERCENT BY CASES CLOSED AT RENEWAL	100 X cases closed at renewal ÷ total cases scheduled for renewal
M8: CASELOAD	Cases beginning of the month + approvals in month — closures in month

APPLICATIONS RECEIVED

"Applications Received in a Month" is a simple count of applications submitted each month for a decision. Outreach efforts and the accessibility of the eligibility process affect the number of applications received by the eligibility system each month. Eligibility offices are required to make decisions on Medicaid applications within a maximum of 45 days or explain the reasons for exceeding the processing time. The processing time typically starts when applications are stamped with the date of receipt by the office.

Applications received in a month and applications carried over from a prior month make up the universe of applications awaiting a decision of approval or denial.

Example: *A total of 2,500 applications were received as a result of an outreach campaign. The 2,500 applications plus the 800 applications carried over from the prior month means 3,300 applications are being reviewed for eligibility for coverage.*

APPROVAL AND DENIAL RATES

An effective eligibility system results in approval for applicants who qualify under the eligibility criteria and denial for those who do not qualify. A basic measurement is the approval or denial rate of applications. Each office can determine acceptable rates to use as a goal for monitoring over time. In Figure 1, the number of applications approved is 2,532 and the number denied is 1,082. The approval rate is 70 percent and the denial rate is 30 percent.

FIGURE 1
Eligibility Decision Points

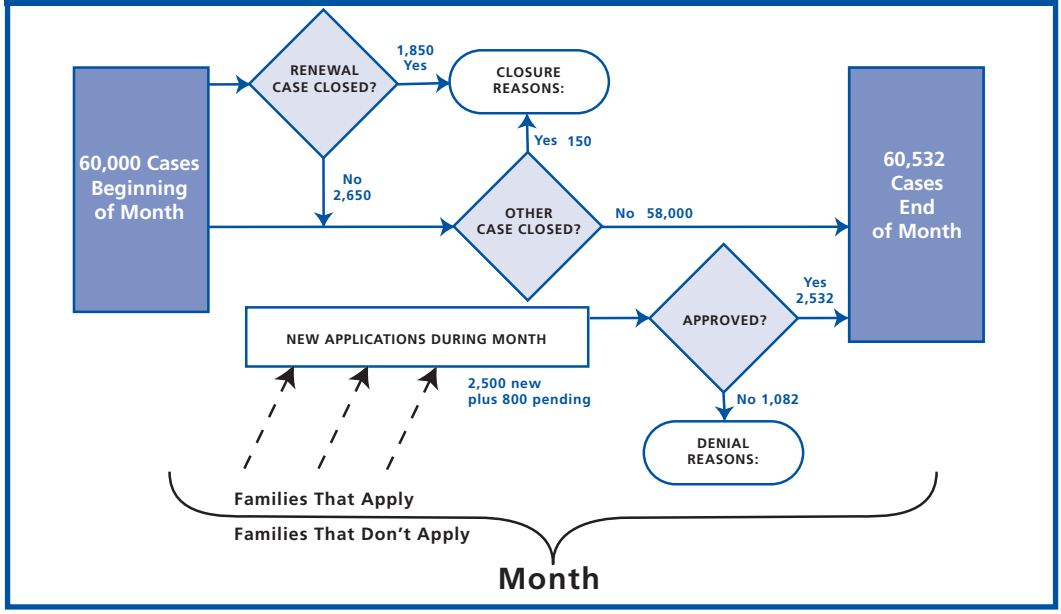


Figure 1 captures the basic measurements as decision points in the eligibility process.

FIGURE 2
Application Decision Process

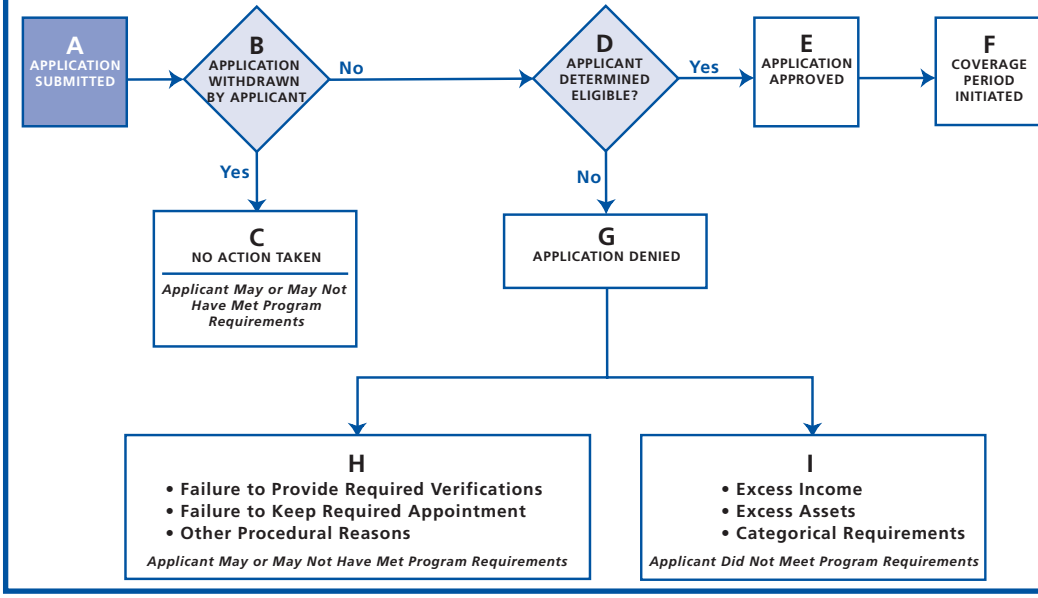


Figure 2 shows the general sequence and outcome of the application decision process. Low approval rates or high denial rates signal a need to look further at reasons for denial to determine where improvements can be made in the eligibility process. The rates may also point to a lack of appropriate outreach.

DENIAL REASONS

In order to understand why applicants are denied, the denial reasons should be analyzed. The questions to be answered are: "Are children and adults accurately denied because they are not eligible due to excess income or other eligibility criteria? Were they denied without a true determination of eligibility because they did not comply with a procedure within the eligibility system?" The answers to these questions provide meaningful information to understanding the accuracy rate.

Each state determines the computerized codes eligibility workers use for designating the reason for a denial of an application. Because the number of these specific denial codes may be large, it is necessary to group the denial codes. The following eight basic categories of denial reasons relate to eligibility policy and are a helpful way to group data for analysis. These are:

- Excess income
- Age not within eligibility criteria
- Excess resources (in states with a resource/asset test)
- Failure to comply with procedural requirements, such as missing an appointment for an eligibility interview or failure to return required verification documents within the required time frame
- Other health care coverage (an SCHIP denial reason)
- Failure to pay premium
- Other basic eligibility criteria, such as undocumented alien, not deprived of parental support and the applicant moved or cannot be located
- Applicant requested withdrawal of application

Procedural denials

The denial reason of "failure to comply with procedural requirements" points to system barriers. A truly simplified and accurate eligibility process should produce almost no procedural denials.

Two major reasons typically found for procedural denials are:

- Failure to keep an appointment for an eligibility interview, commonly known as "no show"
- Failure to return requested verification documents

Denials for procedural reasons do not indicate whether or not a child or adult qualifies under the eligibility criteria. A 1993 study found that 76 percent of these cases were probably eligible if the requested verification had been returned and if it substantiated the information stated by the applicant.[2]

It should be noted that in some states with separate SCHIP programs, procedural denials are not recorded as such. In these states, if an application cannot be approved because of a failure to verify requested information, the application is placed in a pending status. Even though the child is not approved for coverage, the computerized system does not have a code for a procedural denial.

Procedural denials due to "no shows"

If a relatively high number of procedural denials can be traced to "no shows," then a number of policy options can be examined. Face-to-face interviews are a state option, and in many instances, a local office option. Many states are discontinuing the practice, particularly in light of more applicants having full work schedules and being unable to leave work during the typical eligibility office 8:00 A.M.-5:00 P.M. day. The following list of questions is not intended to be complete but to

stimulate thinking about the process of appointments:

- What is the time lag between expressing an interest in having one's eligibility reviewed and the appointment date? In other words, how quickly is the request for service responded to by the system?
- Are applicants given a choice about appointment times, or are they sent a time and date in the mail?
- What is the readability level of the appointment notice?
- Are applicants given a specific and dedicated time for an interview, or are they given a time to check in and then wait for an interview on a first-come, first-serve basis?
- Are interviews scheduled before or after regular office hours and on weekends?
- Are interviews held at locations other than the eligibility office?
- Are local telephone systems adequate and user-friendly so an applicant can make or change an appointment?
- If face-to-face interviews are required, is there an adequate and reliable transportation system for applicants to use to get to the eligibility office?
- Is there a purpose for the face-to-face interview that cannot be met in other ways?

Procedural denials due to failure to return verification

If a relatively high number of procedural denials is for failure to return verification documents requested by the eligibility worker, then verification policies and procedures should be examined. Because this is an area where policy and practice are not always aligned, it is important to understand which documents are not being returned. The following list of questions is not intended to be complete but to stimulate thinking about verification and the process:

- Do eligibility workers request more verification than required by policy?
- Are eligibility workers requesting applicants to submit documents that the eligibility worker can obtain from other agency files?
- Are ex parte reviews being conducted?
- Are standardized, multi-program checklists given to applicants that list documents to provide the eligibility worker, or are applicants asked to bring only required verification documentation specific to their application and circumstances?
- Is it easy or difficult to actually speak to eligibility workers by calling the eligibility office?
- Do office policies require eligibility workers to offer and provide assistance to applicants in obtaining the required verification?
- What verification documents are most likely not to be returned?
- How much time is given to applicants to return verification documents?

CLOSURE RATES

At some point after approval, eligibility for continuing coverage must be reviewed. Medicaid and SCHIP require that coverage of children and adults be reviewed at least once every 12 months, but a state can choose to review eligibility more frequently. Except in states that have adopted the guaranteed continuous eligibility option for

children, recipients are required to immediately report any changes in income or household size so eligibility can be reviewed (see Figure 3).

To better understand the outcomes of the review process, the reasons for closure should be analyzed. Reviewing the reasons for closure is an important step to assure cases are being closed only when children no longer qualify under eligibility criteria. Similar to denials, system barriers might be present when a high percentage of closures are due to failure to comply with procedural requirements or failure to return required reports.

Closures can be measured as a percentage of the caseload closed or as a percentage of cases closed at renewal. As Figure 1 shows, 2,000 cases were closed representing 3.2 percent of the caseload. "Cases Closed at Renewal" is a more sensitive measure and provides more information.

Example: *County X had a beginning caseload of 60,000 cases and approved 2,532 cases. Of that caseload, 2,000 cases, or 3.2 percent, were closed. However, 4,500 cases were due for renewal and 1,850 were closed. The closure rate at renewal was 41 percent.*

FIGURE 3
Medicaid and SCHIP Eligibility Review Process

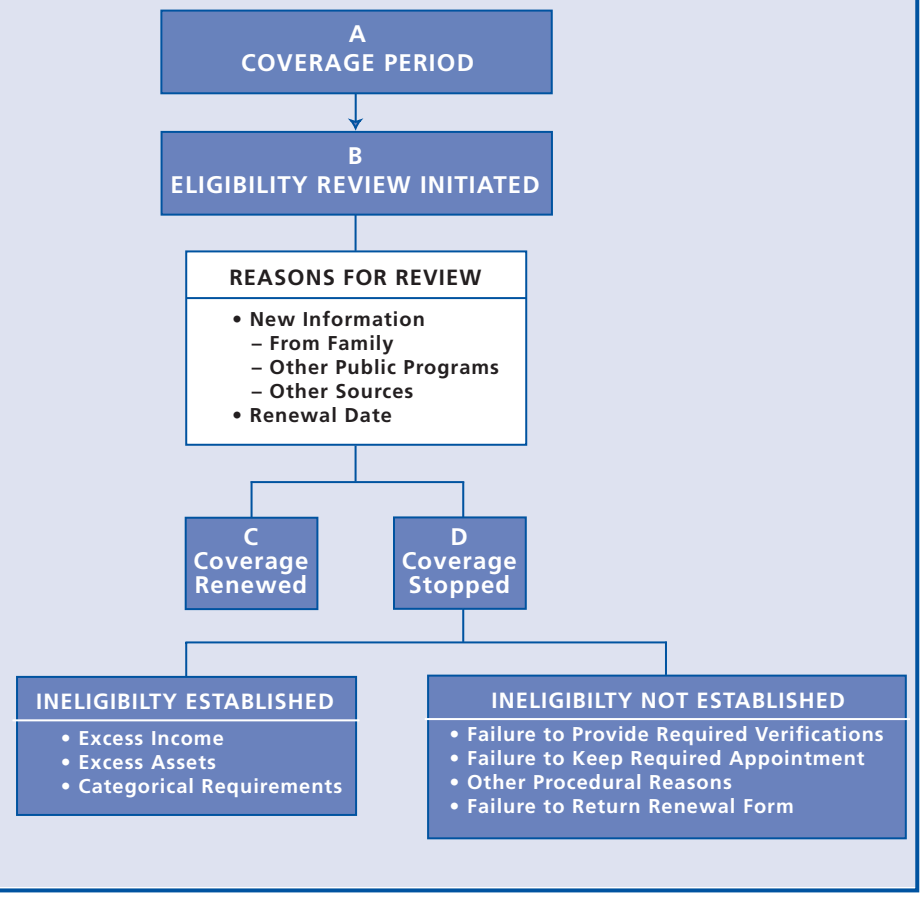


Figure 3 depicts the eligibility review process.

CLOSURE REASONS

As with denial reasons, there are many specific closure codes, and it is helpful to group them into basic categories. Closures can be grouped into the following categories:

- Excess income
- Age not within eligibility criteria
- Excess resources (in states with a resource/asset test)
- Failure to comply with procedural requirements, such as failure to return renewal form, missing an appointment for a renewal interview or failure to return required verification documents or reports within the time frame
- Other health care coverage (an SCHIP closure reason)
- Failure to pay premium
- Other basic eligibility criteria, such as transitional period expired or the recipient cannot be located
- Recipient request

CASELOAD

A simple caseload equation:

Current Caseload
+ Applications Approved
- Cases Closed
Total Caseload

"A caseload number refers to an unduplicated count of the number covered at a point in time. The caseload number reflects the net change in enrollment by offsetting applications approved with cases closed."[3]

When analyzing caseload numbers from automated system data reports it is important to understand what the reports are reflecting:

- Are the caseload counts duplicated or unduplicated counts? Different reports may reflect different counts, and different problems may require different methodologies.

> ***Example:*** *To learn more about the average number of times a family loses coverage within a given period, look for a duplicated count of closures. This will show the family lost coverage during the period and had to reapply.*

- Are the data a point-in-time snapshot or a compilation of data over a period of time? Many federal reports want a yearly report that compiles the data over a fiscal year.
- When are the data run? If the policy allows for reinstatement of closures up until the tenth day of the month and the data reports are run on the third of each month, this needs to be understood to explain the caseload count each month.

> ***Example:*** *If the caseload reports are run on the third and reflect a caseload count of 23,000 cases and between the fourth and the tenth 1,200 cases are reinstated, the caseload figure on the third of the next month will have 1,200 additional cases that were not the result of an application.*

- Program staff should maintain a record of unusual events or circumstances that may be reflected in the monthly data.

> ***Example:*** *If the state/county increased the income eligibility levels for Medicaid, a corresponding increase in the number of applications would be understood within the context of the policy change.*

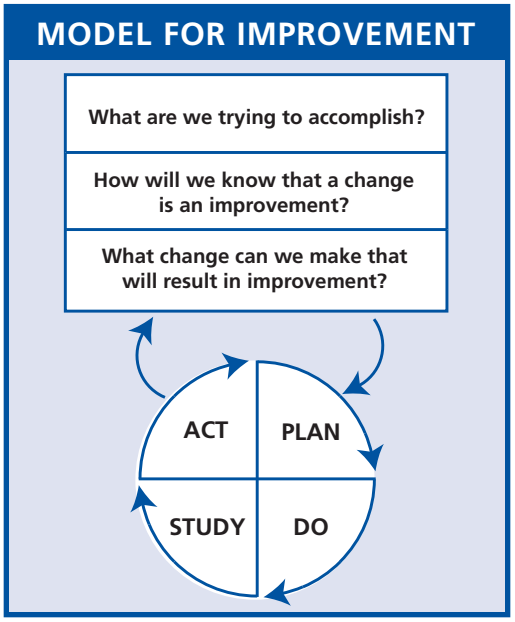
THE IMPROVEMENT MODEL

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 in order to design changes that can be tested. Once satisfied with the tests, the improvements can be spread throughout the system.

In the Medicaid/SCHIP eligibility systems are processes that encompass many components. Problems can exist within each of these components or in the relationships between components. Some of the basic components are:

PEOPLE	THE CUSTOMERS, WORKERS, SUPERVISORS
PROCEDURES	THE STEPS CUSTOMERS AND WORKERS ARE ASKED TO TAKE
POLICY	THE RULES THAT GOVERN THE PROCESS
AUTOMATED SYSTEM	THE COMPUTER SYSTEM THAT COLLECTS ELIGIBILITY INFORMATION, MAKES DECISIONS AND COMMUNICATES WITH CUSTOMERS
ENVIRONMENT	THE ELIGIBILITY OFFICE AND ITS CHARACTERISTICS

The Improvement Guide[4] provides a framework for making changes to work processes that will lead to improvements. This Model for Improvement is depicted in the graphic below.



The three basic questions that form the foundation of the model can be described as follows:

- **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 will be established to record the results of the changes.*
- **What change can we make that will result in an improvement?** *Testing cycles will be used to learn and make continuous improvements.*

PLAN • DO • STUDY • ACT CYCLE	
PLAN	What is the objective of the test? What is the predicted result? How will the testing be carried out? (Who, What, When, Where, etc.)
DO	Carry out the test. Record the results of the test. Document problems or unexpected results. Analyze the data.
STUDY	Complete the analysis of the data. Compare what happened to the prediction that was made prior to the testing. Summarize what was learned.
ACT	Plan your next steps. What changes?

The Plan-Do-Study-Act (PDSA) Cycle is used for testing changes that may lead to improvements. It is a cyclical approach, ensuring that with each test knowledge about the change will increase. Testing allows changes to be temporarily implemented to learn about the potential impact before being spread to a larger group and helps to predict whether the change will be an improvement. "A test should be designed so that as little time, money and risk as possible are invested while at the same time almost as much is learned from the test as would be learned from a full-scale implementation of the change."[5]

Repeat the PDSA testing cycle as necessary. Following is an example of how to put this PDSA cycle to use:

Example: *To try to encourage Food Stamp eligibility workers to make appropriate referrals to Medicaid and SCHIP, it is decided to test the use of a simple fact sheet that workers can use to explain the eligibility requirements for these programs. This is expected to increase the number of applications for health coverage programs by 15 percent.*

PLAN:

The improvement team plans to develop a simple fact sheet that can be used as a desk reference for workers to explain the eligibility requirements for Medicaid and SCHIP.

They predict the number of applications for Medicaid will increase. Applications handed out by the Food Stamp office will have "FS" coded on the first page in the upper left hand corner.

The improvement team will develop the fact sheet. which will be tested in one unit in the South office. They will ask for two volunteers from the casework staff. The test will be conducted Monday – Wednesday of the next week.

DO:

The two volunteer caseworkers reviewed the fact sheet with all Food Stamp applicants with children in the household. They then asked the family if they wanted to complete an application for Medicaid and SCHIP. The applications were then transferred electronically to the Medicaid Eligibility Unit.

An unexpected occurrence was that on the second day of the test one of the workers had to leave at lunch due to a family emergency. This decreased the number of overall cases that were part of the test.

STUDY:

Over the 3-day period, 22 Food Stamp applications were filed and the eligibility requirements for the Medicaid and SCHIP programs were reviewed with 19 of the applicants (3 of the cases had no children in the household).

Of the 19 cases receiving the extra screening, 14 actually filed an application for health care coverage. To date, 9 of the 14 cases have been approved.

The caseworkers estimated that reviewing the fact sheet with the applicant added 3-5 minutes to the interview.

Question: *Would the fact sheet be as effective if it were given to the applicant and applications were simply made available to them?*

ACT:

They are going to expand the test to the entire unit of 6 workers but will still test for only 3 days. Three workers will actually review the fact sheet with the applicant and 3 workers will give a copy of the fact sheet to applicants and tell them where the applications are located in the office.

SMALL SCALE TESTING

Suppose an improvement team is sitting around a conference table charged with the task of making changes to a system. The agency has determined there is a performance discrepancy in the work process, and the team has the responsibility to "fix" the problem. The issues are debated with an attempt to reach consensus and plan for the possible consequences of any decisions made. Frustration grows and the meeting is adjourned and rescheduled for a week later.

The use of small scale testing and the PDSA cycles eliminates this type of activity and encourages the testing of creative ideas that might be overlooked by the group in the conference room. Because the testing is low-risk, a failed test has only minimal consequences and results in quick answers to questions in a safe environment.

In planning small-scale tests, it is important to get initial tests down to the minimal level. For instance, test with 1 or 2 workers for a few days or test changes on the next 10 applications received in the office. Testing at this minimal level yields rapid results that can be studied to measure the effects of the change.

If it takes too long – 30 days or more – to get testing results from the data on the automated system, the test is not small enough. Collect the initial data by hand or record it on simple spreadsheets.

USE MULTIPLE CYCLES

As the results of each test are recorded and analyzed, it is important to determine what is happening. If problems were encountered during the test, or if the results were not as expected, this information must be assessed. This analysis determines any modifications that need to be made to the initial test and any subsequent test cycles that need to be planned.

The collection of before and after data is the most common method for recording change but

there are ways to test changes if the "before" data are not available. If a work process change is made that appears to be positive, stop doing the activity and see if the results return to the previous level. Testing also can be performed using control groups by simultaneously comparing the results of the control group to the test group.

Example: *Minnesota was interested in reducing the number of MinnesotaCare applications being denied for procedural reasons. As a test, they decided to contact customers before denying their application. The initial data (December 31, 2002) showed a decrease in the number of denials from an average of 1,238 to 781 – an improvement of about 37 percent. The following month the workload at the test site prevented any contacts with clients, so the change was not repeated. The denial rate increased, though not to its previous level. The test was repeated in March and the number of denials dropped, as was anticipated.*

CONCLUSION:

The Model for Improvement and the PDSA cycles offer a simple method for making changes that will result in improvement. The model also can be used when the issues are complex and the entire system needs to be redesigned. The documentation of the steps may need to become more sophisticated and additional time may be allocated for testing, but the process can be used regardless of the scale of the test.

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[1] *The Medicaid Program at a Glance.* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2002).
[2] Sarah C. Shuptrine, Vicki Grant, and Genny G. McKenzie, *Improving Access to Medicaid for Pregnant Women and Children* prepared for The Robert Wood Johnson Foundation and Grady Memorial Hospital (Columbia, SC: Sarah Shuptrine and Associates, February 1993), 37.
[3] Vicki Grant and Nicole Ravenell. *Covering Kids & Families Primer Understanding Policy and Improving Eligibility Systems* (Columbia, SC: Southern Institute on Children and Families, December 2002), 4-5.
[4] Gerald J.Langley and others. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (San Francisco: Jossey-Bass, 1996.), 10.
[5] Ibid.

Improvement Strategies For Maximizing Enrollment And Retention

This Improvement Strategies package consists of a combination of general concepts, ideas and strategies that can be used to improve practices and have a positive impact on the enrollment and retention of Medicaid and SCHIP coverage. This package has identified concepts with specific strategies that have been helpful in solving problems.

The idea is to select and test changes on a small scale to determine if there is improvement in enrollment or retention.

This package includes strategies and promising practices implemented in some states. The states are referenced in the package, but because some of the activities may still be in the testing stage the full impact of these changes cannot be determined. Some states are still in the process of collecting data that can be used to assess the impact of the change.

Some strategies may be beneficial to some states based on their structure, but the same strategy may create a more complex problem for another state.

It is clear there is no single solution to structuring enrollment and review processes that will increase the number of eligible children and adults who have health care coverage; rather, each state must assess the positives and negatives of each approach to find the practices that best suit its needs.

The first four pages of this package include the concepts and strategies with a reference to an implementation site or sites. The last section of the package is an excerpt of how a state or county has implemented specific strategies. To best utilize this package, select a strategy under one of the concepts and then under implementation review the reference.

Example: *If the strategy is "improve legibility of notices" and the implementation reference is "C-1, E-3, SF-1," review section C-1 beginning on page 28 for a state or county name and how it may have implemented the strategy. Implementation references that begin with "M" were taken from reports completed by Mathematica Policy Research, Inc., "C" were taken from a report by CMS, "SF" are strategies tested and/or implemented by Supporting Families Collaborative Teams and "E" are additional examples.*

IMPROVEMENT CONCEPT 1

Improve customer service: Management ideas of customer satisfaction are often an illusion. While all departments within an organization may strive for the common goal of customer satisfaction, each group has a separate role to play and unique requirements for customer information, which can create varying levels of customer service. To make customer satisfaction a reality, management should make every effort to test, analyze and implement some of the changes noted below.

STRATEGY	IMPLEMENTATION
1. Improve legibility of notices	C-1, E-3, SF-1
2. Simplify and improve the process for customers to provide information	M-1, M-2, M-3, C-2, SF-2, E-5
3. Minimize requirements for multiple interviews	M-1, M-8, M-9
4. Develop electronic applications and renewals	E-2, C-16, SF-16
5. Provide staff and other resources to assist with the application process	C-2
6. Have scheduled appointments and allow walk-ins	M-14
7. Reduce wait time for customer assistance	M-14
8. Simplify appointment types and scheduling	M-14

IMPROVEMENT CONCEPT 2

Improve policy and procedures: Because of an ever-changing environment, it is important for states to frequently re-evaluate their policies and procedures to determine if they are still consistent with their goals. Policy makers also need to determine how individual program policies may be coordinated to increase the enrollment and retention of benefits for potentially eligible participants.

Federal policy offers states considerable flexibility and opportunities to greatly simplify the enrollment process.

STRATEGY	IMPLEMENTATION
1. Eliminate unnecessary verification (e.g., delivery date, birth date, Social Security number, residency)	C-13, M-4, SF-3
2. Determine ineligibility for all categories prior to denial/closure	C-3, M-9
3. Eliminate requests for child support enforcement on application and renewal forms	C-4
4. Adopt 12-month continuous eligibility for children	C-5
5. Maintain eligibility coverage when families move from county to county within a state	C-6
6. Eliminate asset tests	E-4, C-22
7. Eliminate face-to-face interview requirements at application and at renewal	C-8, C-15, SF-4
8. Follow up with customers prior to closure/denial	SF-5

IMPROVEMENT CONCEPT 3

Improve workflow: All work is a process and it is critical for the organization to understand all steps in the process. How does work flow? Are the various steps in the process arranged and prioritized to obtain quality outcomes? How can workflow be changed so the process is less reactive and better planned?

STRATEGY	IMPLEMENTATION
1. Match staffing to needs	SF-6
2. Use variable work schedules	SF-7
3. Synchronize eligibility periods	M-5, C-19, SF-17
4. Make Medicaid eligibility decision first	C-17
5. Do tasks in parallel	M-6, C-7
6. Minimize handoffs	M-7, M-8
7. Take application and send, rather than refer customer to another office	M-7, M-8
8. Use automation	M-9, M-10
9. Outstation eligibility workers	C-8, M-11, SF-8
10. Work down backlog	SF-18

IMPROVEMENT CONCEPT 4

Change work environment: Changes to the environment in which people work, study and live can often provide leverage for improvements in performance. Most social service agencies have implemented various computer applications designed to support the eligibility determination process. However, many of these systems have been modified to reflect the changes brought about by welfare reform, and the changes frequently involve complex "work-arounds" that make things more complicated for the worker. Many of these technical changes do not lead to improvement because the work environment or the workers are not ready to accept or support the changes.

STRATEGY	IMPLEMENTATION
1. Give people access to information	C-18, SF-9
2. Give workers online manuals	
3. Provide access to other computer systems	
4. Give workers information on their performance indicators	C-20
5. Use proper measurements	C-20
6. Provide training	M-12, C-18, SF-10, E-5

IMPROVEMENT CONCEPT 5

Improve intra-system communications: Improved coordination between Medicaid, SCHIP and other programs also can be particularly effective in ensuring continued health coverage for eligible families and children. For example, through improved coordination with the Food Stamp and TANF programs, states can ensure that they do not terminate Medicaid inappropriately due to requirements of these programs.

STRATEGY	IMPLEMENTATION
1. Use ex parte review sources	C-9, SF-11
2. Collocation of eligibility workers	C-10, SF-12

IMPROVEMENT CONCEPT 6

Error proofing: Improve processes or designs to prevent mistakes or to make the mistake obvious at a glance. A mechanism should be put in place to ensure customers whose coverage is ending or who are being denied are truly ineligible for the program.

STRATEGY	IMPLEMENTATION
1. Use reminders for eligibility workers and customers	SF-13
2. Restrict case closures or denials prior to peer or supervisory review	
3. Remove auto denials or closures options	
4. Develop audit reviews	C-21

IMPROVEMENT CONCEPT 7

Focus on variation: In some states and counties Medicaid and SCHIP policies and procedures have different eligibility requirements. Often variations in the process or system cause the creation of additional steps to compensate for those variations in program requirements. Focusing on these differences and trying to implement changes to reduce some of these variations in programs for the uninsured could make the process easier for potential customers who may be trying to access benefits and for staff who have the responsibility of trying to assist potential customers in gaining access to these benefits.

STRATEGY	IMPLEMENTATION
1. Standardize policies and procedures across programs (create a formal process)	SF-14
2. Use bilingual workers to follow up, assist customers with verifications	C-11

IMPROVEMENT CONCEPT 8

Producer/customer interface: Understanding the specific needs and concerns of customers who visit eligibility offices and assuring they understand the services available to them can generate numerous ideas for improvement. By reviewing the process from the perspective of the customer and the worker and listening to their ideas, changes that lead to improvements can be implemented.

STRATEGY	IMPLEMENTATION
1. Listen to customers	M-13, SF-15
2. Ask customers if there is anything else you can do to help	M-14
3. Use customer cards	M-15
4. Coach customers to use services	C-14
5. Focus on the outcome to a customer	C-12, SF-19
6. Focus on making the customer eligible	C-12
7. Use a coordinator	M-16

LEGEND FOR DOCUMENTING SOURCE OF IMPLEMENTATION

C	***Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*** **CMS Publication # 11000 (August 2001)**
M	**Reports by Mathematica Policy Research, Inc.**
E	**Additional Implementation Examples**
SF	***Supporting Families*** **Breakthrough Series Collaborative Improvement Strategies Tested and/or Implemented**

IMPLEMENTATION

Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage

This information was taken from CMS Publication # 11000 (August 2001)

C-1
IMPROVE LEGIBILITY OF NOTICES

Incomplete and unclear notices can contribute to misunderstanding about Medicaid eligibility, discourage families from pursuing legitimate appeals and deter families from seeking benefits in the future (when they may be eligible). In the case of TANF denials and terminations, states should review their notices to see if they provide the appropriate message regarding the continued availability of Medicaid eligibility and provide a phone number individuals can call for assistance.

The reading level and wording on the application should be in "plain language" and easy to understand.

Illinois: The Livingston County Office sends follow-up letters to beneficiaries that supplement letters generated by the State's computer system. The language in the letters explains exactly what the family must do to maintain assistance. The personal notes are sent to beneficiaries by the caseworkers to remind them of redeterminations, or to explain terminations or denials and to suggest they call the local office if they have questions.

C-2
SIMPLIFY AND IMPROVE THE PROCESS FOR CUSTOMERS TO PROVIDE INFORMATION

PROVIDE STAFF AND OTHER RESOURCES TO ASSIST WITH THE APPLICATION PROCESS

States can improve participation in Medicaid by offering assistance in obtaining required documentation, providing facilities for copying required documentation and following up with applicants to ensure that they submit any needed documentation.

Rhode Island: Rhode Island's Providence Regional Center provides a self-help area for clients in the main waiting room. The self-help area includes forms, a free copy machine and drop boxes for submittal of applications. It allows applicants and recipients to provide documents, report changes and gather information without waiting to see a worker.

C-3
DETERMINE INELIGIBILITY FOR ALL CATEGORIES PRIOR TO DENIAL/CLOSURE

Exhaustion of all avenues of eligibility: States may not deny a completed Medicaid application (or

terminate coverage) unless it has affirmatively explored and exhausted all possible eligibility categories. Therefore, states must have effective processes in place to consider all possible avenues of coverage.

TANF denials and terminations – effects on Medicaid: Since Medicaid eligibility is not tied to TANF eligibility, states may not delay, deny or terminate Medicaid to a family or any family member simply because the family is ineligible for TANF (e.g., due to employment, time limits, sanctions or any other reason).

Durham, North Carolina: The local Medicaid agency staff use an "at a glance" checklist to cross reference TANF closure codes against potential Medicaid eligibility categories. The checklist includes the possible options for continuing Medicaid coverage (e.g., 12-month continuous coverage and transitional Medicaid), lists the steps to establish this coverage and requires a certification with caseworker signature, as well as the date and result of the Medicaid redetermination.

Tennessee: The State uses independent contracted staff to perform third-party reviews of closed or denied TANF cases before taking negative actions. These contractors also explain to families what additional opportunities for coverage are available.

Maryland: The agency has placed a computer block on all TANF work-related terminations and denials. This block remains until cases have undergone second and third party reviews to ensure that Medicaid eligibility is not improperly lost.

North Carolina: The State conducted systems queries to identify terminated TANF cases that have not been reviewed for Medicaid eligibility.

C-4
ELIMINATE REQUESTS FOR CHILD SUPPORT ENFORCEMENT ON APPLICATION AND RENEWAL FORMS

Paternity and assignment of rights as a condition of eligibility: Parents of children born out of wedlock applying for Medicaid for themselves and their child/children must cooperate in establishing paternity and pursuing third-party benefits and assigning rights to medical support and payments (42 CFR 433.147) as a condition of their eligibility (but not the eligibility of the child). A state may not require cooperation, however, if the parent has good cause for not cooperating (e.g., in cases of domestic violence). Furthermore, non-cooperation by the parent does not affect the child's eligibility for Medicaid. States must inform applicants of the exemptions for good cause and advise applicants that their decision whether or not to pursue support will not affect their child's eligibility for Medicaid.

There are no federal requirements for cooperating with Child Support Enforcement under the SCHIP rules. If a state chooses to implement SCHIP through Medicaid, the Medicaid cooperation requirements apply because the SCHIP enrollees are Medicaid beneficiaries.

C-5
ADOPT 12-MONTH CONTINUOUS ELIGIBILITY FOR CHILDREN

Continuous eligibility for children: Under a provision of law enacted in 1997, states may choose to provide Medicaid to children under age 19 for a continuous period of up to 12 months. Once a state determines that a child is eligible, the child remains eligible for the period of continuous eligibility chosen by the state regardless of changes in the child's circumstances (other than reaching age 19 or moving out of state). If a state chooses this option, continuous eligibility applies to all children

found eligible for Medicaid regardless of the basis of eligibility. For example, if a state adopts the continuous eligibility option, continuous coverage must be provided to children in the 1931 family category as well as to the poverty-level children.

C-6
MAINTAIN ELIGIBILITY COVERAGE WHEN FAMILIES MOVE FROM COUNTY TO COUNTY WITHIN A STATE

Moves within the state: A state plan for Medicaid must provide that it shall be in effect statewide (section 1902(a)(1)). This means that the state plan must be in effect statewide and all counties within the state must comply with the state plan provisions.

It also means that when a family moves within the state, even in a state with a county-administered Medicaid program, the state and the counties are responsible for transferring the case record from the old county of residence to the new county of residence so Medicaid can continue without interruption. The state cannot require the family to reapply for Medicaid or have its Medicaid eligibility reviewed solely based on a move to a new county. An eligibility review may be appropriate if there are changed circumstances that might affect eligibility, for example, if the family moved because a parent obtained a new job.

C-7
DO TASKS IN PARALLEL

Massachusetts: The State has a pilot focusing on simplifying the renewal process. The pilot will create the opportunity for families to complete the renewal process at points of service, such as primary care providers' offices, early-childhood service providers or schools, and will allow the family to submit the renewal form to extend the 12-month period of eligibility at any time during the year.

C-8
OUTSTATION ELIGIBILITY WORKERS

Medicaid law and regulations require that states provide an opportunity for children under age 19 and pregnant women to apply for Medicaid at locations other than local TANF offices. States must have such "outstationing" arrangements at each facility designated as a Disproportionate Share Hospital (DSH) and Federally Qualified Health Center (FQHC) unless there is an approved alternative arrangement.

Individuals other than state eligibility staff, such as hospital or health center staff can do the initial processing of the Medicaid application at outstation sites. The eligibility determination also can be done at the outstation site if conducted by state personnel authorized to make the determination.

Kentucky: The State has outstationed staff from all social service agencies, including Medicaid, at various locations in the community connected to middle schools or high schools. In Jefferson County (Louisville), each of these locations is called a "Neighborhood Place" and offers one-stop shopping for residents interested in applying for Medicaid and other program benefits.

New York: The New York State Department of Health has initiated "facilitated enrollment," a $10 million program that funds community based coalitions to enroll children in Medicaid and SCHIP, known in New York as Child Health Plus. The facilitated enrollers help families fill out the Growing Up Healthy application (NY's joint application for Medicaid and Child Health Plus), gather the required documents and ensure that the child becomes enrolled. The interview with the facilitated enrollers counts as the face-to-face interview requirement for Medicaid purposes.

Montana: Agency staff set up tents near a cherry picking plant where many migrant workers are employed during the summer. Eligibility workers accept and process applications onsite. The Montana Migrant Council brings its mobile clinic and provides needed health services onsite. Other entities, which may include the Rural Employment Organization, Montana Food Bank, Job Service and Migrant Legal Services, also are available on site.

C-9
USE EX PARTE REVIEW SOURCES

Washington: For families receiving both Medicaid and Food Stamps, Washington automatically performs a Medicaid review at the time of the Food Stamp review and certifies 12 new months of Medicaid for those who remain eligible.

C-10
COLOCATION OF ELIGIBILITY WORKERS

Kansas: State Medicaid eligibility workers and employees of a private contractor responsible for HealthWave (SCHIP) are housed in one location. Families seeking health insurance for their children complete an application and mail it to a central clearinghouse. The application is first screened for Medicaid eligibility. State workers make final Medicaid eligibility determinations; private contractor employees make final HealthWave eligibility determinations.

Michigan: Applications received in the MIChild (SCHIP) office are screened for Medicaid by the MIChild contractor. If a beneficiary appears to be Medicaid-eligible, the application is given to the Medicaid eligibility worker located on site at the MIChild contractor's office. Coverage begins on the day the Medicaid eligibility worker determines the child is eligible. This process eliminates delays in determining eligibility that might otherwise occur.

C-11
USE BILINGUAL WORKERS TO DO FOLLOW-UP, ASSIST CUSTOMERS WITH VERIFICATIONS

Working with immigrant populations:

California: Some counties have an immigrant liaison in their district to address concerns specific to immigrants.

New Mexico: The State agency entered into an agreement with the Immigration and Naturalization Service (INS) whereby Medicaid staff provides Medicaid training for INS staff, and INS does public service announcements in Spanish on public charge policy to help alleviate immigrant mistrust of government agencies. This was done via their *Covering Kids* contractors.

Delaware: The agency revised its application form for Medicaid and SCHIP to contain a statement that alien verification information will not affect any public charge determination or lead to deportation proceedings.

C-12
FOCUS ON THE OUTCOME TO A CUSTOMER

FOCUS ON MAKING THE CUSTOMER ELIGIBLE

Follow up with families that fail to complete the process: It is a good practice to give families and individuals more than one opportunity to provide information needed to complete the application and renewal process. Several states have developed a process that follows up on non-responses through written reminders, phone calls or personal contact.

Illinois: The Livingston County Office sends follow-up letters to beneficiaries that supplement letters generated by the State's computer system. The language in the letter explains exactly what the family must do to maintain assistance.

C-13
ELIMINATE UNNECESSARY VERIFICATION, (E.G., DELIVERY DATE, BIRTH DATE, SOCIAL SECURITY NUMBER, RESIDENCY)

Documentation requirements: Surveys and reviews have revealed that a leading reason why eligible families fail to successfully enroll in Medicaid is that the families do not supply state-required documentation. Federal law imposes only one documentation requirement for Medicaid: individuals seeking coverage who are not citizens or nationals of the United States must provide proof of alien or immigration registration from the INS or other documents the state determines constitute reasonable evidence of satisfactory immigration status.

States have found they can effectively preserve program integrity without requiring additional documentation from families. States can verify financial eligibility through employers, banks and other collateral contacts. States that want to confirm the reliability of using self-declaration of income and resources also may use Medicaid Eligibility Quality Control (MEQC) pilot projects or other targeted studies on a statewide basis or in a sub-state area.

Self-declaration of income and resources: More states are turning to self-declaration of income and resources. As of December 2000 Arkansas, Florida, Georgia, Idaho, Kentucky, Maryland, Michigan, Oklahoma, Vermont and Washington use self-declaration of income for children's health coverage under Medicaid and SCHIP; Alabama, Arizona and Wyoming rely on self-declaration of income for their separate SCHIP program.

C-14
COACH CUSTOMERS TO USE SERVICE

Applications should not include questions that are not necessary to determine eligibility. It also may be helpful to applicants to provide an explanation for optional items or reasons for questions. Several states have found it helpful to explain that Medicaid applications ask about already incurred medical bills in order to help families pay these expenses if they were incurred during the three-month retroactive period.

Massachusetts: Families in Massachusetts applying for Medicaid and SCHIP benefits receive a Mass Health member booklet similar to what individuals receive when enrolling in private insurance plans. This colorful booklet is given out with the Mass Health application called the "Medical Benefit Request." It describes in plain language how to apply for benefits; provides details on who can get benefits, income standards, covered services and when coverage begins; and it explains other pertinent facts such as how to choose a health plan and a doctor, out-of-state emergency treatment, how to report changes, how the State will use the individual's Social Security number and who to call with questions.

C-15
ELIMINATE FACE-TO-FACE INTERVIEW REQUIREMENTS

Face-to-face interviews are not a federal requirement: Some states, as an alternative, have eligibility caseworkers visit job sites and homes or conduct interviews by phone. When office visits are necessary, some states provide transportation vouchers, and many arrange evening and weekend hours to accommodate working families. Options adopted by some states: (1) Use phone-in applications, in addition states can offer telephone interviews; (2) Use mail-in applications; (3) Use convenient locations. States may place eligibility workers at additional outstationed sites beyond those required by federal law.

C-16
DEVELOP ELECTRONIC APPLICATIONS AND RENEWALS

Florida: The State piloted an electronic application process targeted at minority children served by day care centers.

C-17
MAKE MEDICAID ELIGIBILITY DECISION FIRST

If an individual applies for Medicaid through a joint program application (e.g., a Medicaid, Food Stamp and TANF application), the state must still determine Medicaid eligibility within the Medicaid time standard. If processing an application for another program is delayed due to a requirement that does not relate to Medicaid, processing of the Medicaid portion of the application must continue so a determination is made in a timely manner consistent with Medicaid rules.

C-18
GIVE PEOPLE ACCESS TO INFORMATION

PROVIDE TRAINING

Iowa: The agency has a help desk for income maintenance workers with questions and answers on policy and systems issues available to them at their desk. The help desk plans to have an Internet or intranet site for frequently asked questions that income maintenance workers would access from their desktops.

Other states provide ongoing training that engages worker attention and participation by offering refresher quizzes (Missouri), board games focusing on eligibility issues (Massachusetts) and online interactive training sessions (Utah).

C-19
SYNCHRONIZE ELIGIBILITY PERIODS

What can be done when an additional child in the family becomes eligible for Medicaid to avoid different periods of continuous eligibility in the same family?

At the same time the additional child is determined eligible, the state can redetermine the eligibility of the children already receiving Medicaid and begin a new period of continuous eligibility for them so all children in the family will have the same period of continuous eligibility. If the state determines at the redetermination that the children are no longer eligible, however, the state must continue to provide Medicaid until the end of the original period of continuous eligibility.

C-20
GIVE WORKERS INFORMATION ON THEIR PERFORMANCE INDICATORS

USE PROPER MEASUREMENTS

States can adopt enrollment goals as a performance measure for offices or workers (or both) in order to provide incentives for workers to focus their efforts on enrolling children and families into Medicaid.

Indiana: The State agency set county enrollment goals in their Hoosier Healthwise (SCHIP Medicaid expansion) program. Each local county determined their own strategies for expanding enrollment of children. The central office supported their local decision with regard to outreach implementation and monitored data to assess progress toward goals. Clear and ongoing communication about progress in meeting goals, including data, created a collaborative spirit. Both state and local staff say the county discretion and local flexibility contributed to their success in meeting and exceeding their enrollment goals.

C-21
DEVELOP AUDIT REVIEWS

Idaho: In November 1999 the application process was simplified. This included a shorter application form (3 pages), self-declaration of income and assets and 12 continuous months of eligibility. Idaho reviews a monthly sample of the SCHIP Medicaid expansion cases to determine accuracy rates for the approval and denial process. Case reviews that show improper actions are referred to the regional offices for appropriate action. Based on the reviews, Idaho determines the accuracy rates for the approval and denial process. The State has maintained a 99 percent accuracy rate for the approval process. The accuracy rate for the denial process was 73 percent for the initial two months but has steadily improved to a 93 percent rate for the last quarter. Training for specialists working the cases has been ongoing, and has facilitated the continued improvement of accuracy rates for the denial process.

C-22
ELIMINATE ASSET TESTS

States have used the flexibility available under Section 1931 to:

(1) simplify the resource test;
(2) effectively raise the resource standard; or
(3) eliminate the resource test altogether.

To simplify the resource test, states have chosen to exclude resources counted under Aid to Families with Dependent Children (AFDC). For example, a number of states now exclude one car of any value. Other states have chosen to exclude resources not frequently encountered or which seldom affect eligibility, such as the cash value of a life insurance policy.

Some states have chosen to effectively raise the standard above that used in AFDC by disregarding a flat amount of resources. For example, a state which had a resource standard of $1,000 under AFDC can raise the resource standard to $5,000 by disregarding $4,000 in otherwise countable resources.

Finally, some states have chosen to exclude all resources as a less restrictive methodology. This effectively eliminates a resource test for the Section 1931 group.

Reports By Mathematica Policy Research, Inc.

THE FOLLOWING SECTION CONSISTS OF EXCERPTS FROM VARIOUS MATHEMATICA REPORTS. SPECIFIC REFERENCES ARE INCLUDED IN THE ENDNOTES FOR THIS SECTION.

M-1
SIMPLIFY AND IMPROVE THE PROCESS FOR CUSTOMERS TO PROVIDE INFORMATION

MINIMIZE REQUIREMENTS FOR MULTIPLE INTERVIEWS

Maine: The caseworkers communicate frequently with families to help them complete the application. This is a part of the "Personal Touch of Maine."[1]

The Bureau of Family Independence uses a common intake process that requires eligibility determination for all three programs (TANF, Medicaid/SCHIP and Food Stamps) at the same interview.[2]

The worker actually denies applications if the documentation is not received within 10 days, based on the assumption that families respond quicker than if they simply receive a notice indicating their application is not complete. As long as the family reapplies within 30 days, they do not have to complete a new application. Maine officials believe this policy encourages families to produce documentation sooner than they might otherwise. However, it may also deter some families who do not understand why their application has been denied.[3]

M-2
SIMPLIFY AND IMPROVE THE PROCESS FOR CUSTOMERS TO PROVIDE INFORMATION

Pennsylvania: In addition to altering the appearance of renewal notices and reducing income verification requirements, follow-up telephone calls are conducted to help families complete the renewal process.

Massachusetts: The State sends up to four reminder letters including a self-addressed return envelope and also makes follow-up phone calls.[4]

M-3
SIMPLIFY AND IMPROVE THE PROCESS FOR CUSTOMERS TO PROVIDE INFORMATION

Marion County, South Carolina: Applicants are informed that they have 10 days to turn in their verification, even though workers have 30 days to determine eligibility. If the applicant misses the first 10-day window, the caseworker sends a letter or calls giving them 10 more days until the 30-day window expires. This policy gives workers an active role in encouraging applicants to submit their information, instead of just relying on the applicant to remember what they need to submit.[5]

M-4
ELIMINATE UNNECESSARY VERIFICATION (E.G., DELIVERY DATE, BIRTH DATE, SOCIAL SECURITY NUMBER, RESIDENCY)

States have cited documentation requirements as a barrier to enrollment and retention.

Louisiana: The agency uses online birth records to verify age to reduce the burden on applicants.

Pennsylvania: Policy currently requires documentation of a full month's work; the State is considering allowing one pay stub (for a shorter period) to serve as sufficient verification of income.

New Jersey: They are evaluating the use of alternate verification sources, such as data from the Department of Health and Social Services vital statistics records.

Georgia, Idaho and Maryland: All allow self-declaration of income to decrease the burden on applicants. CMS reports that at least seven states have adopted this approach.

West Virginia: Policy does not require income verification as part of the redetermination process in order to reduce the number of children disenrolling from SCHIP.

Illinois and Ohio: They have reduced other documentation requirements because they realize income verification is a barrier but essential to maintaining program integrity.

Minnesota: The State has a delayed verification process. An applicant has 30 days after enrollment to submit necessary verification.[6]

M-5
SYNCHRONIZE ELIGIBILITY PERIODS

Indiana: The State's extended eligibility periods for the Food Stamp Program, Medicaid and Hoosier Healthwise support the ability of clients to retain benefits and lessen the burden on clients. Caseworkers also synchronize the eligibility redetermination periods for clients who receive multiple programs in an effort to streamline the number of interviews required by clients.[7]

M-6
DO TASKS IN PARALLEL

Washington: Each time a family completes a TANF or Food Stamp recertification, which is generally every 3 months, the 12-month Medicaid certification period is rolled forward in the Automated Client Eligibility System (ACES) for an additional 12 months. This procedure effectively takes advantage of the family's contact with the Community Service Office to "extend" Medicaid coverage further into the future.[8]

M-7
MINIMIZE HANDOFFS

TAKE APPLICATION AND SEND, RATHER THAN REFER CUSTOMER TO ANOTHER OFFICE

Indiana: An important component of Indiana's workflow is that the same caseworker performs all case management activities for each case to which he or she is assigned. This structure results in combined client interviews covering multiple programs, as well as the same caseworker performing eligibility determination and redetermination for all his or her cases. This "super worker" approach results in caseworkers who are knowledgeable in all programs and in all phases of case management with a positive impact on a family's access to Food Stamps and Medicaid. Having caseworkers knowledgeable in all programs results in more holistic case management and increases the potential that families coming in for one program will learn about another for which they might be eligible.[9]

M-8
MINIMIZE HANDOFFS

TAKE APPLICATION AND SEND, RATHER THAN REFER CUSTOMER TO ANOTHER OFFICE

MINIMIZE REQUIREMENTS FOR MULTIPLE INTERVIEWS

Maine: The Portland Bureau of Family Independence assigns a single eligibility worker to each client: a TANF specialist if the client receives TANF benefits or a Food Stamp/Medicaid specialist if the client does not apply for TANF. In practice, the specialist assigned to each case essentially becomes a case manager and assumes responsibility for coordinating the majority of services the client receives. This includes conducting the initial eligibility interview, conducting periodic reviews of eligibility and working with other providers and workers as necessary to coordinate the entire range of services the client may need.[10]

M-9
USE AUTOMATION

MINIMIZE REQUIREMENTS FOR MULTIPLE INTERVIEWS

DETERMINE INELIGIBILITY FOR ALL CATEGORIES PRIOR TO DENIAL/CLOSURE

Cuyahoga County, Ohio: CRIS-E (automated eligibility system) is programmed to automatically determine a client's eligibility for all programs offered by the State regardless of whether the client has formally applied for the programs.

It also is programmed with several checks to ensure that as clients transition on and off assistance programs, they will continue to receive those benefits for which they remain eligible. The system does the same for the recertification process.[11]

M-10
USE AUTOMATION

Maine: As an aid in helping clients return their grant review forms on time, clients receive a second grant review letter if they have not returned an acceptably completed first review before the 15th of the month prior to losing benefits. In addition, the State's automated system prints a list of all clients who have not returned their review forms and workers often call these clients to remind them to complete and return the form so benefits can continue without interruption.[12]

M-11
OUTSTATION ELIGIBILITY WORKERS

Utah: The Department of Health places caseworkers in community organizations, which it says has helped increase Medicaid enrollment. While CMS requires that all states use outstationed Medicaid workers to accept applications, Utah's model goes further. Outstationed workers in Utah also perform eligibility determinations, redeterminations and case management activities for individuals receiving only Medicaid.[13]

M-12
PROVIDE TRAINING

Louisiana: The agency trained eligibility field staff about the importance of health insurance and the consequences of being uninsured. They also explained why families may incorrectly assume children are not eligible and discussed other barriers to enrollment. They then challenged field staff to find solutions in assisting children to obtain coverage in LaCHIP or Medicaid. The State found that staff buy-in reduced procedural rejections. They also reported staff became more creative and proactive in obtaining essential verifications.

Ohio: The County officies found that their workers were perceived as not being helpful in the application process, so the State began a series of technical assistance sessions for front line eligibility staff. These sessions focused on Medicaid eligibility rules, but also promoted consistency and consumer-friendly philosophy.[14]

M-13
LISTEN TO CUSTOMERS

Because SCHIP is a public program, many states have found that some applicants attach a certain stigma to the program, often linking it with welfare or Medicaid. To reduce the stigma associated with SCHIP and Medicaid, states are using a variety of approaches.

Arkansas: The State named its M-SCHIP program ARKids Plus to take advantage of the outreach efforts and positive name recognition associated with its ARKids First, an 1115 waiver demonstration project.

Vermont: Families that apply only for health care benefits mail their applications to a centralized processing unit, which has no overt connection to the State's welfare department

Indiana: The previous Indiana Medicaid card was replaced with a Hoosier Health card resembling a commercial insurance card. Hoosier Healthwise is referred to as health insurance rather than public assistance. Children enrolled in the program are "members" not recipients.[15]

M-14
ASK CUSTOMERS IF THERE IS ANYTHING ELSE YOU CAN DO TO HELP

HAVE SCHEDULED APPOINTMENTS AND ALLOW WALK-INS

REDUCE WAIT TIME

SIMPLIFY APPOINTMENT TYPES AND SCHEDULING

Maine: The principle of respecting clients' dignity and personal needs is more than lip service in Maine. It is carried through many policy choices (e.g., reducing the need for working clients to take off to attend interviews) and implementation decisions (e.g., providing private interview rooms). The principle is reflected in procedures (e.g., short wait time for interviews; returning calls the same day) and reinforced through selective hiring, training and supervisory practices. In the worker-client relationship, the practice of respecting clients goes beyond the quality of their personal interaction to a willingness to be flexible when necessary.

"The Personal Touch of Maine"

Leadership from high-ranking State officials has established the office culture as the "Personal Touch of Maine." Applicants are to be treated with respect at all times; caseworkers are charged with considering applicants as whole persons facing a personal crisis and with being as creative and flexible as possible in enrolling clients. The waiting area includes spaces for children's play and private interview rooms. No face-to-face interview is required for Medicaid, and families can mail the completed two-page application. Applicants who choose to come to the welfare office are seen within 10 to 20 minutes of arrival, even without an appointment. A single interview with one caseworker and completion of a six-page joint application serves to determine eligibility for all

programs. The caseworker checks all eligibility, irrespective of the programs identified by the applicants. Caseworkers communicate frequently with families to help them complete the application.[16]

M-15
USE CUSTOMER CARDS

Indiana: The previous Indiana Medicaid card was replaced with a Hoosier Health card that resembles a commercial insurance card. Hoosier Healthwise is referred to as health insurance rather than public assistance. Children enrolled in the program are "members" not recipients.[17]

M-16
FOCUS ON MAKING THE CUSTOMER ELIGIBLE

Michigan: Maximus (the State's administrative contractor), local TANF offices and local health departments all accept applications via mail or in person. This means there is a "no wrong door" policy in effect.[18]

Additional Implementation Examples

E-1
USE AUTOMATION LISTEN TO CUSTOMERS

Louisiana: Improving retention started with the development of systems to track the reasons children were losing coverage. Computer codes were initially vague, indicating cases were closed for "failure to cooperate." New codes were established to provide more explicit information, such as "failed to return form," "failed to return verification" or "mail not delivered." Another beginning step was to change the vocabulary used on forms, in manuals and in conversation with program participants. "The word 'redetermination' is welfare-speak," said one State official. "The term, 'renewal' makes more sense to families and is a lot friendlier."

The State piloted a host of new strategies, which now have become part of the renewal process. Caseworkers first search the computer to see if the child is receiving another benefit, such as Food Stamps. If so, the family's income is automatically verified and health coverage is continued. For families whose health coverage cannot be continued automatically, the State created a new, simple renewal form. Although families are asked to return proof of income with the form, if the form is returned without it, coverage will not be terminated if the wage information on the Department of Labor database verifies the child still qualifies. Finally, the State is taking steps to track the performance of local Medicaid offices to ensure caseworkers understand and follow the new procedures. This concerted effort to assure children retain health coverage for as long as they remain eligible is showing success. According to State data, case closures for procedural reasons have declined from around 25 percent to less than 10 percent.[19]

E-2
DEVELOP ELECTRONIC APPLICATIONS AND RENEWALS

California: The State's Medi-Cal (Medicaid) and Healthy Families (SCHIP) programs have an online enrollment application, called Health-e-App, which allows enrollees to apply online with the assistance of Certified Application Assistants.

Georgia: The State's SCHIP program, PeachCare for Kids, launched an online enrollment system in April 2001, in order to enroll children more quickly.

Pennsylvania: The Department of Public Welfare developed COMPASS (the Commonwealth of Pennsylvania Application for Social Services) as part of its initiative to make government services more electronically accessible.

Texas: In September 2001 the State launched an online application that provided a more interactive application process and gave applicants a tentative eligibility determination for SCHIP or Medicaid.

Washington: The State agency developed an online application for general benefits to provide citizens another avenue of access to services.[20]

E-3
IMPROVE LEGIBILITY OF NOTICES

Information provided by Penny Lane, Project Manager, Maximus – The Center for Health Literacy and Communication Technologies. (Examples: http://www.cortidesignhost.com/maximus/chl/ourwork.asp)

What makes an easy-to-read/use notice or application?

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

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

E-4
ELIMINATE ASSET TESTS

Arkansas: The State, which expanded Medicaid under a Section 1115 waiver, eliminated the asset test for children who qualify for "regular" Medicaid under the State's pre-expansion income guidelines, a rule that already applied to children who qualify under the expansion guidelines.

North Dakota: The State enacted legislation to drop the asset test for Medicaid, a step it already had taken in its separate SCHIP program. The State implemented this change in January 2002.

Forty-four states, including the District of Columbia, disregard assets in determining eligibility for children in Medicaid and in their separate SCHIP programs.[21]

E-5
SIMPLIFY AND IMPROVE THE PROCESS FOR CUSTOMERS TO PROVIDE INFORMATION

PROVIDE TRAINING

New Jersey: The State agency trained receptionists to have more policy knowledge to better direct clients to the appropriate staff. If the client is requesting Medicaid, the receptionist has been trained to allow clients to complete the Medicaid application on site, therefore the client does not have to take the application out of the office with the intent of mailing it back.[22]

E-6
STANDARDIZE POLICIES AND PROCEDURES ACROSS PROGRAMS (CREATE A FORMAL PROCESS)

Pennsylvania: ("Any form is a good form") Rather than develop a common form across programs, Pennsylvania developed common data items to use across programs.[23]

Supporting Families Breakthrough Series Collaborative Improvement Strategies Tested And/Or Implemented

SF-1
IMPROVE LEGIBILITY OF NOTICES

Maine:
Revised 21 notices and the renewal form

The improvement team assembled a forms rewrite group, which consisted of program manager and administrator, assistant attorney general, field staff, *Covering Kids* team members and a representative from the Bureau of Medical Services. Revised forms also were sent to advocate groups and field offices for input.

The team reviewed forms in existence before implementation and forms generated by ACES, and interviewed clients to get their input on how the forms could be improved.

Maine utilized the services of Penny Lane, a consultant from Maximus – The Center for Health Literacy and Communication Technologies, who also served as a member of the Collaborative faculty.

Alabama:
Revised ALL Kids/Medicaid application
Utilizing the services of project team members, other staff, clients, advocates and Collaborative faculty member, Penny Lane, the application has been revised and implemented.

Cuyahoga County, Ohio:
Revised the Customer Satisfaction Survey

The Customer Satisfaction Survey had been in use in Cuyahoga County prior to the Collaborative. The process to revise it came as a follow-up to customer satisfaction being determined as one of the balancing measures for changes in the Collaborative. With the help of Penny Lane, Collaborative faculty member, the form was revised to make the questions simpler and the card larger so that it is easier to read. The response rate for May 2003 was up to 11 percent over 6 percent in April 2003, which was the first month the revised form was in use.

Connecticut:
Revised the envelopes included with the renewal notice to include the HUSKY logo instead of the State seal

This change became effective October 2001, and was designed to allow for forwarding of agency mail. It resulted in a decrease from 25 percent to 17 percent in the number of case closures due to clients not returning the renewal form.

Minnesota:
Revised the closure notice

The improvement team surveyed workers to get their ideas on what works and what needs to be

changed. They also interviewed potential and current enrollees with specific questions about the notices. Based on this input the closure notice was revised and enrollees were asked for feedback. The notice was piloted for three months at two sites, with the full pilot beginning May 2003. They were unable to substitute the new notice for the existing notice so the clients at the pilot sites received two notices. The results will be used to revise all notices for "HealthMatch," Minnesota's new eligibility system.

Los Angeles County, California:
Returned mail project generated the redesign of the redetermination envelope

Data showed that approximately 8 percent of Medi-Cal cases are terminated for the reason "whereabouts unknown." The county decided to review the mail returned by the post office, try to obtain a correct address and resend the mail. This did not produce the desired results, but it did draw attention to the fact the agency was being charged postage on the returned mail due to insufficient postage. This generated a redesign of the return envelope that is sent with the redetermination form. The envelope was redesigned to include a reminder message to clients to attach appropriate postage.

SF-2
SIMPLIFY AND IMPROVE THE PROCESS FOR CUSTOMERS TO PROVIDE INFORMATION

Minnesota:
Piloted phone applications in MinnesotaCare

Callers requesting an application were offered the opportunity to complete the application over the phone. Completed applications were then mailed out for a signature. A letter listing all verifications needed was mailed out with the application. There were 288 calls taken; 153 requested completion over the phone and 135 blank forms were mailed out. The eligibility rate for phone applications that were mailed out and returned was higher than the eligibility rate for those applicants who received a blank form to complete on their own.

Both groups took the same length of time to return the application – an average of 14 days.

Georgia:
Customer service representatives ask for address changes at each contact

They request updated contact information with each contact with recipients and that information is forwarded to the appropriate site.

Alabama:
Self-declaration of age and child care expenses

There has been a reduction in paperwork and the process of applying for and attaining eligibility has become a more family friendly process.

Connecticut:
Self-declared income and ex parte renewals

Effective July 2001, family income could be self-declared by the applicant/recipient, and information already verified from other Department of Social Services programs could be used for renewals of ongoing eligibility. (This initiative coupled with the HUSKY envelopes described on the previous page has helped reduce the percentage of cases discontinued at time of renewal by 4 percent for HUSKY A and 14 percent for HUSKY B.)

Georgia:
Passive renewal to reduce closures for procedural reasons and to increase caseworker efficiency

Renewal letters with preprinted case information (income, family composition, etc.) were sent to 50

families due for renewal in January 2003, 75 families due for renewal in February 2003 and 75 families due for renewal in March 2003. The letters sent in February 2003 included recommended changes such as a "return by" date. The form was only to be returned if there were no changes to be reported or made. Coverage for recipients who did not return the form was continued. For the month of February 2003, 7 out of the 50 returned the form with changes which is an indication that approximately 86 percent of the cases remained eligible without any required action from the recipient. All indications are that implementation of the passive renewal process will significantly decrease the number of procedural closures. As a follow-up to this Georgia also attempts to make contact with a certain percentage of the cases who did not return the form to ensure the cases are truly eligible. It is a validation of the passive renewal process.

Delaware:
Short renewal form letter (passive renewal)

The project team obtained suggestions from the pilot field office, and had the form reviewed by the policy administrator to confirm that no signature was required. They obtained suggestions from other field staff. Two staff members tested the form for two months. The results were that more families were successfully renewed to have their coverage continued. The utilization of the new form did not decrease the number of families who did not return the form. Based on staff enthusiasm for the form and the process, the form was to be automated for all staff.

Cuyahoga County, Ohio:
Pre-filled applications

The County is in the process of developing the preprinted application with information provided by the state each month. The information to be pre-populated is information that likely will not change. Those fields include birth dates, Social Security numbers and the names of household members. The information to be completed by the recipient includes income and insurance information. The first test was to make sure the form printed correctly. They were still in the testing phase for developing the form as of June 11, 2003. The intended final result would be that the first page of the form will have all the household information filled out, and clients would only have to complete one or two blocks on page two, sign it, attach income verification and return the form in a postage paid envelope for recertification. The redesign of the delivery envelope was rolled into this process also to try to increase the rate of delivery for agency mail. There are no final results to report.

Connecticut:
Pre-filling HUSKY A renewal forms

Effective June 2002, HUSKY A (Medicaid) renewal forms are pre-filled with client and household data.

Alabama:
Preprinted renewal forms

The first preprinted or semi-passive renewal forms went out in August for October 1, 2003, renewals. Data are still being analyzed.

Washington:
Preprinted renewal forms

Beginning April 1, 2003, simplified preprinted recertification forms were mailed to clients due for renewals. All fields are prepopulated and the client is asked to sign and return the form if information is correct or change, sign and return with corrections. The Collaborative team is discussing the need for a signature and the potential for a more passive approach.

SF-3
ELIMINATE UNNECESSARY VERIFICATION

Alabama:
Elimination of birth date verification in both SCHIP and Medicaid

During the first two years of the ALL Kids program, for any application void of a birth certificate, the declared birth dates were checked against vital records in the Alabama Department of Public Health. It was determined that birth dates were declared correctly. Given this information, and the fact that it was a burdensome process for both the families and enrollment staff, birth date verification was eliminated.

SF-4
ELIMINATE FACE-TO-FACE INTERVIEW REQUIREMENTS

Nassau County, New York:
Medicaid recertification by mail: change form

New York State (NYS) recently moved to a mail-in process for Medicaid recertification. Clients are required to complete the recertification form and mail it to DSS even if there has been no change to the application data. In an effort to reduce barriers to recertification, NYS will soon release a change form that simplifies the Medicaid mail-in recertification process. The change form provides recertification data already on file with DSS with a request that the clients manually update the data as appropriate or indicate no change and mail the form back to DSS.

Alabama:
Elimination of interview process at SOBRA Medicaid annual review

SF-5
FOLLOW UP WITH CUSTOMERS PRIOR TO CLOSURE/DENIAL

Georgia:
Caseworker intervention to increase renewal percentage by making follow-up phone calls to recipients who had not returned renewal forms

Georgia's automated system automatically closes a case at redetermination unless the worker indicates a review has been completed. Workers only handle cases after the redetermination form has been returned. To prevent the system from closing cases, the decision was made to have the workers intervene by overriding the system at the beginning of the month indicating that the review had been completed. They did this with the Right from the Start Medicaid cases (Poverty Level Children). A reminder letter was mailed and a telephone contact was attempted with each family who had not returned their form. The test was run for two months and the data were basically inconclusive. In September 2002 the number of cases remaining eligible was 44 percent, which was a decrease of 4 percent from the previous month. The month of October 2002 showed 55 percent of the cases remained eligible, which was an increase of 7 percent from August 2002. No other data were captured during this test.

Minnesota:
Reminder telephone calls to cases about to be denied

Enrollment representatives made reminder telephone calls to applicants whose cases were about to be

denied for failure to provide verifications. They explained to the applicants what additional information was needed, along with how and where to send the information. Applicants were also given a deadline date for when it was needed.

In the 2 months of the pilot, the number of denials for failure to comply with procedures dropped 37 percent from the previous 5-month average.

Los Angeles County, California:
Retention worker

Data sources indicate that a common reason for closures and denials is at clients' request. Los Angeles devised the idea of a retention worker. The responsibility of this worker would be to follow up with clients who have requested their case be closed. By developing a script based on certain scenarios, the worker would call the client/applicant to educate them on the importance of retaining coverage and attempt to convince them to remain enrolled if they continue to meet the eligibility requirements.

No results have been documented yet, but all indications are that this practice should eliminate or reduce the number of cases closed at clients' request.

Washington:
Outreach workers contacted families

Outreach workers focused on recipients whose cases were due for renewal. They contacted the families who had received assistance from them during the enrollment process to see if they needed assistance completing the review. Some of the calls resulted in the clients requesting a face-to-face interview, and some completed the process over the telephone. The test results revealed that the time of the call must be taken into consideration.

Alabama:
Follow-up phone calls to recipients who failed to return renewal forms

Approximately 25 percent of cases due for renewal in ALL Kids did not return their renewal forms. Alabama instituted a phone call to determine the reason for non-renewal. The initial survey resulted in the re-enrollment of 2 children out of 28 children who were potentially eligible to re-enroll. It was determined that this group of non-responders warranted further investigation, so a summer intern was hired to do further analysis and to develop a process to retain these enrollees. The focus is on the Public Health Area 2 (7 counties) July 1, 2003, renewals and will follow up this process with written results which will be shared at a later date.

Nassau County, New York:
Follow-up contact with clients who fail to appear for their scheduled appointments for renewal

The Department of Social Services implemented a telephone survey to enhance Medicaid enrollment and retention by reaching out to clients to confirm receipt and understanding of mailed recertification packets. Eighty-two percent of the cases in the test group were recertified or were awaiting documentation while only 48 percent in the control group were recertified or awaiting documentation. The conclusion was that telephone calls made to Medicaid recipients doing mail-in recertification are a way to induce compliance and that personal contact has a positive enhancement quality. Survey results will be used to enhance the mail recertification process.

SF-6
MATCH STAFFING TO NEEDS

SF-7
USE VARIABLE WORK SCHEDULES

Nassau County, New York:
Enhancing Medicaid accessibility: interview staffing and scheduling

The Medicaid community care interview staff increased by 44 percent, from 16 to 23, decreasing wait times for interviews. After five weeks, application wait time reduced from eight weeks to four weeks. They also experimented with non-traditional hours by staying open until 8 P.M. on Thursday nights.

SF-8
OUTSTATION ELIGIBILITY WORKERS

Nassau County, New York:
Accepting Medicaid applications at community sites

The Department of Social Services is entering into an agreement with an outside agency to take Medicaid applications, reducing the application workload of main office Medicaid staff and freeing up time to address client issues.

Minnesota:
On-site enrollment with *Covering Kids & Families* project

MinnesotaCare enrollment representatives are located at New Family Center school enrollment site in South Minneapolis one day each week to assist families with applications.

SF-9
GIVE PEOPLE ACCESS TO INFORMATION

Delaware: Developed the Verification Checklist

The improvement team conceived the idea of testing the knowledge level of staff in the field to generate discussion between staff members about the differences in verification requirements between programs. The test results indicated staff was requiring verification for elements that were not mandatory. The test was taken a step further by checking to see if the automated system was forcing workers to enter unnecessary information for Medicaid. The automated system was found to present a barrier to completing applications and renewals by requiring the entry of unnecessary information.

As a follow-up to the Verification Checklist, the supervisor reviewed cases that had been completed the month prior to the development of the Verification Checklist. This review revealed that in some of the cases where the eligibility determination process had begun prior to the pilot of the checklist, workers were requesting verifications not required or needed. The review also revealed that the case could be processed without any additional verification from the client.

This document was further revised by pilot staff and generated the development of a training module that was implemented statewide in 2003.

Los Angeles County, California:
Modified the Verification Checklist

The project team obtained a copy of the Verification Checklist from Delaware after it was presented at LS 2. They made the necessary modifications for California and Los Angeles County and tested staff on the verification requirements. As found in Delaware, staff was requiring verification that was not required. When dealing with the disparity in

knowledge level, staff looked at the number of years with the agency as well as the number of years staff had been in Medicaid. They also looked at whether staff had worked in program areas where the verification requirements were more stringent.

This analysis helped to identify training needs and structure the training according to the dynamics of the staff.

The results also generated the development of the monthly *Medi-Cal Verification Q & A Newsletter*.

San Bernardino County, California:
Modified the Verification Checklist

The team received a copy of the checklist from Los Angeles, which had already made the appropriate modifications for California. A quiz was given to staff and the results were compiled to show factors over-verified and under-verified.

Of the 35 factors included in the quiz, only 1 was answered correctly by 100 percent of workers. The results of the quiz generated the creation of a desk reference card that shows all eligibility factors and the correct verification requirements. This card was distributed to all Medi-Cal staff in the county. An analysis of the results also indicated that there might be a need to revise the Medi-Cal handbook for clarification.

They also created the *Pass It On…* newsletter, which was developed to communicate the goals of the project and the importance of staff in successful enrollment and retention efforts. The first issue was published April 2003.

Cuyahoga County, Ohio:
Included all programs in the Verification Checklist

County staff enhanced the Verification Checklist further by incorporating verification factors for all benefit programs. The purpose of the checklist is to streamline the eligibility determination process by ensuring that staff is requiring verifications in a consistent and uniform fashion. Development is complete and staff has been trained.

SF-10
PROVIDE TRAINING

Alabama:
Trained enrollment workers

Realizing that a number of cases were bouncing back and forth between Medicaid and ALL Kids (TIGGER cases), the Alabama Department of Public Health developed training for enrollment workers to provide knowledge on the proper calculation of monthly income as it relates to the two programs. The training reduced the number of TIGGER cases from 3 percent to 1.6 percent.

SF-11
USE EX PARTE REVIEW SOURCES

Connecticut:
Self-declared income and ex parte renewals

Effective July 2001 family income can be self-declared by the applicant/recipient, and information already verified from other DSS programs can be used for renewals of ongoing eligibility.

SF-12
COLLOCATION OF ELIGIBILITY WORKERS

Alabama:
Medicaid outstation workers are now located in the SCHIP office

This change helped facilitate a seamless transfer of 16 percent of ALL Kids enrollees who met Medicaid income eligibility requirements at their annual review.

SF-13
USE REMINDERS FOR ELIGIBILITY WORKERS AND CUSTOMERS

Los Angeles County, California:
Redetermination envelope redesign

Because the return envelope was oversized and required additional postage, redetermination packets were delayed. Now, a reminder message on the return envelope used during the redetermination process advises the recipient to attach appropriate postage.

Alabama:
Revised SCHIP renewal letter that now reflects outstanding premium amount

The ALL Kids intensive renewal and retention study resulted in procedural changes that decreased the number of non-renewals due to non-payment of premium from 5 percent to 1 percent.

San Bernardino County, California:
Reminders on envelopes

Workers were consistently doing follow-up contact with customers to remind them to sign applications or provide additional documentation before the renewal process could be completed. The workers were surveyed for input on the issues about which customers were most frequently reminded. Labels were made and attached to the return envelope based on input from workers. This strategy significantly decreased the number of follow-up contacts needed and has been implemented countywide.

Washington:
Postcard reminders for renewals

Outreach workers at two outreach sites (Clark County and Puget Sound Neighborhood Health Centers) focused on clients who had enrolled a year prior and therefore were due for renewal. They sent postcard reminders to clients and tracked their response. Puget Sound Neighborhood Health Centers is developing an "electronic postcard" process.

SF-14
STANDARDIZE POLICIES AND PROCEDURES ACROSS PROGRAMS

IMPROVE COORDINATION BETWEEN PROGRAMS

Minnesota:
Efforts to coordinate between programs

Efforts to coordinate between programs included testing and implementing a new referral form, testing and implementing a fax process and surveying workers regarding case notes with the goal of promoting consistency between agencies. The MinnesotaCare program hosted a site visit for Medicaid agencies and they agreed to collocate workers beginning in July 2003.

SF-15
LISTEN TO CUSTOMERS

Los Angeles County, California:
Participant glossary

Applicants and recipients do not always understand the terminology used on State-mandated forms. The project team reviewed mandatory State forms, conducted staff interviews and received input from community workgroups to develop the participant glossary.

SF-16
DEVELOP ELECTRONIC APPLICATIONS AND RENEWALS

Georgia:
The PeachCare (SCHIP) application is on the Internet

The PeachCare application became available on the Web in April 2001. Currently about one-third of the applications received are via the website, with 23 percent of those saying they would not

have applied had the application not been accessible on the Web.

SF-17
SYNCHRONIZE ELIGIBILITY PERIODS

DO TASKS IN PARALLEL

Maine:
Rolling review/12-month review

The impact of the rolling review cannot be fully assessed because of the uncertainty of the data being produced by ACES.

ACES had been auto-closing MaineCare in error for any review not returned for other programs. There is only one review date recorded in ACES. Currently, if a review is returned by the deadline, even if not complete, MaineCare remains open. If the review is not returned, the MaineCare is closed but children under the age of 19 still get their 12 months of continuous coverage.

All programs changed to 12-month reviews in June 2003. The impact of the change is unknown at this time.

SF-18
WORK DOWN BACKLOG

Nassau County, New York:
Workload backlogs: targeted overtime project

The targeted overtime program was implemented to address the specific backlog in Prenatal Care Assistance Program (PCAP) and to control lengthy delays in application processing. Under the targeted overtime project, DSS assessed the Medicaid program areas of greatest need and authorized overtime to address these specific backlogs. The backlog has been eliminated. At project start date, 850 applications were waiting more than 30 days for processing. After 7 weeks there were no applications waiting more than 30 days for processing. Staff processing PCAP applications was increased by 2.

SF-19
FOCUS ON THE OUTCOME TO A CUSTOMER

Minnesota:
Online credit card payments

They are currently testing a website that can be accessed by enrollees to pay their premium by credit card or by authorizing payment from their checking account. Payments are credited to their accounts overnight. Enrollees who were first offered the credit card option a year ago continue to use it. The numbers who utilize this service continue to grow. They are now processing thousands of credit card and online payments.

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[15]Ibid., 60-61.

[16]Pavetti. *Promoting Medicaid and Food Stamp Participation*, 43

[17]Rosenbach. *Implementation of the State Children's Health Insurance Program*, 61.

[18]Ibid., 55.

[19]Donna Cohen Ross and Laura Cox. *Enrolling Children and Families in Health Coverage: The Promise of Doing More*. (Washington, DC: The Henry J. Kaiser Family foundation, 2002), 17.

[20]Brendan Krause. *"Enrollment Hits the Web: States Maximize Internet Technology in SCHIP and Medicaid"* (May 29, 2002) http://www.nga.org/cda/files/SCHIPTECH053002.pdf

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TEAM ACTIVITIES AND ACCOMPLISHMENTS

During the course of the *Supporting Families* Breakthrough Series Collaborative, participating teams attempted to change processes that were not working. With the sharing of information among all the participants, teams occasionally duplicated ideas that originated elsewhere and also modified them for their particular situation. Sometimes the original idea was improved; the results were then shared with the group and even further modifications made.

Following are the ideas and changes that took place during the Collaborative, along with the results.

FOLLOW-UP CONTACT PRIOR TO DENIAL/CLOSURE

Minnesota: Reminder telephone calls to cases about to be denied

Enrollment representatives made reminder telephone calls to applicants whose cases were about to be denied for failure to provide verifications. They explained to the applicants what additional information was needed, along with how and where to send the information. They were also given a deadline date for when it was needed.

In the two months of the pilot, the number of denials for failure to comply with procedures dropped 32 percent from the previous 5-month average.

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Nassau County, New York: Follow-up contact with clients who fail to appear for their scheduled appointments for renewal

The Department of Social Services implemented a telephone survey to enhance Medicaid enrollment and retention by reaching out to clients to confirm receipt and understanding of mailed recertification packets. Eighty-two percent of cases in the test group were recertified or awaiting documentation while only 48 percent in the control group were recertified or awaiting documentation.

Telephone calls are a way to induce compliance of Medicaid recipients who use mail-in recertification, and personal contact has a positive enhancement quality. Survey results will be used to enhance the mail recertification process.

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Georgia: Caseworker intervention to increase renewal percentage by making follow-up phone calls to recipients who had not returned renewal forms

Georgia's automated system automatically closes a case at redetermination unless the worker indicates a review has been completed. Workers handle cases only after the redetermination form has been returned. To prevent the system from closing cases they decided to have the workers intervene by overriding the system at the beginning of the month indicating that the review had been completed. They did this with the Right from the Start cases (Poverty Level Children). A reminder letter was mailed and a telephone contact was attempted with each family who had not returned their form. The test was run for two months and the data were basically inconclusive. In September 2002 the number of cases remaining eligible was 44 percent, which was a decrease of 4 percent from the previous month. The month of October 2002 showed 55 percent of the cases remained eligible, which was an increase of 7 percent from August 2002. No other data were captured during this test.

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Los Angeles County, California: Retention worker

Data sources indicate that a common reason for closures and denials is at clients' request. Los Angeles developed the idea of a retention worker. The responsibility of this worker would be to follow up with clients who have requested their case be closed. By developing a script based on certain scenarios, the worker would call the client/applicant to educate them on the importance of retaining coverage and attempt to convince them to remain enrolled if they continue to meet the eligibility requirements.

Preliminary results for this strategy show that from the 46 referrals that were made to the retention worker, the intervention resulted in 31 of the clients retaining coverage. This is an indication that this strategy would be beneficial to clients who may have a misunderstanding of eligibility criteria.

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Washington: Outreach workers contacted families

Outreach workers focused on recipients whose cases were due for renewal. They contacted the families who received assistance from them during the enrollment process to see if they needed assistance completing the review. Some of the calls resulted in the clients requesting a face-to-face interview and some completed the process over the telephone. The results indicated the time of the call is significant and should be taken into consideration.

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Alabama: Follow-up phone calls to recipients who failed to return renewal forms

The goal was to decrease the number of non-renewals for cases that were due to renew in the month of December 2002. Baldwin County was selected for this test population and targeted the 37 recipients who did not renew in this month. Follow-up phone calls were placed to each of these 37 recipients' homes.

Of the 37 recipients who did not renew, 7 (5 percent) had outdated contact information; 19 (13 percent) did not return the call and contact was made with 11 (7 percent) of these non-renewals. Of the 11 contacted, 3 (2 percent) were on Medicaid, 6 (4 percent) did not receive or misplaced the renewal form and 2 (1 percent) were renewed due to this phone call. This PDSA cycle was not repeated.

During the summer of 2003, a project similar to the one described above was conducted. The goal of this project was to decrease the number of non-renewals due to renew in July 2003 by placing follow-up calls to these recipients. Public Health Region 2 (7 counties) was selected for this test population and the 101 non-renewals were targeted for follow-up calls.

Of the 101 non-renewals, 13 were not contacted due to being on Medicaid, over age limit or having a duplicate application in the system. Of the contacted recipients, 19 renewed, 16 were referred to Medicaid, 2 were referred to Alabama Child Caring Foundation, 13 were on private insurance and 38 either did not send in the renewal or were pending after this project was completed.

The final impression was that recipients contacted by phone were much more likely to return a renewal form than those contacted by letter. Several recipients' contact information was incorrect which resulted in no communication. It also was found that an outstanding premium payment was cause for non-renewal. Of 28 recipients who owed a premium, 15 had not paid by the due date, thus causing a non-renewal of coverage. This project has not been repeated to date.

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PASSIVE RENEWAL/PREPRINTED RENEWAL FORMS

Georgia: Passive renewal to reduce closures for procedural reasons and to increase caseworker efficiency

Renewal letters with preprinted case information (income, family composition, etc.) were sent to 50 families due for renewal in January 2003, 75 families due for renewal in February 2003 and 75 families due for renewal in March 2003. The letters sent in February 2003 included recommended changes such as a "return by" date. The form was to be returned only if there were changes to be reported. Coverage for recipients who did not return the form was continued. For the month of February 2003, 7 out of the 50 returned the form with changes, which is an indication that approximately 86 percent of the cases remained eligible without any required action from the recipient. All indications are that implementation of the passive renewal process will significantly decrease the number of procedural closures. As a follow-up to this, Georgia also attempted to make contact with a certain percentage of the cases that did not return the form to ensure the cases are truly eligible as validation of the passive renewal process.

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Delaware: Short renewal form letter

They developed a short renewal form letter with input from the pilot field office and had the form reviewed by a policy administrator to confirm that no signature was required. They obtained suggestions from other field staff. Two staff members tested the form for two months. It was further tested in two offices, and staff offered further revisions to simplify processing. The results were that more families were successfully renewed to have their coverage continued. The utilization of the new form did not decrease the number of families who did not return the form. Based on staff enthusiasm for the form and the process, the form was to be automated for all staff. The renewal form is currently in development and testing in the automated system.

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Cuyahoga County, Ohio: Pre-filled applications

They are currently in the process of developing the preprinted application with information provided by the State each month. The information to be pre-populated is information that likely will not change. Those fields include birth dates, Social Security numbers and the names of household members. The information to be completed by the recipient includes income and insurance information. The first test was to make sure the form printed correctly. The intended final result would be that the first page of the form will have all household information filled out, and clients would be required to complete one or two blocks on page two, sign it, attach income verification and return the form in a postage-paid envelope for recertification. The first edition of the preprinted application has been received with the intent to test it on a group of selected cases in November 2003.

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Alabama: Preprinted renewal forms

The preprinted renewal form was implemented in November 2003. Collection of data on the impact should begin in February 2004.

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Washington: Preprinted renewal forms

Beginning April 1, 2003, simplified preprinted recertification forms were mailed to clients due for renewals. All fields are prepopulated and the client is asked to make any corrections prior to signing and returning the form. The Collaborative team is discussing the need for signature and the potential of a more passive approach. (No data available regarding impact of this change.)

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VERIFICATION CHECKLIST

Delaware: Developed the Verification Checklist

Delaware conceived the idea of testing the knowledge level of staff in the field to generate discussion between staff members about the differences in verification requirements between programs. The test results indicated that staff was requiring verification for elements that were not mandatory. The test was taken a step further by checking to see if the automated system was forcing workers to enter unnecessary information for Medicaid. It was found that the automated system also presented a barrier to completing applications and renewals by requiring the entry of unnecessary information.

As a follow-up to the Verification Checklist the supervisor reviewed cases completed the month prior to the development of the checklist. This review showed that in some cases where the eligibility determination began before the pilot of the Verification Checklist workers were requesting verifications that were not needed. The review of the case allowed it to be processed without additional verification from the client.

This document was further revised by pilot staff and generated the development of a training module that was implemented statewide in 2003.

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Los Angeles County, California: Modified the Verification Checklist

The team obtained a copy of the Verification Checklist from Delaware after it was presented at LS 2. They made the necessary modifications for California and Los Angeles County and tested staff on the verification requirements. As found in Delaware, staff requested unnecessary verification. When dealing with the disparity in knowledge level, staff looked at the number of years with the agency as well as the number of years staff had been in Medicaid. They also looked at whether staff had worked in program areas where the verification requirements were more stringent.

This analysis helped to identify training needs and structure training according to the dynamics of the staff.

The results also generated the development of a monthly *Medi-Cal Verification Q & A Newsletter.*

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San Bernardino County, California: Modified the Verification Checklist

The team received a copy of the checklist from Los Angeles after they had made the appropriate modifications for California. A quiz was given to staff, and the results were compiled to show factors

that were over-verified and under-verified. Of the 35 factors included in the quiz there was only 1 that 100 percent of workers answered correctly. The results of the quiz generated the creation of a desk reference card that shows all eligibility factors and the correct verification requirements. The reference card was distributed to all Medi-Cal staff in the county in September 2003.

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Cuyahoga County, Ohio: Included all programs in the Verification Checklist

County staff enhanced the Verification Checklist further by incorporating verification factors for all benefit programs. The purpose of the checklist is to streamline the eligibility determination process by ensuring that staff is requiring verifications in a consistent and uniform fashion. Development is complete and staff has been trained.

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NOTICES/ENVELOPES/ APPLICATIONS/RENEWALS

Cuyahoga County, Ohio: Revised the Customer Satisfaction Survey

The Customer Satisfaction Survey had been in use in Cuyahoga County prior to the Collaborative. The process to revise it came as a follow-up to customer satisfaction being determined as one of the balancing measures for changes in the Collaborative. With the help of Penny Lane, Collaborative faculty member, the form was revised to make the questions simpler and the card larger so it is easier to read. The response rate for May 2003 was up to 11 percent over 6 percent in April 2003, which was the first month the revised form was in use. The response rate has increased consistently. For June, the response rate was 13 percent, for July it was 15 percent and 15 percent for August. The survey is sent out monthly to 500 randomly selected households. They are continuing to monitor the results and the response rate. The revised survey form also generated more useful information as it related to agency performance.

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Maine: Revised 21 notices and the renewal form

The project team assembled a forms rewrite group, which consisted of program manager and administrator, assistant attorney general, field staff, *Covering Kids & Families* team members and a representative from the Bureau of Medical Services. Revised forms also were sent to advocate groups and field offices for input.

The team reviewed forms generated by ACES and those in use before the ACES implementation.

They interviewed clients to get their input on how the forms could be improved and they utilized the services of Penny Lane, a consultant from Maximus – The Center for Health Literacy and Communication Technologies who is a member of the Collaborative faculty.

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Alabama: Revised ALL Kids/Medicaid application

Utilizing the services of project team members, other staff, clients, advocates and Collaborative faculty member, Penny Lane, the application has been revised and implemented.

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Minnesota: Revised the closure notice

The team surveyed workers to get their ideas on what works and what needs to be changed. They also interviewed potential enrollees and current enrollees with specific questions about the notices. Based on this input the closure notice was revised and enrollees were asked for feedback. The notice was to be piloted for three months at two sites, with the full pilot beginning May 20, 2003. They were unable to substitute the new notice for the existing notice so the clients at the pilot sites received two notices. There were three test groups: Group 1 received both the regular system-generated notice, which could not be suppressed for the test, and the revised notice. Group 2 received the regular notice, then received a second copy of the same notice. Group 3, the control group, received only the regular notice. The response rate was Group 1: 60 percent, Group 2: 68 percent and Group 3: 43 percent. The test was repeated with similar results, which gave enough data to make the decision that notices needed to be improved and simplified. A full time staff person is currently working on a simplified format and new language for the notices to be implemented with HealthMatch, Minnesota's new eligibilty system. No feedback has been received yet, but the results will be used to revise all notices.

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Los Angeles County, California: Returned mail project generated the redesign of the redetermination envelope

Data showed that approximately 8 percent of Medi-Cal cases are terminated for the reason "whereabouts unknown." The County decided to review the mail returned by the post office, try to obtain a correct address and resend the mail. Doing this did not produce the desired results, but it did draw their attention to the fact the agency was being charged for insufficient postage on the returned mail. This generated a redesign of the return envelope that is sent with the redetermination form. The envelope was redesigned to include a reminder message to clients to attach appropriate postage.

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OUTSTATION ELIGIBILITY WORKERS

Nassau County, New York: Accepting Medicaid applications at community sites

The Department of Social Services is entering into an agreement with an outside agency to take Medicaid applications, reducing the application workload of main office Medicaid staff and freeing up time to address client issues.

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Alabama: Medicaid outstation workers are now located in the SCHIP office

This change helped facilitate a seamless transfer of 16 percent of ALL Kids enrollees who met Medicaid income eligibility requirements at their annual review.

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Minnesota: On-site enrollment with *Covering Kids & Families* project

A MinnesotaCare enrollment representative is located at the New Family Center school enrollment site in South Minneapolis one day each week to assist families with applications.

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SIMPLIFY AND IMPROVE THE PROCESS FOR CUSTOMERS TO PROVIDE INFORMATION

Minnesota: Piloted phone applications in MinnesotaCare

Callers requesting an application were offered the opportunity to complete the application over the phone. Completed applications were then mailed out for a signature. A letter listing all verifications needed was mailed out with the application. There were 288 calls taken; 153 requested completion over the phone and 135 blank applications were mailed out. The approval rate for phone applications that were mailed out and returned was higher than for those that were mailed for recipients to complete on their own.

Both groups averaged 14 days to return the application.

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Georgia: Customer Service Representatives ask for address changes at each contact

They request updated contact information with each contact with recipients and that information is forwarded to the appropriate site.

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Alabama: Self-declaration of age and child care expenses

There has been a reduction in paperwork and the process of applying for and attaining eligibility has become a more family friendly process.

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ELIMINATE UNNECESSARY VERIFICATION

Alabama: Elimination of birth date verification in both SCHIP and Medicaid

During the first two years of the ALL Kids program, for any application void of a birth certificate, the declared birth dates were checked against vital records in the Alabama Department of Public Health. It was determined that birth dates were declared correctly. Given this information and the fact that it was a burdensome process for both the families and enrollment staff, there was an elimination of birth date verification.

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DEVELOP ELECTRONIC APPLICATIONS AND RENEWALS

Georgia: The PeachCare (SCHIP) application is on the Internet

The PeachCare application became available on the Web in April 2001. Currently about one third of the applications received are via the website, with 23 percent of those saying they would not have applied had the application not been accessible on the Web.

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USE REMINDERS FOR ELIGIBILITY WORKERS AND CUSTOMERS

Alabama: Revised SCHIP renewal letter that now reflects outstanding premium amount

The ALL Kids intensive renewal and retention study resulted in procedural changes that decreased the number of non-renewals due to non-payment of premium from 5 percent to 1 percent.

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Los Angeles County, California: Redetermination envelope redesign

Because the return envelope was oversized and required additional postage, redetermination packets were delayed. Now, a reminder message on the return envelope used during the redetermination process advises the recipient to attach appropriate postage.

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San Bernardino County, California: Reminders on envelopes

Workers were consistently doing follow-up contact with customers to remind them to sign applications or provide additional documentation before the renewal process could be completed. The workers were surveyed for input on the issues about which customers were most frequently reminded. Labels were made and attached to the return envelope based on input from workers. This strategy significantly decreased the number of follow-up contacts needed and has been implemented countywide.

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Washington: Postcard reminders for renewals

Outreach workers at two outreach sites (Clark County and Puget Sound Neighborhood Health Centers) focused on clients who had enrolled a year prior and therefore were due for renewal. They sent postcard reminders to clients and tracked their response. Puget Sound Neighborhood Health Centers is developing an "electronic postcard" process.

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ROLLING REVIEW/12-MONTH REVIEW

Maine: Rolling review implemented January 2003; MaineCare uses information obtained in most recent review for Food Stamps/TANF

The impact of the rolling review cannot be fully assessed because of the uncertainty of the data being produced by ACES.

ACES had been auto-closing MaineCare in error for any review not returned for other programs. There is only one review date recorded in ACES. Currently, if a review is returned by the deadline, even if not complete, MaineCare remains open. If the review is not returned, the MaineCare is closed but children under the age of 19 still get their 12 months of continuous coverage.

All programs will change to 12-month review in June 2003. This has not been fully implemented so the impact is unknown at this time.

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MATCH STAFFING TO NEEDS
USE VARIABLE WORK SCHEDULES

Nassau County, New York: Enhancing Medicaid accessibility – interview staffing and scheduling

Medicaid community care interview staff increased by 44 percent – from 16 to 23, resulting in decreased wait times for interviews. After 5 weeks, application wait time reduced from 8 weeks to 4 weeks. They also experimented with non-traditional hours by staying open until 8 pm on Thursday nights. Although the initial response to the evening hours was not significant, the County staff felt that increased publicity could improve the results.

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WORK DOWN BACKLOG

Nassau County, New York: Workload backlogs – targeted overtime project

The targeted overtime program was implemented to address the specific backlog in Prenatal Care Assistance Program (PCAP) and to control lengthy delays in application processing. Under the targeted overtime project, DSS assessed the Medicaid program areas of greatest need and authorized overtime to address these specific backlogs. The backlog has been eliminated. At project start date, 850 applications were waiting more than 30 days for processing. After 7 weeks there were no applications waiting more than 30 days for processing. Staff processing PCAP applications was increased by 2 FTEs.

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LISTEN TO CUSTOMERS

Los Angeles County, California: Participant glossary

Applicants and recipients do not always understand the terminology used on State-mandated forms. The project team reviewed mandatory State forms, conducted staff interviews and received input from community workgroups to develop the participant glossary.

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ELIMINATE FACE-TO-FACE INTERVIEW REQUIREMENTS

Nassau County, New York: Medicaid recertification by mail – change form

New York State recently moved to a mail-in process for Medicaid recertification. Clients are required to complete the recertification form and mail it to DSS even if there has been no change to the application data. In an effort to reduce barriers to recertification, NYS will soon release a change form that simplifies the Medicaid mail-in recertification process. The change form provides recertification data already on file with DSS with a request that the clients manually update the data as appropriate or indicate no change and mail the form back to DSS.

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Alabama: Elimination of interview process at SOBRA Medicaid annual review

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IMPROVE COORDINATION BETWEEN PROGRAMS

Minnesota: Improve coordination between Medicaid and MinnesotaCare

Efforts to improve coordination between programs include testing and implementation of a new referral form, testing and implementation of a fax process and surveying workers regarding case notes with the goal of promoting consistency between agencies. The MinnesotaCare agency hosted a site visit for the Medicaid agencies and they agreed to collocate workers beginning in July 2003.

There was a measurable improvement when the new form and fax process was initiated with Ramsey County. The new form was rolled out to other counties, but there is no measurement to tell whether the process has improved. The next step with Ramsey is collocating workers (Medicaid worker at MinnesotaCare and vice versa). The collocation with Ramsey should provide hard data to support this.

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GIVE PEOPLE ACCESS TO INFORMATION

San Bernardino County, California: *Pass It On…* newsletter

Arrowhead Supports Kids "ASK" is a project that promotes maximizing the enrollment and retention of Medi-Cal customers in San Bernardino County. The newsletter was developed to communicate with

staff to explain the project goals and the importance of staff to success. The first issue was published April 2003.

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FOCUS ON THE OUTCOME TO A CUSTOMER

Minnesota: Testing a website that can be accessed by enrollees to pay their premium by credit card or by authorizing payment from their checking account

Enrollees who were first offered the credit card option a year ago continue to use it. The number of recipients who utilize this service continues to grow. They are now processing thousands of credit card and online payments. MinnesotaCare premium bills go out around mid-month (date varies from month-to-month), and include a special announcement of the availability of Web payment by either credit card or checking account debit.

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ELIMINATION OF APPOINTMENT SYSTEM

Nassau County, New York: Elimination of Appointment System for Community Medicaid Applications

To prevent the continuing buildup of a backlog of applications that had grown to approximately 7,500 for Community Medicaid, a decision was made to implement a new procedure for the acceptance and review of applications.

Effective November 1, 2003, the staff assigned to Community Medicaid was reorganized. Three units totaling 20 workers were assigned responsibility for all new applications received after November 1, 2003. Part-time workers were assigned to conduct all application interviews on a walk-in basis, eliminating the requirement to call for an appointment.

An additional group of 10 workers were assigned the responsibility to review and process all pending Community Medicaid applications received prior to November 1, 2003, (approximately 7,500).
At the time of the application interview the applicant is given a list of the documentation requirements required to process their case and advised that they have 10 days to return the documentation.
If an applicant appears for an interview and has all required documentation with them, the case is given to a supervisor for assignment to a worker who will review and make an eligibility determination.

For those applications awaiting the return of documentation, the case remains with a supervisor for 10 days (the amount of time the applicant has been given to return requested documentation) and is then assigned to a worker for review and eligibility determination.

The 20 workers in the 3 units are assigned on a rotating basis as "worker of the day" to respond to telephone calls, review incoming mail/ documentation, pass cases on to the supervisor when all documentation is received or when 10 days for return have past. For productivity projections they planned for 20 workers minus 3 workers of the day, an additional 3 workers out of the office for any reason (training, vacation, sick, etc.) leaving 14 workers processing cases each workday.

Current monthly application volume for Community Medicaid is approximately 2,800 per month. To remain current (process cases within a 30-day period), the 14 workers are expected to process an average of 10 cases each per day. Workers do not have predetermined caseloads but are expected to process the 10 cases assigned to them daily.

There were some start-up bugs that were worked out and they are now experiencing the productivity levels they anticipated. Applications are being processed in 30-40 days from the date of walk-in application as opposed to 60-90 days from request for appointment to completion under the old system.

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GLOSSARY

Action Period: The time between learning sessions when collaborative teams are testing improvement strategies, reporting their activities, sharing with other teams via e-mail, extranet, listserv or conference calls. Teams receive support from the collaborative leadership, faculty and other teams participating in the collaborative. Teams also are making plans for implementing and spreading changes that have been shown to be an improvement.

AFDC: Aid to Families with Dependent Children was a precursor to the current welfare law called Temporary Assistance for Needy Families. AFDC was an entitlement that provided income support to families with children. Families who received AFDC automatically received Medicaid benefits.

Aim: An outcome statement (results) of what a team expects to achieve from testing and implementing a change or improvement.

Annotating: Indicating through a written note (statement) any events that may have caused an unusual fluctuation in the data plotted on run charts. Also could be used to explain any discrepancies in report format, data or any other activities displayed in a report.

Application: A request made by an individual (or on behalf of an individual) to an agency for a Medicaid or SCHIP eligibility decision.

Approval: A decision that an individual meets all eligibility requirements for Medicaid or SCHIP health care coverage.

Assessment: Review of activities with an eye for how the improvement model is being used and the potential for the activities to make significant improvements to reach the goal of the collaborative. A judgment about how something or someone is doing with the collaborative process.

Balancing Measures: Periodic measures taken to determine whether changes that are intended to generate an improvement are causing negative unintended consequences.

Best Practices: Those activities where a change has been tested and implemented, and there is supporting data/documentation that the change accomplished its stated objective. Best practices also can be duplicated in a variety of settings and successfully implemented.

Caseload Number: The caseload number refers to an unduplicated count of the number covered by Medicaid and/or SCHIP at a point in time. It reflects the net change in enrollment by offsetting applications approved with cases closed.

Chair/Co-Chair: The head of the collaborative. This person is usually an expert in the field or topic of the collaborative.

Champion: The person in the agency who strongly supports the goal of the collaborative team and has authority to make things happen.

Change Concept: A general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement. (Ex: Improve customer service.)

Change Strategy (Improvement Strategy): A specific approach to a change concept that should produce the desired results for improvement. (Ex: One way to improve customer service can be to reduce wait time for customer assistance.)

Charter: A statement that documents the gap or problem identified in the collaborative topic. An agreement between the collaborative teams and the faculty on their overall goal and expectations for making improvements related to a specific topic. It helps keep teams focused on the overall goal of the collaborative.

Closure: An eligibility decision to end an individual's Medicaid or SCHIP coverage. A closure results when an individual no longer meets the eligibility requirements or has not complied with an agency request for additional information.

Collaborative: A group of teams and experts who are working toward shared learning and improvement through testing and analysis to generate improvements on a specific topic.

Collaborative Faculty: Experts on a specific topic and on the improvement model who provide guidance, coaching and any technical assistance needed to the collaborative teams.

Collaborative Team: Individuals who have agreed to work together, share learning and make improvements on a specific topic.

Core Measures: The data and factors that are analyzed to let a team know the impact of a change.

Cycle: A series of tests run to assess whether a change strategy has the potential to generate outcomes that impact the collaborative aim.

Day-to-Day Leader (Key Contact – Team Leader): The person responsible for keeping a team's collaborative activities going. This individual also has responsibility for coordination between the collaborative leadership, faculty and team members.

Delivery System Design: The process by which services are provided to, or accessed by, applicants/recipients.

Denial: An eligibility decision to deny an application for Medicaid or SCHIP coverage because the individual does not meet the program eligibility requirements or has not complied with an agency request for additional information.

Director: The person in the collaborative who has responsibility for keeping all teams in the collaborative moving by working with the faculty. This person

also is responsible for planning and coordinating learning sessions and action period activities.

Enrollment: To apply for and become eligible for a particular service or activity.

Extranet: A private, password-protected website for collaborative participants to file reports and share documents.

Goal: The expected outcome of an activity.

Implementation: To put into practice as a permanent part of a process.

Improvement Strategy (Change Strategy): A specific approach to a change concept that should produce the desired results for improvement. (Ex: One way to improve customer service can be to reduce wait time for customer assistance.)

Improvement/Technical Expert: The person in the collaborative leadership who is an expert in process improvement and measurement.

Key Changes: Improvement strategies identified or created by the collaborative faculty that have all indications they will lead to process improvement.

Key Contact (Day-to-Day Leader – Team Leader): The person responsible for keeping a team's collaborative activities going. This individual also has responsibility for coordination between the collaborative leadership, faculty and team members.

Learning Session: A meeting that allows teams who are participating in a collaborative to come together face-to-face to share and learn information from other teams and from the collaborative that will help with testing and implementing changes. It usually lasts for two days.

Measure: The factors a team evaluates to determine whether a change is generating the desired outcome.

Medicaid: A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if one qualifies for both Medicare and Medicaid.

Medicare: The federal health insurance program for people 65 years of age or older, certain younger people with disabilities and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Mission Statement: A declaration of what a particular event or organization is about. The driving charge behind an event or organization's purpose. What the event or organization endeavors to do.

Model for Improvement: An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes.

PDSA (Plan-Do-Study-Act) Cycle:
A structured trial of a process change. It includes: **Plan** – a specific planning phase; **Do** – a time to try the change and observe what happens; **Study** – an analysis of the results of the trial; **Act** – devising next steps based on analysis. The PDSA cycle should lead to the Plan component of the next cycle.

Pilot Site: The location where preliminary testing of proposed changes will be performed.

Planning Group: A group of experts in a particular field along with the collaborative leadership who serve as the core developers of the collaborative topic, charter and change package (improvement strategies), some of whom may remain as a part of the faculty.

Project Coordinator (Project Director): The individual responsible for the collaborative team.

Promising Practices: A change implemented based on the knowledge and expertise of professionals in a particular field where all indications are that the change would be an improvement. There has not been enough data collected to indicate that it would be a best practice.

Pre-work Package (Team Preparation Package): Activities and assignments for teams in a collaborative that helps teams prepare prior to the first learning session.

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Pre-work Period (Team Preparation Period): The time before a learning session that teams use to prepare for a learning session based on the requirements outlined in the team preparation package. Usually 4 to 6 weeks prior to a learning session.

Problem Statement: Written documentation of the gap or breakdown between policy and practice.

Process Change: Changing the way things are done.

Reason Codes: Pre-defined documentation in an automated system or a paper file that tells why a case is closed or denied or why any particular action has been taken.

Renewal (Recertification, Redetermination): Determining the continued eligibility of an individual for Medicaid or SCHIP at specified intervals during the coverage period.

Report Date: The date teams are required to submit data on the core measures of a collaborative as well as complete the team leader report. Each of these reports should be submitted on the extranet.

Report Month/Period: The time covered on the data reports and team leader reports.

Retention: Continuing cases of Medicaid and SCHIP eligibility once they have been determined to be eligible for coverage without any gaps in coverage.

Run Chart: A graphic representation of data over time, also known as a "time series graph." This type of data display is particularly effective for process improvement activities.

Sampling Plan: Documentation of how a collaborative team plans to measure the effects of a change. What data are to be collected, how often and who is the subject of the data collection? This plan may differ by team.

Senior Leader: The person on the collaborative team or in the agency who supports the collaborative efforts and has authority to allocate the resources needed to do the work of the collaborative. This person should have the authority to remove barriers that impede the progress of the team towards an improvement.

Senior Leader Report (Team Leader Report): A report completed by the day to day leader of the collaborative that provides monthly updates on the activities of the collaborative to the senior leader.

Spread: Implementing changes throughout the agency or system that have been tested and proven to be successful.

State Children's Health Insurance Program (SCHIP): The Balanced Budget Act of 1997 created the State Children's Health Insurance Program. The purpose of the program is to provide states with federal funding on a federal-state matching basis to provide more low-income, uninsured children with health coverage through expansions and outreach. States can choose to expand coverage through Medicaid, create a separate health coverage program or implement a combined strategy.

Storyboard: A graphic chronicle of a team's work which showcases the team's activities and is exhibited at each learning session for other teams to review and discuss.

System/Pilot Team Leader: This is the person at the location where tests are being run who has authority over local resources to allow the tests to be run.

TANF (Temporary Assistance for Needy Families): The Temporary Assistance for Needy Families Program became effective July 1, 1997, and replaced what was then commonly known as welfare, or Aid to Families with Dependent Children (AFDC) and the Job Opportunities and Basic Skills Training (JOBS) programs. Its purpose is to provide grants to states, territories or tribes to assist needy families with children so that children can be cared for in their own homes; to reduce dependency by promoting job preparation, work and marriage; to reduce and prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families.

Team: A group of individuals who are working towards the goal of the collaborative. This includes those individuals who are in supportive roles within an agency or several agencies but have some responsibility for making the process work.

Team Leader (Key Contact – Day to Day Leader): This is the person responsible for keeping the collaborative activities going. This person also has responsibility for coordination between the team members and collaborative leadership.

Team Leader Report (Senior Leader Report): Report to be submitted by the team leader that highlights the progress made by the team. It should identify the team aim and all tests run during the report period along with the results of the tests. It should include any unusual or unexpected results and how to deal with those results.

Technical Expert: The person on the collaborative team who has knowledge of the topic of the collaborative and is an expert in the field.

Test: Trying a change to determine the effect on a specific population and/or process.

Test Population: When testing and implementing changes, this is the group that will be impacted the most.

Topic: The subject addressed by the collaborative.

Withdrawals: Requests to discontinue processing of an application for service, prior to an eligibility decision.

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