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Ten Years and Counting: What Have We Learned About Enrolling Kids in SCHIP and Medicaid?
National Academy for State Health Policy
May 21, 2008

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ALAN WEIL: My name is Alan Weil. I am the Executive Director of the National Academy for State Health Policy. We are happy to have you all here this morning. I just want to quickly welcome you on behalf of NASHP with the generous support of the David and Lucile Packard Foundation, NASHP has had privilege of serving as the unofficial home for the nation's SCHIP Director's for now more than a decade, and one of the many pleasure of working with the CHIP Directors is that no matter how bogged down in politics and ideology, the national debate over health reform and children's coverage may get, the state's continue to work on implementing their programs and overcoming the barriers that they confront.

And, so it is a real pleasure today, to be able to bring to Washington, a number of the nation's CHIP Director's to talk about how their approaching the practical issues of running their programs, even in this time of uncertainty about the future of SCHIP.

To run the program today will be Catherine Hess, Senior Program Director at the National Academy for State Health Policy. She leads up our CHIP work and our covering all children work, and I will handed it over to Catherine.

CATHERINE HESS: Thank you.

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Thanks Alan and I will just add my welcomes to Alan's on behalf of the National Academy for State Health Policy. I think you all know and have got a little bit of information about NASHP in your packets. That we are a non partisan organization that works to work across states and across agencies and branches of government to study health policy issues, but more importantly work together on common sense solutions to those problems.

In that vain two years ago, we convened a symposium to look at what we have learned about covering kids as we approach the tenth anniversary of SCHIP. Some of my fellow panelists today were part of that symposium. Some of you in the audience were part of that symposium, some of you watching by webcast. I want to thank the Kaiser Family Foundation for webcasting this session we are part of that symposium.

We summarized the lesson's learned from that expert meeting that convened public and private experts, people at the state and national level, people of all political stripes. The lessons that they suggested we had learned were summarized in a paper called, I will probably get it wrong, *Seven Steps Towards State Success in Covering Children Continuously*, and you will find that paper in your packet.

Two years later, we traced those steps, focusing in very specifically on one, but very important aspect of covering

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kids and that is how we can become more effective in enrolling the kids who are eligible for public programs. That is one slice of what we are up against is we try and reduce the number of uninsured in this country, but it is an important one.

Leading us down the path, retracing those steps will be Alice Weiss, many of you know Alice from her most recent hat, working with the Senate Finance Committee, Alice was instrumental in drafting the Chipper Legislation that was passed on a bipartisan basis couple of times by Congress last year, unfortunately did not make it all the way through. We are very fortunate that Alice joined our staff in the fall last year, to focus on state's, to focus on particularly this issue of how to help state's cover children more effectively.

So, Alice is going to share what we have learned by taking another look at research, and what we have learned by talking further with experts.

She is going to be followed by a panel of state people. These are folks from the West, Midwest and South. They are not representative of state's in the country, except I think in one important respect and that is as Alan indicated, all state's it is safe to say are trying to improve the way that they reach, enroll and retain kids in the programs. We have 36 states with us for these series of meetings.

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And yesterday in our meeting, we had a round of, would have been some of your biggest recent successes and what have been some of your recent challenges. And I would say that outreach enrollment and retention top both lists. States have a lot of accomplishments that they are celebrating, but they have already set out new challenges for themselves that they are grappling with.

So, to share some of those experiences and lessons learned, we have with us Jackie Forba, and I am not going to read all of the information, you have bios in your packets, so I am going to be brief. Jackie has worked with the Montana Children's Health Insurance Plan, Bureau of the Department of Public Health and Human Services since 1999. She was the CHIP Dental and Eyeglass Program Manager from 1999 to 2004, and she has been the Bureau Chief since 2005. She will be followed by Cathy Caldwell.

Cathy Caldwell is the Director of the Bureau of Children's Health Insurance in the Alabama Department of Public Health. She has over nine years of experience in state government working with Alabama's SCHIP Program. And last, on our state group, but not least by any means, is Anne Marie Murphy who is currently the Director of Health Care Programs for the Office of the Illinois Governor. She took this position in January 2007, but she has been working really over

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the past four years in Illinois, and has been instrumental in all of their major health care expansions. She served as the \Medicaid Director and was a prominent, really the leader in developing and implementing the All Kids Program, which she will be talking with us about today.

We have also an additional panelist who will offer some comments, and that is Cindy Mann. Many of you know Cindy as well. Cindy is the Executive Director of the Center for Children and Families. She also is a Research Professor at the Georgetown University Health Policy Institute and an Associate Commissioner with the Kaiser Commission on Medicaid and Uninsured. And Cindy also, it is important to note has both experience at the federal level, she was with CMS, the Centers for Medicare and Medicaid Services at one point, and has done extensive work with states, and so was very knowledgably, both in state and federal health policy and she will offer some comments.

Just before I turn it over to our panelists, I want to thank again the Packard Foundation, also the Kaiser Family Foundation for webcasting and as Alice is going to mention, the Robert Wood Johnson Foundation for supporting the research that we have been doing and the work we have been doing around enrolling eligible kids.

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And my last thing before I sit down for now, is that there cards on all of your tables. As you are listening, if you have questions that come to mind, would really appreciate if you would fill out those cards. There will be staff walking around to collect those. We want to leave plenty of time for questions. We are going to be giving each of our speakers the hi sign when their time is about up, and hopefully we will stick to our time frames and have plenty of time. So without further ado, Alice Weiss.

ALICE WEISS: Good morning everyone. Today I am presenting as Cathy mentioned, today I am presenting on NASHP's recent work to help state's maximize enrollment of eligible children. The discussion today is based on a fourth coming paper which was written with Vikki Wachino, who is here in the audience today. Vikki, raise your hand. And I will just summarize the findings in the paper in this presentation.

For those of you who do not know the National Academy for State Health Policy, NASHP is a non profit, non partisan organization that helps states achieve excellence in health policy. Now in its 21st year, as Cathy mentioned, NASHP has been supporting and reporting on state efforts to improve coverage among children, including work with the SCHIP program for more than a decade.

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Today, state's are at a critical cross road in their efforts to cover kids, and I was searching for the right cultural paradigm to sort of express that, and let us see if we got it right. [Laughter]

So, what my imagery was, the state's are like Dorothy, they have recently been through a twister, SCHIP reauthorization. They have their ruby slippers on, which is their positive intent and support for covering kids, but they face some challenges. They face the wicked witch of budget cuts,[laughter] and they are not quite sure which path to take given their limited time and resources and energy to try to get to the Emerald City of covering kids.

As you see in this picture, this is a recollection of Dorothy meeting the Scarecrow and she says, which way to the Emerald City, and he says, this way.

So, based on that NASHP has been as Cathy mentioned, has been trying to sort of help states find the right path or the best path for them to help them enroll more kids. And this began as Cathy mentioned, with work that we did in 2006, with the symposium that led to this paper that we created that was called, *Seven Steps Towards States Accessing Covering Children Continuously.* And the focus of our work in sort of looking at that paper since then has been, how can we refocus some of the great recommendations that were made by the experts we talk to

then, and sort of sharpen the picture of what really works to help states cover more kids.

And so what we did was, we did a fairly intensive literature review to look at the research and see what we can learn from the past decade of experience that states have. In addition, we surveyed some key state and national experts on these issues and asked for their opinions and as Cathy mentioned, our work in this effort was funded by the Robert Wood Johnson Foundation.

So, any discussion of efforts to cover more uninsured children would be incomplete without a slide like this. This basically shows that nearly two thirds of the uninsured children in the United States are eligible for public programs like Medicaid and SCHIP, but unfortunately unenrolled. So this is really the challenge that states face if they try to improve coverage for all kids and to make end roads on covering more eligible kids.

Also, any discussion about sort of what states need to do going forward, needs to include a slide like this which talks about, why eligible children are not enrolled. This particular chart was taken from our report that was produced by Jenny Kenny and Jennifer Haley, and it sites the top reasons that they found in 2001, that children were not enrolled.

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And basically as you can see, knowledge and perception gaps about these programs, administrative hassles and some state challenges in maintaining continuous enrollment are some of the key issues and certainly coverage loss at renewal is one of the key risk points for losing covering for kids.

There is also an interesting note here about individuals who were interviewed feeling that they did not need or want the program, that may also get to perceptions or to their understanding about the importance of health coverage.

In addition to these reasons, I think some of the tee reasons that need to be mentioned are the importance of language and cultural barriers that are experienced in terms of children's families not really feeling comfortable with the programs. In addition obviously, as I mentioned at the outset, state budget pressures play an important role here.

States have gone through a number of cycles now of wanting to try to figure out how to find more kids, but then finding themselves in budget crisis and feeling concerned about their ability to cover those who might come in the door and sort slowed their efforts. Certainly, the uncertainty of federal funding for the SCHIP Program, and in some cases Medicaid is also a factor that needs to be considered.

So, what are the seven steps that were originally identified, that we decided to retrace? These are the seven

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steps that were identified by the experts and that we sort of memorialized in our paper, the common themes that were identified by the experts we talked to. And they are simply, as you can see first, simplify enrollment and renewal. Second, conducting community based outreach. Third, using technology. Fourth, changing agency culture. Fifth, engaging in leaders. Sixth, building partnerships, and seven implementing marketing strategies.

And these are not necessarily listed in order of importance they are just the seven ideas that were common among the experts. And I will talk about each of these in turn in terms of what our findings were when we looked at the research and expert opinion about how effective these were and which were the most effective strategies moving forward.

So, the first strategy simplifying enrollment and renewal was the step that was best documented in the research. There were so many reports and studies on different strategies for simplifying enrollment and renewal. And as you can see, there are a number of strategies that states have adopted fairly widely.

For those of you who cannot see the chart, basically all the state adoptions are generally in the over 90-percent range, except for 12 month continuous eligibility which is a bit lower, and especially for Medicaid, it is substantially

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lower. But in general I think it is safe to say that these are the strategies that have clearly made it into the state mindset so far.

So, the key, and I will talk about enrollment and renewal a little bit separately. But the key enrollment simplification strategies that were supported and I will say that in general, both the research and the experts supported these types of strategies most often. And specifically application simplification efforts and online applications were the two areas that were most often sited, also the opportunity to submit applications by telephone or fax.

So, going through the list and I will try to be brief, because there is a lot of information to share. But, simplifying the application process was found in the 2007 SCHIP evaluation to sort of be associated with enrollment outbreaks and that was specifically associated with simplifying applications in Ohio and online applications in Georgia as specific examples.

Also Oregon had an experience of saving a substantial amount of time and money associated with simplifying the application process. And Oregon, they shortened the application process from 72 steps to 16 steps and they shortened the time frame for turning around an application

making the determination from 22 days to 3 days. The states saved $28,000 in a month which was substantial.

The second strategy that is often discussed is reducing documentation burdens. And that means both income and other documentation burdens by individuals. There was a study that was done in 2004 that found that lowering income documentation requirements was associated with an increase likelihood of kids enrolling by 3.5-percent.

But certainly the recent requirements under the Deficit Reduction Act citizenship documentation in identity requirements have really I think in some respects, hampered state efforts to promote some of these enrollment strategies, like avoiding face to face interviews or lowering other documentation barriers.

The third strategy that was often discussed, is the eliminating the asset test. This is a situation where basically states allow individuals to apply without having to undergo an asset. And the state's study by the Kaiser Foundation reported that that made the enrollment process substantially easier. The state's also reported that it lowered the administrative burden and increased worker productivity. For example, Oklahoma ended up saving $1.2 million when they eliminated their asset test.

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But studies are mixed as to whether or not there is a link to an increased enrollment associated with eliminating the asset test. Aligning the Medicaid and SCHIP procedures is another strategy that has been quite successful in many states. Actually, in all the separate SCHIP programs, there should be a joint Medicaid and SCHIP application so individuals do not have to go through a different application process. Some states are also looking at ways to further simplify the process so that wherever an individual applies, they can get into the program. Notably, Virginia had adopted a no wrong door policy which really substantially improved Medicaid enrollment by about 43-percent.

Presumptive eligibility is another strategy that has been proven effective in some states. 14 states have adopted it, in Medicaid nine out of 37 in the SCHIP Program and it allows states to provide temporary eligibility for kids. Some evidence has shown an increase in take up rates, but some experts question whether or not the strategy is always effective and suggest that it as only as effective as state implementation efforts can be. We can talk about that more in the question and answer period.

The premium payment flexibility is another important issue. There are a number of studies that have documented an adverse impact on enrollment associated with payment of

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premiums or requiring payment of premiums and waiting periods, and states have moved towards premium payment flexibility, including annual payment of premiums or grace periods to allow individuals to stay on the program even if they cannot pay their premiums and that has had a positive impact according to the research.

And, finally eligibility expansions, and we will hear a little bit more about this from Jackie Forba and Anne Marie Murphy, but basically when states expand eligibility for kids, what they find is they are able to reach more of the people who are eligible in the first place. States have also found that when they expand coverage for parents, that has a positive impact.

So, this slide basically shows you some of the incredibly positive experience that simplification of enrollment strategies can have. This is Virginia's experience when they implemented a number of different enrollment simplification strategies.

Looking at renewals, there were three strategies that were sited most often in the research. The first was administrative renewal. And basically, this is where states simplify the renewal process by using information that they already have to sort of minimize the documentation burdens by the family. And the examples of this are where states allow

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for telephone renewal, where they use a data base to pre-populate forms, and then the family just has to return those forms or when there is a default at renewal towards enrollment.

This slide shows the positive experience that Florida had, as compared to other states when it had administrative renewal in effect for SCHIP during the first renewal, and it shows that only 5-percent of children had disenrolled.

A second set of strategies in the renewal process are looking at ways to promote continuous enrollment through providing a guarantee of twelve month continuous eligibility for children, regardless of whether their income changes, and also providing a longer renewal cycle, not requiring kids to come in every six months, but allowing them to come in every year.

And as you can see, unfortunately this slide does not show necessarily the positive impact it shows the potentially adverse impact when a state rolls it back. And so you see Washington's experience when they rolled it back in July 2003, they rolled back both 12 month continuous eligibility and the 12 month renewal period. And you can see the drop, the precipitous drop in enrollment it was more than 30,000 kids or about 5-percent of their enrollees.

The final renewal strategy that is worth discussing is, just the opportunities to bridge the transition between

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Medicaid and SCHIP. We know from a study that was done in 2004 that about 27-percent of CHIP enrollees or about 1 million kids, and 6-percent of Medicaid enrollees or about 1.4 million kids are transitioning between Medicaid and CHIP every year. And when they do that, there is an opportunity for loss of coverage, and so state's ability to smooth that transition really makes a big difference.

The second strategy that we looked at was community based outreach. And there has been a lot of positive experience that state's have had, sort of when they implement community based outreach strategies, including use of application assistors in the process and direct personal contact and outreach. And as you can see, I will not walk you through the slides, but basically there are four states sited here that showed that there was a substantial impact on enrollment, both in terms of the number of applications that were submitted, and in terms of the number of children who enrolled in the likelihood of enrollment. And I think some of our other presenters are going to be talking a little bit more about their experiences.

The third strategy was technology, and this is a very exciting area that unfortunately, we do not have as much research to sort of document, but preliminary experiences with online applications suggest that states are really making

substantial inroads. And we know from a NASHP surveyed that we did informally, that online application use is up among states, about 38 of 41 states that responded to a NASHP survey are actually using the online applications, although fewer states have allowed the opportunity to complete the application online, only about two in the survey responded that they did.

Another key area that states are exploring is data sharing among agencies. This is where our states have an opportunity to sort of mind data from other programs, like National School Lunch Program, WIC and Food Stamps and look at those and see whether or not there is good data and they are showing income eligibility and use that information to then identify potential enrollees.

And in a NASHP survey we found that 16 of the 38 states that responded to a survey are using some link of online applications to other programs and using data to identify, verify information with positive results.

Finally, a number of states are exploring the electronic verification of vital information, and I think we are going to hear more about that from Cathy, so I will let her talk about her experiences. But the Medicaid transformation grants that were awarded in the past two years have a number of interesting programs in that arena, and hopefully over the next

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couple of years we will get some good research on those experiences.

But overall, I think what we find is that when states are using technology they are reporting state savings and potential for improved enrollment.

I wanted to provide you with sort of a visual, and it does not come out so well up there but, [laughter] a visual of the type of experience that consumers can have when they use a program like Pennsylvania's Compass Program. This is a program that has been in effect for a number of years that Pennsylvania really sort of led the way on, in terms of the online application process and it links individuals to a number of different programs that they can apply to simultaneously and will import their data through the different application processes.

The fourth strategy that we looked at was changing agency culture. And basically the idea here is to shift from state focus on protecting the public fist to a state focused on promoting enrollment. And I think it is clear that state's at a leadership level and agency individuals are supportive of these goals, but unfortunately, what often happens in the agency culture is a focus on trying to keep case load burden low and trying to process cases as quickly as possible.

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So there has been a lot of discussion and the seven steps discussion identifies sort of some key ideas here, about how to make that happen in a state, first making the goals of the program clear, changing the terms, using the term customers instead beneficiaries to create more service oriented approach, training staff and keeping them informed at all levels of the changes, and implementing and monitoring new policies. Finally giving eligibility workers new tools to help them perform.

One of the most interesting examples that we have at this point of this experience, having a positive is in Louisiana, which really transformed its caseworker culture through a series of policy changes from 2000 to 2005. And as you can see they implemented a number of different types of strategies, including marketing to their caseworkers, having their caseworkers go out and do outreach, promoting accountability for, actually providing coverage and making sure individuals who were eligible got enrolled. And the overall goal was trying to avoid unnecessary disenrollments, and they had substantial success. It led to a 1-percent disenrollment rate, and faster application processing.

The fifth strategy was leadership, and basically as the seven steps identified, the idea here is having leaders in the state who will promote a clear message, a strong vision, and set the goal publicly of covering more kids. And that there

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has been some research suggesting that that has been positive, certainly the experience from the covering kids and families study of the importance of state's partnering with leaders to have a success, and NASHP actually just recently has published a paper that sited the importance of state leadership in state efforts to cover all kids.

Sixth strategy, building partnerships with community groups, hospital's providers, schools are most often partnered with and, there is a lot of research documenting the potential benefits, unfortunately, the work with schools has been threatened by the recent Medicaid rule that was promulgated to undermine Medicaid reimbursement for school base services unless it is provided by individual Medicaid employees and states may face some new burdens unless the moratorium on the rule is continued.

These are some examples which are two small to see on the screen, but you have in your packets of all of the types of organizations that states have been partnering with over time, and the diversity I think shows the creativity of the states and the opportunities to really make inroads with different communities.

The last strategy was sort of using marketing to sort of target engagement. And in the early years of CHIP, basically the states were trying to sort of do more mass media

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strategies, get the word out make sure people understood about the program, and in more recent years, states have really focused their efforts. There have been some studies that questioned the utility or the benefit on enrollment of doing mass strategies at this point, and they found that while it generated interest and awareness, it was not the type of advertising that states would have to do would be too expensive and often it was not frequent enough to have an impact.

But, it is important to stress that states should not target just eligible kids and families, but also policy makers and the general public and that that would have a significant impact on improving enrollment over time and support for the program.

So, how do states find their way forward to the Emerald City? I think there are probably a number of paths, but certainly one important factor would be further evaluation of these strategies to determine in areas where there is not enough research, what really works and how to target efforts. And certainly, states do need more support including, help identifying their individual needs because states are very different as we know. Stronger data collection, IT system improvements and technical assistance with nuts and bolts, and most importantly, as we have experience over the last couple of

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days of meeting with the SCHIP is the opportunity to talk to each other and learn from each other.

Finally, I will just mention briefly, because I know others will touch on these, that there are a number of federal policy issues that need to be discussed and identified to help states move forward. First and foremost is, a strong and timely SCHIP reauthorization with adequate funding, addressing the A-17 CMS directive, which may cause some states to roll back coverage, addressing some of the Medicaid rules that have been promulgated that undermine state funding for their efforts on outreach and enrollment and addressing some of the burdens that have been created by the citizenship documentation rule. Thank you very much. [Applause]

CATHERINE HESS: We are going to hear from Jackie Forba next from Montana, and just to remind you that you have got those cards on your table to be filling out questions.

JACKIE FORBA: Good morning. I am happy to be able to be with you today to talk about what we are doing in Montana to try and get more kids covered by health insurance.

For those of you who have been to Montana, you will know that it is a beautiful state, it is a huge state and there is not a whole lot of people who live there. [Laughter]

As you can see on there we are the fourth largest state. We only have six people per square mile. That number

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may not mean anything to you, what you should know is that here in Washington D.C., there are nine thousand people per square mile, [laughter] so that kind of puts it in perspective, little bit of a difference, right. And the average for the U.S. is 80 people per square mile.

So, what does that mean for Montana? It means that we have people who are living at vast distances from each other and often from their health care providers. That provides challenges to us, and we have to get creative in dealing with that.

When we say that we have about a million people living in our state, about half of them live in rural areas, half live in urban areas. What I want you to know is what we say is an urban area, is very different than you all might say [laughter]

I live outside Helena, Montana, which is the capitol of our state. We have about 50,000 people in our city and in the surrounding areas so, quite a bit smaller than some of the towns or cities in your state but, equally important.

What you need to know too, is about the median income for the people who live in our state. As you see on the screen, our median income is $40,627. That is a tough income to live on. What that means is that families are working to make ends meet everyday. It means you are living from paycheck to paycheck. Montana is one of those states where we have a

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vast number of people who are working more than one job and trying to cobble together enough money to be able to pay for the expenses in their family and to be able to afford health insurance, often a tough job.

The population of our state is primarily Caucasian. There are not many minorities in our state. The one minority group that we do have are, Native Americans and that is a wonderful population and a wonderful group to work with and we have just enjoyed what we have learned from working with the sovereign nations from the tribes that are in our state.

I guess what I do need to tell you is, 17-percent of all of the Montanans are estimated to be uninsured, that is at all ages. And we have about 15-percent of our population of children are uninsured, so that is our target. Something that probably seems a little odd to some people is, we have counties that not only do not have a hospital in them. They might not even have a doctor in them. So that means that families often have to drive one, two, three miles to take the child to the doctor, to the dentist or even pick up a prescription. So again, a little different than you might be experiencing in parts of your state.

I would like to talk to you a little bit about our CHIP Program. We are a separate CHIP Program. We self administer our program, which means we contract with Blue

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Cross/Blue Shield of Montana to provide administrative services. However, we are financially responsible for paying all those claims. They provide the medical provider network, those physicians, allied health professionals and hospitals work with us and provide services and they give a discount for their services to the children enrolled in CHIP. That helps us make our money go farther.

What we do in addition to providing the medical benefits through Blue Cross/Blue Shield, is we have dental and eye glasses and an extended mental health program that we directly administer. So we contract with providers to be sure that we have those services available throughout the state.

The eligibility for our program. Families who earn up to $37,100 for a family of four or at 175-percent of the federal poverty level, their children may be eligible for CHIP. That eligibility level is one of the lowest in the country. To many of you, you started above that. We have had to work to get there and we have been able to get there because we have recently really gotten the support, not only of the general public, but also of the legislators and the governor who have said, yes we are interested in expanding coverage for the kids in our state.

What we have for our funding is about $15.9 million grant from the federal government. That represents about 78-

percent of the funding that we have. You will see on the next line that we project that we are going to spend about $34 million. You might ask, how do you do that creative budgeting? The only way that we able to do that is we have money that was not spent in previous years, that situation is changing. We will not have those monies from previous years. We anticipate that we will run out of funds in early 2009. That is why to us, and many other states in this room, timely reauthorization of CHIP is essential.

We have 16,400 kids that are enrolled. That is the highest number that we have ever had. It maybe small to other states, but to us it is huge. We started with a thousand kids in 1999, and have continuously increased the number of kids we have been able to cover.

Some of the things about our program is, we have what is called centralized eligibility. Families can send in applications to our office for CHIP. We determine the eligibility in our office, and if they look to be eligible for Medicaid, we work with county offices of public assistance for them to determine that eligibility. We are able to have electronic interfaces with them, so that if for some reason children are not found eligible for Medicaid, they get that information back to us and then we can work with the families.

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We do have co-payments for some families depending on their eligibility level, we do not have premiums. We also have some things that Alice referred to. We have self declaration of income. So what that mean is a family can complete our four page application, they do not need to send in pay stubs. However, we do audit about 10-percent of all those families who are determined newly eligible for CHIP to just get that income documentation and review those just to do a quality assurance.

What we did up until 2006, is we purchased a fully insured product from Blue Cross/Blue Shield. We are, and we were very happy with that relationship. However, our goal was to decrease the amount of money we were spending in administrative costs for that contract with Blue Cross/Blue Shield. We wanted the maximum number of dollars to go to benefits for kids. So, we did switch from being a fully insured program, to self insured, and so far that has been a great thing.

As I mentioned, we are at 175-percent of poverty. We were at 150-percent since the beginning of the program. It was a great day for us when the legislature and the governor agreed that kids in Montana deserved health insurance and provided the funding for us to be able to expand.

One of the things that we did with families who had previously applied for CHIP and were found over income is, we

contacted all of those families who had applied within the last year say, hey, we have just changed our eligibility, it looks like you may now be eligible and if your kids are still not insured, we would like you to think about contacting our office and possibly reapplying.

What some people have said is that is the low hanging fruit. Those were the people who truly were interested in CHIP, knew about the program, but because in many cases they were over by just a few dollars, were not eligible for our program, so that seemed to help. When we increased from 150-percent up to 175, we ended up having a 29-percent increase in our total enrollment in a year. And something that is important for policymakers to know is that, of those new children who are enrolled, 65-percent of them were children who already would have been eligible because they were at the lower income levels.

This slide just gives you a brief look at what our monthly eligibility and our enrollment is for CHIP. Just shows a steady growth. What it shows you too, is that we need to focus both on that blue section, which are those kids who are continuously enrolled, who are staying in the program, keeping the insurance, as well as the number of new children coming into our program.

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Some of the ways that we have been able to keep the kids who are insured continued in our program is to, do a pre-populated renewal application that we send out to families and they need to just update that information and return it to our office.

The enrollment milestones. Basically this takes us from January 2005 up through May. And it shows a steady increase in enrollment. What it also shows is that there are a number of different changes that we have during that time period that have contributed to the growth. What we have found is there is not just one thing that is going to work. What you need to do is have a whole bunch of different activities that you are using to get the word out to kids and families.

You cannot see this slide very well, but on the right is our CHIP Outreach Coordinator and on the left is Smokey Bear. [Laughter] Some parallels. I guess the main one would be, is that you cannot do it alone. In our state we have one person, Mike Mahoney who is our Outreach Coordinator, who does a fabulous job. He alone cannot get the word out through our vast state to all the families.

What we need to do and what we have done is work with community partners to get that word out. We have over 550 different CHIP Champions. Those are individuals and organizations throughout the state who care about kids and they

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care about health coverage for kids, and at the same time we always have to be looking for new partners. Some of them jump out at you right away, some of them are schools, Head Start, providers, but there are also other groups that are helpful. One group that we started working with this year was Grandparents Raising Grandchildren. That is a group of individuals who are very concerned about the health coverage for children.

We did a back to school campaign earlier this year. What we did is contacted all the principals throughout the state and said, we have materials that are inclusive of CHIP, safe routes to schools and then nutrition programs offered through the WIC program. We distributed over 37,000 of these cards and these went home in kids backpacks, and along with newsletters that go out to families. It was a way of getting that information out.

And as you can see from the slide, it increased our enrollment by 9-percent in a five month period which we are very happy about. This next slide just tells you what does the card look like, a cute little picture on the side. The information on the back is what is important. Most families tell us that they did not apply because they did not think that their kids were eligible for CHIP.

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So one of the things that we constantly do in all of our outreach materials, is we say, here is what the income guidelines are, take a look at it, think about whether your children might be eligible.

One of the great groups that we have working in our state, and I say groups in kind of a, it is a strange way to say it because in fact, we have seven Indian reservations on our state. Each one of those are different, they are sovereign nations and we work with them independently. As you can see from the slide they are in very rural areas, and often far from the large cities that we do have.

The other spots that you see on the slide indicate the urban Indian clinics. We have just started within the last year to be sure that we have visited with each one of those urban Indian clinics and provided information about CHIP.

Outreach for Native Americans children presents an interesting challenge. Many families feel like they do not need to have CHIP coverage if their children can get services at NIHS facility. On the surface that seems to make sense, however, having CHIP makes a difference for kids who normally get their services in NIHS.

It means they not only can get that at an IHS or tribal health facility, but they also have a whole network of providers throughout the states that they can obtain care from.

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What it also does is that it provides a funding stream for IHS and tribal health who as you may or may not know often have a very strapped financial situation, so it benefits the families and it benefits the communities. We have developed specialized marketing materials with those trying to promote those advantages.

The important thing working with Native American communities is really to be trustworthy, to be reliable and to be constant. It is not something where you go out and just do a one time visit and you feel good about it. Your relationship with the tribes makes a difference, as it does with many people.

You need to have the trust that goes back and forth, and quite honestly, Native Americans have not had an overwhelmingly positive experience through our history. So our job is to truly say, this is our program, you can rely on us, and we work with them to provide information. The people in the IHS and Tribal Health Service, they are the ones that families will listen to, they have the credibility, and they have the relationship with the people in their communities.

The last thing that I would like to bring up to you is are the ways in which federal funding and federal policies impact our state. And actually I would like to give you some suggestions for how those policies and regulations might be

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changed in order to make it easier for us in Montana and in other states to enroll children. One is CHIP reauthorization, the importance of timely reauthorization. In our state our legislature only comes to town for 90 days every other year. What that means is that our legislators need to know what federal monies will be available when they come in, in January 2009, they need to know what we can expect for funding and then they can adjust the state budget accordingly, and hopefully increase our eligibility.

We need to have that allocation so that it is reliable, so that we know what we can depend on, so that if we are going to take efforts to expand our enrollment we know that the funds will be there. The third bullet under federal funding, I just wanted to mention is, as a separate CHIP Program we do not get a 100-percent federal matching, for children who receive their services at IHS. Had we been a Medicaid expansion state, there would be 100-percent federal matching. I feel it is important to look at that and increase the matching rate for IHS services for Native American children.

As far as federal policies, as a separate CHIP state we are not able to cover the children of state employees or Montana University system. We have employees who are working just above minimum wage, who are having as much difficulty

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covering their kids with insurance as their next door neighbor who maybe eligible for CHIP.

And then the last thing I would just mention is, there has been a recent interpretation by CMS that if we choose to increase our Medicaid eligibility for children, we would need to pay for that with CHIP dollars. That is a bit of a twist and I am not sure that is what the intention was in the regulations, but that is something I really would hope that federal policy makers would take a look at. Thank you very much. [Applause]

CATHERINE HESS: Thank you Jackie, and next we are going to have Cathy Caldwell from Alabama.

CATHY CALDWELL: Good morning everybody. This morning I want to talk a little bit about Alabama's SCHIP Program and we call it All Kids, not to be confused with the All Kids in Illinois, [laughter] and we had it first, I would have to say. [Laughter] But I am going to talk to you a little bit about the structure of the SCHIP Program in Alabama.

But my main focus today is to talk about some electronic innovations that we have put in place in our state that have really helped to enroll uninsured eligible children, in both SCHIP and Medicaid. We have a very low uninsurance rate for children in our state, it is under 5-percent, but we still have some uninsured kids, and most of those are eligible

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for either Medicaid or SCHIP. About 30,000 children are estimated to be uninsured and currently eligible for Medicaid, but unenrolled, and about 15,000 currently eligible for CHIP, but unenrolled.

I also want to talk a little bit about some creative funding strategies that we use to help build and implement some of these electronic innovations that I am going to talk about, and I am going to talk a little bit about the impact of these as well as some of the challenges that we are facing, and I assume many states are facing similar challenges.

In Alabama we have a separate stand alone program similar to what Jackie described in Montana. Our program is administered by the Alabama Department of Public Health, which is a separate state agency from the Alabama Medicaid Agency, but we work very closely with Medicaid. We do have a joint application with not only Medicaid, but also the Alabama Child Caring Program which is a philanthropic program administered by Blue Cross and Blue Shield of Alabama that provides a limited out patient benefit package for uninsured children who are not eligible for CHIP or Medicaid. That program can also cover non citizen children, so it is a good resource.

The structure of Alabama's public insurance programs is in front of you as well as the Alabama Child Caring Foundation, and we do use a joint application with all of these. As you

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can see the gray bar on the bottom of the graft, that is Medicaid for low income families which only goes up to about 13-percent federal poverty level, and then we have Sober Medicaid, which is the Medicaid that covers pregnant women and children, and as you see the eligibility level goes up higher for young children, and then drops down to 100-percent FPL for children six to 19, and then All Kids, our SCHIP Program sits on top of that. And we go from the Medicaid eligibility level up to 200-percent FPL, and then the child caring program that I talked about fits on top of the CHIP eligibility level.

Currently we have over 71,000 children enrolled in All Kids and over 400,000 children enrolled in Medicaid. Our enrollment in All Kids has continued to grow, we have had record enrollment for the last 15 months, and we think some of the innovations that I am going to talk about today, are certainly having a positive impact on the growth of our enrollment.

We have a web based application that we have been using for several years. We built that application with funds from a Robert Wood Johnson Supporting Families Act to Welfare Reform Grant. The Department of Public Health hired a contractor to build that and he worked very closely with both us and Medicaid and I am going to talk about another component of it in a second. But, hand in hand with the web based application, we

have built automated data integration system, whereby we could electronically transmit application data between all of the programs on the application. But as I said this was joint project with Public Health and Medicaid, and it covers all of the programs that you saw a minute ago in the chart.

Hopefully we are going to roll out effective June 1st, a E-signature for our web based application. What we have had for the last few years is the parent can go online, complete the application, receive a preliminary determination which will tell them it appears that your children are eligible for Medicaid or All Kids and it will instruct them to print out the signature page, sign it and mail it to the appropriate agency. And so the parent signs it, mails it in to us, when we receive the signature page that is when we actually import the data into our system. So that either happens in CHIP or in Medicaid, and then the enrollment procedure happens from there.

There are many families who go online, complete the application and we never receive the signature page. So, once we get E- signature in place, we think that that will really, really enhance that process. In CHIP we have been ready to do E-signature since day one, but we were waiting for Medicaid to get all of their approvals in place and all of that. So a few months ago they came to us and said they were ready to do it, so we are all excited about that.

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I mentioned our automated data integration system. Prior to this, if a joint application came in to the CHIP office we first would screen for Medicaid eligibility. If the children appear to be Medicaid eligible, we would put those paper applications in a bucket almost, and walk them up the street to the Medicaid agency. Then we got a little more sophisticated, we would bundle them and send them out to 67 counties, so we would send a report up the street to Medicaid and then we would send the paper applications out to the counties.

With this automated data integration system, we are able to input all of the application data into our system, if the preliminary determinations says that they appear to be Medicaid eligible, we can electronically transmit those data, and the Medicaid agency can do the same with us, so that has helped tremendously. We still send the paper application, but at least there does not have to be re-keying of that information. With the web based application, this automated data integration system works as well.

The Alabama Department of Public Health is partnering with Medicaid to do some electronic birth verification through the Deficit Reduction Act and the citizenship and identification verification is in every state that has been a real burden. So there has been a system worked out where an

applicant comes into a Medicaid office and birth verification is needed. There is a special fax machine where the Medicaid worker faxes the information to the Department of Public Health, that is worked immediately and the birth certificate is sent back to them electronically.

We also have put some electronic tools in place to enhance the referral process. This is a project that we have worked on with some public hospitals and Medicaid, where a single hospital intake system has been built to collect all of the family demographic information, and if there are uninsured children in the household, the data elements necessary to populate the joint application or extract it from that intake system and sent to our web based application rules engine, where the hospital intake worker will get real time or preliminary determination on either All Kids or Medicaid. That is being piloted in just a few hospitals, so as you see, we have not received a lot of applications through that route, but Medicaid has received 418, so we are pretty positive about it.

Another project that we are working on is called Camellia. This is a project that is actually being directed by Microsoft, they looked at the State of Alabama and felt that many factors were just perfect for us to be their test site, and it is to make the whole application process easier for

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families, hopefully. The goal is have a system whereby a family can input application information and those application data be shared by all the human service agencies. So we are real excited about that, and it was initiated by the governor's office, and like I said it is actually a Microsoft led project.

Another project that we are working on, and this actually began from our Robert Wood Johnson Covering Kids and Families Grant, is a audible Medicaid Assistor. So the way this works, is a Spanish translation software that we have installed on all the Medicaid out station worker computers, and it really does not replace an interpreter, but for maybe a Medicaid worker who can speak some Spanish and a applicant who can speak some English, it really enhances the communication process.

So for example, if the worker needs to ask the parent a question, they can find the question on their computer screen read it in English and then hit it and then it will audibly speak the question in Spanish to the parent. So it is an additional tool to enhance communication. And we are getting very positive feedback from the Medicaid workers on that.

And then another component to this project is we are building a kiosk type system where the applicant will input the joint application information, will be sent electronically to our web based rules engine, but this is specifically to help

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Spanish speaking individuals so they can read the application in Spanish, they can hear it in Spanish or for low literacy, English speaking individuals they can choose to hear the application, and we are piloting that in five counties in five county health departments, and that should go live within the next few months, so we are excited about that as well.

I wanted to talk a little bit about some challenges, and certainly everything that Jackie pointed out, I would echo that. But, the uncertainty of reauthorization is huge, trying to explain to the powers that be, trying to get the state legislature to allocate sufficient funds to run the program at the level at which we all want it run, it is really, really difficult when you do not know what is going to happen beyond March 31st on a federal level. Working with partners, working with families, it is just really difficult and so I would echo the need for a timely reauthorization.

Another challenge that we face continuously, when we are coordinating with other programs is just the different state agencies, different federal regulations, so the coordination can happen and it is very good when it does, but there are some barriers there. Just getting all the appropriate people at the table with the willingness to coordinate, but I think states have come a long way in that area.

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But, that is it for me. Thank you very much.

[Applause]

CATHERINE HESS: Anne Marie Murphy.

ANNE MARIE MURPHY: Hi, I am really delighted to be here. It is always good to be back in D.C. I spent eight years working in the Senate, for a variety of Senators, so it is always good to be back in town, but then wench [laughter] to the states to roll up the sleeves and get some health care done which of course, as we know in the last few years is where most of the health care expansions really have happened.

So I am here today to tell you about Illinois pioneering work in back to cover all children, and I will say that is why we decided to call the program All Kids and was because it actually is the first and only program in the country to actually cover all children, irregards of their immigration status, we cover all uninsured children, and without regard to family income, and I will get to where at the higher income it is really a buy-in, but everyone gets coverage under this program.

And I will talk a little bit about the benefits of having a universal program. We are all familiar with Medicare. Medicare is a universal program, everyone knows that we hope to be eligible for it at 65, and we all sign up, and one of the reasons we all sign up is because we all know we will be

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eligible for it. Likewise, with All Kids, families across Illinois it is a very easy message. Every family who has uninsured children and will hopefully qualify for All Kids.

All Kids came in the context of a Governor who had previously done a lot of expansions. Governor Blagojevich took office in January 2003, and over the first few years we did three family care expansions, we did a children's health expansion, we did a family planning new program, we enacted the most comprehensive Medicare wrap program for seniors and persons with disabilities for prescription drugs, we started the Health Benefits for Workers With Disability Program/

And we also did a variety of expansions for women's health in the area of breast and cervical cancer programs. And so if you add up all of our different expansions, the figure actually today is actually a little higher than this one, it is actually about over 850,000 more Illinoisans now receive health care do to these efforts. So that is pretty massive, I do not think there are any other states that have quite as large an enrollment increase.

However, in spite of all of our efforts to enroll, we knew we had some children that were still uninsured. Just for those of you that like to crunch data, you probably used the CPS data and I will say that there are some very serious problems with that data. It undercounts the number of

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children, anyone enrolled in public programs by a huge amount. In 2006, the undercount for our children is about 46-percent.

I would not really describe that as an error bar, I really describe that as an error, [laughter] if you think that there are 800,000 children enrolled, when there are actually 1.4 million that is a bit of a problem in regards to your data set. There seems to be problems in that data set with regards to public coverage, but also in regards to how many children we think are enrolled in private coverage. Because if you did a correction for how many we really have enrolled, you would have too many children. So, I just caution you about looking at that data.

I am hoping that what it means is that there are less uninsured children here in the U.S. as a whole, and obviously we believe there is a lot less uninsured children in Illinois. However, we did still think that we had uninsured children in the state and University of Illinois had done study for us that showed that we had somewhere around maybe slightly under 250,000 uninsured children, and that a large number of them were already eligible, but not enrolled.

And so, in November 2005, the general assembly in a bipartisan fashion in the House, though not in the Senate, under the Governor's leadership we enacted All Kids, and the program started July 1st. For families everyone is in All Kids.

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It does not matter which revenue stream is paying for a child, whether it is Medicaid or SCHIP or state funds.

We use state funds for children who are in families above 200-percent of the federal poverty level, or for those that have a immigration status not consistent with federal funding. But it does not matter to the family, they just apply, we work out which level of premium they pay. Obviously if they are Medicaid, they are not paying premiums. So, they all get an All Kids card and everyone in the state tends to know about All Kids, and I will talk a little bit about why that is. [Laughter]

So, the program is a comprehensive health insurance. It is almost entirely the Medicaid benefit package, some very minor modifications. As I said every uninsured child under the age of 19 regardless of their immigration status is eligible. We do have the crowd out provision. It is a 12 months level of uninsured for eligibility, though that does not apply at birth, and we have a few exceptions, such as if you lost your job, or if you are using Cobra, and there are few exceptions to the 12 month uninsured period.

It is not free, it is affordable, it is a sliding scale. I could bring you the very complex chart, but you can get it on our website as to what the different premiums are for the different levels and we have a sliding scale co-pays as

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well. At the highest end it really is a buy in, it is comparable to what you pay in the private market, about $300.00 a month.

So we are not trying to undermine private coverage, however, Illinois is not a state that has guaranteed issue, and so there will be children in families who have medical conditions that they are denied coverage in the private market. And there will be people that will tell you what, you are covering people that earn $80,000. Well in reality, if you live in Chicago for instance, and you are earning $80,000 and if you are going to buy private insurance for a family, in post tax dollars it is going to cost you $12,000 or $13,000 a year in post tax dollars.

And so you can make a reasonable income, but with mortgage and gas prices and groceries, and saving for your kid's college or anything like that, you do not have $12,000 or $13,000 in post tax dollars to pay for health insurance, and so we provide this, as an affordable alternative.

So, we now have 1.4 million children and over half a million parents enrolled in our program. We did pretty much everything in regards to getting the word out and making it easy. And that is why we have gotten such robust enrollment. We simplified the applications, we have one application, everyone applies with the same application, there is no wrong

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door, we have what are known as application agencies, a community based groups, it is a very accountable system. If they enroll a child successfully they get $50.00. So, it is not a grant to some community group that may or may not be able to show that they enrolled anyone. It is a pay for performance outreach project.

We have online applications, you can call in over the phone, you can mail it in. Pretty much you can go to the local offices, any which way there is no wrong door. We have a call center, and as I said we have a website. We also started more recently to do automatic renewals. We made the decision that one should not penalize children for inaction by their parents, so we do not cut off children whose parents have not sent in the renewals. We do cut off parents, but not their children.

We also had previously, done pretty much every simplification you can imagine. The only one we have not done is self declaration of income.

I am just going to quickly go through these next slides. We do outreach to every group imaginable. The applicant agents are of interest I think, not so many states have them, but we work with everyone. All of our agencies are co-opted into the effort to enroll children and we leave no agency behind. [Laughter] We find our most successful outreach is with providers. People sign up their children for health

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care when they need health care. We work with schools, we have not found that the most successful outreach strategy, we find it much better to enroll kids in health care facilities. We also do all kinds of public partnerships and we spent about $5.3 million on TV ads.

These ads were what I described as jay jill like, they were very sort of middle class ads and in a nice has not too nice, reasonably nice. But, we find that people aspire to, they want a program that looks attractive. They do not want to sign up for a program they think is a poverty program. So, we never mentioned the word Medicaid, that is banished, we do not use it anywhere.

We even changed [laughter] the name of our agency from Public Aid to our Health Care and Family Services, so we have done everything pretty much to sort of we-brand. And the enrollment results have been fantastic. Since the Governor took office, we have 400,000 more children enrolled. And since All Kids started, we have 240,000 more children enrolled of which, I think it is about 63,000 are in the expansion group.

So that is either they have an immigration status that makes them ineligible for federal funds or their income is above 200-percent of poverty. So, what you will notice that ratio is about a 3 to 1 for every one child we enroll in the

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expansion, there is at least three that were previously eligible.

But a card is obviously not enough you need to give quality health care, and so at the same time that we initiated All Kids, we transformed our Medicaid and our whole program into a primary care case management program based on the American Academy of Pediatrics and Medical Homes Project. And this has been very, very successful, over 70-percent of physician services are now provided to people in their medical homes, and we have a 9-percent decrease in hospital utilization.

You can go through all the new innovations that we have in the program. One of the things that we are doing is we are able to give doctors all the patient information on what health care person has had in the last two years, they get all the medications someone has had, what ER visits they have had and the diagnosis, all that is now grouped and provided to them, in sort of spread sheet they can go on the web and get. And we also provide a profiles and a pay for performance. We have also instituted disease management, and are also doing outreach about preventive health visits.

So, I just want to point out that it is possible to do all of this in a cost effective means. Our per member, per months have decreased in all categories and in fact, our

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blended per member, per month has also decreased over these years, so we are covering more people and we are saving money because quality health care actually costs less, and yet people are getting more preventive services, the Heated Scores are up, so it is all generally good news.

And the lessons learned are that universality works and that it is not enough to just give someone a health card, and that unlike federal Medicare, it is actually possible to save quite a lot of money through disease management, and I would be happy to discuss that with federal CMS if they want any hints on how to do that, but it is actually possible even in a Medicaid program to save a lot of money by disease management.

With the challenges, I am just going to very quickly talk about our challenges for two seconds. Challenges are that we have run out of allotment over and over again, due to CMS policy that told us that we had to use charge presumptive eligibility from Medicaid children against our SCHIP allotment that certainly did not help. I think many in the room here helped us with some legal briefs that suggested that was not a correct interpretation of statute. We also have been denied the opportunity to move our unborn back into Medicaid where they previously were covered as pregnant women because we were told that would be disenrolling children of course, it would be the same person getting the same health care and the same

health care benefits, so we disagree with that, but that is what we were told.

So, were are looking forward obviously, to a new administration, and hopefully revisiting of some of these issues. But we are delighted with this program, it has been a fantastic success and we are very interested in some of the other technology improvements that other states are doing. Thanks. [Applause]

CATHERINE HESS: And Cindy Mann to offer a bit of commentary and then we will still have some time for questions, less than we hoped. So if you have questions again, please note them on the cards.

CINDY MANN: Good morning. A commentary means no slides. [Laughter] So, first let me commend NASHP for convening the event and highlighting this very important issue of enrolling eligible, but unenrolled children, and commend my colleagues from the states for their effective efforts.

The good news is that state's all over the country are really digging in and doing amazing things to cover eligible children, in addition to these states, we have new activities going on in Iowa and Oklahoma, Louisiana, New York, Washington, Colorado, Pennsylvania. Just to name a few of the states that are making great strides, or at least trying to make great strides to cover more uninsured children.

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As these efforts show, there is enormous interest around the country in a diverse array of states to reach, enroll and retain eligible children. And as I think the presentations this morning demonstrate, it is not an intractable problem to find, enroll and retain and ultimately cover eligible children. Sometimes people began to say, oh you can never find those kids, you in fact can.

We may not have at this point all of the answers, but we have a lot of answers, we know a lot about at this point what works. We know from what we have been told from Illinois and from Montana that when you expand program coverage, whether it is up to 175 or whether it is universal, the act of expanding and broadening your coverage actually brings in previously eligible, but unenrolled children.

We also know from the data that a big part of the problem is on renewals. By one study shows that about 42-percent of the kids who are uninsured, eligible, but uninsured children had been in the Medicaid or CHIP Program within the past year. Getting to those renewal problems can be very important, and we know for example from Louisiana, and Alice had this in her slide that they have gotten the renewal loss rate down to 1-percent. It is not an intractable problem, these are solvable problems.

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Just as we know a lot about what does work, we also know a lot about what does not work. Mississippi lost over 14,000 children when it went to a face to face interview for renewals instead of mail in renewals. The Washington State slide that Alice showed earlier about the ups and downs, those were ups and downs that were caused by changes in procedural rules, not changes in eligibility that caused kids to loose coverage, not withstanding the fact that the eligibility rules remain the same, and that ultimately for kids to gain coverage again once those enrollment barriers and retention barriers were dropped.

So, if we know what work, and we know what does not work, why do we still have a problem? Well at the state level, the decisions about what to do and what not to do are largely budget driven. We often see states like we saw in Washington that adopt or drop measures that affect enrollment or retention, as a budget control device, and it is very effective. The good news is that it is politically difficult to roll back your eligibility levels for children when you want to save money, but it is tends to be under the radar when you achieve those budget savings, sometimes even more effectively by putting in enrollment and renewal barriers, and by dropping your outreach and curtailing all the mechanisms that you hear today that states have adopted in order to move forward.

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California for example, facing a very large budget deficit right now, has proposed quarterly renewals, quarterly reporting for children in its Medicaid and CHIP Programs, which undeniably will lead to the loss of coverage for eligible children throughout that state if it is adopted. It is adopted strictly as a budget measure, not because people think it is a good way to deliver health care to children.

So, what does this tell us? It tells us in part that we have to get to a place where as a nation, covering children is not something we do just around a good election or around a good budget times. But in fact, we have to do it even when the economy is in down turn. And as we all know, when the economy is in a down turn that is even more the time when families are in greater need and need help affording their health care coverage for their children.

To their credit, there are several states that despite severe budget problems this year, they are still moving forward, but it is really difficult for them to do that, and they cannot always do that.

Which brings us not just to what state’s can do to maintain coverage, but really looking at what the federal government can do to support and promote these positive state efforts. All of the speakers today really have identified some of these measures.

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Obviously, we can look at what was in the CHIP Reauthorization Bill, not just the fact that it happened, but the elements in that Bill were so carefully geared in many respects to provide states the tools, the financing and the incentives to reach those eligible, but unenrolled children.

The Congressional Budget Office estimated that of the 4 million children who would have gained coverage as a result of CHIP reauthorization, 87-percent of them would have been the children who were already eligible but not enrolled because of the various measures that were in the CHIP Reauthorization Bill that was of course as we know, widely supported with bipartisan majorities in both the House and the Senate.

In addition to the kinds of measures that were in CHIP reauthorization, we have seen in the past that when the federal government has taken action to deal with the counter cyclical problems of Medicaid funding. When states are in the worst fiscal crisis themselves, that is when more people are eligible for and apply for Medicaid coverage and the state's are in the least best position to afford to sustain that coverage.

So, we did some counter cyclical funding during the last recession, it has been somewhat considered during this economic crisis and maybe considered again. And, we ought to think about how to permanently put it into the Medicaid program so that it is an automatic feature.

We did not get an FMAC relief, we did not get CHIP reauthorization. Instead, we are left with at this moment insecure funding for the CHIP Program, the continuation of pretty ridged rules around citizenship documentation which has been shown by lots of different states to have kept eligible citizen children from gaining or retaining coverage. And we have the August 17th Directive that is affecting nearly half the state's and is already dampening efforts to move forward even as the economy worsens and more families need affordable coverage.

As these state's leaders have shown, there is a strong commitment for moving forward in a diverse array of states. And there is overwhelming support for doing so, and there is always been very strong bipartisan support here in Washington for doing so.

So, hopefully step by step, we can put aside some of the federally erected barriers that are now in place and instead get back to the business of providing the tools and the fiscal support and the incentives to continue the progress.

Covering kids as we all know is the right thing to do. It is not right just for some kids, and it is not right just for sometimes, it is right at all times for all kids. We are really getting close and we can get to that finish line. So, thank you. [Applause]

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CATHERINE HESS: So, we do have a bit of time for questions. If you wrote them out on cards, maybe you can hold those up so folks can collect those and bring them up, or if you would rather just ask now, we do have some cards, great. John, there is more, great.

We are working on a method to have two way transfer of application data between Medicaid and SCHIP. This has been implemented received information from Medicaid to SCHIP. The challenge is how to send data back to local Medicaid agencies. This seems to be complex.

How long did it take Alabama to develop its system?

CATHY CALDWELL: To answer your question, probably almost a year to do all the assessment and do the programming and actually build the system. And we built the automated data integration system first, and then we built the web based application. And the question I think was specific to data, like the county workers, they all have access to the same systems, so when data are transmitted from public health, the CHIP Program to Medicaid, all of the Medicaid workers around the state can open up the same system, so it is just that one transmission and they go into the system to access the data.

Does that answer the question? Okay.

CATHERINE HESS: This is for Anne Marie. How much of Illinois success do you attribute to your application

assistors, and do they have a role in signing folks up for other health care products that your state offers?

ANNE MARIE MURPHY: Yes, so the great thing about these community base application agents are that we go out and recruit specific groups for specific populations. So we have Polish American Group because Polish is most spoken outside Poland as in Chicago. We have Chinese American, Korean, you name it, we have a group there that does outreach to specific groups.

We find that yes, some people are amenable to the, hi, I am from the government and I am here to help, but there are plenty of people that are not necessarily so amenable to that as the type of outreach. And so we do a lot with the faith based community, and what we really like though, about this particular methodology is that it is so accountable. You get someone signed up, you do the whole thing you get your $50.00. You do not get someone signed up you do not get the $50.00

So, they therefore gather all the right information, but we do all those application agents, provide information on all our programs, and in fact we have a new website that actually has all our state programs on it. It is very easy to navigate, which we have brochures for and so you can click and say I am a parent, I am a child, I am a woman, I am a person

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with disabilities and it will tell you all the different programs that the state has for you. So it is pretty easy.

CATHERINE HESS: Got a couple of questions about the impact of budget shortfalls. I mean we know that states are all in different economic situations, but those situations are worsening in other states. And so, I think we are asking all of our state panelists maybe if you could talk about what your state situation is, and what impact that it may have on these efforts that you have described.

ANNE MARIE MURPHY: Well, in Illinois the general assembly is not always very fond of fully funding our programs, but they do not want us to cut anyone off. So, I do not necessarily want to raise new revenue either, so what we do is we push our medical bills into the next cycle and we have what is known as the nasty pay cycle, and so the people that suffer the most are the providers who provide service to our beneficiaries. And so I think that is the crux of the matter is Medicaid is an entitlement, so we do not cut anyone off there, and with the other programs there is not desire to roll them back, but we punt into the next year.

CATHERINE HESS: Cathy.

CATHY CALDWELL: Alabama is facing some huge budget issues for fiscal year '09. The legislature has fully funded CHIP and Medicaid and they realize that they are just such

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critical programs for the citizens of our state. And I think one reason we are successful in CHIP, in getting the legislature typically to allocate what we ask for is we have good quality data. We have a wonderful actuarial model that we can run projections on, so we just monitor the cost and enrollment just almost continuously and we are very open with all of our information and fully informed all of the decision makers.

So, right now we should be able to maintain everything that we have in our SCHIP Program.

CATHERINE HESS: Great. Jackie.

JACKIE FORBA: Right now in Montana, I guess what I would say is that we are hopeful and optimistic for CHIP, as far as the budget. I will tell you that there is a valid initiative that is in the face of gathering signatures that would increase Medicaid to 185-percent of poverty and CHIP to 250-percent of poverty, and also put in a premium assistance program.

So, there are great ideas that are out there. I do have to tell you though, all of those programs even if the signatures are gathered the legislature will have to deal with the issue of how to fund it. And it is totally contingent on available federal and state funds.

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CATHERINE HESS: I know we are right at 10:30, but I am going to take the liberty of moderator and just take a few more questions, maybe go another five minutes.

We had a question from Montana, although I think this is relevant to all states and it has been one of the issues that states have been grappling with in addressing the August 17th *State Health Official* letter which a number of our panelists have mentioned. One element of that letter suggested that state's that wanted to move up the income scale in coverage needed to document that they had 95-percent of children enrolled below 200-percent poverty, I believe.

So, the question was in Montana, do you know what percent of the eligible populations enrolled, and I wanted as you speak about that you might, I am assuming want to talk a little bit about the challenges of trying to figure that out.

JACKIE FORBA: There is a study that was done, and I do not know if it is in your packet, but we certainly can make it available to you that tells what the rates are for every state, as calculated by CMS. I believe we are somewhere in the 67-percent or so. I do not hold a whole lot of faith in the numbers that are out there. I do have to tell you though, part of the reason that we are low is that we were at 150-percent of poverty, but we will be working to the higher levels.

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So, right now it does not appear that the August 17th Directive affects us at this time, but what we know is we are in the same boat as every other state. As we seek to expand the coverage for our kids, we will face those same issues. So we are watching this and are participating in this discussion because it affects each one of us.

CATHERINE HESS: Do other states have comments on trying to measure your participation rates or other elements of the August 17th letter.

ANNE MARIE MURPHY: One thing that would be a challenge is that I am presuming that CMS would use CPS data, and as I said our error bars are really errors there, so we would never get the right numbers there if they were going to use CPS data. We think we have at least 90-percent of eligible's enrolled at least, but it kind of depends on how many people accurately say whether they are insured or uninsured.

The other part of the CMS document, we are not affected because we use state dollars above 200-percent, but the other part that is entirely unfair is, state's have no ability to mandate that employer's retain coverage for anyone, including children. And so holding state's responsible for employers, not rolling back coverage it is unfair, we have no tools to do that.

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CATHERINE HESS: Which is another element of the August 17th letter. Cathy.

CATHY CALDWELL: In our uninsurance rate for children is less than 5-percent, so I think we have been pretty successful in enrolling the eligible children. But we do still have uninsured children in the state and most of those are eligible now for Medicaid and SCHIP. So we continue to do quite a bit of outreach to try to get those children enrolled.

Since we are at 200-percent FPL, the August 17th letter is not affecting us right now, but I have no doubt that in the future it will if we do not get these issues worked out now.

CATHERINE HESS: And maybe I will just pose one last question for our panel, and invite those of you who had questions that did not get answered maybe to come up and check with the panelist.

But what mechanisms do you all use to measure the effectiveness of your efforts? I think some of you have talked about it a little bit. We know this is challenging, but I wonder if folks can speak to that a bit.

CATHY CALDWELL: Certainly we monitor the uninsurance rate, and we have to rely on CPS. We did a state survey a few years ago, but we have not been able to replicate it. So we first look at the number in percent uninsured, we look enrollment rates, but we also survey our enrollees to ask them

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about their experiences, about their access to care prior to enrolling in CHIP, verses after enrolling in CHIP. We ask them about how they were treated by the providers, their enrollment, their renewal processes, and we have found consistently for the ten years of our program that families absolutely love our program. Even when we surveyed the disenrollees, if we have found them to be ineligible, typically they just want to be back on the program. So, we monitor it in many ways, we certainly review our claims data to hopefully see that the kids are getting all the preventive services they need.

So, really on many levels we monitor and typically get just wonderful feedback on the program.

CATHERINE HESS: Anne Marie do you have a comment?

ANNE MARIE MURPHY: Sure. Obviously it depends on what your definition of affective is. We are pretty sure that our outreach has been extremely affective, because it speaks in the numbers. If you have 850,000 more people enrolled, clearly your outreach is going reasonably well. And our budget office might sometimes tell us that it is going a little too well, [laughter] but the governor is very committed to it.

But I think in regards to effectiveness, we have been really interested also on the health outcomes side, and so that is why we change our program to a primary care case management program, and what was really interesting about that was we use

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to have a lot of issues in regards to trying to get providers for enrollees. And we now have 5.3 million medical homes for 1.7 million beneficiaries in the PCCM Program. And in that process, it was interesting the safety net hospitals realized that to get admissions you need to have a referral, and so therefore they went out and made sure that all the doctors that are associated with them signed up as primary care providers. And so we got actually a large number of new end providers and we are now feeding information back to the providers on how well they are doing relative to their piers which is improving the quality of care overall.

CATHERINE HESS: Great. Jackie do you have a comment?

JACKIE FORBA: I guess my answer would be similar to what the other panelists said. The number one measurement of how affective your outreach is, is your enrollment. Are you getting to cover more kids? And just getting the kids enrolled is not the final goal. The goal is to get the kids insured, have them be able to go to the doctor, pick up the prescription to get the care that they need.

So, what we do is we also monitor the services that kids are getting. How many kids are accessing care, and what are the services that they receive, as well as the number of providers. Is our provider network expanding and is it

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expanding in the geographic areas in which we need it and in the specialty areas?

We also do surveys. It is satisfaction surveys, but also retention surveys to say, okay you did not reapply, is there a reason or what is the reason? And what we are finding out in many cases is, often just life happens, I have been busy, I meant to do it, I did not get around to it. Oh yes, can you send me in another application.

So I guess I would say, just monitoring the numbers of kids enrolled, the services they are getting, and then just really how the families feel about the program.

CATHERINE HESS: I think that was a great place to end on because, it is all about, technical difficulties [laughter]

This is all about not just getting the kids enrolled, but ultimately those kids getting access to care and having their outcomes improved.

I want to thank the panelists again. Thank you for joining us. Please fill out your evaluation forms so we can plan further sessions like this. [Applause]

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