Covering Kids & Families
Southern Partnership Forum
December 6-7, 2006
Summary Report

Acknowledgements

Covering Kids & Families would like to express appreciation to Mississippi Governor Haley Barbour, Chair of the Southern Governors' Association, for making this meeting possible. Special thanks are extended to Diane Duff, Executive Director, Southern Governors' Association and Lee Stevens, Director of Health Policy and Programs, Southern Governors' Association. Finally, appreciation is extended to the meeting participants for sharing their observations and insights.

About *Covering Kids & Families*

In order to address the need to reduce the number of uninsured children and adults who are eligible for public health care coverage programs but are not enrolled, the Robert Wood Johnson Foundation launched *Covering Kids & Families* (CKF), a four-year, $55 million dollar initiative to increase the number of children and families who benefit from Medicaid and the State Children's Health Insurance Program (SCHIP). The CKF initiative has benefited from the work of coalitions in 50 states and the District of Columbia with more than 5,500 member organizations. CKF coalitions include public officials, health professionals, educators, businesses, social service agencies, faith-based organizations and others all working to ensure that eligible children and adults are insured through Medicaid or SCHIP.

The CKF coalitions focus on the following three strategies to reduce the number of uninsured children and adults who are eligible for but not enrolled in Medicaid and SCHIP:

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

The Southern Institute on Children and Families, a private, non-profit public policy organization located in Columbia, South Carolina, serves as the National Program Office for the CKF initiative. The Southern Institute provides leadership and direction for CKF statewide grantees and local projects nationwide.

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Introduction

In 2005, there were 6.5 million uninsured children across our nation that live in families with incomes below 200 percent of the federal poverty level ($40,000 annual income for a family of four in 2006).[1] Additionally, 2002 data show that 70 percent of uninsured children are in families with one or more full-time workers.[2]

In the region represented by the Southern Governors' Association (SGA) nine of the 17 southern states have a higher uninsured rate than the national average of 15.7 percent.[3] For the purposes of this report, the District of Columbia is referred to as a state. Collectively, the uninsured children's rate for the southern states is 13.4 percent, compared to 11.4 percent nationally, with six southern states having a higher uninsured rate for children than the national rate.[4] However, two of the six states are less than one percent above the national rate.[5]

The *Covering Kids & Families* (CKF) National Program Office, in collaboration with the Southern Governors' Association (SGA) convened the CKF Southern Partnership Forum in December 2006. The purpose of the Forum was to provide an opportunity for open dialogue with state officials on Medicaid and SCHIP enrollment and retention issues. The agenda was designed to allow participants to explore and discuss strategies to improve the accuracy and efficiency of Medicaid and SCHIP eligibility processes so as to increase access for children and adults who are eligible under current state guidelines. Using the CKF strategies of outreach, simplification and coordination as the framework for the dialogue, participants discussed the following areas:

- Barriers to enrolling and retaining eligible children and adults in Medicaid and SCHIP; and
- Strategies to simplify and coordinate existing Medicaid and SCHIP.

This report summarizes the discussion at the CKF Southern Partnership Forum in each of these areas. The agenda, list of participants and presentations can be found in the appendix of this report.

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[1] Kaiser Commission on Medicaid and the Uninsured. *Health Insurance Coverage of America's Children.* January 2007.

[2] Kaiser Commission on Medicaid and the Uninsured. *The Uninsured: A Primer, Key Facts About Americans Without Health Insurance.* December 2003.

[3] The nine states include Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, Texas and West Virginia. 16 states and the District of Columbia are included in the SGA region: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.

[4] Florida, Georgia, Mississippi, North Carolina, Oklahoma and Texas. Kaiser Commission on Medicaid and the Uninsured. Urban Institute analysis of March 2006 and March 2005 Current Population Survey. This is uncorrected data prior to the Census Bureau's revision on March 23, 2007.

[5] Georgia and North Carolina.

Barriers to enrolling and retaining eligible children and adults in Medicaid and SCHIP

A number of issues and barriers to improving Medicaid and SCHIP enrollment and retention were discussed, as follows:

- **Proof of Citizenship and Identity Verification Requirements.** In accordance with the federal Deficit Reduction Act (DRA), effective July 1, 2006, applicants for Medicaid and SCHIP and recipients due for renewal are required to provide proof of citizenship and proof of identity. These requirements not only place additional burdens on the applicant, but on the state administration and local eligibility determination offices as well. When policy directives are dictated without resources for implementation, problems are created, such as lack of funding to cover the additional expenses incurred for the state vital records to provide the data and postage expenses to return original legal verification documents to the applicants. In contrast, states are now finding it easier to enroll a legal immigrant than a United States citizen.

  States are experiencing significant declines in enrollments for Medicaid attributed to these new federal requirements. Several states are tracking eligible children and adults who lose coverage due to lack of citizenship and identity verification, as well as identifying barriers and strategies to simplify and improve the process for applicants and the eligibility determination agency. Lack of consistency among states in adhering to the DRA requirements and the inconsistent administration of the requirement across the federal regions also were identified as problematic.

- **Medicaid Stigma.** Negative public perceptions continue to be associated with Medicaid, particularly when Medicaid is erroneously viewed as a "welfare" program rather than as health care coverage for lower-income children and adults. The stigma may be driven, in part, by the growing differences between Medicaid and SCHIP in some states, such as requiring more verification for Medicaid than for SCHIP.

- **Coordination Between Medicaid and SCHIP.** In the past several years states have worked to coordinate and align their Medicaid and SCHIP programs to minimize the stigma toward Medicaid and make the transition between the two programs seamless. Currently, however, the two programs seem to be diverging in several states and the programs are becoming more bifurcated with retrenchment in policy and procedures for children's Medicaid.

  Southern Institute staff cited some examples of recent actions that created policy differences between Medicaid and SCHIP. Tennessee is beginning a new separate SCHIP program called CoverKids with more simplified eligibility requirements than the current TennCare program, and Georgia now requires income verification for Medicaid, but not for SCHIP. In Texas, there is movement to restore some of the simplification policies for SCHIP, but not for Medicaid. Even with a joint application for Medicaid and separate SCHIP programs, there are eligibility barriers when two agencies are involved in making eligibility decisions. This requires communication between the two agencies, sharing of

data and tracking the application, which can increase the processing time for eligibility determination.

- **Reduced Outreach.** Some states have reduced outreach efforts for Medicaid because of budget constraints. Outreach strategies are especially important in relation to the implementation of the DRA proof of citizenship and identity verification requirements. State representatives see the need for continued outreach to reach the remaining uninsured, eligible children and adults and inform current enrollees about the DRA verification requirements for their renewals.

- **State and Local Eligibility Determination Staff Workload.** In an effort to reduce Medicaid and SCHIP costs to state budgets, many states have reduced staff and at the same time implemented policies that require staff to conduct additional verifications for application and renewal determinations. These changes have created workload challenges at the state and local levels and contributed to staff turnover.

- **Medicaid and SCHIP Staff Turnover.** States have been experiencing frequent turnover of staff from the local frontline workers to the state administrators, to some extent due to workload demands. Kentucky has experienced four commissioners in four years, while the District of Columbia has had three agency directors and two interim directors within the past three years. With frequent staff turnover, there is a lack of historical knowledge and continuity of administration.

- **Premiums.** Premium requirements are becoming more prevalent among the southern states as a way to support state budgets and for families to assume some responsibility for their health coverage. The impact of the premiums on enrollment and retention is being monitored by the states. West Virginia and Georgia have recently added premiums. In 2006, Texas reinstated their premium requirement, and Virginia indicated premiums may need to be reinstated to support the budget. Even small premium costs can be a barrier to eligibility for lower-income families. Additionally, the way in which states collect premiums can adversely affect the ability of families to maintain public health coverage and can present barriers to families who may otherwise be eligible for Medicaid or SCHIP. Ineffective communications also have contributed to misinformation regarding premiums.

- **Lack of Affordable Employer Coverage Plans.** There is a growing trend in the workplace of fewer employers offering a health coverage program or offering one that is affordable for employees and their families. Available, affordable employer health plans are particularly an issue for small businesses. Loss of private health coverage for employees increases the pool of uninsured, eligible children and adults for the public health care programs. In addition, some employers are reluctant to make information on Medicaid and SCHIP available to lower-wage employees. Issues related to confidentiality and inequities can be barriers to employers working with public agencies to make public health coverage available to their lower-wage employees. For example, employees with children may qualify while single adults would not be eligible. Additionally, employers are unaware of how public coverage can help them retain employees.

- **Hurricane Katrina.** Louisiana and to some lesser extent Mississippi, Texas, Tennessee, Georgia and Alabama continue to be faced with challenges related to the Hurricane Katrina disaster. A small percentage of lower-income families (income less than 200% of the federal poverty level) have returned to Louisiana. The Medicaid Department has been unable to contact the majority of families for renewals, and the state's grace period ended January 14, 2007. Renewal notices were sent November 15, 2006, with a two-week response due date. Based on the low response, 40,000 cases were likely to be closed. In addition, the state has dropped the policy allowing eligibility workers to make telephone calls to the families due to limited staff resources. For enrollees born in Louisiana, the Medicaid staff members are able to verify citizenship and identity and can conduct ex parte reviews, which means verifying eligibility requirements using existing data from other state agencies, case file records, etc. However, thousands of families have not been reached.

- **Undercount of Uninsured Eligible Population.** States find it difficult to determine an accurate estimate of the number of uninsured children and adults eligible for Medicaid. This figure seems to be a moving target. The challenge is to identify who are the uninsured eligibles and where they are. West Virginia and Virginia are facilitating household surveys to assist in determining this information and targeting their outreach efforts.

- **State Computer System Capabilities.** For many states, their computer systems have not kept up with technology advancements. Databases are not linked across program areas; thus sharing of common data is not feasible. This causes duplication of efforts for staff and clients for Medicaid/SCHIP application and renewal determination and complicates the coordination and transitioning between programs. However, implementing technological improvements is usually an expensive undertaking for states in the short term and often prohibitive for state budgets.

- **Budget Limitations.** Most southern states are anticipated to have an SCHIP budget shortfall within 12 – 18 months. In fact, Georgia expects to max out their SCHIP funding by March 2007 and has had to scale back outreach efforts. Kentucky is experiencing a two to one ratio in Medicaid/SCHIP enrollments. Texas is faced with creating a balance between increasing enrollment with what is considered reasonable for the state budget.

Strategies to simplify and coordinate existing public health care coverage programs

To address the barriers, participants discussed simplification and coordination strategies with which their states have experience. These are outlined below.

Simplification

In the context of CKF, simplification is defined as eliminating barriers that prevent eligible children and adults from enrolling in and retaining public health coverage. Simplification strategies discussed during the Southern Partnership Forum included the following:

- **Reducing Medicaid stigma.** States need to align Medicaid and SCHIP policies and processes, speak more universally about health coverage and simplify the Medicaid application and renewal processes for families. One suggestion from the discussion is to establish a single, global children's program instead of the two tiers – Medicaid and SCHIP. Eliminating the issuance of a Medicaid monthly enrollment card and generating one card, effective for the entire enrollment period, like the SCHIP card, helps to improve the image of Medicaid. In addition, this strategy would simplify the process for the Medicaid staff and reduce administrative expenses.

- **Addressing citizenship and identity verification requirements.** States can be more informed if they measure the impact of these new requirements on eligible children and adults by collecting data on the eligible children and adults who lose health care coverage due to these new requirements. States can consider conducting a cost analysis of the expenses associated with the state's implementation of these requirements.

- **Targeted outreach.** State representatives stressed the importance of continued outreach and in working with community-based organizations, medical providers and others. States recognize that with limited outreach resources it is important to identify and target outreach at the local level to reach the remaining uninsured, eligible children and adults. Community outreach can be enhanced and sustained through community partnerships with schools, medical providers and employers. Locating eligibility staff at hospitals and other frontline locations is an effective outreach strategy for enrollment and renewals. Several states have established collaborative partnerships with local school health and lunch programs. Increased outreach efforts are being directed to employers, particularly in developing public/private partnerships. Providing Medicaid and SCHIP application information through the workplace is a way to reach families that are reluctant to get public coverage.

- **Enhancing electronic applications.** Many states have implemented online applications; however, the degree of simplification varies widely. For instance some online applications must be printed and manually completed and mailed to the eligibility determination office. Online application systems are more effective when the application can be completed and submitted electronically with an electronic signature. Online applications are also more effective when the applicant can check the status of the application and when the online

application system is made available at multiple community locations, such as medical provider sites, schools, libraries, etc.

- **Providing premium payment options.** As several states are adding premium charges for health coverage, states should consider offering a variety of payment options including offering online payment, accepting payment by telephone and mail and facilitating automatic bank withdrawals for payments. Investing in development of effective communication strategies and materials can alleviate misinformation and misunderstandings.

- **Training and retaining staff.** States may use simplification of policy and process as leverage for training and retaining staff. Standardization of application and renewal processes for Medicaid and SCHIP and implementation of express renewals will help to simplify staff training, reduce workloads and potentially alleviate staff turnover.

Coordination

As defined by CKF, coordination means aligning eligibility and retention policies and processes for separate state health coverage programs to allow children and families to move seamlessly between programs as their eligibility for those programs changes. Insufficient coordination between separate Medicaid and SCHIP programs, or among Medicaid categories, is a significant contributor to administratively expensive churning in and out of public health coverage – primarily due to procedural reasons. Some state studies show that children who lose their public health coverage return within two to nine months. This churning on and off of health coverage programs results in increased processing time for eligibility determination staff, thus contributing to increased administrative costs. Coordination strategies discussed at the forum include:

- **Improving state technological systems.** Technology is an effective tool that can significantly improve coordination between Medicaid and SCHIP and streamline the enrollment and renewal processes. A range of technological strategies to consider for implementation include:
    - Implementing screening tools to help families apply for appropriate health coverage or other benefit programs for which they may be eligible;
    - Developing an online application and renewal form that can be submitted electronically with an electronic signature and tracked by the applicant; and
    - Linking existing, separate computer database systems, so that common client information can be shared and clients are transitioned seamlessly from one program or category to another for which they are eligible.

- **Developing public/private partnerships.** Several states are considering options to develop an equitable system of health care coverage across employees to reduce the number of uninsured citizens. For instance, currently adults with children may qualify, but the eligibility is much more limited for single adults in some southern states where adult coverage is available only for pregnant women and adults who are very poor, aged, blind or disabled. Another strategy is eliminating a waiting period to transition from a private coverage program to Medicaid or SCHIP to improve coordination and provide the opportunity for families to maintain continuity of coverage. Public and private cost-sharing options are under development in some states. Premium assistance is one

public/private cost sharing option in which the state will contribute funding, such as the $100 premium assistance initiated in Virginia to assist eligible families in purchasing private coverage through their workplace.

Another option is establishing a cost-sharing program for care, rather than an insurance program, such as the three-share benefit program in Texas where the state, employer and employee share the cost for the employee's family to receive care through the University of Texas Medical Branch. Another example is the nationally recognized Access Health program in Muskegon, Michigan. Access Health is known as a "three-share" community partnership model in which the employer and employee each pay 30 percent of the cost of the services and the community pays the remainder. Participants also suggested that states should increase efforts to work with employers to explain the benefits of public health coverage for their lower-wage employees with children.

Conclusion

The CKF Southern Partnership Forum provided participants an opportunity to identify and discuss strategies to improve the accuracy and efficiency of Medicaid and SCHIP. The identified strategies focused on simplifying and coordinating Medicaid and SCHIP eligibility policies and processes, identifying approaches to enhance eligibility performance and operation practices and engaging public/private health coverage partnerships.

As states continue to struggle with budget constraints, the new citizenship/identity verification requirements and finding the remaining uninsured, eligible children and adults, the strategies discussed at the forum can help states reduce program and process inefficiencies and eliminate procedural barriers that prohibit eligible children and adults from accessing and maintaining public health coverage.

APPENDIX A

Covering Kids & Families
Southern Partnership Forum Agenda
December 6-7, 2006
Atlanta, Georgia

Wednesday

6:00 pm	**Dinner** Au Pied de Cochon – InterContinental Buckhead Hotel

Thursday

7:30 - 8:30 am	**Breakfast Buffet**
8:30 - 9:15 am	**Welcome** Lee Stevens, Director of Health Policy and Programs Southern Governors' Association **Introductions, Purpose and *Covering Kids & Families* Overview** Sarah C. Shuptrine, President and CEO Southern Institute on Children and Families *Covering Kids & Families* National Program Director
9:15 - 10:15 am	**State of the Region** Nicole Ravenell, Deputy Director for Policy *Covering Kids & Families* National Program Office Judi Cramer, Regional Coordinator *Covering Kids & Families* National Program Office
10:15 - 10:30 am	**Break**
10:30 am - 12:30 pm	**Discussion of Enrollment and Retention Issues Related to Access to Medicaid and SCHIP Coverage for Eligible Children and Adults in the Southern States** **Discussion of Strategies to Improve Accuracy, Efficiency and Access to Medicaid and SCHIP Coverage**
12:30 - 1:30 pm	**Lunch**
1:30 - 2:30 pm	**Identification of Partnership Opportunities to Improve Accuracy, Efficiency and Access to Medicaid and SCHIP for Eligible Children and Adults in the Southern States**
2:30 pm	**Adjourn**

APPENDIX B

Covering Kids & Families
Southern Partnership Forum
Participant List

Deborah H. Bae
Program Associate, Health Care
Robert Wood Johnson Foundation
PO Box 2316
Route 1 and College Road East
Princeton, NJ 08543-2316
Phone: (609) 627-5812
Email: dbae@rwjf.org

Carrie Banahan
Deputy Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621
Phone: (502) 564-4321
Email: annam.dunn@ky.gov

Sharon L. Carte
Executive Director
WV Children's Health Insurance Program
1018 Kanawha Blvd. East, Suite 209
Charleston, WV 25302
Phone: (304) 558-2732 x101
Email: scarte@wvchip.org

Judi Cramer
Regional Coordinator
Covering Kids & Families
National Program Office
500 Taylor Street, Suite 202
Columbia, SC 29201
Phone: (803) 779-2607
Email: jcramer@thesoutherninstitute.org

Rebecca Kellenberg
Director
PeachCare for Kids
Medicaid Eligibility and Quality Control
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303-3159
Phone: (404) 651-9981
Email: rkellenberg@dch.ga.gov

Ruth Kennedy
LaCHIP Director
Department of Health and Human Services
PO Box 91030
Baton Rouge, LA 70821
Phone: (225) 342-3032
Email: rkennedy@dhh.la.gov

Lisa Lee
Assistant Director
Department for Medicaid Services
Division of Children's Health Insurance
275 East Main Street, 6W-D
Frankfort, KY 40621-0001
Phone: (502) 564-6890 x3107
Email: lisa.lee@ky.gov

Linda Nablo
Director
Division of Maternal and Child Health
VA Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
Phone: (804) 225-4212
Email: linda.nablo@dmas.virginia.gov

Ann-Marie Price
Special Assistant to the Associate
Commissioner for Medicaid and CHIP
Office of Governor Rick Perry
4900 North Lamar Blvd., Mail Code 1010
Austin, TX 78751
Phone: (512) 487-3467
Email: ann_marie.price@hhsc.state.tx.us

Beth Shine
Director of Communications
Southern Institute on Children and Families
500 Taylor Street, Suite 202
Columbia, SC 29201
Phone: (803) 779-2607
Email: bshine@thesoutherninstitute.org

Sarah C. Shuptrine
President and CEO
Southern Institute on Children and Families
Director, *Covering Kids & Families*
National Program Office
500 Taylor Street, Suite 202
Columbia, SC 29201
Phone: (803) 779-2607
Email: sshuptrine@thesoutherninstitute.org

Lee Stevens
Director of Health Policy and Programs
Southern Governors' Association
Hall of the States
444 North Capitol Street, NW, Suite 200
Washington, DC 20002
Phone: (202) 724-5633
Email: leestevens@sso.org

Nicole Ravenell
Deputy Director for Policy
Covering Kids & Families
National Program Office
500 Taylor Street, Suite 202
Columbia, SC 29201
Phone: (803) 779-2607
Email: nravenell@thesoutherninstitute.org

Jill Shirey
Program Assistant
Covering Kids & Families
National Program Office
500 Taylor Street, Suite 202
Columbia, SC 29201
Phone: (803) 779-2607
Email: jshirey@thesoutherninstitute.org

Brenda Sligh
Deputy Administrator for Monitoring and
Quality Assurance
Income Maintenance Administration
Department of Human Services
645 H Street, NE
Washington, DC 20002
Phone: (202) 724-5633
Email: brenda.sligh@dc.gov

Andrea D. Willis
Director
CoverKids
812 8th Avenue N
26th Floor Tennessee Tower
Nashville, TN 37243
Phone: (615) 253-8408
Email: andrea.willis@state.tn.us

APPENDIX C

Covering Kids & Families
Southern Partnership Forum

PowerPoint Presentation
Presenters

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

Nicole Ravenell, MPP
Deputy Director for Policy
Covering Kids & Families National Program Office

Judi Cramer, MS
Southern Regional Coordinator
Covering Kids & Families National Program Office