Maximizing Enrollment in Alabama:
Results from a Diagnostic Assessment of the State's Enrollment and Retention Systems for Kids

A Maximizing Enrollment for Kids Diagnostic Assessment Series

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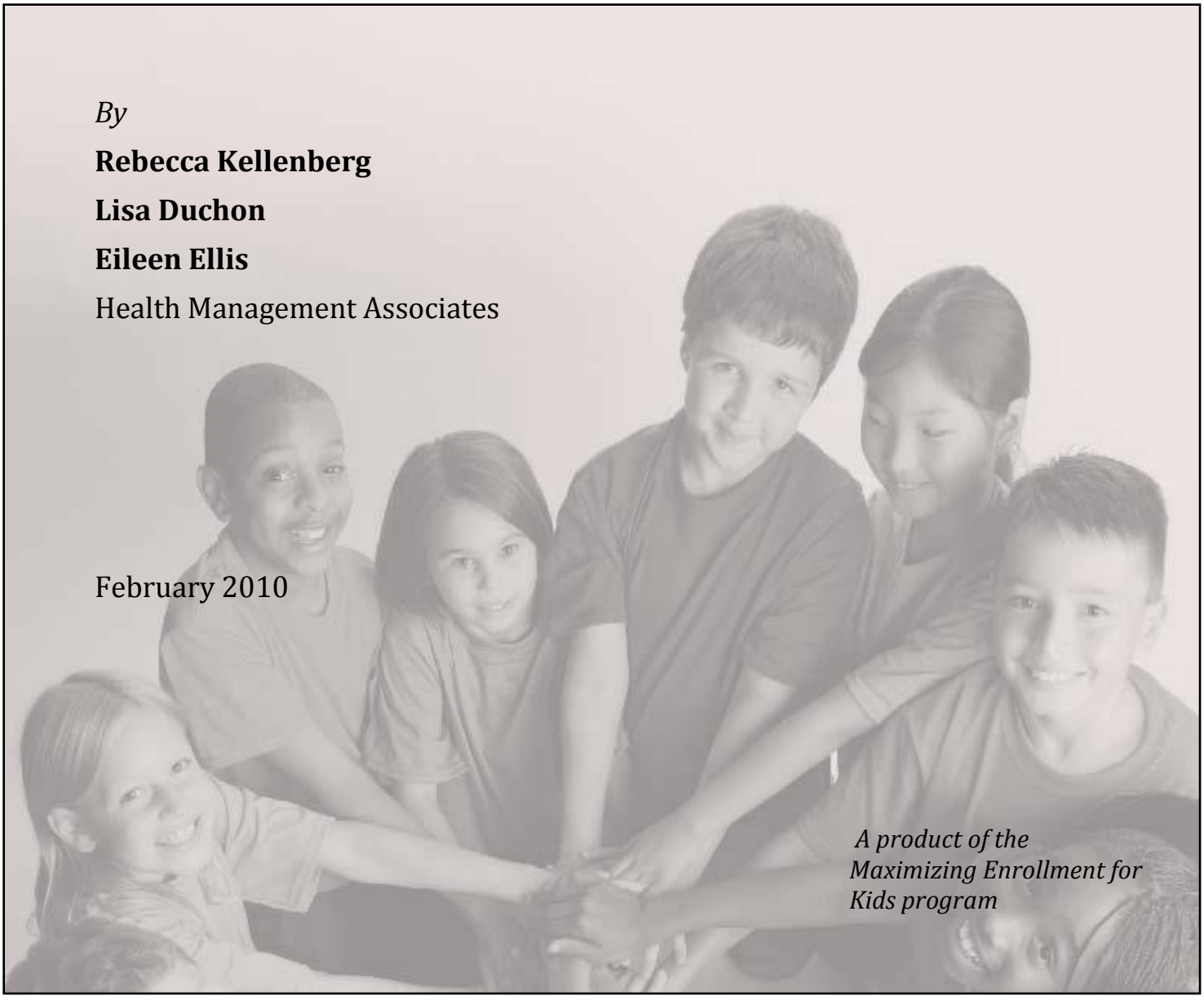

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This report is a product of the Maximizing Enrollment for Kids program, a $15 million initiative of the Robert Wood Johnson Foundation (RWJF) to increase enrollment and retention of children who are eligible for public health coverage programs, especially Medicaid and the Children's Health Insurance Program (CHIP), but not enrolled. Under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office, Maximizing Enrollment for Kids aims to help states improve their systems, policies and procedures to increase the proportion of eligible children enrolled and retained in these programs.

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Executive Summary

In February 2009, Alabama was selected as one of eight grantees of the Robert Wood Johnson Foundation's (RWJF) *Maximizing Enrollment for Kids* Program, with the goal of helping states enroll and retain more eligible children in Medicaid and the Children's Health Insurance Program (CHIP). In the first year of the grant, the National Academy for State Health Policy (NASHP), serving as the National Program Office on behalf of the RWJF, collaborated with Health Management Associates (HMA) to conduct a baseline assessment of each state's policies and processes for enrolling and retaining children in coverage. The assessment of each state included reviewing the state's reports and policies, conducting onsite interviews with stakeholders and administrators in children's health insurance programs, and reviewing published research about the impact of policies on coverage. This report summarizes the information gathered, distilling the state's current strengths, challenges, and opportunities for improvement in Alabama's enrollment and retention of eligible children.

Findings

On January 30, 1998, Alabama was the first state in the country to receive federal approval for its CHIP plan. Alabama's enthusiasm and leadership on children's health insurance coverage continues, as do its efforts toward covering all children. According to the most recent federal estimates, 6 percent of the state's children are uninsured (70,500).[1]

Based on site visit interviews, review of program materials provided by the grantee, and best practices across the states, we have identified the following themes:

- **Alabama's ALL Kids (CHIP) program has worked to maximize support and financing to improve coverage for kids.** The Alabama Department of Public Health (ADPH) and the Alabama Medicaid Agency (AMA) have created a collaborative relationship that benefits enrollees in both programs and encourages administrative efficiencies. Through shared marketing and outreach efforts, aligning eligibility rules, and constantly improving system interfaces, ADPH and AMA have worked successfully to overcome many barriers common to states with separate CHIP programs.
- **ADPH has succeeded in establishing community-based partnerships, building trust and fostering relationships at the local level that yield statewide support for children's coverage.** Community leaders report that the agencies have done an outstanding job of partnering with the community-based organizations (CBOs) and hospitals, and encouraging local stakeholders to develop and improve their outreach and enrollment efforts. As a result, some innovative partnerships have formed. For example, the Birmingham Chamber of Commerce and Business Council of Alabama included Medicaid and ALL Kids funding on their 2008 legislative agenda.

[1] KFF State Health Facts, based on 2007-2008 CPS data, unadjusted for program enrollment. Available at: http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=127&cat=3&sub=39.

- **Both Medicaid and CHIP agencies use technologically-driven solutions well to simplify application and renewal processes.** Alabama recently added an online application and electronic signature that are popular and simple for families to use. ADPH and AMA share goals for identifying and implementing additional system improvements and data interfaces that will create more efficient and customer-oriented eligibility processes. An initiative to create a common client index across Alabama's social service agencies may further simplify Medicaid and ALL Kids data sharing. The client index would also potentially make Express Lane Eligibility for children in other public programs such as Food Stamps (recently renamed to Supplemental Nutrition Assistance Program, or SNAP) and WIC easier to implement. Both agencies hope to develop the capability to complete renewals online, and when appropriate, verify information using third party data sources.
- **While the agencies work well together in most regards, differences in agency structure sometimes interfere with joint priority setting, especially related to information systems changes.** ADPH's focus on health needs and the Medicaid agency's fiscally-driven model occasionally create difficulties in coordinating priorities for system and operational improvements. Although both ADPH and AMA are committed to coordinating on both a policy and operational level, the differences in how the two agencies are able to leverage their resources means constant re-evaluation of shared priorities and timelines for system improvements. Recognition of differences and a commitment to continue formal and regular inter-agency discussions is seen as the best way to navigate this process. Max Enroll grant funding could help the two agencies prioritize system enhancements that would have the most impact on enrollment and retention.
- **Both ADPH and AMA rely on a heavily paper-driven application and renewal process.** Paper case records impose numerous constraints on the eligibility and enrollment process. Paper records restrict AMA supervisors from easily transferring cases between workers in different regions in order to distribute caseload based on capacity. Also, paper records referred between Medicaid and ALL Kids are difficult to track, contribute to a slower processing time, can be easily misplaced, and are becoming increasingly difficult to store. An electronic case records system for AMA and ADPH would alleviate the need for paper applications and case files to be maintained and transferred between agencies. They would also like to implement an electronic case record system in order to decrease paperwork and shift the burden of any required documentation for eligibility determination from families toward the state.
- **Adopting procedures that further shift the burden from families to the state will help maximize the potential of online applications (and renewals).** Like other application modes, online applications may require proof of income and/or citizenship when applying for Medicaid, which is an additional step for initial enrollment. This creates a risk that an application may be delayed or denied for being incomplete. This should not be an issue with the introduction of online renewals. However, AMA will still require documentation of income. Both ALL Kids and AMA will need to expand their use of third-party data sources and adopt other processes such as training more community-based application assisters; strengthening call center customer services to field case-specific queries; and other efforts to help families make the most of online tools. These efforts will also generate administrative efficiencies for both agencies.

The assessment identified the following as important opportunities to improve policies and processes that will increase the number of eligible children enrolled in Alabama:

- Conduct additional analyses of successes and failures with application and renewal processes to guide next steps, including an in-depth analysis/use of the process maps developed as part of the Diagnostic Assessment process. As a result, this may include pursuing electronic case files.
- Expand the Medicaid agency's use of technology for application and renewal processing to increase efficiency and reduce staff burden, ensuring that automation doesn't supercede necessary process improvements. In the interim, more Medicaid staff appears to be needed.
- Build on the current interagency communications strategy to help navigate any of the changes that are undertaken through the Max Enroll project.
- Consider how CHIPRA funds can maximize project goals. Collaboration with current CHIPRA Outreach projects as well as attention to upcoming opportunities will be crucial to improving and targeting outreach activities for ethnic and racial minorities.

Introduction

As many as five million children in the United States may be eligible for but not enrolled in Medicaid or CHIP programs in their state and a third are estimated to have been covered in the last two years. *Maximizing Enrollment for Kids*, a national program of the Robert Wood Johnson Foundation (RWJF), aims to address these problems by helping states improve the identification, enrollment and retention of eligible children. Directed by the National Academy for State Health Policy (NASHP), *Maximizing Enrollment for Kids* is a $15 million initiative that RWJF launched in June 2008. In support of enrollment and retention goals, the initiative also aims to establish and promote best practices among states.

To achieve these goals, the program includes:

- A standardized diagnostic assessment of participating states' enrollment and retention systems, policies and procedures;
- Individualized technical assistance to help states develop and implement plans to increase enrollment and retention of eligible children, consistent with the findings of the assessment, and to measure their progress; and
- Participation in peer-to-peer exchange to share information regarding challenges and discuss solutions and effective strategies with other states.

Through a competitive application process, eight states were selected to receive four-year grants of up to $1 million to participate in the program: Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin. This paper reports on the diagnostic assessment of Alabama.

The economic and political environment at the time of this assessment (March - June 2009) provides important context for understanding the status of children's health insurance programs and the opportunities emphasized in this report. During the development of the assessment protocol in late 2008 and throughout the spring of 2009, the United States was in a deep recession with high unemployment leading to a greater demand for public health insurance coverage. State budgets were greatly depressed, two-thirds of states were facing budget shortfalls, and the outlook was for worse shortfalls for about the next three years. There was an enormous tension in most states about how to maintain access to insurance and still balance the budget.

On February 4, 2009, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA), a law reauthorizing the Children's Health Insurance Program (CHIP) until 2013, increasing funding for the program and outreach activities for eligible but unenrolled children and creating new financial incentives for states that increase enrollment and adopt key enrollment simplification strategies. Two weeks later on February 17, 2009, Congress passed the American Recovery and Reinvestment Act (ARRA) to help buffer the impact of the recession on individuals and states. Medicaid relief for 2008, 2009 and 2010 was included, contingent upon states not reducing Medicaid eligibility levels from 2008 levels.

The tension of the recession and the opportunities to obtain new funding for simplifications and expansions serve as a backdrop for the state assessments.

Methodology

NASHP has partnered with Health Management Associates (HMA) to complete the Diagnostic Assessment phase of the program. In consultation with NASHP, HMA designed and administered a set of data collection and interview protocols to complete an assessment of the strengths, weaknesses and potential opportunities associated with each participating state's enrollment and retention systems, policies and procedures and external environment.

The diagnostic assessment centers on six areas:

- Enrollment and Renewal Simplification and Retention Policies
- Coordination between Medicaid and CHIP and Other State Agencies
- Analytic Capacity for Program Management and Decision-making
- Client-Centered Organizational Culture
- Non-Governmental Partnerships and Outreach
- State Leadership

In March 2009, information was collected from each state in advance of onsite interviews. Each state provided annual or progress reports on Medicaid and CHIP; trend data on program enrollment and disenrollment, and the number of uninsured children; policy and procedure manuals related to enrollment and renewal; process flow charts for enrollment and renewal; interagency agreements that would affect enrollment and renewal, such as with a sister agency that conducts intake interviews; and contracts with third party vendors who handle enrollment, retention, or a call center.

Each state was then asked to fill out a 20-page questionnaire covering key components of enrollment and renewal practices and outcomes outlined in the six themes identified above.

Based on the findings from the pre-site visit materials and questionnaire, an interview guide was developed to be used during a two day site visit in each state. During the visit to each state, interviews included state program staff as well as people outside the program whose views would help identify current strengths of the program and new opportunities to cover and retain more children. The type of people interviewed included: the Governor's health policy director, state legislators or staff of the legislative health care committees, policy advocates, organizations that work directly with families in completing applications, officials from sister agencies or bureaus, such as public health, and health plans involved in enrollment and retention. The names of interviewees in Alabama are listed in Appendix I.

The findings in this report are based on information collected from the state, a recent review of the literature,[2] and experience from our work in numerous states to distill the opportunities states have to improve enrollment and retention of children in coverage. While many opportunities were identified, this report highlights those we thought would have the greatest impact on children's coverage and also be administratively and politically feasible.

Findings across all eight states' assessments are published in a separate report.

[2] Victoria Wachino and Alice M. Weiss, "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children," National Academy for State Health Policy for Robert Wood Johnson Foundation, February 2009. Accessible at: www.nashp.org/files/Max_Enroll_Report_FINAL.pdf.

About Alabama's Health Insurance Programs for Children

Alabama's progress toward covering all children is a product of continuous outreach, close coordination with community-based partners, and simplified enrollment strategies. According to the most recent federal statistics, just six percent of Alabama's children remain uninsured.[3] The state estimates that approximately two thirds of these uninsured children are eligible for an existing public program. Alabama ranks 9th in the country and first among Southern states in covering children. The economic downturn in Alabama is causing an increased volume in both ALL Kids and Medicaid applications. Perhaps as an indication of a downward trend in statewide household incomes, senior program staff stated they are seeing a decline in ALL Kids enrollment and increasing Medicaid enrollment.

Eligibility for Coverage

In early 1998, Alabama expanded the Medicaid program (called SOBRA) to extend coverage for children ages 15 to 18 up to 100 percent FPL. Previously, Medicaid only covered children from birth to age five, up to 133 percent FPL, and children through age 14 up to 100 percent FPL. In late 1998, Alabama created ALL Kids, a new separate CHIP program to cover children under age 19 in families with incomes up to 200 percent FPL who are not eligible for Medicaid.

In 2009, the Alabama legislature voted to expand ALL Kids eligibility up to 300 percent FPL, starting October 2009. ADPH estimates an additional 10,000 children will be eligible for coverage under this expansion in the first year. Based on other states' experiences, it is expected that the expansion will result in an increase in enrollment of previously eligible children.

Health Coverage Opportunities for Children Ineligible for Medicaid or CHIP

The Alabama Child Caring Foundation, administered by Blue Cross Blue Shield of Alabama, provides coverage for primary and preventive care[4] for children with family incomes up to 235 percent FPL who are not eligible for Medicaid or ALL Kids due to citizenship status, or income. Since its inception in 1988, the program has covered over 65,000 children. Currently, enrollment in the Caring Program averages 7,000 children, while the waiting list can be as high as 3,000 children.

Organizational Structure of Medicaid and CHIP

ADPH administers the state's separate CHIP program, ALL Kids. The Alabama Medicaid Agency (AMA) administers the Medicaid program. Despite their separate policy and operational structures, the two agencies have a collaborative working relationship. As just one example of the high level of cooperation, most Medicaid eligibility workers, who are all state employees, are housed in local ADPH

[3] KFF State Health Facts, 2007 -2008, CPS Analysis.
[4] There is no coverage for inpatient or pharmacy services.

offices (in addition to disproportionate share hospitals, and federally qualified health centers, or FQHCs) around the state. A third agency, the Department of Human Resources, administers other non-medical social services such as TANF, Food Assistance (SNAP) and Child Care Assistance.

Applying for and Renewing Coverage

Families may apply for ALL Kids or Medicaid by mail or online, either on their own or with assistance. Local AMA eligibility offices also accept applications submitted in person. Assistance is provided by out-stationed eligibility and outreach workers, and several hospitals and CBOs. There are at least 171 AMA certified application assisters statewide. There are no trained or "certified" CHIP application assisters. However, applications are distributed widely throughout the state to many health care providers, social service agencies and educational institutions, whose staff assist families in completing an application.

ALL Kids initiates the renewal process by sending a reminder post card two and a half months before the renewal month and sending a pre-populated renewal form two months prior to the renewal deadline. AMA sends families a pre-populated renewal form requesting updated information and income documentation within one month prior to the renewal month. Both ADPH and AMA would like to implement online renewals. Currently, renewing applicants must submit a new application online if they wish to renew via the Internet.

Priorities Identified by the Grantee

In their grant application, Alabama identified the following priorities, which will be considered along with opportunities identified in this report, as they work with NASHP to plan the use of grant funds to:

- Move to a paperless application/renewal system;
- Gather information on the uninsured in Alabama; and
- Develop new and enhance existing community systems to find and assist consumers with enrollment/renewal processes.

ADPH believes that many uninsured children are already known to the Medicaid and ALL Kids systems. Therefore, their challenge is to ensure operational and system elements are in place to expand enrollment to remaining eligible but uninsured children and improve retention.

Findings from the Diagnostic Assessment

1. Enrollment and Renewal Processes and Policies

Current Approach to Enrollment

Alabama has used a joint application for ALL Kids and Medicaid since 1998. The current online application may be used to determine eligibility for ALL Kids, SOBRA Medicaid, Medicaid for Low Income Families (MLIF)[5], the Alabama Child Caring Program, and Family Planning. The online application, started in July 2004, began accepting electronic signatures in July 2008. ADPH indicated mostly positive experiences with this new technology. However, due to the receipt of duplicate applications individuals are limited to one online application every 30 days. Approximately 15 percent of applications received by ALL Kids are submitted online.

Both programs have adopted 12 months of continuous eligibility for children. When ALL Kids was created, Medicaid and CHIP staff intentionally aligned the programs by using the same eligibility rules (such as countable income and budget grouping methodologies) to simplify the enrollment process for families with children eligible in both programs, and to streamline the transfer between programs.

SELF-DECLARATION ACCEPTED IN ALL KIDS, BUT NOT MEDICAID

A key policy difference in income documentation creates an administrative burden for eligibility workers and some families. ALL Kids accepts self-declaration of income, while Medicaid requires income documentation such as pay check stubs or a letter from the employer. Under the current process, AMA uses third-party data matches to verify social security income and unemployment benefits, meaning they obtain information from existing databases in lieu of asking for documentation. AMA officials indicated that they are piloting several approaches to a self-declaration policy for earned income. However, AMA staff also noted their desire for ADPH to require ALL Kids to document income as a means of avoiding unnecessary referrals of applicants to Medicaid, who, intentionally or not, under-report their income. ADPH and AMA officials reported that they are continually working to determine complementary operational solutions to this specific policy difference. Both agree that consensus on income verification would decrease workload on workers and decrease the processing time associated with applications being forwarded from one agency to the other, however the volume of these applications is minimal.

STRONG RELIANCE ON MANUAL PROCESSES

AMA and ADPH use a data exchange system called Automated Data Integration (ADI) to electronically refer applications between programs. However, the referred applications must be accompanied by a signed paper form before eligibility can be determined. This often adds a week to the processing time for referred applications. Average processing times for ALL Kids applications is

[5] MLIF is Medicaid for families with income levels that meet TANF eligibility guidelines.

10 days. Due to eligibility system constraints, Medicaid staff does not have sufficient data to track average processing times. However, their standard is 20 days for applications when proper documentation is provided. They are currently upgrading the system to improve their analysis capabilities.

ADPH and AMA eligibility staff and advocates acknowledge that the current paper-driven process is vulnerable to worker error or inconsistencies, misplaced applications, and delayed processing times due to the need to move case files between two agencies and within Medicaid local offices.

Medicaid officials also indicated that their workers are so overloaded with manual work and high caseloads (average 1,277 cases per worker) that they do not have time to perform more customer-oriented tasks such as proactive research on missing information and phone follow-up to non-responding families. Medicaid officials view an electronic case record system as the key to overcoming many of these challenges, saying it would improve their ability to more evenly distribute caseloads across staff, enhance accountability for case maintenance and case status, and quicken processing times by mitigating delays caused by paper transfers.

SEPARATE CALL CENTERS

ALL Kids eligibility functions and the customer service call center are centralized at the state ADPH office in Montgomery. AMA employs 180 eligibility workers who are located throughout the state, mostly in local ADPH clinics, FQHCs, and disproportionate share hospitals, with a centrally located call center also in Montgomery at the AMA central office. The AMA call center fields basic eligibility and application questions, and refers some case-specific questions to the appropriate local office where eligibility is determined.

ALL KIDS REQUIRES ANNUAL PREMIUMS BASED ON INCOME

ALL Kids applicants must pay premiums based on income. Premiums are $50 or $100 per child per year, not to exceed a maximum of three premiums per family. Annual premiums must be paid prior to annual renewal and quarterly statements are mailed to those with balances. Premiums may be paid online or by phone, with a credit card or by mail. Additionally, families may chose to pay the annual premium in installments over the course of the year. ADPH conducted an analysis of ALL Kids enrollees who returned their renewal forms and were eligible for coverage, but disenrolled for non-payment of premium. In December 2008, 2.8 percent of children who were due to renew were included in this group.

Current Approach to Renewal and Retention

Medicaid and ALL Kids employ joint renewal forms. Medicaid sends families a pre-populated renewal form requesting updated information and income documentation (paycheck stub or letter from employer) one month prior to the renewal month. ALL Kids starts the renewal process by sending a reminder post card two and a half months before the renewal month and a pre-printed renewal form two months prior to the renewal month in which the family is required to respond.

While enrollment in ALL Kids has increased steadily, annual disenrollment rates for FY 2004 – FY 2006 have also risen: 37 percent, 41 percent and 43 percent, respectively.[6] ADPH has conducted and/or participated in studies regarding disenrollment, but the reasons families fail to respond to renewal notices are not fully understood, nor have they been quantified. Staff point to anecdotal evidence that relates the non-return of renewal forms to: families not understanding or remembering that they have to renew annually; the transient nature of the enrollees (families move and do not notify the program of their new addresses); obtaining other insurance and no longer needing ALL Kids; or self-determining their children as ineligible.

Premiums are somewhat of a barrier, but relatively small. In 2008, just 2.8 percent of otherwise eligible children[7] were disenrolled for non-payment of premium. If the premium balance is not paid within the enrollment year, an applicant has a 60 day grace period to pay any outstanding balance if an attempt to renew is made on time and determined eligible. Insurance would be restored with no break in coverage. If the payment is not made during that period, a "new" application must be submitted in order to be re-enrolled and the premium balance must be paid prior to re-enrolment. To decrease the number of families missing premium payments, ALL Kids changed their premium notice mailing to an invoice format, rather than a letter. One advocate indicated that this seemed to be helping, but data is not yet available to confirm the impact of this change.

Both ADPH and AMA would like to implement online renewals. Currently, families can renew by filling out a new application online, a workaround both agencies would like to improve. ADPH and AMA hope to use MaxEnroll grant funds to add an account log-on feature to their website for families to complete renewals and otherwise update account information as needed.

Information Technology (IT) staff at ADPH perform all programming and maintenance for the web-based application. ADPH is therefore taking the lead with online renewals. ADPH indicates one barrier is the inability to fully access the Medicaid eligibility data. Currently, ADPH has case-by-case access. The AMA IT staff (a separate division from AMA eligibility staff) are willing to research ways to provide more system access to ADPH while maintaining security of data.

New Initiatives

Recently, Birmingham Children's Hospital began fast tracking applications for Medicaid and ALL Kids by enhancing their application assister functions and faxing applications directly to the ADPH eligibility unit upon receipt. Advocates encourage broader use of application assisters as a way of overcoming barriers related to lack of understanding about the application process and resistance to engaging in a government program, concerns often common among immigrant populations.

The Audio Visual Application Assistor (AVAA) is a new computer software that talks applicants through the application process in Spanish or English. These computer kiosks, to assist low-literacy populations, are currently in pilot testing in four local ADPH locations. The software was designed by a physician, Dr. Charles Lee, who is interested in using technology to remove barriers in the health care setting. If the AVAA program proves useful, the state intends to make it available at local ADPH offices throughout the state.

[6] Grant Application for Southern Institute on Children and Families, August 2007.
[7] The survey included children whose families had returned the renewal form and were eligible, but were disenrolled for non-payment of premium.

ADPH is trying to reduce the number of bad addresses it has by mitigating the number of incorrect addresses filed upon application. In January 2009 ADPH began using software that auto-corrects keyed-in address information to ensure it is a valid address. Staff has not evaluated its effectiveness. To improve mail delivery on the Medicaid side, AMA has recently begun using the U.S. Postal system's mail forwarding service to send returned mail to the next known address. AMA has seen a 50 percent reduction in returned mail as a result of this initiative. When families receive the mail at their new location, they are then able to provide updated address information by contacting Medicaid.

Camellia II is an initiative of the Governor's office to develop a common client index of basic demographic information on all individuals who apply for a public program. The goal is to allow individuals to provide their information once, instead of multiple times for each program, and to provide access for each agency to use that information for their own eligibility determination purposes.

EXPRESS LANE ELIGIBILITY

Both ADPH and AMA hope to implement Express Lane Eligibility (ELE) per CHIPRA 2009 for children applying for Food Assistance. They are only in the initial stages of determining the system and policy requirements for ELE. The Camellia II system may provide the needed data. ADPH, while supportive of ELE and Camellia II goals, is concerned that privacy and consent issues for these projects be fully addressed prior to implementation.

OTHER APPLICATION STREAMLINING EFFORTS

With the focus to date largely on application processes to improve take-up rates, the ADPH staff acknowledged the need to put more emphasis on the renewal process. They are initiating some efforts to improve renewal rates and reduce case closures of eligible children. ADPH and AMA have shared goals for making the renewal process for public services as streamlined and administratively efficient as possible. Both ADPH and AMA staff interviewed described several service automation efforts underway:

- ADPH is currently discussing the possibility of conducting telephone renewals for ALL Kids members. Staff would send the pre-populated renewal forms to those not completing renewal by phone.
- AMA eligibility staff would like to implement electronic case records, which would make it easier to track open, pending, and closed cases electronically, as well as update address and eligibility information. They have studied and visited numerous states including Florida, Louisiana and Wisconsin. However, the eligibility staff is currently negotiating with its counterparts in the IT division on priorities for system changes. Eligibility staff maintained that electronic case records should be implemented soon because they have heard from other states how easy they are to implement. ADPH would also like to move to an electronic case record.
- AMA is exploring using other third-party data sources to match applicant information such as income, address and third-party liability insurance information. They are conducting pilots and analyzing results to determine which data sources would achieve the best results as they move forward in their efforts to align verification requirements between the two programs.

Strengths

Using information from the site visit, materials provided in advance, and context from our collective work in other states, we have identified the following characteristics and strategies in use in Alabama as contributing to the successful enrollment and retention of children in coverage:[8]

- **Simplified applications and documentation.** The joint application, web-based application, and electronic signature have proven to be a simpler and more user-friendly method of application than traditional paper forms. Past simplification efforts have also been important, and include no asset test, no face-to-face interview, aligned rules, and some data matching in lieu of paper documentation.
- **Technology-supported application assistance.** Medicaid and ALL Kids application sites have successfully employed and are further testing technological solutions such as Medicaid Assistor and AVAA to assist applicants with low-literacy and limited English proficiency. The Automated Data Exchange also supports transfer of information between agencies.
- **ALL Kids outreach benefits more than just CHIP kids.** ADPH has dedicated staff and outreach support to proactively find and enroll eligible uninsured children. ADPH staff has made the most of this good standing by taking the lead on technology-driven enrollment solutions and conducting successful outreach campaigns for both ALL Kids and Medicaid programs. State staff noted that despite a difficult state fiscal environment, outreach activities continue. ALL Kids, in coordination with Medicaid, continues to invest in promotional materials, out-stationed outreach workers, and outreach events.

Challenges

The following program characteristics may hinder enrollment and retention. There is little data to measure the actual impact of these factors. In the recommendations section, we suggest looking at any available data to facilitate setting priorities among these issues.

- **Continued reliance on paper.** Paper case records impose numerous constraints on the eligibility and enrollment process. Paper records restrict supervisors from easily transferring cases between workers in different regions to distribute caseload based on capacity. Also, paper records referred between Medicaid and ALL Kids are difficult to track, contribute to a slower processing time, and can be easily misplaced. Finally, storage space for case records is becoming a burden.
- **Workloads limit the extent to which staff can assist families.** Extremely high Medicaid caseloads (1,277 per worker, on average) preclude supervisors and workers from focusing on customer-oriented activities like proactive follow up, calling employers to verify income, and timely processing of new applications.
- **Documentation burden on families.** Medicaid still requires income documentation even when tested systems exist to use third-party data matching.

[8] While the strategies listed here appear to promote coverage and enhance enrollment and renewal, the impact of these strategies has not been systematically evaluated. Additional strategies not included in the assessment may also contribute to successful enrollment and renewal.

- **Limited data to support agenda setting.** Both agencies lack sufficient data needed to fully understand barriers to renewal. Data and analytic capacity to monitor disenrollment due to non-responders appear limited.
- **Staff time spent on processes that could be more automated.** Both programs are heavily reliant on manual processes. For instance, even though they use the Automated Data Integration system (ADI) to electronically refer applications between programs, those applications are not worked until the paper application is received by fax, courier or mail. Further, applications submitted online are printed out and worked in queue with paper applications received by mail.[9]
- **Staff shortages.** AMA's insufficient funding for additional case workers and IT support has hampered efficiencies and made it difficult to sustain an operational environment. Further eligibility process enhancements will be difficult without financial support for these infrastructure improvements.

2. Interagency Coordination

Current Approach

MEDICAID AND CHIP COORDINATION

Alabama started the first CHIP program in the country when it used the newly available funds to expand Medicaid. ADPH, which is headed by the State Health Officer who is appointed by a public health governing board, rather than the governor, became the home agency for ALL Kids in 1998. Senior Staff reported that many of the original organizations and individuals involved in the CHIP implementation workgroup continue to advocate for health insurance for children which has engendered a spirit of cooperation. Their efforts to align the programs' eligibility rules, collaborate on outreach functions and create program interfaces demonstrate a strong commitment by both programs to support health insurance coverage for Alabama's children.

A chief tool in enhancing the enrollment coordination between agencies, for children who move between Medicaid and ALL Kids, was the development of the Automated Data Integration (ADI) system. Through a nightly batch match process, ADI passes applications back and forth between the two programs. As described earlier, these applications are processed once the paper application is received by fax, courier or mail from the program in which they originated (sent weekly).

ADPH staff report that about 500 applications a year are left in "received from Medicaid" status, which means those ADI accounts never got connected and processed with a paper application. There are some valid reasons for a portion of these applications to go unprocessed, such as a Medicaid applicant requesting not to have an application forwarded or an applicant has already filed another application directly to ADPH. However, some applications may be lost between agencies even though several measures have been implemented to limit potential risk in this area. There is an opportunity to continue to improve the system's accuracy and perhaps implement more frequent staff checks and follow-ups on applications sitting with this "received from Medicaid" status.

[9] AMA staff indicated that although this is not a Medicaid operational policy, it may often be worker preference.

COORDINATION BETWEEN HEALTH INSURANCE AND OTHER PUBLIC PROGRAMS

The Camellia II initiative is a statewide effort to coordinate the collection of demographic information from Alabamans applying for public programs. The Express Lane Eligibility effort will require close coordination with Department of Human Resources (DHR), the agency in charge of administering the Food Assistance program(SNAP). The Camellia II and ELE efforts require AMA and ADPH to work on operational and system interface strategies with each other and DHR. Close coordination among agency leadership is essential for these initiatives to succeed. Issues related to "ownership" of these initiatives and protection of member data that would be shared between AMA and ADPH were apparent during the site visit, and could impede progress.

Alabama's Department of Education is using ARRA Stimulus funds to develop a statewide electronic system for tracking students' enrollment information. Beginning in the fall of 2009, school districts will be collecting health coverage information on students. This effort may present a new opportunity for enrolling children in health coverage. The information will be reported a second time after the winter school break to ensure DOE has the most current contact information throughout the school year.

Strengths

- **Shared resources.** ADPH has taken the lead on outreach activities and development of the major portions of the technological infrastructure needed for the online application and electronic transfers via the ADI. This reliance even extends to office space, where most of the regional Medicaid offices are housed in ADPH buildings, if they are not in another provider location. Outreach activities that benefit both ALL Kids and Medicaid are funded by the CHIP program, which receives enhanced federal financial participation (FFP).
- **Shared goals.** For the most part, ADPH and AMA coordination efforts appear strong enough that they can put aside differences to focus on mutual goals. Both AMA and ADPH staff have monthly meetings and staff from both programs noted that they communicate regularly and effectively with each other by phone and email on an as needed basis. The Commissioner of AMA is head of the National Association of State Medicaid Directors (NASMD). When she receives policy updates or noteworthy news, she forwards to the ALL Kids Director in addition to Medicaid staff.
- **Deliberate alignment of eligibility criteria.** ADPH and AMA intentionally aligned eligibility rules to avoid unnecessary confusion for families with children enrolled in both programs or transferring between programs.
- **Staff devoted to transfers.** There is a unit of Medicaid workers located with ALL Kids staff at ADPH to work some cases that are referred to Medicaid from ALL Kids. ALL Kids also has a dedicated worker to process cases that are referred to Medicaid and returned to ALL Kids after income verification (referred to as "Tiggers").

Challenges

- **Separate systems—big and small.** The fact that dedicated staff is needed to troubleshoot transfers and Tiggers suggests that improvements are needed to align systems. On a smaller scale, Medicaid eligibility workers placed in ADPH offices are on ADPH computers. This means they have different email and calendar systems than their counterparts at AMA. They also access the Medicaid eligibility system differently. This leads to communication and coordination difficulties within AMA.
- **Medicaid's limited resources.** AMA's reliance on ALL Kids to fund and otherwise provide a lot of the administrative (technological infrastructure, office space) and outreach functions may preclude ALL Kids from pursuing additional opportunities to support CHIP coverage. Because they have not reached their 10 percent administrative cap, there is little concern with the fact that all of these functions are matched with the enhanced CHIP match. However, there may be some incentive to change this in the future.
- **Privacy and security barriers.** The major barrier to online renewals is due to privacy issues and agency policies on the part of AMA IT. Citing privacy concerns, AMA IT staff is researching the ability to give ADPH access to the Medicaid enrollment files beyond a case-by-case look-up basis.

3. Analytic Capacity for Program Management and Decision-Making

Current Approach

ADPH has conducted numerous enrollment-related studies using their own research staff as well as through contracts with the University of Alabama at Birmingham School of Public Health. ADPH has the ability, internally, to track enrollment rates, denial rates by reason and various renewal metrics. ADPH officials stated that a report from their enrollment system detailing the volume of pended applications, by reason, and by length of time pending would be helpful in further assessing barriers to the overall application processes for enrollment and renewal.

AMA staff has had less success in analyzing enrollment data due to system constraints. AMA reported they are developing new system capabilities to better analyze their data by moving from a flat file format to a DBII relational database. AMA data from October 2008 through January 2009 showed that, on average, 11 percent of applicants were denied for "failure to respond to needed information." AMA staff indicated a need to develop more defined denial reason codes to improve their capacity to assess the causes of procedural denials (and closures), and thus reduce barriers to enrolling and retaining eligible children.

New Initiatives

Camellia II, described in Section I New Initiatives, will potentially provide additional data for the state to use in their enrollment analyses. With a unique identifier for health and non-health social services, ADPH and AMA would be able to track children's participation in programs and further understand enrollment characteristics such as churning and mobility.

Strengths

- **Epidemiologic support for research and analysis.** ALL Kids program employs an epidemiologist to direct their Data Unit. This is indicative of their public health roots, but also signals a high priority is placed on program analysis. Much of the research on uninsured children in the state can be leveraged by the Medicaid program as well.

Challenges

- **Medicaid needs additional data capacity.** AMA staff discussed the need to strengthen their data analysis capacity. Their current eligibility system is a flat file format. They are in the process of converting to a more flexible system but there is no known timeframe for completion among the staff interviewed. (The AMA IT staff are a separate division within AMA). Currently, the AMA eligibility system does not calculate simple metrics such as "average time to process," and has limited capacity to track disenrollment or churning rates.
- **Additional studies needed.** ALL Kids would also benefit from additional data monitoring and targeted studies to understand the barriers families face at enrollment and disenrollment.

4. Client-Centered Organizational Culture

Current Approach

Both ALL Kids and Medicaid share goals to simplify application and renewal processes and be as client-oriented as possible. ADPH's centralized eligibility and customer services center serves as the single point of contact for ALL Kids families. With locally placed outreach staff, ADPH uses community partnerships to communicate the ALL Kids and Medicaid outreach message in formats that are culturally appropriate and relatable at the local level. ADPH has successfully branded ALL Kids and has used technological and policy solutions to simplify applications and renewals.

Advocates and AMA staff acknowledge that welfare-associated stigma and resistance to government programs still create barriers to the enrollment process. Plans for increasing the use of application assistors and locally placed outreach partners can help in alleviating some of these barriers. Additionally, AMA continues to participate in numerous outreach and enrollment simplification strategies to smooth the path for families and cover all eligible children.

Strengths

- **Spanish language access.** The Medicaid Assistance Language Tool on Medicaid worker's computers is a popular feature with eligibility workers. Spanish-speaking applicants applying in person interact with the computer, rather than the eligibility worker, in Spanish. ADPH also has English/Spanish translation technology readily available. In the call center, customer service representatives can use a live translator through a contract with AT&T. The AVAA program has a translation feature as well. Applicants can choose which language they prefer before they begin completing the application. ALL Kids also employs two Spanish speaking employees to assist with communication needs.

- **External input welcome.** ADPH relies on outreach staff field experiences, input from Children's Hospital, disenrollee studies and other resources to learn how to make the enrollment and renewal process simpler and more customer-oriented.

Challenges

- **Multiple factors may hinder the Medicaid program from being more consumer-oriented.** A legacy Medicaid eligibility system and understaffing at local AMA offices may limit opportunities to develop policies or procedures to make renewal more passive, and may prevent eligibility workers from having the time or tools to actively research cases to determine eligibility. Instead, the burden falls largely on families to prove their eligibility, which likely results in some portion of eligible children being denied coverage or disenrolled for failure to provide required documentation.
- **Fiscal conservatism.** Legislative and Governor's office staff indicate they are willing to fund Medicaid to meet current enrollment levels each year, but are concerned about the impact of increasing enrollment in the program.

5. Non-Governmental Partnerships and Outreach

Current Approach

ALL Kids regional outreach staff have established relationships with the Native American tribes, Vietnamese community organizations and the migrant community Head Start programs. For example, in one area each season when migrant families arrive, Head Start completes an application for each child. ALL Kids regional outreach staff also participate in a "rapid response system" around the state. As soon as they learn about a plant closure they implement a targeted outreach effort in the area.

The state school system, under Department of Education (DOE) leadership, is in the process of implementing a computerized system for maintaining student enrollment records. As a system feature, the schools will track insurance status by type of coverage – commercial, Medicaid, All Kids or None. ADPH may use this opportunity to coordinate with DOE to get applications to students needing health coverage. Because this will be a point in time data collection effort, the school plans to do a refreshed data exchange each January as well.

AL ARISE, an advocacy organization comprised of 150 congregations and organizations, and Voices for Alabama's Children are two of the largest advocacy organizations in the state. AL ARISE is actively involved with the Covering Kids and Families coalition, which remains active and participates in eligibility policy discussions as well as outreach and education activities. Advocates interviewed said they maintain a close working relationship with ADPH, AMA, the Legislature and Governor's office.

New Initiatives

AL ARISE is meeting with ADPH staff to discuss the different policy options for implementing Express Lane Eligibility and determine how they can play a role in the process.

Strengths

- **Child advocates are active on children's coverage issues.** Voices for Alabama's Children has significant credibility and gets the attention of key legislators and the Governor. AL ARISE has a very strong relationship with the agencies. Advocates report that the Commissioner of AMA is always open to hearing from them, even if they do not always agree.
- **Community groups recognize and support Medicaid and ALL Kids' efforts.** CBO leaders, such as the Morgan County System of Service Director,[10] report that the state agencies have done an outstanding job of partnering with the private sector and building trust with partners in the community. ADPH has placed regional outreach coordinators through the state to foster relationships at the local level. As a result, some unique partnerships have evolved. The Birmingham Chamber of Commerce and Business Council of Alabama have put Medicaid and ALL Kids funding on their legislative agenda. Birmingham Children's Hospital has participated in research to better understand ways of ensuring that parents apply for health care coverage for their children. To this end, they have looked at literacy issues, conducted surveys and enhanced their application assistance. Both ADPH and AMA have strong partnerships with BCBS of Alabama's Caring for Children Foundation and Children's Policy Councils, which are local coordinating entities for children's services.

Challenges

- **Additional partnerships could be developed, but face administrative barriers.** Birmingham Children's Hospital hosts two on-site Medicaid eligibility workers. However, they would like to do more. They wish they could process applications, but there is very little political support for Presumptive Eligibility, which is the only way a non-state owned entity could participate in the eligibility determination process.

6. State Leadership

Current Approach

From the Governor's Office perspective, the goal of Medicaid is to cover eligible individuals as efficiently as possible within budget constraints. This strong fiscally-driven approach to Medicaid can limit the extent to which AMA is able to implement system improvements to more efficiently cover Alabama's eligible children.

There are several children's health champions in the legislature. The 2009 legislature voted to expand ALL Kids eligibility up to 300 percent FPL, starting October 2009. ADPH estimates this will cover an additional 10,000 children in the first year. In 2007, the Governor established the Alabama Rural Action Council (ARAC). The ARAC was built on the successful efforts previously initiated in the state's "Black Belt," named for the region's rich soil. The region, made up of mostly poor, rural counties, is in

[10] Morgan County SOS is a private, non-profit agency that offers an array of services for at-risk youth, including assistance in ALL Kids and Medicaid application processing.

need of economic development and struggles with health care access barriers. As a result, the Kid Check program was started, which promotes screenings of height, weight and vision, and assesses health insurance status.

Strengths

- **Resourcefulness.** AMA and ADPH leadership try to match as many federal dollars as possible, and leverage technological solutions to promote a more efficient operational structure.
- **Advocacy within state government.** ADPH's head, the State Health Officer, is a separate and independent position from the Governor's Cabinet. While the State Health Officer maintains a close working relationship with the Governor, he has used his position and medical standing to frame children's health coverage issues in terms of need. Advocates report that this approach has been particularly powerful during legislative proceedings.

Challenges

- **Fiscal conservatism.** The legislature is committed to maintaining Medicaid funding at its current level. This viewpoint, shared by the Governor, limits the options AMA has to invest in efforts to simplify application and renewal processes and otherwise implement more innovative approaches to administering the program, unless a business case can be made for improving program efficiency.

Opportunities

Based on our interpretation of opportunities that would have the greatest impact, our suggestions center around operational and infrastructure improvements that would facilitate a more customer-oriented, streamlined and efficient approach to enrolling eligible but uninsured children.

1. **Both ADPH and AMA would benefit from some additional analyses of successes and failures with application and renewal processes.** More detailed analysis of enrollment, to quantify the number of children who lose coverage each month (AMA) and why (AMA and ADPH), would assist both agencies in considering the best strategies for reducing barriers, such as application assisters, further automation, renewal simplification or other options. With ALL Kids disenrollment rates averaging 40 percent between FY 2004 and FY 2007,[11] a more detailed understanding of barriers may help. These specific analyses may be helpful:

    a. Conduct a small study with a few eligibility workers and applicants to determine the most common barriers that prevent more applicants from successfully enrolling in coverage. Determine if the application is too hard to comprehend, whether more personal or

[11] Grant Application for Southern Institute on Children and Families, August 2007

computerized assistance would be helpful, and what documentation is problematic, for example. Complementary information could be gained by interviewing several applicant families about their experiences. Further, interviewing enrollment assisters in the field about particularly challenging populations would be useful.

b. Determine how many children lose coverage each month (AMA) and why (AMA and ADPH). Develop measures to track procedural denials and closures (occurring for reason other than ineligibility). This information could help prioritize where to target improvement efforts.

c. Consider whether outreach and enrollment assisters (community-based and provider-based) could provide more or different types of assistance, and if they would additionally be helpful in guiding families through the renewal process.

d. Consider linking renewal to use of health care services in order to reach families when health is higher on their agenda. Partnering with community health centers and hospitals to provide renewal assistance at the point of care is one example of this type of effort.

e. Use process maps completed as part of diagnostic assessment process in order to identify opportunities for process improvements within and between both programs.

2. **The Medicaid agency could implement a variety of operational and policy measures to alleviate the burden imposed by a combination of high caseloads and a heavily manual process.** Medicaid officials indicated that their workers are so overloaded with manual work and high caseloads (average 1,277 cases per worker) that they do not have time to perform more customer-oriented tasks such as proactive research on missing information and phone follow-up to non-responding families. An expansion of some technological solutions such as enhancements to the eligibility determination system, electronic case records, and third party data matching for verification would go a long way to assisting Medicaid workers in determining eligibility in a more efficient, service-oriented manner.

3. **Numerous technological solutions already underway could reduce the manual nature of application and renewal processing that currently exists in both programs.** It may be possible to promote further changes on the basis of cost savings and efficiency.

   a. An online renewal functionality along with further enhancements of the Automated Data Integration system would allow workers to process applications and renewals once received by the system, without waiting for the paper application to arrive.

   b. An electronic case records system for both programs would assist workers in dealing with numerous constraints associated with paper case records such as transferability, accountability, and storage. More efficient business processes would also facilitate caseworkers' ability to interface with families and improve clients' experiences in applying for their children's coverage.

   c. Determine which address update systems used by other states (or by AMA) can be most effective.

4. **AMA could also explore policy and operational procedures to improve administrative efficiency through third-party verification for earned income, a more robust centralized customer service that can field case-specific queries, and retention-related metrics in performance evaluations of eligibility staff.**

5. **Increased Medicaid eligibility staff levels would allow workers to not only process applications and renewals in a more timely manner, but would enable eligibility workers to be more customer-oriented in their approach to helping families navigate the eligibility process.**

6. **Although both ADPH and AMA are committed to coordinating on both a policy and operational level, the differences in how the two agencies are able to leverage their resources means constant re-evaluation of shared priorities and timelines for system improvements.** Recognition of this and a commitment to continue formal and regular inter-agency discussions will help both agencies navigate this process. Max Enroll grant funding could possibly be used to provide technical assistance on the order and feasibility of system enhancements for both programs.

Appendix I:

Diagnostic Assessment Interview Participants

Name/Title	Organization
Cathy Caldwell, Director	Bureau of Children's Health Insurance (ALL Kids)
Viki Brant, Program Operations Division Director	ALL Kids
Chris Hutto, Alabama Maximizing Enrollment (PEAK) Grant Project Director	ALL Kids
Chris Sellers, Epidemiologist	ALL Kids
Knoxye Williams, Education and Outreach Coordinator	ALL Kids
Teela Carmack, Program Services Division Director	ALL Kids
Keith Wright, Program Services Division Asst. Director	ALL Kids
Ava Rozelle, Regional Coordinator Director	ALL Kids
Melissa Hornsby, Coordinator, CHIP-Related Software	ALL Kids
Lee Rawlinson, Deputy Commissioner, Beneficiary Services	Alabama Medicaid Agency (AMA)
Gretel Felton, Certification Support Director	AMA
Aretha Woodson, Senior Eligibility Specialist	AMA
Susan Luckie, Programmer	AMA
Robin Rawls, Communications Director	AMA
Sharon Parker, Director, Family Certification	AMA

Name/Title	Organization
Margaret McKenzie, Policy Analyst	Governor's Office
Mary Lawrence, Legislative Fiscal Analyst, Health and Social Services	State of Alabama, Legislative Fiscal Office
Suzanne Respess, Director, Government Relations	Children's Hospital of Alabama
Jim Carnes, Publications Director	Caring for Alabama's Kids & Families, AL Arise
Sara Bruce-Hall, Executive Director	Morgan County System of Services

Appendix II:

Data on Children's Coverage

Table 1. 5-Year Enrollment Trends for Children

	Number of Children				
	2004	2005	2006	2007	2008
Medicaid Enrollees					
Total	342,362	355,299	357,653	349,519	350,154
New	N/A	N/A	N/A	N/A	N/A
Disenrolled	N/A	N/A	N/A	N/A	N/A
SCHIP Enrollees					
Total	60,655	63,954	65,343	69,076	71,393
New	16,219	19,224	20,037	21,119	20,739
Disenrolled	25,145	26,995	29,438	30,063	30,720
Retention Rates*					
Medicaid	N/A	N/A	N/A	N/A	N/A
SCHIP	63.2%	58.8%	57.1%	57.5%	59.2%

SOURCE: Medicaid enrollment data are from the MSRE 138 report of poverty level children and children in low income families. These figures represent the number of children enrolled in December of the calendar year listed. The report does not capture the number of children that were added or terminated each month. Source of CHIP data: AllKids "Current Enrollment" – "New Enrollment" data and CMS Annual Reports.

Table 2. 5-Year Uninsured Trends for Children

	Number of Children			
	2003-2005	2004-2006	2005-2007	2006-2008
All uninsured children	104,000 (8.9%)	79,000 (6.8%)	73,000 (6.3 %)	78,000 (6.7%)
Eligible but not enrolled	2.9%	1.7%	1.3%	1.2%

SOURCE: U.S. Census Bureau. Current Population Survey, Annual Social and Economic Supplement, 2003-2008, 2004-2006, 2005-2007, 2006-2008.

NOTE: Data compiled using 3 year averages.

Table 3. Characteristics of Children by Insurance Status and Eligibility for Public Programs 2006-2008

	Number of Children				
	Total Children	Total Insured	Total Uninsured	Uninsured, Eligible for Public Program (200%)	Enrolled in Public Coverage
Age					
0-5	382	356	26	19	13
6-18*	784	733	51	33	58
Race/Ethnicity					
African Am./Black	366	336	31	25	25
White, Non-Hispanic	765	723	42	25	41
Hispanic	**	**	**	**	2
Asian	7	7	0	0	1
Other	24	20	4	2	2
Poverty					
0-100% FPL	256	218	38	38	
101% to 200% FPL	225	211	14	14	71
201% to 300% FPL	219	205	14		
> 300% FPL	466	454	12		
TOTAL	1,165	1,089	77	52	71

SOURCE: U.S. Census Bureau. Current Population Survey, Annual Social and Economic Supplement, 2003-2008, 2004-2006, 2005-2007, 2006-2008.

NOTE: Data compiled using 3 year averages.