Maximizing Enrollment in Massachusetts:
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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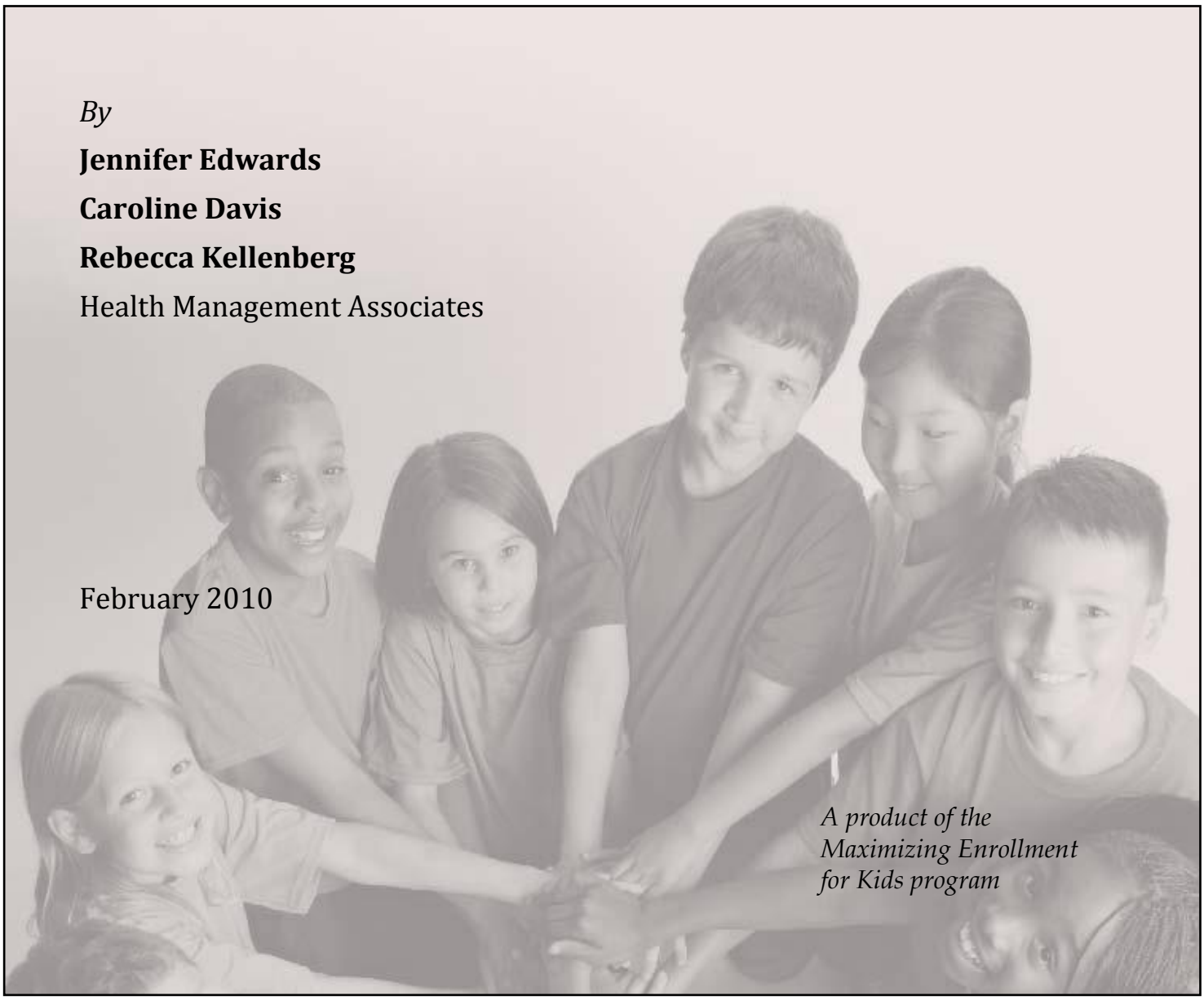

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This report is a product of the Maximizing Enrollment for Kids program, a $15 million initiative of the Robert Wood Johnson Foundation (RWJF) to increase enrollment and retention of children who are eligible for public health coverage programs like 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.

Acknowledgements

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Executive Summary

In February 2009, Massachusetts 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 to improve the enrollment and retention of eligible children in Medicaid and the Children's Health Insurance Program (CHIP). In the first year, the National Academy for State Health Policy (NASHP), which is 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 systems, 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 synthesizes the information gathered, distilling the state's current strengths, challenges, and opportunities for improvement in Massachusetts' enrollment and retention of eligible children.

Findings

Massachusetts leads the nation in covering children. Following major state health reforms in 2006, Current Population Survey data showed just 3.2 percent of children remained uninsured in 2007-2008. Children up to 300 percent of the federal poverty level are eligible for MassHealth, the single state program encompassing both Medicaid and CHIP. In addition to increasing the income eligibility level for children, health reform increased the income eligibility level for adults, thereby providing a single access point for families below 300%FPL through the integrated MassHealth application and eligibility system

Based on site visit interviews, review of materials provided by Massachusetts, and best practices across the states, the following themes relating to Massachusetts' enrollment and retention policies, practices, and procedures emerged:

- **Massachusetts has made its children's health insurance programs and their management seamless, reducing barriers and complexity for families.** In establishing Medicaid and CHIP as one integrated program having one application process, the State has avoided the confusion that occurs when families have to navigate multiple coverage options with different names, eligibility levels, and points of entry. Massachusetts has also avoided the complexity of interagency coordination and state-local handoffs. In addition to being the program name, the office that operates the State's integrated Medicaid and CHIP programs is referred to as MassHealth and directly employees the local eligibility staff.
- **Massachusetts' web portal, the Virtual Gateway, coordinates public benefits for families and provides a communication vehicle between State eligibility workers and community-based assistance workers, called Virtual Gateway Providers.** Families can apply for many different public benefits through one portal which reduces complexity and repetition of submitting personal information to various agencies. An added benefit of the Virtual Gateway is that it records and coordinates correspondence and documentation over time, so information is available to applicants to understand the status of their application, needed documentation, and some information about renewal (though more could be done with

renewal in the future). The “My Account Page” gives Virtual Gateway Providers access to member eligibility information, instructions for completing applications, and copies of correspondence with the applicant. They help families navigate and interpret information from the State. In the future, MassHealth intends to make My Account Page directly accessible to heads of households.

- **MassHealth, the Massachusetts advocacy community, and the legislature have been successful in affecting policy and program changes together.** Interviewees noted successful collaborations between advocates and the State agency, which are having positive effects on the programs. Advocates report that they have frequent input into the State’s deliberations, and that MassHealth and legislative health committee leaders are attentive to and supportive of their health reform agenda. The legislature has shown commitment to children’s coverage through administration changes and budget shortfalls.

The assessment identified some challenges in the current program policies and procedures.

- **Excessive amounts of time and money are spent re-enrolling children who intended to keep their insurance coverage but could not complete the process.** Massachusetts loses nearly half of eligible children at their annual renewal, causing disruptions in continuity and very high workloads for eligibility workers when children re-enroll.
- **Despite the relative simplicity of the MassHealth program, some families do need help navigating the application and renewal processes and are not getting the help they need.** Very high staff workloads at regional enrollment centers and the Central Processing Unit was causing call diversions and inadequate phone responses. Although MassHealth has responded to some of the problems by implementing a 24 hour 7 day per week telephone self –service feature for applicants and members, further improvements and monitoring may be needed to ensure that applicants are getting the help they need on an ongoing basis.
- **MassHealth has not fully utilized the data capacity they have to identify systems barriers and monitor program and policy changes.** Little is currently known about the reasons for disenrollment among the nearly half of children who lose coverage, nor the status of those who do not immediately re-apply. Such information would help guide improvement efforts.

Building on its notable successes, Massachusetts could further improve policies and processes to increase the number of eligible children enrolled in MassHealth and be more efficient in its use of limited resources. The following may have the greatest payoff:

- Reduce churning, which disrupts access to care and costs the State in staff processing time. Specifically, Massachusetts could consider eliminating documentation requirements for some or all income groups, as Illinois and Louisiana have done. Explore third party data matching opportunities, such as with tax returns, SNAP records, or other sources of income data. Analyze existing or new data on renewal and retention to inform policy decisions. For example, conduct a longitudinal analysis of children’s eligibility to understand who is churning.

- Conduct focus groups with families and advocates to learn more about barriers to renewal, and get their feedback on proposed changes.
- Target outreach and assistance to those who would benefit the most, Consider children already in the state's data system who are not currently enrolled but who appear to be eligible.
- Prepare for the likely need for assistance if the Virtual Gateway were to be made directly accessible to families.

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 discussion 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 Massachusetts.

The economic and political environment at the time of this assessment (March - June 2009), provides important context for health insurance program status 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 with 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 was requested to provide 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 in each state, interviews were held with 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 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 Massachusetts are listed in Appendix I.

The findings discussed in this report are based on information collected from the state, a recent review of the literature,[1] 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 state assessments will be published in a separate report.

[1] Victoria Wachino and Alice M. Weiss. "Maximizing Kids' Enrollment in Medicaid and CHIP: What Works in Reaching, Enrolling, and Retaining Eligible Children." National Academy for State Health Policy and the Robert Wood Johnson Foundation. February 2009.

About Massachusetts' Health Insurance Programs for Children

Massachusetts has succeeded in achieving near universal coverage of children. According to the Current Population Survey, 3.2 percent of children were uninsured in 2007-2008[2], though the annual state survey has the uninsured rate at 1.2 percent (18,600 children) in 2008.[3] The state survey found that Hispanic children (2.6 percent uninsured) and children living near poverty (3.3 percent uninsured) were each disproportionately represented among the uninsured (see Table 3 of Appendix 2.)

Massachusetts combines Medicaid and CHIP in a single state children's health insurance program called MassHealth, avoiding the confusion that families sometimes experience when there are multiple program names. Disabled children eligible for public coverage do receive somewhat different benefits through the MassHealth CommonHealth program, although such benefits are accessed through the same application and administrative process as those for non-disabled children.

Children's coverage levels were expanded twice in the recent past. Massachusetts used the 1997 passage of the Children's Health Insurance Program to create a combination program, meaning they both expanded Medicaid eligibility (infants up to 185 percent FPL and other children up to 150 percent FPL) and created a separate CHIP program with eligibility up to 200 percent FPL. In 2006, state health reform raised CHIP eligibility to 300 percent FPL. The effect of parental coverage on children's access has been demonstrated previously and was further supported in Massachusetts by health reform including an expansion of parental coverage. In addition to the higher children's coverage level, the creation of affordable health insurance products for parents led to more previously eligible children becoming enrolled. The implementation of health care reform also saw more parents applying for benefits and, as a result of the single application, their children's eligibility was screened at the same time and more eligible children were enrolled. The State also promoted enrollment by capping premiums for households with both parents and children enrolled in public health insurance.

MassHealth provides premium assistance to MassHealth-eligible families if employer-sponsored insurance is available and cost-effective for the State. There is a six-month waiting period for CHIP for eligible children if they were previously covered by private insurance.

In total, there were 492,000 children enrolled in MassHealth at the end of federal fiscal year 2008. Ninety percent were in the Medicaid program, and ten percent in the separate CHIP program, a distinction relevant for administrative and funding purposes, though not apparent to families. Table 1 summarizes children's enrollment over the last five years.

Additional Health Coverage Opportunities for Children

The Children's Medical Security Plan (CMSP) is a state-funded program for children without access to other coverage. CMSP has premiums, co-payments, and a more limited benefit package. The

[2] www.statehealthfacts.kff.org/comparetable.jsp?ind=127&cat=3

[3] Long SK, Cook, A, Stockley K. "Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey," March 2009, Division of Health Care Finance and Policy, Boston, Massachusetts. Rates of uninsured children calculated from the Current Population Survey (CPS) are about 3 percent higher a year, potentially due to an under-reporting of public coverage. (See Kenney GM and Dorn S. "Health Care Reform for Children with Public Coverage: How Can Policymakers Maximize Gains and Prevent Harm?" Urban Institute, June 2009.)

program is open to citizens and qualified aliens with incomes over 300 percent FPL; aliens with special status (AWSS) over 200 percent FPL; and non-qualified aliens regardless of income.

The February 2009 CHIPRA legislation creates the option for the state to move some children covered by CMSP into MassHealth where they would be covered with federal matching funds. The State has implemented this option and is working with CMS on the effective date of this change.

Recent Initiatives to Expand Insurance Coverage

Massachusetts' 2006 health reform legislation affected children's coverage in several ways. As noted above, the income eligibility threshold for children was increased from 200 to 300 percent FPL for citizens and qualified aliens. In addition, health reform mandated nearly all adults obtain insurance, and it created a new program for adults called Commonwealth Care that serves people who do not get or cannot afford insurance through their work. Though Commonwealth Care is an adult-only program, it benefits children by utilizing the same application and eligibility process that is used for MassHealth, which screens all members in the family for coverage. Since health reform was implemented, 32,750 previously eligible children (below 200 percent FPL), and 18,500 children newly eligible children (200 to 300 percent FPL) have been enrolled in MassHealth. In addition, the State waives premiums for children if parents are enrolled in Commonwealth Care and are subject to paying premiums.

Applying for and Renewing Coverage

MassHealth has a unified application and eligibility process. Applications can be submitted directly by families via mail, fax, or in person at one of the four regional MassHealth enrollment centers and the Central Processing Unit (CPU). Since 2004, families may alternatively choose to apply with assistance through the Virtual Gateway, a web-based portal. Using the Virtual Gateway requires families to be assisted by one of the 6,581 registered and trained application assistors, either health care provider staff (such as from health centers and hospitals) or outreach workers affiliated with community based organizations (CBOs).

Until 2009, families who renewed coverage did so by responding to a letter sent to them by the regional MassHealth Enrollment Center on the anniversary of the child's enrollment. Participating managed care plans receive a weekly list of members due to renew and contact them to encourage them to return forms. In 2009, MassHealth began handling Commonwealth Care renewals through the Virtual Gateway in a process called Streamlined Renewal.

Retention has been a large problem, with just 58 percent of children renewing within the generous 100-day window. Detailed analysis to understand the low renewal rate is underway.

Leadership and Political Context

MassHealth is the state agency primarily responsible for public health insurance coverage. Its executives report to the Secretary of the Executive Office of Health and Human Services, a state cabinet position. Day-to-day leadership related to coverage policy rests entirely within three units of the MassHealth agency. The Operations Unit manages enrollment and renewal processes. The Office

of Medicaid sets program standards and strategic direction and the Member Policy Implementation Unit handles communication to frontline enrollment, retention, and customer service staff. In contrast to other states where local governments or other agencies participate in enrollment and eligibility determination, in Massachusetts these functions are performed by employees of the MassHealth agency located in regional offices and at the CPU.

Health reform was passed under the prior Republican administration with bi-partisan support of the legislature. The current Democratic administration remains very committed to the health reform agenda and continues to support the agency's efforts to cover children. The current budget crisis has led to eligibility changes for state funded immigrants enrolled in Commonwealth Care but children's coverage has not diminished. Grant funding for outreach assistance was nearly cut, but in the end, the legislature appropriated money from other sources.

Priorities Identified by the Grantee

In their grant application, Massachusetts 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:

- Increase and enhance existing data matching capacities of MA21, the eligibility information system, to reduce paper verification;
- Incorporate scanned/digitized paper verification into an electronic image for use in the eligibility and renewal processes;
- Improved operational workflow at eligibility operations field offices;
- Improve interactive voice response and telecommunications venues to enhance a member's direct access to info and customer service supports;
- Make the Virtual Gateway screening and application pages accessible to applicants, including adding the use of an electronic signature; and
- Collaborate with schools and CBOs.

Findings from the Diagnostic Assessment

1. Enrollment and Renewal Processes and Policies

Current Approach to Enrollment

Massachusetts has two processes by which children can apply for public health insurance. Families can submit a paper application by mail or fax to the CPU, or in person, mail or fax at one of four, geographically-dispersed enrollment centers in the State.[4] Alternatively, a family may complete a web-based application using a relatively new tool called the Virtual Gateway, which can only be done with assistance from one of the nearly 7,000 registered and trained Virtual Gateway Providers in 300 locations. For either method, MassHealth has a presumptive eligibility period which allows for members to submit verification of income and immigration status.

The Virtual Gateway has quickly gained in popularity since it was introduced in 2004, accounting for 57 percent of family applications by 2008. The Virtual Gateway is a "one-stop shop" for public health and human service programs, meaning applicants can use the one interaction to apply for many public benefits. A home page for each family stores demographic and eligibility information, as well as a record of mail communication sent to the family. This page helps Virtual Gateway Providers to be more effective in working with families who have been in the system before and may need to re-apply or update their information, as well as helping families understand application questions and adhere to application processes (such as submitting documentation needed for non-health insurance programs).

Some of the registered Virtual Gateway Providers are provider-based, particularly in health centers and hospitals. Community-based Virtual Gateway Providers are based at or will go into venues typically used for outreach – community centers, non-governmental social service agencies, schools, neighborhood events, etc. They are familiar with the community and help people who seek them out, as well as those who may not expect to be eligible. These organizations help individuals understand the health insurance options that they qualify for and help them navigate the application and renewal processes. A third group is also involved in the application process -- the health plans with whom the State contracts for health insurance are also permitted to help people with applications. The importance of Virtual Gateway providers in playing a critical role in helping families apply for health insurance has been demonstrated since the Virtual Gateway's implementation.

All applications are processed by MassHealth's CPU. Applicants receive an eligibility determination or a request for additional information by mail. Letters to applicants were reported by State staff, advocates, and assistors to be problematic. Members and applicants receive a new letter each time there is a benefit change in the Virtual Gateway, which can be several times in the same interaction with a Virtual Gateway Provider. Letters received the same day may appear to contradict each other, and the volume and order of letters can also contribute to client confusion. For families using the Virtual Gateway, assistors can help applicants understand and respond to these letters, copies of which are posted to the family's account on the Virtual Gateway.

Families have 60 days after they submit an application to supply any information needed (such as birth records that cannot be obtained electronically, as described below, or income), during which time children are presumptively eligible for benefits. MassHealth used to have retroactive coverage for

[4] Located in Revere, Springfield, Tewksbury, and Taunton.

three months prior to the date of application, but in 1997 it was scaled back to ten days to encourage providers to be more pro-active and expeditious in helping patients enroll in coverage. MassHealth did not have data on the percent of presumptively eligible children who never completed the application process.

If they have questions about the eligibility decision or if further action is needed, families can contact the organization that helped them with enrollment, one of the four regional MassHealth Enrollment Centers, or the Customer Service Team Call Center, which is operated by Maximus. The Call Center, with a staff of 150, receives 180,000 calls per month. Advocates report it is often hard to reach staff at either the Call Center or the Enrollment Center, and responses are sometimes incomplete or wrong, creating frustration for families and assistors. Enrollment Center staff explained that in order to keep up with application volume, they divert calls to the Call Center for specified periods each week, and that Call Center staff are probably not as well-prepared as they are to field some types of questions.

MassHealth has responded to some of the complaints by implementing a 24 hour self-service functionality that provides callers with information about case status, key eligibility dates, health plan information, outstanding items to be processed, examples of acceptable verifications, the address to send outstanding verifications and forms, descriptions of notices sent by MassHealth to the caller, and the ability to request a lost or misplaced form. MassHealth staff has also identified some changes needed, such as simpler, consolidated correspondence with members, and expressed optimism that an outward-facing Virtual Gateway (meaning that families can access it without the help of a Virtual Gateway Provider) will improve communication with families. Families also receive needed assistance with application and enrollment process through Virtual Gateway providers which include hospitals, health centers and community based organizations. Although grant funding for outreach, enrollment and retention activities for these organizations is unknown due to uncertainties in the state budget, ongoing training and technical support remains a priority for MassHealth to ensure that these assistors have the latest information, training, resources and tools to do their jobs effectively.

Application volume is large for a state with approximately 18,600 children left uninsured. In June 2008, the most recent quarter reported, there were nearly 34,000 new children's cases opened, and 30,000 cases closed. Similar numbers were reported for each month in 2008. Nearly half of the "openings" were actually closed cases being reopened, 35 percent were new cases, and 22 percent were children moving between eligibility categories of MassHealth.

APPLICATION PROCESSING

Applications are received at the Central Processing Unit by mail, fax, or occasional walk-ins at the MassHealth Enrollment Centers, or transferred electronically by the Virtual Gateway. All applications are manually entered into the eligibility system, called MA21, which stores information about applications and determines their eligibility status. The paper application is six core pages, with instruction pages, supplements and forms totaling up to 9 additional pages, for use if applicable to the family's circumstances. Data from the Virtual Gateway applications cannot be electronically transferred into MA21 for an eligibility determination without manual worker intervention due to differences between the two data systems, a common problem with legacy systems. There is an initiative underway to expand automation of importing Virtual Gateway information into MA21. The automatic importation functionality is tentatively scheduled for a production deployment in early 2010.

MassHealth performs data matches with the Social Security Administration database to verify citizenship and identity, the MA Department of Public Health Registry of Vital Records and Statistics data to verify citizenship, and the MA Registry of Motor Vehicles to verify identity. Immigration status will be verified thought matches with the Social Security Administration, Medicare and the MA Department of Transitional Assistance. Although income is not matched during the application process, income is subsequently checked against a quarterly wage database, and plans are underway to add an alternative check against state tax data, which would be more accurate for children of self-employed parents or whose wages vary quarterly. If any needed eligibility information cannot be confirmed electronically, a letter is sent to the family requesting they submit documentation. As noted above, there is a 60-day window to provide documentation, after which the application is denied or benefits are reduced. Children and pregnant women are presumptively eligible for benefits during this period. During a recent sample week, documentation of in-state birth was obtained through the match for 32 out of 44 children, lower than was expected due to the higher than expected number of children born before 1986 (and therefore not in the database.) Information was not available about success rate in using other matches, nor in the rate of applications turned down for missing information.

Data on timeliness and accuracy of eligibility determinations were provided as part of the assessment, and both surpass the state's goals. Processing time for paper applications is 15 days, and 9 days for the Virtual Gateway. A recent audit found 100 percent accuracy in eligibility determinations. At renewal, over 80 percent of applications are processed within 14 days, and again, 100 percent accuracy was determined upon audit.

PREMIUM PAYMENTS

Families pay sliding scale premiums if their income exceeds 150 percent FPL, but premiums are waived if the family pays a premium for other public coverage (such as the adult program, Commonwealth Care). Premiums are $12 per child/$36 per family for children with family income between 150 and 200 percent FPL; $20/$60 for those with income between 200 and 250 percent FPL; and $28/$84 for the highest income group, between 250 and 300 percent FPL. Members can request a hardship waiver of premiums for up to 18 months with no loss of benefits. We do not know how many use this option.

Families who owe a premium are billed 30 days after the start of coverage by the vendor, Maximus. They are billed again at 60 days if they don't pay, and subsequently may be sent a termination notice if their account remains in arrears. The State has a system for withholding overdue premiums from any payment being made to them by the Commonwealth, such as tax refunds, if payment is overdue by at least 150 days. If the family pays within 14 days after the 60 day notice, they are not removed from the program. If they pay anytime within 16 months after their last eligibility determination and make up their premiums, they are re-enrolled. Data were not available on the number of children losing eligibility due to nonpayment of premiums.

PREMIUM ASSISTANCE

The MassHealth Family Assistance Premium Assistance program is designed to make employer-sponsored insurance affordable to low-income workers. For all applicants, the Commonwealth performs a health insurance investigation, accessing a comprehensive database and contacting all employed members of the household and their employers to determine if there is insurance offered that meets the basic benefit level, is cost effective and has an employer contribution of at least 50%. If access to qualifying insurance is confirmed, enrollment in employer-sponsored insurance is mandatory for all MassHealth-eligible populations. Premium Assistance subsidies are provided directly to workers to help pay their share of ESI for child(ren). MassHealth offers direct coverage only when there is no other access to health insurance

Current Approach to Renewal and Retention

Renewals are handled by the four regional enrollment centers. On the enrollee's anniversary date, the regional enrollment center mails an Eligibility Review Form (ERV) to the household. Families have 45 days to return the form documenting their income level and need for continued health insurance. If documents verifying their eligibility for renewal ("verifications") are not received, staff send a second notice and extend coverage for an additional 60 days.

In 2008, 42 percent of renewal forms were not returned within the 100 day window, resulting in termination of benefits, including about 10 percent of ERVs that were returned as undeliverable. If eligibility is terminated and families are able to document continued eligibility within 12 months, they can be reinstated. This happens most often when a family next seeks health care and the provider informs them they are no longer enrolled. MassHealth does track reasons for terminations, but they lack the specificity needed to help improve the processes. The top two termination reasons are, "Did not provide the required verification" and "Failure to complete or return form."

Of the families that do not complete renewal in time, 44 percent re-enroll within the subsequent 90 days. This suggests that these families have likely been disenrolled for process, rather than income eligibility reasons. Data on the cost to the State of re-enrollment would be useful in considering additional simplifications, but was not available.

As a cost-saving measure, in December 2007, MassHealth had shortened the timeframe to return the redetermination form from 60 to 45 days. In December 2008, the timeframe was shortened to 30 days. In response to CMS's interpretation of the requirements to receive additional matching dollars from the federal stimulus package, MassHealth has since returned to a 45 day timeframe to return the redetermination form. (Regardless of the timing of returning the renewal form, the member still has 60 days from that date to return the verifications.)

New Initiatives

MassHealth staff described several changes underway to simplify application and renewal processes to enroll and retain more children in coverage.

STREAMLINED RENEWAL

MassHealth has just begun a streamlined renewal option using the Virtual Gateway. For some CommonwealthCare members, assistors can help families complete an online renewal prior to the start of the mail renewal. However, once a renewal form is mailed, online renewal is no longer available, thereby preventing a family from having duplicative renewal forms under review simultaneously.

GREATER CUSTOMER INVOLVEMENT IN MANAGING THEIR BENEFITS

Staff believe that empowering members to manage their eligibility information will improve efficiency for families and workers. Therefore, MassHealth is re-tooling My Account Page to make it "customer-facing" – that is, to allow families to sign on independently, update contact information, and track eligibility information.

THIRD-PARTY DATA MATCHING

MassHealth has already gone further than most states in creating systems that look up eligibility information to reduce the documentation burden on families and workers, a process known as third-party data matching. Income and immigration status documentation can be challenging for families to supply, and if the State can look it up for applicants the State expects the number of incomplete applications will fall.

Data matching requires agencies to reach a data sharing agreement which addresses confidentiality and the process by which applicants' information will be looked up in the third party dataset. Other states have gotten bogged down with either the agreements or the mechanics of data sharing (e.g., identification numbers may not match, or the data held by the other agency may be out of date.)

MassHealth is working on two new matches that would benefit children:

- MassHealth already uses data in the State's quarterly wage report, but the information is not adequate for some families, including those who are self-employed and those whose income varies seasonally. MassHealth has a data match with the Department of Revenue to verify annual income for these families upon annual review. Those whose annual income is within five percent of eligibility levels (which allows for the possibility income has changed since the quarterly wage data was reported) can be determined eligible. Data were not yet available on the number of applications or renewals processed through the comparison and verification of the quarterly wage data.
- MassHealth has also begun matching with State Vital Statistics records to verify citizenship. Immigration status will be verified through matches with Medicare, the Social Security Administration and Department of Transitional Assistance. Soon matches will begin with other states' Vital Statistics to confirm out-of-state births. MassHealth could not supply data on how often they expect this match to be important.

Further matching may be possible in the future, such as identifying children receiving other public benefits. The Secretary of EOHHS issued a memo directing all agencies to cooperate in the development of an index of "common data" so they can communicate about a shared family and

develop a uniform client identifier. Each of the EOHHS agencies are subject to agency and program-specific federal and state statutes governing the disclosure of client data, the requirements of which must be analyzed and addressed to assure that such information is shared among those agencies only in a manner that meets the applicable requirements.

VOLATILITY REPORT

Recognizing that too many enrollees were not succeeding in retaining coverage at renewal, MassHealth staff are in the process of developing monthly volatility reports that will help them understand how many children lose coverage due to administrative barriers, move between eligibility categories, or lose eligibility for coverage. It reports point-in-time status of people in coverage, so that quarterly volatility reports will provide a sequence of snapshots, as opposed to allow longitudinal tracking of individuals.

Preliminary data suggest the churning figure is quite large. Forty-two percent of children do not renew on time, and of these, the reason recorded by staff is incomplete information. Thirty-four (34) percent of children joining the caseload each month are re-entries of children who had been covered in the last 90 days. No details are available about which type of information is causing the cancellation.

Strengths

Massachusetts' enrollment and renewal policies and processes for children demonstrate many outstanding features that are likely contributing to the high rate of coverage in the State. [5]

- **Breadth of coverage.** The completeness of the coverage options (such that all children are either enrolled in private coverage or eligible for a public program) has simplified the dialogue about enrolling and retaining children in coverage. In addition to the universal nature of coverage, the very high rate of enrollment means that outreach is a much simpler task. In fact, many suggested that all children are either in coverage (because the margin of error on the survey is about the same size as the uninsured number) or are in the database and can be flagged for follow-up (because they lost coverage at renewal, but can be identified.)
- **Family coverage.** The single application has clear advantages for identifying uninsured children of parents' applying for MassHealth and Commonwealth Care.
- **Organizational simplicity.** The early decision by Massachusetts to unify Medicaid and CHIP means policies are aligned, families are less confused, and children are enrolled in the programs for which they are eligible.
- **Web-based application.** Adoption of the Virtual Gateway has been a valuable tool in many ways. The embedded logic helps to collect all needed information with a higher degree of completeness than can be achieved in a paper application where families can skip questions or provide wrong answers. Because it is coordinated with other public benefits, it provides

[5] 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 that were not forthcoming in the assessment may also contribute to successful enrollment and renewal.

more complete help to low-income families. It is faster for staff to determine eligibility for a Virtual Gateway application than a paper application. Advocates report a high degree of satisfaction with the Virtual Gateway.

- **Navigation assistance.** The importance of the application assistors has not been assessed independently of the impact of the Virtual Gateway. It seems very likely, though, that the role they play in helping people navigate the system is essential for at least a subset of the population.
- **Long windows.** For renewal, many MassHealth policies seek to keep children in coverage rather than move them out. For example, the time enrollees are given a to complete a renewal (45 days following the end of the 12-month eligibility period plus an additional 60 days if needed) promotes continuity of coverage and doesn't penalize children if parents need more time for the renewal process. Also notably different than other states, children losing coverage for failure to pay premiums are reinstated rather than being made to reapply.
- **Reduced documentation.** Use of third-party data matching in Massachusetts removes a great deal of the documentation burden from families, though more needs to be known about how well it is working.

Challenges

There are some processes and systems that appear to inhibit successful enrollment and retention. There is little data to measure the actual impact of these factors, and further discussion about these is warranted in order to prioritize actions to address them.

- **Churning.** The number of children lost at renewal is clearly the largest challenge Massachusetts faces. Though at least one interviewee thought it may not be a big problem because children may be re-enrolled when they next need health care, national studies suggest that breaks in coverage have an impact on the use of primary and preventive care. Further, re-enrolling churners has costs to the State and to health plans. In California, for example, costs have been estimated at $180 for each child.[6] There are several factors contributing to churning that MassHealth has already identified related to mail-based renewal (e.g., outdated addresses, unclear letters, and families not opening letters). Competing priorities within families also contribute to failure to respond.
- **Difficulty receiving assistance by phone.** Phone assistance has been difficult for consumers and assistors. The regional enrollment centers are known to provide better information than the Call Center, but they are hard to reach by phone because of volume and the fact that they have to divert calls some days in order to process renewals and adult applications. In addition, advocates reported that the interactive voice response system (IVR) did not guide callers well to the right answers. Advocates and state officials agreed that better letters could reduce the demand for phone assistance.
- **Premiums as a potential barrier:** There was no data on the impact of premiums on enrollment and retention in MA, but national research shows that both the absolute amount

[6] Fairbrother, G. "How Much Does Churning in Medi-Cal Cost?" California Endowment, April 2005.

and the process of paying premiums is a barrier to retaining coverage. Again, more information is needed to know if this is a big or a small problem in Massachusetts.

- **Need for more data and analysis.** The absence of data hampers Massachusett's ability to analyze and improve enrollment. Several types of information could help MassHealth understand the impact of past changes and guide further improvements. For example, we suggest collecting and using information on:
    - Families' views of the reasons for disenrollment
    - Reasons for application denials (e.g., completeness of the paper applications, how often documentation is requested and provided); and differences in successes between electronic and paper applications
    - Reasons for high call volume to the enrollment centers and Call Center
- **Resource constraints.** The CPU and enrollment centers may not have the capacity they need to sustain the current pace of application and renewal processing. The volume keeps rising, while resources are tight for hiring new staff. Resource constraints are also evident in the recent eligibility changes for 31,000 legal immigrants in Commonwealth Care. Absent an increase in resources, Massachusetts may need to consider other strategies for improving efficiencies.
- **Potential loss of application assistance.** MassHealth wants to allow families to use the VG without relying on application assistors, but advocates and assistors were skeptical that families would be able to navigate it. Testing with consumers could help answer this question.

2. Interagency Coordination

Current Approach to Medicaid and CHIP Coordination

Medicaid and CHIP are managed as a single program, with a joint eligibility system called MA21. MA21 calculates the highest level of benefits a child is eligible for and approves the child in that eligibility category internally, while simply calling the program MassHealth externally. For example, when approximately 11,000 children in the state-funded CMSP were upgraded to CHIP in 2006, those children experienced no disruption in coverage.

Policy, operations, and communications functions for Medicaid and CHIP are unified. Because the staff of the CPU and the four regional enrollment centers are state employees, Massachusetts lacks many of the coordination challenges faced by states where enrollment and renewal is handled by a different entity.

Current Approach to Coordination Between Health Insurance and Other Public Programs

Four other agencies that are part of the Executive Office of Health and Human Services (EOHHS) play supporting roles in children's coverage. The Department of Public Health runs a toll-free call-line and helps families connect with coverage. The Boston Mayor's hotline, just one of the public health points of contact for consumers, fields 10,000 calls a year related to health insurance coverage. In

addition, MassHealth and DPH are collaborating on the use of the Vital Records data to alleviate families' burden of documentation of citizenship. MassHealth is working with the Department of Revenue to allow use of income tax data for income verification. The Departments of Transitional Assistance and Youth Services enroll the children whom they serve. The Division of Health Care Finance and Policy provides research and analytic support about health care reform, including the annual coverage survey.

The development of a uniform client index would assist with coordination across programs. As noted above, each of the EOHHS constituent agencies are subject to agency and program-specific federal and state statutes governing disclosure of client data, the requirements of which must be analyzed and addressed to assure that such information is shared among those agencies only in a manner that meets the applicable requirements.

Strengths

- **Coordination works from the families' vantage point.** Families experience Medicaid and CHIP benefits seamlessly as MassHealth, so there is no confusion as is seen in some states.
- **Data sharing agreements.** Massachusetts is one of the very few states (New Jersey and Iowa being the others) to have successfully navigated data sharing with their tax department for determining eligibility for children.

Challenges

- **Lack of a single child identifier.** The effort by the Secretary of EOHHS to direct agencies to collaborate on a common client identifier across public programs is progressing slowly as each of the EOHHS constituent agencies are subject to agency and program-specific federal and state statutes governing disclosure of client data, the requirements of which must be analyzed and addressed to assure that such information is shared among those agencies only in a manner that meets the applicable requirements.

3. Analytic Capacity for Program Management and Decision-Making

Current Approach

States need to collect and analyze data that help them "understand the populations they are targeting, the impact of changes they make, and to compare themselves to other states."[7] MassHealth has a data warehouse that includes current and past enrollees and uses a single child identification method so that information about children's eligibility and enrollment can be examined. Data are provided by internal staff who are part of another department, but co-located with agency staff. MassHealth staff have ready access to the information they need both through requests from the data warehouse and using a decision-support system that can provide pre-built and ad hoc reports.

Data provided to us showed that the State runs regular reports for monitoring program enrollment and disenrollment, but that children are not followed over time (i.e., longitudinally) to examine movement

[7] Wachino and Weiss, 2009.

on and off the program. A new volatility report (as described in the enrollment/renewal section) is intended to assist the MassHealth operations staff in examining patterns of churning to help with future policy changes.

The Division of Health Care Finance and Policy funds a periodic state health insurance survey that provides MassHealth with uninsured rates and some demographic characteristics of the uninsured. In recent years, the survey has been conducted annually.

New Initiatives

Through the development of a common data index and data sharing agreements, the State is looking to improve the capacity to track children who receive benefits from other public programs, and assure that they receive health insurance if they are eligible.

The State has invested in a new information system that was implemented this spring.

Strengths

- **Information system capacity.** The current eligibility system, MA21, is capable of producing longitudinal data about enrollees to support the program.
- **Current data on the uninsured.** The State has funded periodic household surveys to quantify and describe characteristics of the uninsured.
- **Report generation.** The Volatility Report will soon provide better information about coverage stability, and there are possibilities of getting more specific drilling down into the data information about the impact of policy or process changes. Further enhancements are possible, such as stratifications of the population by age, income, race, ethnicity, and geography.

Challenges

- **Making full use of data.** State staff may not be thinking of their data systems as a tool for process redesign. We did not see that data are being used systematically to identify the need for program improvements, nor did appear that process improvements were being measured and tracked.
- **Longitudinal analysis of churning.** As beneficial as the volatility report is relative to currently available data, the State is relying on repeated snapshots of enrollment (e.g., monthly) rather than tracking children longitudinally, which could provide other useful insights.
- **Understanding reasons for disenrollment.** The State is not collecting detailed information about the causes of disenrollment. Better coding would help the State track and quantify reasons for disenrollment to better enable them to prioritize changes.

4. Client-Centered Organizational Culture

Current Approach

Massachusetts has gone far in de-stigmatizing public health insurance. The attention that has been paid to universal health insurance coverage through health reform has raised awareness of the importance of health insurance for everyone, and the intention of the State to help those who cannot afford private coverage, even in higher income levels than were previously covered.

Interviewees reported that the stigma sometimes experienced by clients of public programs is not evident in Massachusetts. No one relayed stories of clients being treated disrespectfully. The primary concern voiced by advocates and community-based organizations was the difficulty people faced in trying to get answers to questions about their eligibility or a letter they had received. They attribute this to resource constraints, not ill-will. Advocates say they have an opportunity to represent consumer concerns to the agency at monthly meetings, and that they feel the input is valued.

Long waits are not limited to just phone calls. At the Revere enrollment center (the only one of the four we spoke with), a waiting area and interview rooms were designed to handle 30 walk-ins per day, but currently see 150 walk-ins per day resulting in delays and overcrowding.

As we spoke to MassHealth staff from a variety of departments, they all indicated broad support for the agency's coverage mission. For example, the CPU Director said eligibility workers are told that if someone appears eligible, be as flexible as possible within program requirements in interpreting applicant's information. Another example given is that staff can move a renewal form to the top of their order if there's a risk that the child is about to lose coverage. Further, workers prioritize ERVs that are past due above ERVs that come in within the normal 45 day period. The worker can generally complete an overdue ERV in four to five days. This helps keep eligible children in the program.

Strengths

- **Advocates are a welcome voice of the consumer.** There is a good and close working relationship with advocates that promotes a client-centered organizational culture. Conversations between advocates and the State have been constructive according to both groups.
- **Positive enrollment culture.** The culture at the CPU and the MEC supports flexibility and enrolling/retaining kids.

Challenges

- **Consumer access to information is constrained.** A consumer's success with the call center can depend on how well they know how to use the system. One community-based organization reported training consumers on how to structure their questions so they get the information they need, and how to skip through voice response systems to reach a person rather than a recording.

- **Market testing is not part of the mindset.** MassHealth did not have data to indicate whether families felt an outward facing Virtual Gateway would be an improvement for them, nor does MassHealth know how burdensome paperwork is for families. Having seen the tool, the authors of this paper also had concerns that many families could find it difficult to navigate.

5. Non-Governmental Partnerships and Outreach

Current Approach

Massachusetts has moved entirely to a private sector approach to outreach and enrollment. The Health Care Reform Outreach and Education Unit was formed in 2008 to coordinate outreach efforts, disseminate educational materials, and collaborate with state and community based agencies. Outreach grants have been given out to 45 community-based, consumer focused, non-profit organizations over the past two years to conduct outreach and enrollment in the community to those uninsured and underinsured Massachusetts residents. In that time, outreach grant recipients have helped over 86,780 individuals apply for and 17,500 renew coverage in all MA public programs. MassHealth staff along with other sister health and human service agencies provide high quality training on changes to programs and policies and procedures to community based partners and providers through the Massachusetts Health Care Training Forum (MTF) program. This includes local eligibility offices meeting face to face with advocates and providers in their community to talk about outreach, enrollment, and retention as well as providing the opportunity for networking with colleagues and identifying resources to help them better serve the populations they serve. Community-based organizations, community health centers, hospitals, and health plans assist families in applying for and retaining coverage

Faced with greatly diminished state resources, neither the Governor's proposed budget nor the House proposal included outreach funding for the upcoming fiscal year. There was a risk that grant funding for outreach assistance would end, which could negatively impact enrollment and retention. However, in early July, the final budget did include $2.5 million to fund organizations providing outreach and enrollment assistance.

The Office of Medicaid has recently pursued federal outreach grant funding for children enrollment and retention into MassHealth, through CMS' CHIPRA Outreach and Enrollment funding opportunity. The Office of Medicaid submitted a grant proposal in August 2009 which includes an in-depth targeted approach involving conducting a community needs assessment specific to children and teen populations who remain unenrolled or who are having difficulties utilizing the system. Based on findings of the assessment, implementation of targeted outreach strategies and approaches in youth programs, daycare centers and other community settings, with particular focus on those children and families with limited English proficiency, and those unemployed and underemployed parents and getting their children enrolled, will be core components of the approach. Also, additional supports to outreach efforts will include the creation and wide disseminate of culturally and linguistic materials (print, audio, and websites) that resonate with different identified target populations. If awarded funding, the Office of Medicaid would ensure all messaging and approaches would dovetail with the HHS National Outreach and Enrollment Campaign.

As noted in the prior section, advocates had very positive messages about MassHealth. MassHealth meets with consumer advocates regularly, takes input well, and mostly shares information with

advocates. Program and policy updates are provided as well as communication about operational enhancements. These include recent enhancements to the Virtual Gateway's My Account Page and 24/7 telephonic self service that has been implemented to help address call volume to MassHealth customer service and enrollment centers.

Strengths

- **CBOs are effective in finding and enrolling children.** The State's heavy reliance on CBOs and providers for outreach and enrollment assistance has been successful in enrolling almost all eligible children in coverage. No one identified a group of children that has been overlooked in outreach and enrollment efforts.
- **Good relationship with advocates.** Advocates are seen as partners and have good access to State staff.

Challenges

- **Maintaining the commitment to outreach.** The budget process that nearly ended the State's outreach grant funding effort suggests the importance of CBOs to consumers may be undervalued. CBOs we interviewed know a proportion of their clients would not be able to navigate the application and renewal processes independently. If outreach workers are not supported through grant funding in the future, it is quite possible that enrollment and retention will decline. The continuation of learning opportunities for outreach workers and front-line staff through the MTF program and advocate meetings remain an important educational support for Massachusetts community outreach efforts.
- **More assistance available at renewal.** MassHealth, through My Account Page, provides Virtual Gateway providers with electronic copies of notices on when a renewal form has been sent to a member, as well as listing what information is needed in order to process the renewal. Virtual Gateway providers have expressed that more information about when a renewal was submitted to and received by MassHealth would be helpful information to have in the future. Knowing this information will avoid calls from Virtual Gateway providers and members to obtain the status as to whether MassHealth has received the renewal paperwork.

6. State Leadership

Current Approach

Massachusetts has made an unprecedented commitment of public resources to covering uninsured residents. Executive and legislative branch involvement in sustaining and improving MassHealth was evident during our meetings and in the materials provided. The Senate President is personally committed to health reform's success. EOHHS Secretary Bigby has health reform on her regular agenda to discuss with heads of health and human services agencies. EOHHS provides reports to the legislature every 60 days on the status of health care reform implementation.

In last year's session, specific improvements in children's coverage included: expansion of coverage to children aging out of DSS care up to age 21 and the elimination of premium payments for families under 150 percent FPL.

In the 2009 session, there were no cuts to children's coverage or benefits, despite the budget crisis. The Governor testified before Congress on the importance of coverage, and his budget reflected this priority.

New Initiatives

A new bill was introduced in 2009 to institute continuous eligibility for kids.

Strengths

- **Evidence of leadership commitment to coverage.** Interviews and a track record of health reform legislation make it clear that Massachusetts leadership has embraced the goal of children's coverage and committed resources to the goal.

Challenges

- **Budget constraints.** Like most states, Massachusetts faced severe budget constraints this year and will continue to be challenged to cover health care costs in the next few years. One of the ways this impacts the children's coverage is that staffing is very tight and could impact the effectiveness of the program.

Opportunities

Based on our understanding of Massachusetts current practices, systems, and partnerships, we have identified the following opportunities to help the State realize its goal of maximizing enrollment of eligible children:

Reduce churning, which disrupts access to care and costs the State in staff processing time. Determining the best way to reduce churning in Massachusetts will require talking with other states about their experiences, and analyzing existing data.

1. Simplify renewal for lower income children by eliminating documentation requirements, and instead verify eligibility with existing data -- a process called ex parte renewal. Experiences of other states may be instructive:
    a. Illinois renews children in families with incomes up to 150 percent FPL without requiring contact with the family. Ninety-five (95) percent of eligible children stay in the program at renewal.
    b. Louisiana renews 98 percent of their children without requiring family contact, based on the Food Stamps eligibility.

2. If ex parte renewal is not feasible, consider working with health plans or providers to renew children at the time they seek health care services, or by outreaching to them. In New York, health plans participate in CHIP renewal, with a resultant renewal rate of 77 percent.
3. Analyze existing data on renewal and retention to inform policy decisions:
    a. Conduct further analyses of the potential churning problem, not limited to the information captured in the volatility report. For example, conduct focus groups with families to learn more about current barriers and get their feedback about proposed improvements.
    b. Conduct a longitudinal analysis of children's eligibility (i.e., track children by ID number over time) to understand who is churning. Consider focus groups of families who have been churning to understand their barriers to staying enrolled. This is different than the volatility report, which is a series of snapshots, but which provides aggregate information.
    c. Conduct a small study to quantify the costs of churning, which could be valuable to help the State commit resources to any solutions that have costs associated with them.
    d. Learn more about current third party data matching. It should be helping greatly with the eligibility determination and if it's not, look at whether or not the assistance is specific enough to help families accurately estimate their eligible income. Maybe question wording could be clarified, or assistors could get new training on guiding that process.
    e. Collect information from the Call Center on the information needs of callers, and look for system improvements that could address work with advocates to document problems and perceptions.
    f. Examine options for supporting application assistance in the absence of outreach grants. Which populations need it? Who are the right groups to provide it – providers, plans, CBOs, public health?

Target outreach and assistance to those who would benefit the most.

1. States with many eligible but uninsured children need multiple outreach strategies to find and enroll children. But with just 1.2 percent uninsured, and a very high churn rate, we think Massachusetts' outreach efforts should start with those children who are (we assume) in the data system, but not currently enrolled. The State could try to identify the children who have been enrolled in MassHealth in the past but are currently uninsured. Evaluate currently available information from existing data to determine the proportion who are likely to still be eligible for coverage. Obtain wage or tax data for a sample in order to be able to estimate the proportion still eligible. Develop outreach to these families to re-enroll children still needing coverage, working with the entity that provided them application assistance, if there was one.
2. Working with the schools, one of the priorities identified in the grant application, is likely to be a lot of work for a relatively small payoff in finding uninsured children.
3. Collect and analyze data on people calling for assistance. Understand what information people are people seeking, and how does not getting the answer they need in a timely way affect children's coverage? If this problem has a large impact, consider partnerships that may provide better call response time and helpfulness.

4. Understand the likely need for assistance when the Virtual Gateway becomes accessible to families. Examine the experience of other states (UT, GA) in using outward facing web-based applications. How much simplification did they achieve? Savings in staff time? How did families respond? Which families still needed assistance?

Other opportunities:

1. Determine the impact of premium payment on retention.
2. Make sure new letters are sufficiently clear. Test them with consumers. If they are not clear enough, determine what legal concerns must be addressed in letters, and which may be the result of too strict an interpretation of statute. Look at letters from other states for ideas.
3. Put computers in the MECs where families are currently experiencing long waits for assistance. In Utah, for example, where they have placed computers in enrollment centers, staff are available to help applicants when needed, but the electronic application is completed rather than a paper one.
4. Work on improving addresses through inter-agency information sharing, and using an address updating protocol during every phone call.

Appendix I

Diagnostic Assessment Interview Participants

Name/Title	Organization
Philip Poley, Chief Operating Officer	MassHealth
Russ Kulp, Operations Director	MassHealth
Amy Andrade, Director of Eligibilty Processing and Member Policy Implementation	MassHealth
Amy Dybas, Team Manager, Policy and Implementation Unit,	MassHealth
Josh Ruminski, Deputy Director	MassHealth
Robin Callahan, Director, Member Policy and Program Development	MassHealth
Carolyn Pitzi, Outreach and Education Manager	MassHealth
Howard Caplan, Director of Staff Development, Virtual Gateway	MassHealth
Patricia Murphy, Director	MassHealth Central Processing Unit
Dan Shea, Director	Revere MassHealth Enrollment Center
Judy Fleisher, Senior Project Lead, MA Maximizing Enrollment for Kids Program	University of Massachusetts Medical School
Judy Ann Bigby, MD, Secretary	Executive Office of Health and Human Services
David Seltz, Senior Policy Advisor	Massachusetts Senate President's Office
Neil Cronin, Advocate	Mass Law Reform Institute
Lindsay Tucker, Health Reform Policy Manager	Health Care for All
Matt Noyes, Children's Health Coordinator	Health Care for All
Danna Boughton and Brian Eno Outreach coordinators	Community Action of the Franklin, Hampshire, & North Quabbin Regions
Pat Edraos, Health Resources Director	Mass League of Community Health Centers
Meg Kroeplin, Executive Director	Community Partners

Appendix II

Data on Children's Coverage

Table 1. MassHealth and CMSP Enrollment 2004-2008

	Total	Title XIX	Title XIX Expansion	Title XXI Separate Child Health	CMSP
FFY 2004	443,868	347,715	44,627	20,525	31,001
FFY 2005	490,345	387,310	48,303	24,778	29,954
FFY 2006	492,203	384,335	51,640	36,693	19,535
FFY 2007	490,464	376,061	47,956	48,689	17,758
FFY 2008	509,173	391,229	52,776	47,828	17,340

MassHealth Enrollment Source: CMS Statistical Enrollment Data System (SEDS)

CMSP Source: Unicare, the CMSP vendor.

Notes:

1. Massachusetts has a combination program, where some CHIP funds are used to expand the Medicaid program (the column titled XIX expansion) and some are used as a designated separate program (the column titled Title XXI Separate Child Health). Figures represent enrollees at the end of the year.
2. There are some CMSP children that qualify for and are enrolled in MassHealth Limited, which provides additional benefits. These children would also be counted in the Title XIX column.

Table 2. 5-Year Uninsured Trends for Children

Uninsured Children	2000	2002	2004	2006	2007
All uninsured children	3%	3.2%	3.2%	2.5%	2.3%
Eligible but not enrolled					
<=200 FPL	4.4%	6.2 %	6.3%	3.6%	N/A
>200 FPL	1.8%	1.7%	1.8%	1.6%	N/A

SOURCE: Division of Healthcare Finance and Policy Massachusetts Household Health Insurance Survey 2007 (June 2008) – For 2007 Only

Division of Healthcare Finance and Policy Massachusetts Health Insurance Status of Residents Report, 5th Edition (December 2006), Chart Book 2006, 2004, 2000, 1998.

Table 3. Characteristics of MA Children, by Insurance Status

	Number of Children				
	Total Children	Total Insured	Total Uninsured	Uninsured, Eligible for Public Program	Enrolled in Public Coverage**
Year: 2009					
Age					
0-18	1,538,737	1,509,414	29,323	All uninsured children are eligible for public coverage	277,849
Race/Ethnicity					
African Am./Black	Not Available			"	
White, Non-Hispanic	1,111,223	1,090,863	20,360	"	105,947
Hispanic	170,078	168,245	1,833	"	83,353
Asian	Not Available			"	
Non-white, non Hispanic	257,436	250,306	7,130	"	88,549
Poverty					
Less than 150% FPL	330,465	321,523	8,842	"	186,835
150% to 299% FPL	310,121	293,419	16,702	"	69,468
> 300% FPL	898,152	894,473	3,679	"	21,546
TOTAL	1,538,737	1,509,414	29,323	"	277,849

*If eligibility for public coverage is extended to an age beyond 18 (e.g., 19, 21, 25), please indicate and include totals up to the eligible age limit.

** The number represents those enrolled in MassHealth, Commonwealth Care, and Commonwealth Choice programs. It most likely does not include children in MassHealth Premium Assistance as most respondents with this coverage would indicate that they have employer-sponsored insurance. Even though Commonwealth Choice is not a public program, it is combined with MassHealth and Commonwealth Care due to potential respondent confusion about health care reform programs. In addition, children enrolled in Medicare are excluded from this number.

SOURCE: Urban Institute Tabulations of the 2009 Massachusetts Health Insurance Survey, Division of Health Care Finance and Policy