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

A Maximizing Enrollment for Kids Diagnostic Assessment Series

By

Caroline Davis

Lisa Duchon

Health Management Associates

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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.

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Executive Summary

In February 2009, Virginia 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 Virginia's enrollment and retention of eligible children.

Findings

Over the last seven years, Virginia has implemented a number of policies and procedures to streamline and simplify enrollment and retention processes for the Commonwealth's Medicaid and CHIP programs (known as FAMIS Plus and FAMIS, respectively).[1] By 2007, over 90 percent of children in Virginia had health insurance coverage. Of the remaining 9.6 percent, approximately two-thirds were eligible for but not enrolled in public coverage. Based on the site visit interviews, review of materials provided by Virginia, and best practices across the states, the following themes emerged from the Virginia diagnostic assessment:

- **Virginia has taken important steps to improve the ease with which children can enroll in and retain coverage.** Virginia has adopted a "No Wrong Door" approach to children's coverage which allows families to submit an application through a local social services office by mail, fax or in person, or centrally by mail, fax, or online. Paperwork at renewal has been reduced for families.
- **Despite committed leadership, valued partnerships, and a strong sense of mission, the complexity of Virginia's program management has impeded further simplifications to eligibility and retention processes.** The Department of Medical Assistance Services (DMAS) has overall responsibility for Medicaid and CHIP, but co-manages the eligibility and renewal functions with the Virginia Department of Social Services (DSS), which oversees 120 locally administrated social service agencies across the Commonwealth. This bifurcated structure has created two separate eligibility determination systems, organizational cultures, and practice standards. Most of the improvements DMAS would like to make to reach its goal of 95 percent enrollment have hit a structural barrier related to these program differences.

[1] The CHIP program began in 1998 as a Medicaid Expansion program and was called CMISIP. It was redesigned in 2001 as a separate CHIP program and was given the name FAMIS. Later, Virginia renamed the Medicaid program FAMIS Plus to connect it with the more popular FAMIS program and reduce negative CHIP program and was given the name FAMIS. Later, Virginia renamed the Medicaid program FAMIS Plus to connect it with the more popular FAMIS program and reduce negative associations with welfare. The "Plus" was added to indicate that Medicaid provided more benefits than FAMIS. Based upon site visit observations and review of materials, however, it appears that at least some local social service agencies and their clients continue to call the program Medicaid.

- **One of the most significant challenges resulting from the shared responsibility is the limited abilities of DSS and DMAS to exchange data to manage the programs on a day-to-day basis.** Virginia's two separate data systems, one maintained by DSS and the other by a DMAS-contracted Central Processing Unit (CPU), do not interface with each other. The Commonwealth cannot track sources of applications, reasons for disenrollment, and rates of churning for all children. This kind of information that could inform managers about where and how to target resources to improve enrollment and retention, and would have contributed to this assessment.
- **Parents are expected to play an active role in the eligibility and renewal process.** Applicants and enrollees bear much of the responsibility for getting and retaining coverage. A recent survey of families and anecdotal reports from staff indicate that failure to provide required documentation is the most common reason why children lose coverage. As Virginia continues to drive more enrollment online, it would be advantageous to adopt procedures that further shift the burden of required verification from families to the Commonwealth. Both FAMIS programs could expand their use of third-party data sources, adopt other processes such as adding more community-based application assisters, and explore other opportunities to help families make the most of online tools. Such changes would additionally help the agencies maximize administrative efficiencies.
- **The Commonwealth's partnership with the Virginia Health Care Foundation brings additional support that does not otherwise exist in the public sector.** The Foundation, which is supported by Commonwealth funding and private contributions, publishes a biennial study of the uninsured, provides leadership to a key advisory committee, the Children's Health Insurance Program Advisory Committee (CHIPAC), and collaborates with Commonwealth staff to support outreach, enrollment and retention efforts by community-based organizations (CBOs). The Commonwealth contracts with the Foundation to provide grants to four community-based organizations that hire outreach workers to assist families with applications. VHCF raises private funds to supplement this effort, currently funding four additional outreach projects. Local CBOs target communities identified by surveys with the highest need. At the same time, Virginia has not established statewide partnerships with CBOs to certify them as online application assisters, as some states have, which then market the availability of CBOs in the communities they serve. Other states have used this strategy to help alleviate the workload of local DSS agencies—the primary source of face-to-face assistance for families.

Based on our understanding of Virginia's current practices, systems and administrative structure, we believe the following may provide the best opportunities for the Commonwealth to move closer to its goal of maximizing coverage to eligible children:

- Develop an analytic agenda, assessing the impact of current policies and practices on enrollment and retention rates. Where data are not accessible, consider small scale, manual data collection and analysis that do not rely on the full program dataset.
- Strengthen relationships with the FAMIS programs' internal stakeholders to improve program coordination, management and decision-making as well as to leverage stakeholders' expertise to improve enrollment and retention rates.

- Further promote a customer-centered organizational culture in the FAMIS programs by aligning processes for enrolling and retaining children in coverage and lessening the burden placed on families to apply for or renew coverage. This includes increasing reliance on third party data matching.
- Share information about children's coverage with key policymakers, particularly information about the impact of churning on program efficiency and quality of care for children's health to build support for future improvements.
- Evaluate the costs and benefits of needed systems upgrades to enhance data analysis capabilities and streamline processes.

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 Virginia.

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 Virginia 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 Virginia's Health Insurance Programs for Children

Over ninety percent of Virginia's children are currently enrolled in public or private health insurance coverage. Virginia's uninsured rate for children is 9.3 percent according to the most recent federal statistics.[3] State officials estimate that two-thirds of uninsured children are eligible for public coverage.[4] Hispanic children are more than three times as likely to be uninsured as non-Hispanic children (24.6 percent v. 7.2 percent). Low income children (under 200 percent FPL) have the highest uninsured rates (between 17 percent and 20 percent). Just eight percent of middle income children (201 to 300 percent FPL) are uninsured, as are 3.5 percent of children above 300 percent FPL.[5]

As of early 2009, over 491,000 children in Virginia were enrolled in public health insurance, as shown in Appendix II, Table 1. Most are FAMIS Plus (Medicaid for children) enrollees, with just 15 percent enrolled in FAMIS, the Separate CHIP program.

Eligibility for Coverage

With the CHIP funds made available in 1997, Virginia both expanded Medicaid eligibility and added a separate CHIP program. The children's Medicaid program, FAMIS Plus, extends coverage to 133 percent of FPL to children ages six to 19. Virginia's separate CHIP program, FAMIS, covers eligible children up to 200 percent of FPL. No premiums are required in either program. Virginia will provide premium assistance to enroll children in private coverage (employer or other private health plan) at a set amount deemed cost-effective to the Commonwealth.

Since 2002, Virginia has made a number of improvements to streamline eligibility and enrollment and remove barriers for FAMIS Plus and FAMIS including:

- Implementing a single application for multiple programs (FAMIS Plus, FAMIS, FAMIS MOMS, and Medicaid for Pregnant Women);
- Rebranding Medicaid for Children as FAMIS Plus;
- Reducing the number of required verifications;
- Implementing ex parte renewal for some FAMIS Plus enrollees;
- Increasing use of online applications for children's programs; and
- Allowing FAMIS Plus applicants one year to provide their DRA citizenship and identity documentation (i.e., new applicants are enrolled in FAMIS Plus and do not have to provide the necessary documents until the first annual redetermination occurs).

[3] KFF State Health Facts, 2007-2008, CPS analysis

[4] Genevieve Kenney, Louise Palmer, Allison Cook, and Aimee Williams, "Profile of Virginia's Uninsured and Trends in Health Insurance Coverage, 200-2006," The Urban Institute for The Virginia Health Care Foundation, February 2008.

[5] Kenney, et.al., 2008.

Leadership and Political Context

Two state agencies are involved in managing and administering the FAMIS Plus and FAMIS programs: the Department of Medical Assistance Services (DMAS) and the Virginia Department of Social Services (VDSS). DMAS sets overall policy for both programs, but the two agencies share responsibility for eligibility and renewal functions, as is the case in many states. DMAS eligibility determination processes, designed for the CHIP program in 2001, rely on a newer information system and are carried out by a private contractor in a centralized, modern facility. VDSS eligibility determination processes grew out of the historic connection between Medicaid and welfare, rely on older software systems and are carried out by local employees across 120 local departments of social services. As in other states with local eligibility offices, there is potential for inconsistencies in processes, resources, leadership; thus, client experiences can vary significantly from office to office. This complexity, not unique to Virginia, makes coordination of programs more challenging.

Prior Governors and Legislatures have been strong supporters of covering all eligible children.[6] In Virginia, however, the governor's office is a four-year, one-term position, which means the Governor's leadership, and potentially that of current agency heads, has a short time horizon. The Children's Health Insurance Program Advisory Committee (CHIPAC) was established by the legislature in 2004 to ensure a permanent, high-level focus on the FAMIS programs and children's health insurance coverage.

Applying for and Renewing Coverage

Virginia uses a joint application for children and pregnant women which can be submitted by mail, fax, online, or in person. There is no asset test for FAMIS Plus or FAMIS, no face-to-face interview is required, and enrollees do not have to pay a premium. Applicants have 45 days from the date of application to provide all needed documentation. Children's coverage must be renewed every 12 months. Ex parte renewals are available for some Medicaid enrollees.

Priorities Identified by the Grantee

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

- Enroll 95 percent of eligible but unenrolled children by the end of the Maximizing Enrollment grant period through the following strategies:
  - Implementing electronic renewal notices;
  - Implementing data exchanges with the National School Lunch Program;
  - Implementing electronic verification of citizenship and identity; and
  - Tracking enrollment and retention trends.
- Improve data analysis capabilities by combining data from the Commonwealth's Medicaid Management Information System (VaMMIS), the Department of Social Services, and the CPU's eligibility system (known as CHAMPS) to monitor enrollment trends and policy impacts.

[6] Since the research period for this report (February – June 2009), Virginia elected a new Governor. Governor Robert McDonnell was inaugurated in January 2010.

Findings from the Diagnostic Assessment

1. Enrollment and Renewal Processes and Policies

Current Approach to Enrollment

Virginia has taken steps to make the process of applying for children's coverage simple for families. The Commonwealth has adopted a "No Wrong Door" policy and a joint Medicaid/CHIP application.[7] For children, families may apply for coverage by mail, fax, online, or in person for either program. An application can be started by phone with CPU staff who will then mail it pre-populated to the family for signature. Further, families can receive application assistance by applying in person at an LDSS office, and in some areas of the Commonwealth, through a CBO. Families seeking TANF and Food Stamps must use the LDSS office. A study of Virginia's efforts to streamline eligibility found that Medicaid enrollment increased by 43 percent during the quarter in which the "No Wrong Door" policy was implemented.[8]

As of May 22, 2009, Virginia began following federal legislation that provides a "reasonable opportunity" period for individuals to be enrolled until the time of their next annual renewal, without providing documentation of citizenship and identity, providing they meet all other eligibility criteria for Medicaid. Virginia plans to implement the SSN match with Social Security Administration (SSA) in 2010. For identity, Virginia uses an affidavit on applications for children under age 16 and uses Department of Motor Vehicles' electronic records for children ages 16 and older. The Commonwealth also uses a batch electronic verification process with the Virginia Department of Health (VDH) to verify citizenship status for Virginia births.

Applicants who use the online application are required to submit a hard copy signature page via fax or mail. Once a signed application is received, applicants have 45 days to provide all information and documentation necessary to complete it. However, the eligibility determination process depends on whether the application is submitted to the LDSS or CPU. Both of these processes are discussed in detail below.

Data about the proportion of applications submitted in each method and their success rates are unavailable, limiting Virginia's, and our, ability to learn about the impact of current practices on enrollment.

ENROLLMENT THROUGH THE LDSS

A paper application received by an LDSS office is entered into both a local application tracking system and ADAPT, the eligibility determination system operated by VDSS. The application may be submitted in person, by fax or mail. If any information required for determining eligibility is missing, a worker provides the applicant with a list of outstanding verifications or sends a letter to the applicant to request that missing information or documentation be returned within 10 days. Often the eligibility worker will follow up by phone for additional information. Applications that remain incomplete are normally denied by ADAPT at day 45.

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[7] As noted earlier, the joint application for children and pregnant women can also be used to apply for FAMIS MOMS and Medicaid coverage.

[8] Embry Howell, Christopher Trenholm, Kathy Gifford, and Bridget Lavin, "Covering Kids and Families Evaluation Case Study of Virginia: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice," Mathematica Policy Research, Inc., The Urban Institute, and Health Management Associates for The Robert Wood Johnson Foundation, July 2006. Available at: http://www.allhealth.org/BriefingMaterials/CaseStudyofVirginia-565.pdf.

If a case is determined eligible by ADAPT for one of the FAMIS programs, the case is entered into the VaMMIS system either through an interface with ADAPT and the VaMMIS or manually by the eligibility worker. Upon entry into VaMMIS, the child is officially enrolled in either FAMIS Plus or FAMIS. If the child is eligible for Medicaid, the LDSS office will maintain the case and is responsible for conducting the renewal process. If the child is eligible for Separate CHIP (FAMIS), the application is batched with other case files and electronically forwarded by ADAPT to the CPU for processing and follow-up. The CPU will enter the case into the CHIP eligibility system, CHAMPS, and is responsible for ongoing case maintenance and the renewal process.

Some LDSS agencies, through negotiations with community hospitals, local health departments and other providers agree to outstation eligibility workers at provider sites that predominantly service women and children. At the local social service agency visited during the site visit, a Spanish-speaking employee works almost exclusively in the field conducting outreach and application assistance. DMAS did not have data on the number of LDSS workers out stationed across the Commonwealth, or their locations.

ENROLLMENT THROUGH THE CPU

The Central Processing Unit (CPU) vendor, Affiliated Computer Systems, handles paper applications received by mail or fax as well as all applications submitted online. According to DMAS officials, as of August of 2009, on average just over half (52%) of new applications received at the CPU were submitted online. The remainder is submitted by either mail or fax, with mail comprising the largest percentage of the two sources.

Upon receipt, all applications are scanned, indexed and entered into a queue for review by a clerk to determine if the case already exists in CHAMPS. Applications are reviewed for completeness, and, if incomplete, the CPU worker will attempt a call to the family if the missing information can be gathered verbally. If documentation is required, the worker will initiate the “deficiency” process which puts the application into a pending status. A “deficiency” letter is auto-generated for the client showing the missing information needed. If the information is not received within 30 days after a deficiency letter is issued, CHAMPS will initiate the denial process.

Once the application is complete, a CPU worker will review the eligibility determination within the CHAMPS system. If the application is approved for FAMIS, the CPU worker will update enrollment in CHAMPS, which will automatically generate a confirmation letter. The following business day a report will be generated indicating that the enrollment is ready to be manually entered into VaMMIS.

If the applicant is eligible for FAMIS Plus, the case is forwarded to the FAMIS Plus Unit (FPU) co-located in the CPU offices and staffed by Commonwealth DMAS eligibility workers. DMAS co-located staff has 45 days from the date of receipt by the CPU to complete the case to decision.

If the reasonable opportunity guidelines established by CMS which allows children to be enrolled for up to one year with a pending verification of citizenship and identity (DMAS put this policy into effect May 22, 2009). If approved, the FPU worker updates case information in CHAMPS and enrollment status in VaMMIS. The final step is to print all application documents related to the case, which are then assembled and mailed to the appropriate LDSS for case maintenance and renewal.

APPLICATION DENIAL RATES AND PROCESSING TIMES

Data were not available on denial rates for applications processed by LDSS offices. Officials estimated that 28 percent of all applications (new and renewals) received in the CPU were denied for either ineligibility or incompleteness.

While all applications must be processed within 45 days of receipt, the Commonwealth holds the LDSS offices and CPU to different processing standards. For the LDSS offices, VDSS requires that 97 percent of FAMIS and FAMIS Plus applications be processed within 45 days, and measures accuracy through MEQC pilots, quality assurance activities and monitoring by VDSS staff and local agency supervisors. The Commonwealth reported that 90 percent of applications were processed within 45 days in March 2009. No data were available regarding the LDSS offices' accuracy rate. For Separate CHIP applications submitted to the CPU, DMAS requires that the CPU process complete applications within 12 business days with a 95 percent accuracy rate. The current average application processing time for the CPU is eight business days with an accuracy rate of 97.1 percent.

NO PREMIUMS REQUIRED FOR FAMIS ENROLLEES

Premiums for FAMIS enrollees were eliminated in 2002. While the Commonwealth did not provide data on the impact of the elimination of the FAMIS premium, research indicates that premiums have a negative effect on enrollment and retention in public health care programs due to inability to pay or failure to pay on time.[9] Accordingly, it is likely that enrollment and retention increased after the premiums were eliminated.

Current Approach to Renewal and Retention

Children's coverage must be renewed every 12 months for both FAMIS Plus and FAMIS. FAMIS Plus renewals are handled by the LDSS offices, and FAMIS renewals are handled by the CPU. Each process is described below.

FAMIS PLUS RENEWAL PROCESSES

For FAMIS Plus enrollees, the state DSS data warehouse using MMIS data received from DMAS will generate a monthly list of upcoming renewals. Working from this list, LDSS eligibility workers determine whether the ex parte renewal process can be used. According to Commonwealth policy, local agencies are required to use online information systems to verify eligibility—without requiring verification from the individual or family—when the agency has access to any number of online information systems, including TALX/Work Number system,[10] Virginia Employment Commission (VEC), and Department of Child Support Enforcement (DCSE). Local agencies have access to Food Stamp (now referred to as Supplemental Nutrition Assistance Program, or SNAP), TANF, child care subsidy and other local program records as well. When ex parte is appropriate, workers should verify income eligibility via the third party data source and enter any new information into ADAPT and complete the redetermination process. Eligibility workers also have the capacity to align renewal dates for all programs for which the child or family is eligible. For a child who is part of a family also enrolled in SNAP, some LDSS eligibility workers will renew FAMIS Plus eligibility at the same time Food Stamps eligibility is renewed.

[9] See discussion of the impacts of premiums on Medicaid and CHIP enrollment in Wachino and Weiss, 2009.
[10] A commercially-developed data set, including wage and other income data.

DMAS does not have statistics on the number of ex parte renewals completed in local DSS agencies, nor does VDSS appear to track ex-parte renewals. Based on anecdotal reports, officials believe that, in practice, ex parte is utilized more frequently for the SSI population through various sources of Social Security Administration data than for children and families.

If the case is not eligible for the ex parte process, the eligibility worker will send a renewal packet to the family 30 to 60 days before coverage ends. Families have 10 days to return the renewal packet before the case is closed in ADAPT. If the family complies with the 10 day timeframe, the eligibility worker determines whether any information or documentation is missing and notifies the family. Families have an additional 10 days to respond before they are disenrolled. Once the renewal is complete, ADAPT completes the redetermination, and the family is notified that their enrollment has been continued. If ADAPT determines the child is eligible for FAMIS, the approved and enrolled case is transferred to the CPU for ongoing case maintenance.

FAMIS RENEWAL PROCESS

For FAMIS enrollees, CHAMPS identifies enrollees with coverage ending in 85 days and sends a renewal reminder post card to the family. A renewal packet that includes a pre-filled renewal form is mailed to the family 75 days before the coverage period ends. FAMIS enrollees have 20 days to return the renewal packet before the CPU places an automated “reminder” phone call to the family. If the family still does not respond, a cancellation letter is mailed 40 days prior to the end of coverage. This is followed by a second automated reminder call 30 days before coverage ends. If the renewal is still incomplete, the case is cancelled in CHAMPS on the 20th of the month prior to the end of the renewal period (although coverage continues through the end of the renewal period). This is followed by a second automated reminder call 25 days before coverage ends. If the family completes the renewal process before the end of the month, the child will be evaluated and reinstated with no break in coverage.

Once a complete renewal packet is received, the eligibility worker completes the redetermination utilizing CHAMPS. Any child found eligible for FAMIS Plus is transferred to the co-located FAMIS Plus Unit (FPU). Once enrolled in FAMIS Plus, the case is transferred to the LDSS agency for ongoing case maintenance. Unlike FAMIS Plus, there is no ex parte renewal process for FAMIS enrollees.

DISENROLLMENT RATES AND REASONS

DMAS did not provide information on disenrollment rates for FAMIS Plus. Nor were data available on disenrollment reasons. Commonwealth officials indicated that CPU data provided in advance of the site visit was incomplete. Commonwealth staff also indicated that the reason codes differ between the CPU and ADAPT, making comparisons difficult.

Virginia does not track rates for procedural denials or closures (for reasons other than ineligibility). However, the CPU does track the number of clients who are disenrolled and re-apply within 90 days (called “re-applications” in Virginia). In 2008, the CPU averaged 586 reapplications per month, while total disenrollment averaged 3,312 per month, suggesting an upper limit of 18 percent as a churning rate. Since reapplications are not necessarily received in the same month the disenrollment occurred, a true denominator for determining a monthly churning rate cannot be calculated without further analysis.

Virginia conducted a disenrollment study in 2004 to understand the reasons families fail to re-enroll in the FAMIS programs. Medicaid enrollees were less likely to be aware of the renewal process and the required steps (e.g., to know they needed to renew annually and to remember receiving written renewal notification letters). As a result, Medicaid enrollees were almost twice as likely to have a break in coverage as CHIP enrollees.

RENEWAL PROCESSING TIMES

Similar to application processing times, renewal processing times are measured using two different standards, one for the LDSS offices and one for the CPU. VDSS requires that LDSS offices process 97 percent of FAMIS Plus renewals within 30 days. In March 2009, 95.4 percent of renewals met this standard. VDSS measures LDSS accuracy rates through MEQC pilots, quality assurance activities, and monitoring by VDSS staff and LDSS supervisors. For FAMIS renewals, DMAS holds the CPU to a processing standard of 12 business days and a 95 percent accuracy rate. Virginia reported that the CPU's current average renewal processing time is eight business days with an accuracy rate of 97.1 percent.

New Initiatives

Virginia has made strides to streamline processes at the LDSS offices. With support from the Virginia Health Care Foundation, DMAS provided grants to 14 local offices in 2004 and 2005 to work on retention efforts. A number of new strategies were tested locally and several were later adopted. These included:

- Using a one-page renewal form;
- Mailing renewal packets 60 days in advance of the client's termination date;
- Making follow-up phone calls after renewal packets were mailed; and
- Assigning cases back to the original worker if the client re-applies within three months.

Commonwealth staff reported that a number of these strategies were successful and provided examples where retention rates increased after implementation. The Commonwealth has shared the "best practices" with other LDSS offices, but each individual office has discretion about whether to adopt these practices, which may depend on local resources and commitment of local leadership.

DMAS is working to improve the FAMIS online application to implement a new pre-filled renewal form in the fall of 2009. Additional planned enhancements include the ability: to collect e-signatures; to electronically submit address changes; and to save an incomplete application and return to it at a later time. DMAS also is working on enhancing the CHAMPS reporting functionality to track applications through the entire process.

Strengths

Virginia's enrollment and renewal policies and processes demonstrate many outstanding features that likely contribute to successful enrollment and retention of eligible children.[11]

[11] 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.

- **"No Wrong Door."** Virginia's "No Wrong Door" approach allows applications to be submitted to either an LDSS or the CPU, making enrollment more convenient for families seeking coverage.
- **Joint application and ability to apply online.** Using a single application for multiple programs (FAMIS, FAMIS Plus, FAMIS MOMS, and Medicaid for Pregnant Women) and offering an online application simplifies enrollment and enhances opportunities for families to apply for coverage.
- **No premium requirement.** Premiums can be a barrier to enrollment and retention of coverage. Virginia does not require premiums in either FAMIS program.
- **Ex parte renewal for FAMIS Plus.** An ex parte renewal option is available for FAMIS Plus enrollees. If the LDSS eligibility worker determines the family qualifies for ex parte renewal, no action is required by the family. According to policy, the eligibility worker verifies the family's income using any number of third party information systems (e.g., TALX/Work Number, Virginia Employment Commission or Department of Child Support Enforcement), and ADAPT processes the redetermination.
- **Eased documentation requirement.** Virginia has made a recent change to provide FAMIS Plus applicants one year to provide their DRA citizenship and identity documentation under the flexibility granted to states by CHIPRA. Therefore, new applicants enrolled in FAMIS Plus do not have to provide the necessary documents until the first annual redetermination occurs. Prior to this change, Virginia utilized electronic verification of citizenship through data sharing with VDH and DMV.
- **Paperless process at CPU.** The application and renewal process at the CPU are incorporated into a paperless workflow through the utilization of workflow software and an imaging process.

Challenges

The following design features are likely to be impeding enrollment and retention in the FAMIS programs:

- **Complex structure.** Virginia's eligibility and renewal processes and structure are complex and challenging for eligibility workers and clients to navigate. Two different organizational cultures (DMAS and VDSS/LDSS offices), eligibility and renewal processes, and eligibility determination systems that do not easily communicate or exchange information limit the Commonwealth's ability to streamline eligibility, and lead to confusion for eligibility workers and families. Further, the lack of data (a result of both the bifurcated system and a Legacy DSS eligibility system) make it difficult to assess the systems.
- **Active role for families.** CPU and LDSS eligibility workers take a relatively passive approach to the eligibility and renewal processes.[12] Families must provide documentation and keep track of deadlines with little prompting. As a result, FAMIS Plus and FAMIS applicants and enrollees

[12] CPU does provide some reminders to families at renewal by placing outbound calls, sending reminder post cards followed by renewal packets with pre-filled out renewal forms.

bear the responsibility of achieving and retaining coverage. Research demonstrates, however, the importance of reducing the burdens on families in order to increase enrollment and retention rates for Medicaid and CHIP.[13]

- **Duplicate applications.** Families can submit an application simultaneously online and to the LDSS. The lack of an interface between CHAMPS and ADAPT, coupled with the fact that CPU and LDSS eligibility staff cannot access each other's systems, can lead to duplicative work which is frustrating for eligibility staff. Applicants also may not understand why they are being contacted by both LDSS and CPU eligibility staff regarding the same application. While Commonwealth staff and LDSS staff acknowledge that this is an issue, the frequency with which this occurs is unknown.
- **Different processes and organizations.** Families with children enrolled in both programs have to follow different renewal processes and interact with different organizations. Interviewees indicated that this leads to confusion and may deter families from completing the renewal process.
- **Paper-intensive processes are inefficient for LDSS office staff.** In contrast to the CPU which is nearly paperless (all documents are scanned and stored electronically), the LDSS application and renewal processes are paper intensive. The LDSS offices do not use an electronic case record, and case records are stored for three years from the date the case closes, per library of Virginia General Schedule 15 for local government.
- **Transfers between FAMIS programs.** While some stakeholders we interviewed believe children are transferred seamlessly between FAMIS Plus and FAMIS when eligibility changes, interviews with some Commonwealth, CPU, and LDSS staff indicate problems exist. For example, if eligibility is determined outside of the ADAPT system, the LDSS worker must send the paper case record by interoffice courier to the CPU, rather than using an electronic transfer process to send FAMIS-eligible cases to the CPU.
- **Ex parte acceptance unclear.** While the ex parte process for FAMIS Plus offers the potential to greatly simplify the renewal process for some families, Commonwealth staff noted that the Deficit Reduction Act's citizenship and identity documentation requirements derailed ex parte renewals temporarily. Virginia has worked with the LDSS offices to reinstate this policy. It is not clear, however, to what extent LDSS offices are using it. Some of the stakeholders interviewed were not convinced that it has "caught on" at the local level.
- **Ex parte checks may not be timely.** As part of the ex parte process, VDSS contracts with TALX/Work Number to provide online access to LDSS workers to verify enrollee income. It appears, however, that LDSS demand often exceeds the number of monthly TALX database inquiries purchased by VDSS. Once the monthly allotment is exceeded, LDSS workers must request information from TALX via fax—which can take five to six days for a response. Alternatives are to try another system or give up on ex parte renewal and begin the regular renewal process.

[13] Wachino and Weiss, 2009.

2. Interagency Coordination

Current Approach to Medicaid and CHIP Coordination

As noted above, FAMIS Plus and FAMIS are operated as separate programs but managed by a single agency (DMAS). While DMAS's CPU conducts eligibility determinations for both programs, the CPU is only responsible for on-going case maintenance and renewals for FAMIS.

A separate state agency, VDSS, oversees the work of the LDSS offices, which conduct eligibility determinations for both FAMIS Plus and FAMIS; however, these local offices are only responsible for on-going case maintenance and renewals for FAMIS Plus enrollees. VDSS also serves a liaison role between DMAS and the LDSS offices by providing policy updates, technical assistance to local agencies, and monitoring of policy implementation through quality assurance activities and training. VDSS consultants and a VDSS Home Office staff provide technical assistance and consultation to LDSS offices in each of the five geographic regions of the Commonwealth.

Virginia has taken steps to improve the coordination among the FAMIS programs and CPU, VDSS, and LDSS staff. In addition to the paperless process used to transfer cases for FAMIS-enrolled children (who were previously enrolled in FAMIS Plus) from LDSS offices to the CPU, DMAS eligibility workers are stationed at the CPU to work closely with LDSS workers to resolve issues and answer questions. These workers also handle any FAMIS Plus-eligible applications that are submitted to the CPU. At the management level, DMAS and VDSS leadership meet monthly to discuss policy issues related to the FAMIS programs.

Mirroring the different roles played by the CPU and LDSS offices, two different systems are used to determine eligibility: CPU staff use CHAMPS and LDSS staff use ADAPT. As noted earlier, no interface exists between CHAMPS and ADAPT, although ADAPT sends electronic updates to VaMMIS. The buffer that allows electronic updates to VaMMIS is operated by VDSS. Several years ago, DMAS considered allowing CPU staff to input FAMIS Plus-eligible cases directly into ADAPT, but this policy was never implemented due to budget cuts. VDSS officials believe that implementation would both improve the accuracy of processing cases and positively impact the workload for LDSS agencies. To address the need, DMAS instead implemented system enhancements to CHAMPS and has offered to provide a data file to VDSS to mirror the process in place for DSS case transfers to the FAMIS CPU.

Current Approach to Coordination between Health Insurance and Other Public Programs Serving Children

The Commonwealth has not explored opportunities to link to other programs, but some advocates interviewed expressed interest in having the Virginia Department of Taxation collect information about insurance status on the state income tax form as a means of identifying potentially eligible children for coverage in the FAMIS programs. DMAS explored this option with the Department of Taxation in 2005. A bill was introduced to have a check box added to the state's tax form; however, it did not get out of committee. The issue has not been revisited since.

COORDINATION WITH SCHOOLS

DMAS conducts a "Back-to-School" campaign each fall to identify eligible but uninsured children. The Department sends flyers to principals and provides school nutrition directors with a brief insert to

distribute with school lunch program approval letters. The flyers refer families to the FAMIS website, the CPU call center, and the LDSS to enroll. DMAS does not track the number of applications generated by this campaign, but data show a 30 percent increase in new applications received at the CPU in September over August each year. Program leadership also expressed interest in exploring a possible data match between FAMIS and the National School Lunch Program (NSLP) but indicated a need for technical assistance on how to implement this kind of match.

Strengths

- **Frequent staff interaction.** Virginia has taken a number of steps to promote coordination among the FAMIS programs, including the monthly meetings held by DMAS and VDSS leadership and the co-location of DMAS eligibility staff at the CPU.
- **LDSS eligibility workers.** Because the LDSS offices use ADAPT for the FAMIS programs, Food Stamps and cash assistance, local eligibility workers can help families apply for more than one program. ADAPT data also may provide opportunities to identify eligible but uninsured children, although more information would be needed to determine the feasibility of this kind of match.

Challenges

- **FAMIS brand.** Although DMAS has re-branded children's Medicaid as FAMIS Plus, the program is still commonly referred to as Medicaid (or Children's Medicaid) among advocates, LDSS offices, and clients. In addition, the DSS website still contains links to forms that refer to Families & Children's Medicaid (see http://www.dss.virginia.gov/benefit/me_famis/forms.cgi). It also may be confusing to have two similar sounding names for the Medicaid and CHIP programs, especially since the FAMIS "Plus" name sounds like a newer program, which would make one think of the CHIP program. In addition, coverage for low income pregnant women through Medicaid and through a CHIP program waiver maintain different names (Medicaid for Pregnant Women, and FAMIS MOMS, respectively), rather than being co-branded under FAMIS. This further maintains the Medicaid vs. FAMIS distinctions. It may be useful for DMAS to collaborate more closely with the LDSS offices to burnish the FAMIS brand in the minds of local eligibility workers and clients.
- **DMAS, VDSS, LDSS roles and relationships.** A number of advocates and other stakeholders interviewed commented that DMAS and VDSS do not always work well together, while one official commented that the relationships among DMAS, VDSS and the LDSS offices "has greatly improved" over the last few years. The different roles played by DMAS and VDSS in managing the FAMIS programs also may not be clear. One interviewee stated that "DSS oversees eligibility, and DMAS oversees providers."

3. Analytic Capacity for Program Management and Decision-Making

Current Approach

Because of the FAMIS programs' complex organizational structure and different eligibility systems, Virginia faces challenges in its ability to organize and analyze data for program management and decision-making. Different data reside in each system, and ADAPT and CHAMPS cannot exchange

data directly. Further, CHAMPS and ADAPT users are not able to access each other's systems; VaMMIS is the only place the CHAMPS and ADAPT can "talk" to each other. As a result, the ability to compile comprehensive FAMIS Plus and FAMIS program data is very limited. DMAS only has access to the data available in CHAMPS regarding sources of applications, enrollment and renewal data, and application and renewal processing times. Inconsistencies across the two systems (e.g., CHAMPS and ADAPT use different disenrollment reason codes) further hamper data integration capabilities. Both DMAS and VDSS only have access to the data stored within their respective systems.

The Virginia Health Care Foundation (VHCF) contracts with the Urban Institute to conduct analyses of federally reported Current Population Survey data to profile Virginia's uninsured and analyze trends in health insurance coverage in the Commonwealth.[14] VHCF used to conduct a state survey to gather this information, but it was discontinued due to cost concerns. While the Urban Institute analysis does not provide detailed information about the composition of the remaining eligible but uninsured children in the Commonwealth, the Foundation contracts with Community Health Solutions to produce local estimates based on a formula which includes population and poverty data to help target outreach activities.

New Initiatives

The CPU vendor, ACS, was recently awarded the VaMMIS contract. As part of this contract, Virginia has the option to purchase a data warehouse component that can integrate CHAMPS, ADAPT and VaMMIS data. Leadership is hopeful that funding will be made available to purchase this data warehouse option to improve their ability to analyze program data.

In addition to the data warehouse, the Commonwealth is planning a number of projects to improve the integration of CHAMPS and DMAS data:

- DMAS plans to enhance CHAMPS to allow for a fully electronic transfer of data between CHAMPS and ADAPT (electronic transfers to the CPU from ADAPT are currently in operation);
- VDSS is planning for a new eligibility system (to replace ADAPT), although this is not expected to occur in the near-term; and
- Planned CHAMPS upgrades include enhanced reporting functionality to track applications through the entire process (from submission to determination) by late 2009.

The Commonwealth's Child Health Insurance Program Advisory Committee (CHIPAC), created by the legislature in 2004 to ensure a permanent, high-level focus on the FAMIS programs and children's health insurance coverage, has increased focus on data analysis related to the FAMIS programs (see Section 5, "Non-governmental Partnerships and Outreach"). One of CHIPAC's key initiatives is the Child Health Data Project, which was initiated to address a lack of readily-available data about the programs. CHIPAC is working with DMAS to develop a set of quarterly management reports to track and analyze enrollment, retention, utilization and quality of care.

[14] Note that public insurance coverage appears to be underreported in the CPS data.

Strengths

- **CHIPAC Child Health Data Project.** CHIPAC's interest in understanding and improving DMAS's data capacity and their authority to request data from DMAS has helped to lay the groundwork for prioritizing data capacity and analytic goals for DMAS. Significantly, many of the questions and areas of interest identified by CHIPAC are similar to those included in the Max Enroll diagnostic assessment.
- **Prior effort to improve intra-department efforts.** Secretary of Health and Human Resources, Marilyn Tavenner led an effort to bring department heads together to improve systems communication across agencies. Part of the goal of this effort was for the Commonwealth to be able to track health care outcomes to improve accountability. While this initiative has stalled due to the economic downturn, it may yield insights that could help the Commonwealth address the FAMIS programs' systems issues and data needs over a long-term horizon.

Challenges

- **Data on Virginia's uninsured.** While the Urban Institute's analysis of Virginia's uninsured population is helpful, advocates interviewed noted concerns about some aspects of the data, including whether undocumented residents are included in the uninsured counts, and commented on the lack of general understanding of the research results.
- **ADAPT eligibility system.** ADAPT is a legacy system which does not interface with CHAMPS. Until DSS can upgrade to a modern eligibility system, DMAS will not have access to data across both FAMIS programs.
- **Program data limited.** The lack of consistently defined data and measures across the FAMIS programs (e.g., denial codes, application and renewal processing times, churn rates) present considerable challenges to DMAS and VDSS leadership for both day-to-day management of the programs and assessing the effects of new initiatives. Creating the new CHAMPS-VaMMIS data warehouse will help, but until data from ADAPT can be integrated, Virginia's analytic capabilities will continue to be constrained.
- **Lack of real-time data.** By definition, the planned data warehouse will not be able to provide program leadership with real-time data on the FAMIS programs. Accordingly, the lack of timely information about the programs will remain a challenge.

4. Client-Centered Organizational Culture

Current Approach

DMAS has worked to move toward a client-centered service model over the last few years. As noted earlier, the Commonwealth has implemented a "No Wrong Door" approach that allows families to apply via the CPU or the LDSS, and families can apply using one of four different methods: mail, by fax, online or in-person (at the LDSS offices). Even so, CPU and LDSS eligibility staff takes a fairly passive approach in terms of their roles in the application and renewal processes. The burden for completing an application or renewal in a timely manner falls squarely on the client with seemingly little assistance from workers. This is reflected in recent efforts by some LDSS offices to begin the renewal notification process earlier to give families more time to comply before being disenrolled.

While ex parte renewals represent a step in the right direction, for most families, applying or renewing requires taking a highly active role to obtain or retain coverage.

The cultural differences between the CPU and LDSS are stark. The atmosphere in the CPU is "corporate" and high tech (e.g., all staff had double monitors on their desks and call volumes and wait times were tracked on a flat-screen wall monitor), while the LDSS we visited had the atmosphere of a traditional welfare office, where workers keep manual logs of their activities and must do many more manual types of checking in cramped offices with lots of filing cabinets. In fact, LDSS agencies are traditional welfare offices that also encompass eligibility determination responsibilities for TANF, SNAP (formerly the Food Stamp Program), General Relief, Energy Assistance, Auxiliary Grants and, until recently, the State and Local Hospitalization program. Further, some local DSS offices may be responsible for locally-funded programs such as food pantries.

Recognizing the important role played by LDSS eligibility workers, DMAS partnered with DSS, VHCF, and Virginia Commonwealth University to conduct staff trainings with eligible workers in 2006. Known as "Making the Pieces Fit," the purpose of the trainings was to educate local workers about the importance of health insurance and the challenges faced by low-income individuals and families. Eight trainings were held across the Commonwealth, reaching more than 800 eligibility workers. These trainings reviewed policy, focused on the branding of the FAMIS Programs, and emphasized best practices of LDSS agencies resulting from retention grants.

VDSS also provides training through regional consultants, as described earlier, through its contract with VISSTA, and through presentations and workshops, which include DMAS, at the bi-annual eligibility workers' conferences.

DMAS periodically engages families directly to learn about their experiences with the FAMIS programs. In 2004, DMAS conducted an enrollment survey of parents of children in FAMIS Plus or FAMIS to better understand the reasons families apply for the FAMIS programs and how well the process works. The survey found that approximately 90 percent of parents rated the enrollment process as "easy," and 37 percent of FAMIS enrollee parents rated it "very easy" (compared to 25 percent of FAMIS Plus parents). In addition, the survey found that 75 percent of FAMIS Plus enrollees were assisted by an LDSS office compared to 37 percent of FAMIS enrollees. As expected, FAMIS enrollees were much more likely to be assisted by the CPU (57 percent).

Strengths

- **Commitment to clients.** The steps Virginia has taken since 2002 to streamline eligibility, enrollment and retention (e.g., implementing a "No Wrong Door" approach, developing a joint application, and implementing ex parte renewals for FAMIS Plus enrollees) demonstrate the Commonwealth's commitment to making the program work more easily for families.

Challenges

- **Performance standards.** The focus on processing timelines (rather than successful applications or renewals) may constrain eligibility workers' ability to help families enroll and retain coverage. The VDSS provides oversight of the LDSS offices' eligibility and retention work, but does not have authority to hold LDSS agencies accountable for their performance, through sanctions or other means. At the CPU, DMAS also monitors processing timelines and has the ability to impose sanctions per the terms of the contract.

- **Local variability.** While program leadership has worked to create a "culture of eligibility" and stated that LDSS offices do not see themselves as gate-keepers, some advocates interviewed disagreed. Officials from both programs and advocates agreed that there is wide variability across and within the LDSS offices and that clients' experiences will depend on which offices they visit and which workers assists them.
- **Local resource constraints.** The economic downturn is taking a toll on the LDSS offices, which are experiencing growing caseloads while revenues are stagnant and/or declining. The inability to add eligibility staff to address the increasing case loads impacts the ability of workers to be proactive when working with clients. This view was echoed by program leadership, who acknowledged that resource constraints limit the ability of the LDSS offices to facilitate enrollment and retention and conduct outreach.
- **Client experience varies.** As noted earlier, the application and renewal processes are not standardized between the CPU and LDSS offices or across the LDSS offices. As a result, client experiences can vary dramatically in terms of how long it takes to complete an eligibility or renewal determination as well as how much time an applicant or enrollee has to complete the process.

5. Non-Governmental Partnerships and Outreach

Current Approach

The Commonwealth relies on the Virginia Health Care Foundation as a key partner in outreach, enrollment and retention efforts. Created by the legislature in 1992, VHCF is a free-standing, 501(c)(3) organization that receives an annual appropriation from the legislature as well as grant support from private entities (e.g., Anthem Blue Cross, the Danville Regional Foundation). In addition, the Foundation contracts with DMAS on a project-specific basis. As noted above, VHCF contracts with the Urban Institute to conduct analyses of health insurance coverage in Virginia using federal data. The Foundation also served as the lead agency for Virginia's RWJF Covering Kids and Families Initiative.

Working with VHCF, DMAS has funded part of the "Project Connect" program, which provides grant funding to nine community-based organizations in localities with the highest numbers of uninsured children to hire outreach workers who work with families to apply for the FAMIS programs. These outreach workers educate families about the programs as well as provide assistance with application and renewal. DMAS also funds VHCF to provide the training for Project Connect outreach workers and hundreds of advocates, school nurses, and others interested in learning how to help enroll children in a FAMIS program using the Foundation's "Sign-Up-Now" toolkit and online interactive training modules. DMAS also provides funding to VHCF to host quarterly meetings to discuss progress and challenges.

The Commonwealth's own community-based outreach efforts have been heavily impacted in the last year by substantial decreases in the marketing and outreach budget. Until this year, DMAS regularly placed widespread media buys across the state each spring and fall to increase FAMIS program enrollment. When funding was available, DMAS also sponsored the statewide high school basketball championship as a way to publicize the FAMIS programs (e.g., DMAS produced a teen commercial which aired during the tournament and provided an on-site presence).

This year, DMAS is depending more heavily on community partnerships and an online presence, but has continued its support of two major statewide enrollment campaigns, "Cover the Uninsured Week" and "Back-to-School."

DMAS has built a strong partnership with school nurses across the state. In 2008, DMAS partnered with Chesterfield County school nurses to perform targeted outreach to teens. The Marketing and Outreach team continues its work in Hispanic communities and has targeted outreach efforts to families newly uninsured, due to unemployment, who have little to no experience with public programs.

Overall, the advocacy community is not well-organized and tends to operate as a loose coalition. The Virginia Coalition for Children's Health (VCCH) is a statewide advocacy organization comprised of more than 100 members (e.g., Virginia Poverty Law Center, Voice's for Virginia's Children, the state chapter of the American Academy of Pediatrics) that are committed to increased enrollment in the FAMIS programs. Program leadership noted that VCCH support is critical to making any changes that require legislative approval.

New Initiatives

DMAS has a strong interest in using new technologies to reach eligible but uninsured children and families. They are especially interested in exploring ways to reach teenagers, who have relatively higher uninsured rates. For example, they have developed a YouTube video targeted to teens. DMAS leadership would like to explore the use of e-mail and text messages to communicate with FAMIS families. Virginia is at the forefront, nationally, in designing outreach efforts that target teenagers; most states have not focused specifically on reaching this population.[15]

Strengths

- **Partnership with VHCF.** VHCF is supported by Commonwealth and private funding, and as such has considerable flexibility in the way that it serves DMAS and the Commonwealth. Further, VHCF served as the chair of CHIPAC since 2006[16], making the foundation a valuable partner to DMAS in outreach efforts, policy development, and collecting and translating data for a variety of audiences within the Commonwealth.
- **Partnerships with community-based organizations.** Through Project Connect, DMAS provides critical support to local outreach workers who provide application assistance to FAMIS program clients in targeted communities with high uninsured rates. National research demonstrates that partnering with community-based organizations to conduct outreach and to support enrollment and retention improves program enrollment.[17]

[15] Maureen Hensley-Quinn and Elizabeth Osius, "SCHIP and Adolescents: An Overview and Opportunities for States," National Academy for State Health Policy, May 2008. Accessible at: http://www.nashp.org/Files/shpbriefing_adolescents.pdf.

[16] Term expires December 2009. VHCF will remain on CHIPAC as a member when term expires.

[17] See, for example, Laurie E. Felland and Andrea M. Benoit, "Communities Play Key Role in Extending Public health Insurance to Children," Center for Studying Health Systems Change, 2001 (accessible at: http://www.hschange.com/CONTENT/377/); Michael J. Perry, "Promoting Public Health Insurance for Children," *The Future of Children* 13, no. 5, Spring 2003 (accessible at: http://www.princeton.edu/futureofchildren/publications/docs/13_01_12.pdf); and Christopher Trenholm, "Expanding Coverage for Children: the Santa Clara County Children's Health Initiative," Mathematica Policy Research, Inc., 2004 (accessible at: http://www.mathematica-mpr.com/publications/pdfs/chiexpandcov.pdf).

- **Teen outreach.** Virginia's teen outreach strategy is an innovate approach to targeting a hard-to-reach population. Success in increasing enrollment should help improve health outcomes for Virginia's teens.[18]

Challenges

- **Limited role of providers and health plans.** While many states have looked to their providers and managed care organizations (MCOs) to play an active role in enrollment and retention, Virginia has not taken this approach.[19] Similarly, DMAS does not appear to partner regularly with local providers to improve enrollment and retention. A recent initiative to install kiosks at Virginia Commonwealth University (VCU) medical center (to provide patients with access to a computer and phone to submit an application) was abandoned due to a change in leadership at VCU. CHIPAC, whose membership includes providers and health plans, may be able to work with DMAS on exploring ways that providers and MCOs can better support families in enrolling in FAMIS programs and renewing their coverage.
- **Lack of formal, statewide community partnerships for online application assistance.** Although the Commonwealth is aware that some CBOs assist applicants with online applications, Virginia has not established a partnership with CBOs to formally enlist their assistance and thus does not track to what extent this is occurring. Virginia could follow the lead of other states that certify CBOs as online application assisters and market their availability and location on the website of the online application.

6. State Leadership

Current Approach

Despite the budgetary constraints of 2009, Governor Kaine and the Legislature remained supportive of the FAMIS programs. There were no reductions in eligibility levels, but other spending reductions, including cuts in provider rates seemed likely. Virginia is considered a relatively poor payer by providers, and program leadership is concerned that future rate cuts will erode access to care.

During the time this report was being researched, Governor Kaine's health care interests focused on health coverage expansions (e.g., three-share models) and issues related to safety-net providers. He was also viewed as a champion for the FAMIS programs and strongly supported enrolling all eligible children in coverage.

During Governor Kaine's tenure, DMAS submitted an annual report on the FAMIS programs to the Governor's office and the Legislature, and submitted quarterly enrollment data to both the Governor and the Legislature. The Secretary of Health and Human Resources received monthly enrollment data reports as well, which are posted on the FAMIS website.

The League of Social Services Executives (the League) represents the LDSS offices' interests at the state capitol and around the state. The League is considered a "key advocate" by the Legislature and has developed close relationships with selected members over the years.

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[18] Maureen Hensley-Quinn and Elizabeth Osius, "SCHIP and Adolescents."

[19] Pat Redmond, "Medicaid and SCHIP retention in Challenging Times: Strategies from Managed Care Organizations," Center on Budget and Policy Priorities, 2005 (accessible at: http://www.cbpp.org/archiveSite/9-13-05health.pdf).

New Initiatives

The recent expansion of FAMIS MOMS from 185 percent to 200 percent of FPL is indicative of the Commonwealth's support for DMAS programs. It also illustrates, however, that Virginia is an "incremental state" and moves slowly: the eligibility expansion from 133 percent to the current 200 percent of FPL took six years to enact, according to state officials.

Strengths

- **Program leadership.** Program leadership is viewed as strong and therefore may be an asset with the change in Governor 2010.
- **Permanent state-level infrastructure to sustain progress in children's health insurance coverage.** Created in statute by the legislature in 2004, the Children's Health Insurance Program Advisory Committee (CHIPAC) provides continuous state-level leadership on children's coverage issues, regardless of changes in administration.

Challenges

- **One-term governor.** Virginia's governor is limited to a single, four-year term in office, meaning the Commonwealth's priorities can shift every four years.
- **Fiscally conservative state.** Virginia is viewed as fiscally conservative. Policymakers have been hesitant to increase health care spending in some areas. For example, they have considered and rejected presumptive eligibility and continuous eligibility for Medicaid over the years due to cost concerns. Stakeholders interviewed emphasized the need to "make the business case" for any changes in FAMIS Plus program eligibility levels or simplifications.
- **Short legislative session.** Because of its short session, the Legislature has very limited oversight capacity. While the Legislature has historically been a strong supporter of health insurance coverage for children, their health agenda is often developed in a short time frame with limited opportunities for education and input from DMAS about the FAMIS programs toward crafting legislation. Further, the agenda of the Joint Commission on Health Care focuses on long-term care and behavioral/mental health, rather than eligibility and retention issues associated with Medicaid and CHIP.
- **Need for stakeholder education.** It appears there is a general lack of knowledge about the number of uninsured children in Virginia, the characteristics of this population, and the reasons children may not be insured.

Opportunities

The Commonwealth has implemented a variety of strategies to help eligible children obtain and maintain health insurance coverage and some of them have likely made an important contribution to enrollment and retention. However, Virginia is hampered by significant systems issues and its

complicated organizational structure. While these are longer term challenges, there are incremental steps Virginia can undertake in the near term to improve policies and systems. The following recommendations may help the Commonwealth move closer to its goal of maximizing enrollment and retention of all eligible children:

1. **Develop an analytic agenda.** Enhanced use of data from existing systems could help program managers diagnose sources of bottlenecks in application processing, and their causes, in order to help set priorities for implementing policies and practices that can have a significant effect on enrollment and retention rates and
    a. While the data available to DMAS are not integrated across programs, we believe the Commonwealth can get more out of its existing systems. DMAS and DSS should work together to develop management reports to track trends that will improve understanding of challenges for both FAMIS programs. Where it is truly impossible to get needed information out of the two systems separately, manual data collection over a short period of time can be very helpful in diagnosing problems and checking progress.
    b. Compare data by LDSS, by application method, and by population (low versus higher income; Hispanics versus non-Hispanics) to discern the impact of practice variation on enrollment and retention.

2. **Strengthen relationships with FAMIS program stakeholders.**
    a. Better communication among DMAS, VDSS and the LDSS offices is necessary to improve coordination, program management, and decision-making. Although there is an organizational infrastructure in place to support regular communication, better interpersonal communication between VDSS and DMAS and between DMAS and the LDSS offices would greatly increase the likelihood that any changes to the FAMIS programs' application, enrollment, and renewal processes will be embraced and implemented successfully.
    b. VHCF and CHIPAC are both valuable sources of support to the Commonwealth and the FAMIS programs and therefore may be able to help bridge some of the communication gaps between DMAS and VDSS. As noted above, they also could provide regular updates and education to stakeholders (e.g. advocates, legislative leaders, Administration policymakers) about uninsured children and churning issues. Further, CHIPAC leadership has been studying the CHIPRA provisions and could help the Commonwealth pursue opportunities to access CHIPRA funding.
    c. Consider a greater role for providers and health plans in outreach, enrollment and retention efforts. Given the financial benefits to plans and providers of having children continuously enrolled with no breaks in coverage, this could be a win-win strategy for the Commonwealth to help expand coverage of eligible children.
    d. Consider establishing partnerships statewide with CBOs to formally engage them as online application assisters. Some states have done so by certifying CBOs and marketing their availability on the website of the online application. This could be a helpful strategy for alleviating the workload of local DSS agencies—the primary source of face-to-face assistance for families.

3. **Further promote a customer-centered organizational culture in both FAMIS Plus and FAMIS.**

    a. Identify strategies to reduce processing times for applications and renewals at both the CPU and LDSS offices. Reducing processing times could free-up resources and allow CPU and LDSS eligibility staff to provide more assistance to families and make the application and renewal process less burdensome.

    b. Synchronize review processes and timeframes, as well as performance expectations, across the LDSS offices and CPU to reinforce the importance of increasing enrollment and retention rates.

    c. Explore options to make enrollment and renewal processes more streamlined for families, such as expanding the use of ex parte renewals to both FAMIS programs or implementing an electronic case record (ECR). As long as LDSS workers see these efforts as simply creating more work, or legislators see any new investments as increasing costs rather than producing efficiencies, support for more passive strategies may be limited. It will be important to make a strong business case for any changes. The experiences of other states with successful passive enrollment and retention strategies should provide Virginia with useful models.

4. **Share data and information about children's coverage with policymakers.** Educate policymakers about children's coverage issues, particularly the impact of churning on program efficiency and children's use of health services, to gain support for further improvements.

    a. Create brief, standardized "dashboard" reports for tracking enrollment and retention, and make this information readily available to policymakers, advocates, and others.

    b. Create a process, possibly through CHIPAC, that provides regular updates and information about enrollment and retention to key policymakers.

5. **Evaluate the costs and benefits of needed systems upgrades.**

    a. The LDSS offices' processes are highly manual and paper-driven, particularly compared to the CPU's operations. Use of an ECR would reduce the amount of paper associated with each case and streamline the enrollment and retention process. The implications of an ECR should be included in discussion of the data warehouse plans under consideration by DMAS.

    b. DSS indicated that they intend to implement an updated version of ADAPT at some point in the future. The new system should be able to interface with CHAMPS and allow data to be shared across the FAMIS programs. Not only would this improve program leadership's ability to manage the FAMIS programs, but it also would introduce efficiencies into the CPU and LDSS enrollment and renewal processes.

Appendix I:

Diagnostic Assessment Interview Participants

Name/Title	Organization
Leah Dozier Walker, Quality and Data Supervisor	DMAS, Maternal and Child Health Division
Patrick Finnerty, Director	DMAS
Cynthia Jones, Chief Deputy Director	DMAS
Rebecca Mendoza, Director	DMAS Maternal and Child Health Division & CHIP+ Director
Steve Ford, Director	DMAS Policy & Research Division
Cindy Olson, Eligibility Policy Manager	DMAS Policy & Research Division
Stephanie Sivert Manager, Medical Assistance Programs	DSS Division of Benefit Programs
Marilyn Tavenner, Secretary	Health and Human Resources, Commonwealth of Virginia
Joe Flores, Legislative Fiscal Analyst	Senate Finance Committee
Susan Massart, Legislative Fiscal Analyst	House Appropriations Committee
Marsha Sharpe, Assistant Director of Benefits Programs	Chesterfield/Colonial Heights Department of Social Services
Janice Holmes, FAMIS Program Manager	DMAS, Maternal and Child Health Division
Jeness Vaccarella, Executive Account Manager	ACS Government Healthcare Solutions
Jill Hankin, Staff Attorney	Virginia Poverty Law Center
Judith Cash, Director	VA Health Care Foundation & Chair of Children's Health Insurance Advisory Committee
Debbie Oswalt	
Candice McAuliffe, Director	Regional Medicaid Operations for VA, Anthem

Appendix II:

Data on Children's Coverage

Table 1. 5-Year Enrollment Trends for Children

	Number of Children		
	2005	2006	2007
Medicaid			
Total	424,386	419,206	450,814
New	67,128	48,637	49,628
Disenrolled	65,174	31,940	34,773
CHIP Enrollees			
Total	46,440	43,956	52,726
New	8,925	7,449	2,189
Disenrolled	9,086	5,315	4,919
Retention Rates*			
Medicaid	N/A	N/A	N/A
CHIP	N/A	N/A	N/A

SOURCE: Data from the Virginia Pre-Site Visit Information Request. Data derived from Virginia SEDS (SCHIP Statistical Enrollment Data System) reports submitted to CMS. These figures represent the unduplicated enrollment as of the last day of the first quarter of the year. (i.e., for the year 2005, data provided is as of the last day of the 1st quarter of FFY 2005 or December 31, 2005 and represents the unduplicated enrollment for the entire quarter). Medicaid enrollment counts include CHIP Expansion enrollees.

Note: Data not available from 2003 and 2004.

Table 2. 5-Year Uninsured Trends for Children

Uninsured Children	2004	2005	2006	2007	2008
All uninsured children	155,000	167,000	203,000	212,000	153,300
Eligible but not enrolled	79,000	102,000	124,000	112,000	80,000

SOURCE: SHADAC estimates of Current Population Survey Annual Social and Economic Supplement (CPS), 2008 - 2009. Eligible but unenrolled numbers are estimated based on the percent of children below the state's eligibility threshold (200 percent FPL).

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

	Number of Children				
	Total Children	Total Insured	Total Uninsured	Uninsured, Eligible for Public Program	Enrolled in Public Coverage
Year: 2007-2008					
Age					
0-5	617,000	558,000	58,000	36,000	214,000
6-18	1,352,000	1,228,000	124,000	60,000	375,000
Race/Ethnicity					
African Am./Black	453,000	406,000	47,000	25,000	201,000
White, Non-Hispanic	1,192,000	1,097,000	94,000	46,000	271,000
Hispanic	160,000	129,000	31,000	17,000	63,000
Asian	91,000	83,000	8,000	8,000	16,000
Other	73,000	71,000	2,000	1,000	39,000
Poverty					
0-99% FPL	271,000	225,000	46,000	46,000	187,000
100%-199% FPL	359,000	309,000	50,000	50,000	161,000
200%-399%FPL	623,000	566,000	57,000	N/A	143,000
400% + FPL	707,000	680,000	27,000	N/A	94,000
TOTAL	1,969,000	1,786,000	183,000	95,700	589,000

SOURCE: SHADAC estimates of Current Population Survey Annual Social and Economic Supplement (CPS), 2008 - 2009. Numbers for uninsured but eligible for a public program are estimated based on the percent of children below the state's eligibility threshold (200 percent FPL).