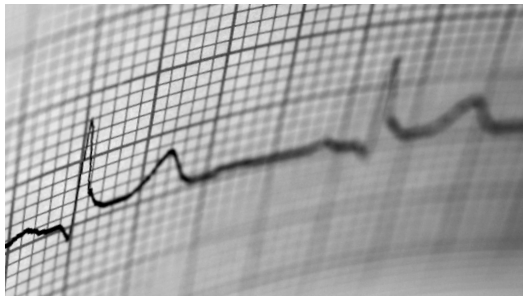
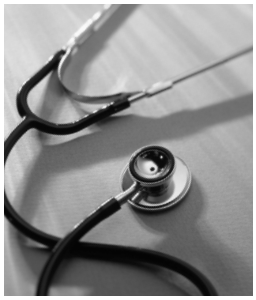
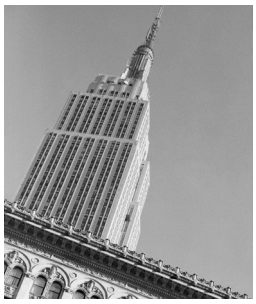
United Hospital Fund

Streamlining Renewal in Medicaid and SCHIP: Strategies from Other States and Lessons for New York



AN ISSUE BRIEF





United Hospital Fund

The United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

United Hospital Fund

Streamlining Renewal in Medicaid and SCHIP: Strategies from Other States and Lessons for New York

Andrea Cohen
Melinda Dutton
Kerry Griffin
Gregory Woods

Manatt Health Solutions

ISBN 1-88127-7852

For additional copies, write to the Publications Program, United Hospital Fund,
350 Fifth Avenue, 23rd Floor, New York, NY 10118-2300, or call (212) 494-0771.

Contents

Foreword

One of the greatest continuing challenges confronting our public health insurance programs is the issue of beneficiaries' "churning" in and out of those programs. Despite remaining eligible for coverage, significant numbers of Medicaid, Family Health Plus, and Child Health Plus beneficiaries fail to complete their annual renewals because of complex administrative rules and procedures that serve, in effect, as barriers to retaining coverage. The consequences are serious. Beneficiaries lose the continuity of care so important to improving health status, while plans incur an increased burden in administrative time, staffing, and costs.

As New York State takes steps to simplify the public insurance renewal process, a number of innovative strategies being tested by other states offer promise as options for effective streamlining that maintains program integrity. This issue brief examines the experiences of eight other states, the lessons that can be drawn from them, and the questions and challenges that remain to be resolved.

Prepared by our colleagues at Manatt Health Solutions, this work was undertaken with support from the United Hospital Fund, the Children's Defense Fund-New York, and the New York State Coalition of Prepaid Health Services Plans. It is a valuable extension of the authoritative research and insightful policy analysis that the United Hospital Fund has been conducting and supporting, through our Health Insurance Project, for more than a dozen years. We are pleased to be disseminating it to the health care community, and are sure you will find it a helpful addition to the ongoing dialogue.

James R. Tallon, Jr.
President
United Hospital Fund

Acknowledgments

The authors would like to thank the Children's Defense Fund–NY, the New York State Coalition of Prepaid Health Services Plans, and the United Hospital Fund for their generous support of this project.

The authors would also like to thank Donna Cohen Ross and Laura Cox of the Center on Budget and Policy Priorities, Catherine Hess of the National Academy for State Health Policy, and the state Medicaid and SCHIP administrators we interviewed, without whose valuable input and guidance this brief would not have been possible. Any errors in this brief are the authors' own.

Introduction

An estimated 40 percent of uninsured New Yorkers are currently eligible for free or low-cost health insurance through public programs but are not enrolled (Cook, Miller, and Holahan 2007). Efforts by New York State officials to reduce the number of uninsured have focused on this population and, increasingly, on eliminating barriers enrollees face in completing the annual eligibility review ("renewal" or "recertification") for the Medicaid, Family Health Plus, and Child Health Plus programs (Holahan, Cook, and Powell 2008).

Research suggests that eligible individuals and families are involuntarily disenrolled from public health insurance programs at high rates during the renewal process. A 2006 study suggests that 46 percent of New York's Medicaid and Family Health Plus (FHP) recipients are involuntarily disenrolled at renewal; a similar analysis shows that, of those leaving the Child Health Plus (CHP) rolls, 60 percent have failed to complete the renewal process (Bachrach and Tassi 2000). Many beneficiaries who lose coverage involuntarily at renewal reapply and re-enter the public health insurance system within a few months, suggesting that they remain eligible for health coverage but are unable to complete the processes necessary to demonstrate their continued eligibility while retaining coverage (Boozang, Braslow, and Fiori 2006).

This "churning" in and out of public health insurance programs has serious negative consequences, including discontinuity of care for beneficiaries and increased administrative costs (Boozang, Braslow, and Fiori 2006).

Recognizing the need to keep eligible families covered, state officials have taken key steps to streamline the renewal process. A review of New York's current renewal process, federal requirements and audit guidelines, and simplified renewal procedures in eight key states[1] suggests several promising strategies to further reduce the burden on beneficiaries of proving their continued eligibility for public health insurance programs in New York. Simplified renewal strategies would, in turn, increase program retention rates and minimize the costs associated with the churning of eligible individuals. Promising approaches include:

- Administrative renewal, in which the state assumes continued eligibility in the absence of information — from the enrollee or other sources — indicating otherwise;
- Ex parte renewal, in which the state relies on data available through other public programs or data banks, rather than from the enrollee, to confirm continued eligibility;
- Rolling renewal, which allows enrollees to renew eligibility on a flexible time schedule rather than within a rigid annual window of time; and
- Telephone renewal, which allows enrollees to renew by telephone as an alternative to mail-in and in-person renewal options.

[1] Based on conversations with national experts who research states' renewal procedures, we selected states known to have experience with administrative renewal and additional states with innovative renewal procedures. We then reviewed renewal processes and/or conducted interviews with state Medicaid /SCHIP administrators in Arkansas, California, Florida, Georgia, Hawaii, Illinois, Louisiana, and Utah. We also conducted a brief review of the policy literature, and an analysis of the laws, rules, and regulations that govern Medicaid and SCHIP policies and procedures in New York State. Finally, we reviewed the Centers for Medicare and Medicaid guidance regarding the Payment Error Rate Management (PERM) audit.

While it is unlikely that any single strategy will eliminate churning in public health insurance programs, the experience of key states indicates that implementing a variety of approaches aimed at specific Medicaid and State Children's Health Insurance Program (SCHIP) populations is likely to significantly increase the retention of eligible New Yorkers in public health insurance programs, while preserving the integrity of program eligibility requirements.

Findings

New York's Renewal Process

Prior to April 2003, the renewal process for public health insurance programs in New York — Medicaid, Family Health Plus, and Child Health Plus — essentially required families to re-apply for these programs on an annual basis. Families were sent notices instructing them to report at an appointed time for a face-to-face interview, and to complete a renewal application and supply supporting documentation to substantiate the information in the application. It was not uncommon for families to make multiple trips to the Medicaid office to complete this process; requests that families re-document information already contained in the case file were also routine. Not surprisingly, rates of renewal under this process were very low, with some reports of disenrollment rates at renewal of as high as 70 percent (Bauer and Hopkins 1999).

New York has made considerable progress in the past several years in improving the renewal process. Limits have been placed on the documentation requirements — starting with rules that prohibit Medicaid offices from requiring beneficiaries to re-submit documentation that was supplied with the original application and is unlikely to change, such as birth certificates and Social Security cards. As of April 1, 2003, New York eliminated the requirement that all Medicaid, CHP, and FHP beneficiaries complete an annual face-to-face interview in order to maintain coverage. Instead, New York now utilizes a mail-in renewal process for most beneficiaries. In New York City, local Medicaid officials have developed a renewal form pre-populated with eligibility information that the eligibility system retains, further facilitating the mail-in renewal process. And since January 2008, most beneficiaries are able to self-attest to their income, residence, and child care expenses, eliminating the need for beneficiaries to supply supporting documentation for those items.

Yet even with these improvements the renewal process remains a burden on beneficiaries and administrative resources alike. New York State Medicaid eligibility criteria are complex, and completing the renewal form can be daunting, particularly for populations with limited English proficiency and/or low levels of literacy. Rigid time frames for completing renewal often leave families and Medicaid officials scrambling to meet deadlines. This is compounded by the fact that, for many beneficiaries, renewal is completely unrelated to utilization of care. Renewal for Family Health Plus and Medicaid is implemented by local Department of Social Services offices; health plans and health care providers, who are most directly linked to the beneficiary's care, have only a limited role, if any. Families enrolled in a health plan who receive a renewal notice from the local Department of Social Services may not identify the information as connected to their coverage. Finally, while documentation requirements have decreased, Medicaid still relies on beneficiaries to navigate lengthy

New York's Public Health Insurance Programs: Annual Renewal Process

Each month, local Departments of Social Services send a renewal package to Medicaid and FHP beneficiaries whose coverage is due to expire in the next 60-90 days. The package advises the recipient to provide the local district with current information and documentation by a specified deadline, for coverage to continue.

Enrollees in CHP complete a similar annual renewal process. One key difference, however, from the procedure for Medicaid and FHP is that health plans, rather than local Departments of Social Services, conduct the renewal process for CHP B.

renewal forms and to provide information that often resides in state and local data bases. All of these factors combine to reduce beneficiaries' success rate in completing the annual renewal process.

Lessons from Other States: Options for Streamlining Renewal

Other states' strategies for streamlining renewal, including administrative, ex parte, rolling, and telephone renewal, present a viable array of options for New York. A review of renewal practices in eight key states indicates that states employ these strategies in different ways and in different combinations, sometimes targeting specific populations for streamlined or more accessible renewal processes. (See the Appendix for a table of streamlined renewal practices used in these states.)

Administrative Renewal

Administrative renewal involves sending a pre-populated renewal form to an individual or household in advance of the renewal month. The individual/household is required to return the form *only* if the information reflected on the form has changed. Typically, states use administrative data to verify continued eligibility.

Administrative renewal is often applied only to select populations in Medicaid and/or SCHIP. For example, in Hawaii, it is applied to all households that have a child participating in either Medicaid or SCHIP.[2] In Utah, all SCHIP enrollees are eligible for administrative renewal except those whose eligibility information is deemed "likely to change," such as households with a self-employed worker, or those who have reported income changes to the state during the past twelve months.[3] Until June 2007, Georgia had an administrative renewal option for all SCHIP populations, but not for Medicaid beneficiaries.[4]

States use a variety of methods to verify that individuals who are renewed administratively remain in state and eligible for the program. For example, Florida used families' payment of required premiums as verification that enrollees remained in state.[5]

2 Interview with a program administrator, Hawaii Department of Human Services, August 31, 2007.

3 Interview with a program administrator, Utah CHIP Program, September 5, 2007.

4 Interview with a program administrator, PeachCare for Kids, September 5, 2007.

5 All interviewed officials from states doing administrative renewal noted that at least a portion of their enrollees did not have to pay premiums.

Hawaii, Utah, and Illinois use mail returned by the U.S. Postal Service to detect changes in residence. Some states, including Illinois and Utah, also routinely match information in beneficiaries' Medicaid/SCHIP case files with other key data sets to confirm continued eligibility or to detect changes in a household's circumstances that might render its members ineligible.[6] Databases used for verification include those related to Medicaid (for SCHIP program eligibility), state employment, state university systems, wages, taxes, and state motor vehicle departments.

Administrative renewal has been shown to significantly increase retention rates (Rosenbach et al. 2007). Moreover, it decreases administrative costs per beneficiary. For example, according to one state official, when Florida ended its administrative renewal option in 2004 due to political and budgetary pressures, approximately 120,000 children were dropped from the rolls in a 90-day period.[7] (It is important to note, however, that additional policy changes, as well as hurricanes that hit Florida at this time, also likely contributed to this decline.) At the same time, total program administration costs rose 33 percent, from an estimated $3 per family per month to $4 per family per month.[8] Even in 2005 and early 2006, after challenges related to hurricanes and the transition to new policies had largely dissipated, Florida's disenrollment rates remained ten times higher than they had been under administrative renewal (Herndon, Shenkman, and Vogel 2007).

Conversely, when Illinois instituted administrative renewal, the percentage of SCHIP enrollees who lost coverage because of non-response during the renewal process dropped from 20 percent to 5 percent.[9] In Georgia, where political and budgetary pressures also caused the state to end administrative renewal, per-case procedural costs rose sharply from approximately $3 to over $20 per case (the additional cost of income verification alone is approximately $17).[10]

While further data analysis is required to draw conclusions about the impact of administrative renewal on program integrity, some officials interviewed noted no increased risk to program integrity in their states.[11] In Florida, for example, a state official noted that random sampling to test eligibility suggests that the number of households found to be "over income" or otherwise ineligible remained low throughout.[12] Hawaii and Illinois officials also indicated that they conduct random sampling testing (although results were not provided), and officials noted that, in their view, the testing results indicate that the

6 Interviews with state program administrators.

7 Interview with a program administrator, Florida Healthy Kids Corporation, September 5, 2007.

8 Interview with a program administrator, Florida Healthy Kids Corporation, September 5, 2007.

9 Interview with a program administrator, Illinois All Kids Program, September 13, 2007.

10 Interview with a program administrator.

11 None of the state officials interviewed identified or provided specific useable data comparing eligibility error rates under administrative renewal with such rates under other recertification techniques. Florida officials provided results of random sampling eligibility checks done during and after the use of administrative renewal as a renewal technique. Because of significant changes in the review methodology, and because the administratively renewed sample was not treated as a separate population for purposes of calculating error rates, it is impossible to draw any conclusions from these data about the impact of administrative renewal on program integrity. A majority of interviewed state officials with experience using administrative renewal expressed the view that administrative renewal did not pose a meaningful risk to program integrity. A minority of state officials, however, believed otherwise. It is important to note that officials' views on the impact on program integrity do not correlate with whether the state in which the official worked had a current administrative renewal process.

12 Interview with a program administrator, Florida Healthy Kids Corporation, September 5, 2007.

administrative renewal process has presented no increased risk to program integrity.[13]

Ex Parte Renewal

With ex parte renewal, a state verifies continued eligibility without contacting the beneficiary directly, but rather by collecting and assessing other available eligibility-related information. For example, a state may determine that active enrollment in another public program with similar eligibility requirements, such as Food Stamps, provides enough information for the state to renew a beneficiary's Medicaid or SCHIP coverage.

Arkansas, Illinois, and Louisiana conduct ex parte renewal based on the Food Stamp program database, and notify households of continued eligibility for Medicaid when there is a match. Louisiana also uses a series of case-worker-driven techniques to verify beneficiaries' continued eligibility for Medicaid or SCHIP, including matching with state databases. Using such streamlining techniques, Louisiana reports recent success in reducing the number of procedural closures: the number of enrollees dropped for "procedural reasons" decreased from a documented baseline of approximately 20 percent to just over 1 percent by August 2007.[14]

Rolling Renewal

A "rolling" renewal option allows households to renew coverage during a window of time extended beyond the usual renewal period. For instance, renewal may be allowed at any time of year, or at any point during a period of time — perhaps six months — leading up to the annual renewal deadline. This approach gives busy or working households the flexibility to renew at a time most convenient for them. It also allows renewal reminder messages to be coordinated with provider visits or renewal of eligibility for other public programs.

Louisiana and Utah report that rolling renewal has eased the burden both on program beneficiaries and case workers.[15] This option can be particularly effective when renewal dates for Medicaid and SCHIP can be tied to the renewal date for other public programs, such as Food Stamps. Coordinating the timing of these renewals can reduce the burden on beneficiaries by requiring the reporting of income and other eligibility information just one time during the course of a year.

Rolling renewal also works well with a telephone renewal option (see below). Beneficiaries calling at any time of year to report a change in eligibility or personal information can be given the option to complete the renewal process at that time. As noted below, in Utah, an individual calling with a change that makes a child in the household eligible for SCHIP can choose to complete the renewal at that time and thus establish eligibility for the following twelve months. For households with guaranteed, twelve-month continuous coverage that voluntarily report a change with a detrimental effect on program eligibility, that information is noted and the household's eligibility is not re-examined until the previously scheduled annual review.[16]

One official noted that policymakers in the state were concerned that rolling renewal would allow households with changing income status to strategically time their renewals to maximize time covered by the program.[17] Although none of the officials we interviewed

13 Interviews with state program administrators.

14 Interview with a program administrator, September 5, 2007.

15 Interviews with state program administrators.

16 Interview with a program administrator.

17 Interview with a program administrator.

described rolling renewal as a genuine risk to program integrity, data are needed to draw conclusions about the impact of this strategy on program integrity.

Telephone Renewal

Several states use some form of telephone renewal for Medicaid and/or SCHIP. For example, in Louisiana, case workers sometimes call a household to verify continued eligibility without ever sending a renewal notice (see above).[18]

Among the states we examined, Arkansas, Georgia, Illinois, Louisiana, and Utah all have telephone-based renewal options.[19] California is considering adding a telephone option when it switches to self-certification of income at renewal (estimated to begin in January 2009), and Indiana is also reported to be implementing telephone renewal. In some states, telephone contact is sufficient to finalize a renewal, at least where eligibility changes requiring documentation are not reported. In other states, enrollees may provide information via phone but must also sign and mail in a renewal form.

Streamlining and Federal Audit Issues

While it appears that states are permitted under federal law to adopt any of these renewal streamlining methods — administrative renewal, ex parte renewal, rolling renewal, and telephone renewal — without having to seek a special waiver from the Centers for Medicare and Medicaid Services (CMS), a new federal program may increase the burden on states that choose to adopt these and similar streamlined approaches. CMS has recently begun requiring states to conduct in-depth payment and eligibility reviews for a sample of Medicaid and SCHIP claims and cases as part of the new Payment Error Rate Measurement (PERM) program. As part of the PERM audits, which states undergo once every three years, states must verify the eligibility of approximately 500 Medicaid and 500 SCHIP beneficiaries in the month in which those beneficiaries were enrolled or renewed, using national standards for the verification. If a state is not able to verify eligibility according to those national standards for a significant number of beneficiaries, the state may be subject to overpayment recoupment by CMS or imposition of a corrective action plan, and/or may be labeled as having a high program "error rate" (CMS 2007).

Under the CMS PERM eligibility guidance, states must verify all eligibility information in their sample cases when that information is more than twelve months old. PERM standards for verification are rigorous, particularly for Medicaid; even if a state permits Medicaid renewal based on a beneficiary's self-attestation of conditions of eligibility, such as income or residency, the state must verify some of those conditions of eligibility with third-party documentary evidence to complete the PERM. (Self-attestation is generally permitted for verification in SCHIP.)

The full implications of the PERM audits for states' streamlining initiatives are not yet known. But it is clear that the PERM audits can put a state at risk of increased burdens and recoupments if the state does not have some contact with beneficiaries, sufficient to update eligibility information, on at least an annual basis. The audits are also likely to impose additional verification burdens on states that do not collect documentary evidence to support certain categories of

18 Interview with a program administrator.

19 Georgia allowed households to report changes by telephone when the state had an administrative renewal option; that option ended in June 2007. Attempts to confirm whether Georgia continues its telephone-based renewal option in the absence of administrative renewal were unsuccessful.

eligibility information at renewal.

Georgia, for example, noted it had difficulty finding and contacting beneficiaries selected for PERM review because the administrative renewal process meant that the state had not had direct contact with the household for over a year. In those cases, the state was required to contact the beneficiary (which in some cases meant tracking down new contact information) and solicit verification of eligibility as of the review month.

According to state officials whose programs already have been subject to these audits, PERM burdens and risks can be managed in the context of a highly streamlined enrollment and renewal process. This requires efforts to facilitate the updating of beneficiary contact information so that beneficiaries may more easily be found and contacted for additional information if their cases are included in eligibility verification samples. It also requires ensuring some update of eligibility information annually, and encouraging the provision of documentary evidence whenever it will not pose a barrier to continued enrollment.[20]

Discussion

From conversations with state officials about their experiences using various streamlined renewal techniques, several themes and recommendations have emerged that could help guide New York policymakers in efforts to improve program retention rates.

- **Streamlined renewal processes, including administrative, ex parte, rolling, and telephone renewals, can have a substantial impact on reducing the number of administrative closures, with little risk to program integrity.** The officials interviewed all indicated that they believed that streamlined renewal processes had improved program retention rates, and the majority said that they had done so with little or no impact on program integrity. Several officials noted that audits done both when streamlined renewal was in place and when more rigorous renewal processes were required showed little difference in overall error rates, although we were not able to access data that would verify these results.

- **A single approach to streamlining renewal may not fit all.** Because not all enrollees in public health insurance programs are subject to the same eligibility and proof requirements, and because individual circumstances related to literacy, residence, income, and stability vary, a single technique for streamlining renewal may not be permissible or practical for all populations. All of the state officials interviewed indicated that they used different renewal techniques for different populations to improve program retention rates. Even when a streamlined technique such as administrative renewal could not be used universally, implementation for even a small sub-population (for example, for a group whose income eligibility could be verified through existing databases) could make a difference in renewal rates.

- **Creating multiple opportunities for reporting case information changes can help with renewal rates and ease the state's burden in PERM audit verification processes.** Simply locating all program enrollees to initiate renewal processes or to verify eligibility information for a federal audit was a challenge for most of the state officials interviewed. Several officials indicated that having a good

[20] Under an administrative renewal process, this can be done via database checks or other methods that do not require direct contact with the beneficiary.

"feedback loop" from enrollees, providers, or managed care plans to report changes in enrollees' address/contact information could minimize the number of "lost" enrollees who might not receive renewal notices or wouldn't be available to verify eligibility if selected as part of an audit sample.

- **Using existing databases to verify income, residence, resources, citizenship status, and other eligibility criteria can reduce enrollee burden and focus verification requirements.** Most states already have a significant amount of information about public health insurance program enrollees in other program databases. Accessing and using that information in a targeted and secure way to confirm continued program eligibility can reduce the obligation for large numbers of enrollees to provide program officials with documentation or detailed information to ensure continued health insurance coverage.

Conclusion

Streamlining renewal for Medicaid and SCHIP can help some of New York's poorest residents keep health insurance coverage, while improving continuity of care and reducing the wasted time and effort associated with program churning. Several states have already implemented dramatically streamlined renewal processes, with generally very positive results for program retention. Improvements to New York's renewal processes should be informed by the successes and challenges of other states' programs.

Appendix:

Renewal Techniques in Select State Medicaid and Children's Health Insurance Programs

State	Administrative Renewal	Telephone Renewal	Select Additional Renewal Techniques
Arkansas	No (Medicaid and SCHIP)[1]	Yes (Medicaid and SCHIP)[2]	• When the mail-in renewal form is not returned, workers make follow-up phone calls; this policy has been in effect since 2005.[3] • Ex parte renewal through Food Stamps has been in place for both Medicaid and SCHIP populations since 2001.[4]
California	No (Medicaid and SCHIP)[5]	No (Medicaid and SCHIP), but contemplating telephone renewal in 2009, with shift to self-certification of income[6]	• When the mail-in renewal form is not returned, workers make follow-up phone calls (SCHIP).[7]
Florida	Yes, from 1992-2004 (SCHIP)[8]	No (Medicaid and SCHIP)	• Under administrative renewal, non-responding households were renewed if the household continued paying its monthly premium.[9] • Risk of being disenrolled at renewal increased ten-fold, from 1.3 percent to 13 percent, following the switch from administrative to "active" renewal process.[10]

continued

Note:
Information in this table is based on telephone interviews and follow-up e-mail communications with state administrators from each key state. This table does not provide an exhaustive list of states using simplified renewal techniques or, for each state included, an exhaustive list of the simplified renewal techniques used.

1 Arkansas Department of Human Services Policy Directive. *Medical services policy manual*. [Last accessed December 7, 2007, at http://www.arkansas.gov/dhs/webpolicy/Medical%20Services/MS16150.]

2 Arkansas Department of Human Services Policy Directive. ARKids first telephone renewals (MS 05-05). *Medical services policy manual*, valid August 1, 2005, until superseded. Available online at http://www.arkansas.gov/dhs/webpolicy/Medical%20Services/Man%20Trans%20MS%2005-05_PD.htm.

3 National Academy for State Health Policy. SCHIP information available online at www.chipcentral.org.

4 Arkansas Department of Human Services Policy Directive. Medicaid renewals at Food Stamp QR and midpoint review (MS 01-14). *Medical services policy manual*, valid December 5, 2001, until superseded. Available online at http://www.arkansas.gov/dhs/webpolicy/Medical%20Services/Man%20Trans%20MS%2001-14_PD.htm.

5 See annual eligibility review/redetermination rules for the Healthy Families Program and Medi-Cal for Children at http://www.healthyfamilies.ca.gov/English/caa/pdfs/caaupdate4.pdf. Also confirmed, via e-mail, by the deputy director for eligibility, enrollment, and marketing, Managed Risk Medical Insurance Board, November 27, 2007.

6 While California does not currently have telephone renewal, the state may consider a telephone renewal option when it allows self-certification of income, which is tentatively slated to begin in 2009. E-mail communication with the state's deputy director for eligibility, enrollment, and marketing, November 27, 2007.

7 National Academy for State Health Policy. SCHIP information available online at www.chipcentral.org.

8 Current renewal information for Florida's Healthy Kids program is available online at https://www.healthykids.org/renewal/index.php?lang=ENG.

9 Herndon JB, EA Shenkman, and B Vogel. 2007. *The impact of renewal policy changes in the Florida Healthy Kids program*. Available online at http://www.healthykids.org/documents/evaluation/institute/2007/tab_1.pdf.

10 Herndon JB, EA Shenkman, and B Vogel. 2007. *The impact of renewal policy changes in the Florida Healthy Kids program*. Available online at http://www.healthykids.org/documents/evaluation/institute/2007/tab_1.pdf.

State	Administrative Renewal	Telephone Renewal	Select Additional Renewal Techniques
Georgia	Yes, from 2001-2007 (SCHIP only)	Yes, with administrative renewal, 2001-2007 (SCHIP only)	• Until June 2007, Georgia used administrative renewal in SCHIP and changes in household information could be reported by phone. • Administrative renewal was available only to SCHIP enrollees, most of whom paid premiums. (Premiums are not paid for children under six — approximately 81,000 enrollees, or 20 percent, in 2006.) • When the U.S. Postal Service returned renewal forms to the SCHIP agency as undeliverable, workers made multiple follow-up calls and sent at least one follow-up mailing before coverage was cancelled. • Verifications conducted with Medicaid (for SCHIP), State Employee, University System, and Department of Labor wage databases.
Hawaii	Yes (since 2004, children only, for Medicaid or SCHIP)	No (Medicaid and SCHIP)	• Administrative renewal allowed for children only in the Medicaid or Medicaid Expansion (SCHIP) populations.[11] • Hawaii uses the return of undeliverable mail as a way to identify families that have moved out of state.
Illinois	Yes (since 2006, applies to children only, for households with incomes less than 200 percent FPL)[12]	Yes (for those eligible for administrative renewal)	• Administrative and telephone renewal available for children in Medicaid and SCHIP (Medicaid expansion) with family income under 200 percent FPL. • Telephone renewal conducted through household caseworker. • Verification conducted with the state's "new hire" database. • If renewal mail is returned unopened to the state, internal databases are checked for updated address information, and a second request is mailed. If it is returned again, then coverage is cancelled. • Ex parte renewal is conducted for those with Food Stamps.[13] • Proportion of SCHIP beneficiaries disenrolled because of failure to respond during renewal has dropped from 20 percent to 5 percent with the implementation of administrative renewal.

[11] Hawaii's administrative program rules are available online at http://www.hawaii.gov/dhs/main/har/har_current/AdminRules/document_view.

[12] Criteria for "passive" renewal in Illinois' AllKids programs are explained in further detail at http://www.allkidscovered.com/assets/032206_akalert5.pdf.

[13] Automatic "medical" renewal for families with Food Stamps, and other renewal criteria for AllKids, are available online at http://www.allkidscovered.com/assets/032206_akalert5.pdf.

State	Administrative Renewal	Telephone Renewal	Select Additional Renewal Techniques
Louisiana	No (Medicaid and SCHIP)	Yes (since 2003, Medicaid and SCHIP)	• Telephone, rolling, and ex parte renewal in Medicaid and SCHIP (Medicaid expansion). A policy that follow-up phone calls must be conducted before closing a case began in 2000. • Notice is sent to enrollees not able to be renewed on ex parte basis, requesting they call a caseworker to renew their coverage. If there is no response, caseworker follows up by mail and/or phone. Enrollees may also renew via an automated hotline or the internet. • If mail is returned unopened, caseworkers use multiple approaches to find enrollees, including contacting a known primary care provider or using directory assistance. • Retention rates have improved significantly with the implementation of these renewal techniques; "procedural" closures in the state dropped from a baseline 20 percent to less than 5 percent.
Utah	Yes (since 2003, SCHIP)	Yes (Medicaid and SCHIP)[14]	• Administrative renewal available only in SCHIP, and certain populations — such as those reporting an income change during the eligibility period — are excluded. • Rolling renewal allowed when the household reports a decrease in income during the eligibility timeframe (SCHIP only). • Verification of eligibility information is conducted through the wage and driver's license databases at renewal for all populations. • If renewal forms are returned by the U.S. Postal Service as undeliverable, the state asks for a forwarding address. • Telephone renewal has been conducted for SCHIP populations since prior to 2004. Telephone renewal is also allowed for Medicaid populations, but must still be followed with a mail-in form.

[14] For more on Utah's Medicaid program, see http://utahcares.utah.gov/infosourcemedicaid/.

References

Bachrach D and A Tassi. 2000. *Coverage gaps: The problem of enrollee churning in Medicaid managed care and Child Health Plus*. New York State Coalition of Prepaid Health Services Plans. Available online at http://www.manatthealthsolutions.com/publications/articles/3425_00-06-01.htm.

Bauer T and S Hopkins. 1999. *Keeping New York children insured: The revolving door of recertification — new options*. New York: The New York Academy of Medicine. Available online at http://www.nyam.org/initiatives/pdf/recertification.pdf.

Boozang P, L Braslow, and A Fiori. 2006. *Enrollment churning in Medicaid: Coverage gaps undermine the managed care system and continuity of care for the chronically ill*. New York State Coalition of Prepaid Health Services Plans. Available online at http://www.manatthealthsolutions.com/publications/articles/Enrollment_Churning.pdf.

CMS (Centers for Medicare and Medicaid Services). August 31, 2007. Medicaid program and State Children's Health Insurance Program (SCHIP); Payment error rate measurement; Final rule. *Federal Register* 72(169): 50490-50513. Available online at http://www.cms.hhs.gov/PERM/Downloads/PERM%20Final%20Reg.pdf.

Cook A, D Miller, and D Holahan. 2007. *Health insurance coverage in New York, 2004-2005*. New York: United Hospital Fund. Available online at http://www.uhfnyc.org/usr_doc/Chartbook_2004-05_Final.pdf.

Herndon JB, EA Shenkman, and B Vogel. 2007. *The impact of renewal policy changes in the Florida Healthy Kids program*. Available online at http://www.healthykids.org/documents/evaluation/institute/2007/tab_l.pdf.

Holahan D, A Cook, and L Powell. 2008. *New York's eligible but uninsured*. New York: United Hospital Fund. Available online at http://www.uhfnyc.org/usr_doc/Eligible_but_Uninsured.pdf.

Rosenbach M, C Irvin, A Merrill, S Shulman, J Czajka, C Trenholm, S Williams, SS Limpa-Amara, and A Katz. 2007. *National evaluation of the State Children's Health Insurance Program: A decade of expanding coverage and improving access*. Mathematica Policy Research Inc. Available online at http://www.mathematica-mpr.com/publications/pdfs/schipdecade.pdf
(see p. 29).

Additional copies of *Streamlining Renewal in Medicaid and SCHIP: Strategies from Other States and Lessons for New York* may be downloaded, at no charge, from the United Hospital Fund website, www.uhfnyc.org.

United Hospital Fund

Shaping New York's Health Care: Information, Philanthropy, Policy

Empire State Building
350 Fifth Avenue, 23rd Floor
New York, NY 10118
(212) 494-0700
http://www.uhfnyc.org

ISBN 1-88127-7852