



# *Managing Medicaid Take-Up*

## *The Complexity of Simplifying the Medicaid Application Process*

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### **Study Highlights**

*The type and extent of Medicaid application simplification measures varied among the 18 states participating in this study.*

- ❖ All states in the study implemented at least some application simplification measures to make the process more “user-friendly.” These measures ranged from simplifying the application form to screening for eligibility for both the Children’s Health Insurance Program (CHIP) and Medicaid in a way that appeared seamless to the applicant. States could also implement less rigorous verification processes, or provide more personal assistance for individual applicants. The range of simplification measures left Medicaid administrators with the difficult task of determining which methods worked best and how to implement them.

*States implemented application simplification measures at various times.*

- ❖ After an initial drop in Medicaid enrollment after welfare reform, a handful of states aggressively implemented measures to make the application process easier. Some simplified their application process in conjunction with administrative changes that resulted from enactment of CHIP. Other states did not substantially change certain aspects of the application processes until later or until they were threatened by lawsuits.

*Personal contact to assist Medicaid eligible individuals with the application process varied at the local level and appeared to impact the likelihood of the application’s successful completion.*

- ❖ Outreach workers who assisted individuals with completing application forms and workers who helped verify information on the applications were a vital part of the application process. Ohio, Arizona, and New York noted that the degree of assistance from these workers could vary among local offices depending on staffing levels and local priorities.

*Medicaid budget cuts are likely to negatively impact Medicaid by forcing a rollback of some recent improvements by states that had simplified the application process.*

- ❖ Many states noted that the extra measures that were taken by frontline workers to simplify the application process may not be sustained in times of fiscal stress on state budgets because frontline workers are likely to experience tight staffing and heavier caseloads — leaving less time for personal assistance, referral, outreach, and follow-up.

## Introduction

Medicaid's role as a support for people in need has been dynamic especially as it relates to working families that are unable to obtain or pay for private insurance. When the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) passed in 1996, more states began experimenting with measures to expand Medicaid eligibility to working, uninsured individuals. Then in 1997 legislation was signed to enact the Children's Health Insurance Program (CHIP), which provided states with another opportunity to extend Medicaid eligibility by enacting CHIP programs that were a Medicaid expansion.

For state governments, Medicaid provides a tremendous opportunity to use the incentive of partial federal financing to expand health coverage to millions of uninsured children. The establishment of CHIP programs undoubtedly increased states' success with providing health insurance to more kids and has helped to identify children who were Medicaid eligible but not enrolled. CHIP also provided an opportunity for state Medicaid administrators and frontline workers to modify the administration of their existing Medicaid programs by leaving them with a new set of complex choices about how to administer Medicaid in relation to CHIP. *Some of the most complex of these choices were about how to administer the application process.*

To assist with administering Medicaid, the Health Care Financing Administration (now known as the Center for Medicaid and Medicare Services) made several recommendations for states in the late 1990s to simplify the application process. As a result, several states undertook efforts to eliminate previous requirements such as face-to-face interviews or asset tests.<sup>1</sup> Studies have

shown that changes to application and eligibility policies affected Medicaid beneficiaries' ability to obtain coverage.<sup>2</sup> Assuming there was a positive impact on Medicaid enrollment from these application simplification measures, questions remain about which simplification methods have worked best, what else can be done to simplify the application process, and whether the current strain on state budgets will reverse the efforts that states undertook to make enrollment easier.

To study the application process, the Rockefeller Institute of Government surveyed 18 states as part of a larger study on the administration of state Medicaid programs from 1995-2000. This period was significant because both the enactment of the PRWORA and CHIP brought a new level of complexity to administering an array of programs that differed in terms of eligibility levels and application requirements. This paper is part of a series of Management Briefs, published by the Institute, outlining various findings from a larger study about Medicaid management practices and how they impacted Medicaid take-up.<sup>3</sup> Take-up is defined as the rate at which eligible individuals are enrolled. The states in the study are listed on page 3.

This paper outlines some of the actions states took to simplify the Medicaid application process and whether simplification measures improved the degree to which Medicaid eligible individuals enrolled. The particular set of factors related to simplifying the application process that are examined in this analysis include:

- ❖ Access to an application.
- ❖ Assistance and follow-up to ensure an application was complete.
- ❖ Simplification of the application form.
- ❖ Integration of the Medicaid application process with other social service programs.

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<sup>1</sup> See "Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures," by Donna Cohen Ross and Laura Cox, Center on Budget and Policy Priorities, October 2000.

<sup>2</sup> See "Medicaid and SCHIP States' Enrollment and Payment Policies Can Affect Children's Access to Care," General Accounting Office, September 2001.

<sup>3</sup> Unless otherwise indicated, information about particular states is taken from field reports written by researchers in each state commissioned by the Rockefeller Institute. A listing of the researchers is provided at the end of this paper.

<b>States Participating in the Study</b>		
<i>Arizona</i>	<i>Colorado</i>	<i>Florida</i>
<i>Georgia</i>	<i>Kansas</i>	<i>Maryland</i>
<i>Michigan</i>	<i>Missouri</i>	<i>New Jersey</i>
<i>New York</i>	<i>Ohio</i>	<i>Oregon</i>
<i>Tennessee</i>	<i>Texas</i>	<i>Utah</i>
<i>Washington</i>	<i>West Virginia</i>	<i>Wisconsin</i>

- ❖ Rigor of the verification requirements and the level of documentation required for enrollment.
- ❖ The extent of complexity involved in applying for Transitional Medical Assistance (TMA).

**Findings**

*Access to an Application Form*

The first step in the Medicaid application process is knowing where and how to get an application. In order to make the application process for Medicaid or CHIP easier, most states eliminated the requirement of a face-to-face interview for certain populations and began to station eligibility workers outside of local offices, extend office hours, or allow individuals to mail-in applications if they were applying for Medicaid-only and not Temporary Assistance for Needy Families (TANF). Of the measures that states implemented to ease access to applications, one of the most commonly used was to allow applicants to mail in application forms. The mail-in option made it easier for individuals to submit applications if they had transportation difficulties, geographic barriers, or feared being socially stigmatized by going to a local social service office. Placing applications on websites and allowing individuals to fill them out online also increased access for individuals with access to internet technology. Overall, every state in the study undertook at least one measure to make applications more readily available. Table 1 gives a brief overview of some of the measures taken by states to make it easier to access a Medicaid or CHIP application. This table is by no means comprehensive, but does provide an overview of the

variety of measures that states used to make applications available.

What is interesting to note in Table 1 is that every state undertook at least some measures to improve access to applications. However, most states implemented application process changes over time and many did not implement such measures until more recently. Texas implemented comprehensive Medicaid simplification legislation in 2002. New York passed simplification measures in 2002 — after the primary time period examined in this study. Some of the provisions to simplify the application in Texas will not be fully implemented until 2003 and may be dependent upon the state’s fiscal situation.

Even when states enacted simplification measures, it was difficult to tell if local agencies had the capacity to administer the programmatic changes. For instance, could they handle the increase in applications? Did they have enough time to follow up with applicants if forms were incomplete? Did many applicants actually get an application by downloading it from a website? It is also difficult to tell which methods for increasing access to applications were most effective. And just because a state implemented a policy to make applications more accessible did not necessarily mean the policy was implemented as intended. For instance, if a state accepted applications by phone, eligibility workers often felt uncomfortable making final determinations. This was true in Utah, where applications could be completed by phone but eligibility workers were reluctant to actually make an eligibility determination. Regardless of the difficulty in linking the accessibility of application forms to enrollment, it is reasonable to assume that there is a rough correlation between increased enrollment

**Table 1: Overview of Selected State Actions to Increase Access to Medicaid/CHIP Applications**

Arizona	Mail-in applications accepted; phone and at-home interviews conducted; outreach efforts increased significantly with passage of proposition 204.
Colorado	Individuals seeking Medicaid only can apply by fax or mail; there is a 24-hour 800 number and 82 satellite eligibility determination sites; many county offices stay open until 7P.M. on Tuesday and Thursday.
Florida	Application is available on-line; a great deal of outreach was done for CHIP, which also increased Medicaid enrollment.
Georgia	Medicaid applications have been made available primarily through outreach; an online application for the CHIP program is available; the school lunch application has been used as the Medicaid application.
Kansas	An 800 number is available for assistance; letters were recently sent directly to individuals who lost coverage after welfare reform telling them about potential Medicaid eligibility.
Maryland	So many outreach efforts were undertaken to increase the availability of applications that the state exceeded enrollment targets by a large margin – a lot of “spillover” from CHIP outreach occurred.
Michigan	In 1998 and 1999 outreach workers went door to door; outreach workers were paid \$25 for each person successfully enrolled in Medicaid or CHIP.
Missouri	Mail-in, fax, and phone applications accepted; Jackson County has 59 “Caring Community” sites, mostly at hospitals and schools where applications are available.
New Jersey	Mail-in applications are accepted (although most are done in person).
New York	Albany County tried evening hours (but there were few takers); most outreach was done for CHIP on a statewide level and little to no outreach was done locally for Medicaid.
Ohio	Mail-in application accepted and available on website; there is a hotline to help applicants.
Oregon	Mail-in applications accepted; 24-hour hotline to help with questions about the application.
Tennessee	Caseworkers are overburdened with applications so little was done to increase access since there is no shortfall of applicants.
Texas	Simplification measure was passed in 2001(took effect in 2002) to allow children to mail-in applications.
Utah	Application can be done by phone; outreach was only done on a statewide level although brochures were given to community-based organizations for distribution.
Washington	Community-based method for outreach was used as a national model.
West Virginia	Application by phone or in person, or by a toll-free hotline.
Wisconsin	Application by phone or in person.

and the degree to which applications were made accessible to individuals. For instance, Texas, which experienced a decrease in enrollment during the time period studied, had not implemented measures to make applications more accessible while Missouri, which undertook efforts earlier, saw large gains in enrollment from 1995 to 2000.

### *Assistance with Completing an Application*

For individuals who had trouble filling out applications, it was important that they be able to easily receive assistance from local staff. Access to a staff person was so important that Oregon noted that the lack of face-to-face application assistance was a major reason why 40 percent of Oregon Health Plan (OHP) applications were pended. Officials claimed that applications that were not done on a face-to-face basis were often incomplete or contained erroneous information. To mitigate the likelihood of incomplete or erroneous applications, several states placed workers at various locations to assist applicants with completing application forms. In Arizona, eligibility workers were expected to make the number of collateral contacts necessary to complete the verification requirements. The only pieces of information excluded from this mandate were proof of citizenship status and of family relationships. Before July 2000, such follow-up measures were largely the client's responsibility. Medicaid workers in Georgia had the discretion to pend cases for longer than the allotted time if they believed that an individual was making a sincere effort to obtain information. In Washington, workers contacted clients if the application form was incomplete. In Wisconsin, if an applicant was potentially eligible for other services, a Resource Specialist would make an appointment with a county eligibility worker in order to help the applicant with completing the application process. However, not all workers felt that assistance had to be provided unless it was sought by the applicant.

Regardless of these efforts, a few states noted that it was difficult to provide personal assistance and outreach with limited staff. This was true in Kansas where administrative attention to Medicaid take-up was seen as difficult. There were many responsibilities for administering Medicaid and welfare and thus the time available for outreach was limited. Wisconsin's Dane County Medicaid managers were worried about staff-to-caseload ratios. In Washington, there was an effort to defund outreach efforts and outreach for certain programs in Michigan ended after funding ceased.

With recent declines in state revenue, the efforts of frontline staff to provide outreach and provide increased access to applications are likely to decrease as workers struggle with increased caseloads and less staff to provide outreach and follow-up. Many states noted that increased caseloads equated to decreased follow-up and that this aspect of the application process was the most likely to suffer setbacks during an economic downturn.

### *Simplification of the Application Form*

Another component of the application process is the application form. Almost every state undertook efforts to make the Medicaid form easier to use, although the effort afforded to this endeavor, varied greatly. Application lengths ranged from 24 pages in West Virginia to 2 pages for Missouri's MC+ application for Medicaid and CHIP.<sup>4</sup> Several states' applications were a similar length. For instance, Colorado and Oregon's application form was 8 pages, while New Jersey's was 6 pages. What is important to consider is that a shorter application form did not always equate to an easier process, especially if a state required more documentation. (See the section on "Rigor of Verification Requirements" on page 8.) Table 2 outlines some of the efforts of states to simplify the Medicaid application form.

The most notable aspect of Table 2 is that the large majority of states in the study undertook efforts to simplify the application form. Unless

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<sup>4</sup> Several states have recently reduced the length of their application form. See "Enrolling and Retaining Low-Income Families and Children in Health Care Coverage at <http://www.cms.hhs.gov/schip/outreach/progress.pdf> for the most up-to-date information.

<b>Table 2: Summary of Medicaid and CHIP Application Form Simplification</b>	
Arizona	As of 2000, a simplified, shortened, universal, experimental form is used for Food Stamps, Medicaid and TANF in English and Spanish.
Colorado	The application form is considered “highly readable” and is available in Spanish. A simplified CHIP form was recently developed for use in July 2001 using focus groups that changed the form from 22 to 12 pages to 8 pages.
Florida	An integrated application is used for TANF, Medicaid, and Food Stamps; application forms considered to be simple and straightforward and are available in Spanish and Creole.
Georgia	The application is 2 pages in length; school lunch applications were accepted as initial Medicaid applications.
Kansas	There is a consolidated TANF, Food Stamp, and Medicaid application and the current form is considered to be fairly readable; translators are available to assist individuals who speak other languages.
Maryland	The application was recently redesigned to make it easier to use and a policy specialist was hired to implement simplification measures.
Michigan	Michigan FIA uses the same form (1171) for all initial eligibility determinations and redeterminations for TANF, Food Stamps, and Medicaid. The form is long but much improved from the 26-page form used in the early 1990s. It is available in English, Spanish, and Arabic.
Missouri	All non-TANF clients use the MC+ application, which is 2 pages; the TANF application serves as the application for MC+.
New Jersey	Applications for Medicaid, CHIP, and NJFamily Care are considered readable and easy to understand and are 6 pages in length. Telephone assistance is available in multiple languages.
New York	There are two separate applications for Medicaid — one for those seeking cash assistance and one for those seeking health insurance or nutrition assistance (called Access NY HealthCare.)
Ohio	The form was redone and simplified in July 2001.
Oregon	Outreach workers have a 1 page preliminary form they can fax to the county, which does follow-up to complete applications. The regular application is 8 pages (with 14 point font) and is accompanied by a “who to call” sheet that has a 20-page instruction booklet. State managers hope to revise the OHP application to make it easier for caseworkers to place enrollees in the right category.
Tennessee	There is a common application process and applicants for Families First, Medicaid, and Food Stamps; unless they specify they don’t want other services, are considered for all. A computer system, ACCENT, assesses their eligibility for all three.
Texas	A general DHS application is used for a variety of assistance programs; a new joint application was made available for CHIP and Medicaid in January 1, 2002; pictures were added to the form to make it easier to understand.
Utah	A separate application is used for CHIP and Medicaid. The form is considered to be fairly readable except for a section on 3rd party insurance.
Washington	Applications are available in seven languages; there is a pilot program to simplify links between the school meals and Medicaid eligibility.
West Virginia	The standard form is 24 pages, replicating a face-to-face interview.
Wisconsin	The application is simplified and is available in English, Spanish, and Hmong.

states' used a focus group, such as was done in Colorado, it is difficult to tell which application forms actually appeared easier to the applicant. The biggest difference between states was *when* they started using their simplified application form and *what documentation* had to accompany the form. Several states, such as Arizona, Colorado, Ohio, Texas, and New York, did not significantly simplify the application form until after January 2000. Other states, such as Missouri, began using their simplified form earlier. The actions of states to simplify the application form are likely to be sustained during an economic downturn because the programmatic change (the form) was standardized statewide.

It is also interesting to note that most states simplified the application form for Medicaid if it was part of a joint application for Medicaid and CHIP or if it was for Medicaid only. Many states undertook these efforts after the passage of CHIP because they saw the value of a simplified form. Individuals who were seeking other benefits had to fill out an application for Medicaid that was part of a more generic benefits form. At times this lengthier application form may have been difficult for individuals to complete or may have been a deterrent to application. Regardless, most states recognized the value of a simplified application not just for the applicant but also for the eligibility worker. A shorter form often meant less information to input in an automated eligibility system, making the process easier for applicants and Medicaid workers alike.

### *Integration of the Application Processes (Medicaid and CHIP Integration)*

Several of the descriptions in Table 2 apply to both Medicaid and CHIP applications. The simplification of an application form could be enhanced further through other modifications to the application process. For instance, referral processes could be established to assure that individuals received benefits. If states did not have a joint form or if they did not develop a system to assure referrals then there could be instances where individuals did not receive services.

States in this study could be grouped in two categories in terms of their success with integrating the application process between Medicaid and

CHIP: those with a fair degree of integration and those that appeared to have gaps. The states that appeared to have gaps with referral processes between CHIP and Medicaid from 1995-2000 include Texas, New York, Georgia and West Virginia. In New York, the gap in assuring completion of the application process occurred when individuals were referred from CHIP to Medicaid. In Albany County, it was estimated that only half of the children who were referred from CHIP to Medicaid actually applied for Medicaid. In New York's Monroe County, the estimate of people who applied for Medicaid when referred from CHIP was 58 percent. In Texas a gap also occurred between the CHIP and Medicaid program. Many children were supposedly misplaced when they transferred from one program to another and it was estimated that only 25 percent of children were enrolled in Medicaid after being referred. In West Virginia, the gap occurred but often in the reverse order. Individuals who were determined ineligible for Medicaid but likely eligible for CHIP had to wait 30 days before they received a CHIP application. Similarly, in Georgia not all caseworkers were diligent in referring and providing applications to individuals that were found not to be eligible for Medicaid and many "fell through the cracks." It is important to note that all states have taken measures to improve enrollment and referral across programs since 2000. Texas' recent implementation of legislation to simplify the application process is expected to decrease the number of individuals going without benefits while West Virginia is making a concerted effort to improve take-up for CHIP.

Other states noted a fair degree of success with integrating the application process. For instance, children in Arizona who were about to lose Medicaid benefits because of excess income were automatically moved to KidsCare so there was no break in coverage. In Washington, the enrollment process for Medicaid and CHIP was integrated with a common application form. Distinctions between Medicaid and CHIP were invisible in Wisconsin. Referrals between the programs were said to run smoothly because the computer system (known as CARES) automatically checked Social Security and state Unemployment Insurance to flag

if an individual's income exceeded eligibility levels and they would be moved to the appropriate program. Even states that had a "stovepiped" administrative structure between CHIP and Medicaid could overcome obstacles to integration by creating strong referral systems. For instance, Michigan, which had separate structures for administering the programs, was able to overcome this separation by implementing effective referral processes between programs.<sup>5</sup> This was also the case in Utah where Medicaid workers could enroll individuals in Medicaid or CHIP.

### *TANF and Medicaid Integration*

Over the time period studied and with the encouragement of the federal government, several states began to promote increased enrollment in health programs. Many states were already using a common application form for Medicaid and other social services programs to enroll people in Medicaid. Other states began to establish processes to encourage referral across a variety of programs. In New Jersey, CWA staff screened applicants for all services provided by the agency. Staff in Ohio's Franklin County explained all benefits possible and relied upon the CRISE computer system to help determine an individual's eligibility for a variety of programs. Even in Georgia, where relationships between TANF, Food Stamps, and Medicaid were considered to be predominately stovepiped at the state level, there was still an integrated intake, eligibility, and case management information system (SUCCESS) for the programs that helped identify when an individual might qualify for services other than those they were originally seeking. Even in states like Wisconsin where Medicaid eligibility was determined independent of TANF, frontline workers screened for eligibility for all types of programs.

Integrating the application form for Medicaid and CHIP and for Medicaid and other social service programs appears to have simplified the application process from the point of view of the applicant. However, integrating the application

form did not always make the process easier for frontline workers because they had to know more about each of the programs. During the time period studied, states appeared to make modest efforts to train frontline workers about the various programs. As caseloads and budgets are cut back there may be less time for training and less time for workers to provide follow-up and referrals. This may result in some retrenchment of the progress that was made to integrate the programs and increase enrollment via referral.

### *Rigor of Verification Requirements*

Depending on what is required, verification of eligibility can be the most involved part of the application process. The list of verification requirements varies considerably among states and is partially dependent upon whether an individual is seeking eligibility for other types of assistance and whether they are considered an adult or child. Many states eased verification requirements during the time period studied. By October 2000, 42 states had eliminated asset tests for Medicaid-eligible children while 10 allowed self-declaration of income.<sup>6</sup> A few other examples of how states simplified their verification requirements include Georgia, which used less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, and has moved away from income verification for Medicaid and instead depends on a statement for income and savings. Maryland amended their coverage plan in response to Section 1931, making standards less restrictive and increased resource standards to \$2,000. They also stopped including cars and allowed children to earn up to \$2,000 without counting their earnings as family income. In response to concerns about take-up, Wisconsin changed to a simplified Medicaid application procedure where local eligibility workers did not have to verify as many items on the application.

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<sup>5</sup> See "Health Insurance for Children: How Seamless are Relationships Between Medicaid and CHIP?" by Frank Thompson, October 1, 2002.

<sup>6</sup> See "Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures," by Donna Cohen Ross and Laura Cox, Center on Budget and Policy Priorities, October 2000.

In contrast, some states had a number of verification requirements that posed a barrier for applicants. For instance, in Tennessee, one of the biggest transaction costs was providing the required documents. In Oregon, staff believed that income verification requirements were a barrier for many enrollees and that the requirement to list Social Security Numbers of household members intimidated immigrants. New York listed about 16 items that were used during the verification process, ranging from school attendance to alien status. Several states changed their verification requirements more recently. In West Virginia there has been a move away from using an asset tests which has greatly simplified eligibility determination. Income verification, such as pay stubs or letters from employers, are accepted. In May 2001, legislation was signed in Texas to use CHIP documentation and verification standards beginning in January 2002 for Medicaid — although Medicaid resource limits (\$2,000) remain intact but do not affect CHIP eligibility.

What is interesting to note is that many factors such as the type of assistance needed, the point of application, or the age of the applicant impacted the level documentation required. For instance, in Kansas only income for non-TANF Medicaid had to be verified but for TANF, verification included proof of utility expenses, address, age, ID, citizenship, childcare bills, Social Security Numbers, child support, vehicles, rent/mortgage, alimony paid, bank statements, and tax returns. The variation in required documentation for Food Stamps and Medicaid between counties in Ohio concerned some state officials. In Arizona, applications could be submitted in person or by mail, with the major requirement being a valid signature, but people who applied at local DES-FAA offices were asked for a much longer list of verifications since it was assumed they were applying for TANF and Food Stamps. In terms of examples of policy variations based on age, Washington did not necessarily require children to provide proof of income eligibility while adults were required to do so. With the simplification law in Texas, income and asset reporting was no longer necessary for children on Medicaid.

It is difficult to quantify the impact of the different verification requirements on simplifying the overall application process. This analysis, however, does show the wide range of states' choices for simplifying application verification measures. Eliminating such requirements made the application process simpler for the eligibility workers because they spent less time searching for documents. The efforts of states to simplify this part of the application process may be sustained even during an economic downturn because less verification reduces workloads for frontline staff that would otherwise spend valuable time tracking down documentation.

### *Transitional Medical Assistance*

The message under welfare reform to “reduce the rolls” largely contradicted efforts to “increase Medicaid take-up.” These mixed messages may have been difficult for frontline workers who processed applications for both TANF and Medicaid. Most states were fairly successful in making sure that Medicaid was provided to individuals who left TANF and went to work. However, a handful of states had difficulty as a result of PRWORA, which initially caused “glitches” in the process for receiving transitional medical assistance. Two states in the study, Colorado and Washington, undertook major efforts to reinstate individuals who incorrectly lost benefits because of lawsuits or the threat of a lawsuit. In Colorado, the problem was largely the result of a “glitch” in the COIN computer system. Because of this “glitch,” a class action lawsuit, known as *Tatum*, was brought against the state and the system was subsequently fixed. In Washington, the inappropriate discontinuance of Medicaid eligibility was first noticed by advocacy groups who were approached by clients who left welfare and were uninsured. These advocacy groups began outreach efforts in 1998 to find and enroll individuals who might be eligible for TMA. In 1999, they threatened to sue the state if the problem was not resolved in a matter of weeks. As a result, by the third quarter of 1999, the problem was fixed and in 2000 the state mailed out letters to families who lost coverage between August 1997 and August 1999 to begin the process of reinstating eligible individuals.

In West Virginia, Medicaid dropoff appeared to be a problem during the first full year of TANF/WVWORKS. Of the people who left TANF, 59 percent were receiving Medicaid benefits when income reports showed that many more should have been eligible. Wisconsin and Ohio also indicated that administrators felt pressure from advocates to increase enrollment of individuals that were working but still eligible for Medicaid. As a result, some counties in Ohio implemented a policy that required completion of a pretermination form to assure that people were not dropped from Medicaid when they began work. Ohio and Wisconsin were quicker than Washington and Colorado in responding to advocate's concerns.

If a state was able to reprogram its computer system or use manual workarounds to avoid "glitches," the easiest way to assure a simplified application process for TMA was to make the process "passive" by eliminating any requirement for leavers to fill out additional paper work to keep Medicaid. Of the state's studied, Kansas, Colorado, Michigan, Missouri, Oregon, New Jersey, New York, Utah, West Virginia, and Washington made the transition process simple for individuals leaving TANF and TMA was automatically given to clients with increased earnings. The mechanism that these states used to assure continued Medicaid eligibility varied and relied on both manual processes and on automated computer systems. Some states backed up automated systems with manual review processes to assure that people were not dropped from Medicaid when they began work by requiring workers to review closed cases to assure continued Medicaid eligibility.<sup>7</sup>

Other states required some effort on the part of the client to continue Medicaid when they went to work. Individuals leaving TANF in Texas had to inform DHS that they would no longer need TANF due to employment entry. An improper coding would jeopardize receipt. When people left the rolls in Florida, they had to provide information on income so that eligibility workers could verify that they still

qualified for Medicaid and individuals would remain eligible for 6 months. In Arizona, if a person went to work, the cash assistance leaver had to submit a change report form to the FAA office. This requirement appeared to create an opportunity for individuals who remained eligible to lose coverage.

### ***Typology of States' Success With Simplification as it Relates to Enrollment***

This examination shows that most states undertook efforts to make the Medicaid application process simpler at some point between 1995 and 2000. However, a few states, such as Texas, West Virginia, Colorado, Arizona, and New York did not implement substantial simplification measures *until later*. The following typology ranks states as "high," "medium," or "low." The states that tended to be successful at simplifying the application process across the board in all regions of the state earlier in the study period are considered "high." Those that implemented comparable measures but not in all categories, or had to overcome initial application processes problems with transition medical assistance or were not as consistent in terms of implementation on a statewide basis, are considered "medium." Those that implemented less measures to increase access, made the receipt of TMA more difficult, provided less personal assistance, or did not implement significant measures until *after* the time period studied are considered "low." In order to see if there was a rough correlation between this categorization and the state's enrollment growth, each state's rank in terms of its success with increasing total average monthly Medicaid enrollment between 1995 and 2000 is noted next to the state.<sup>8</sup> (Enrollment data were not available for New York or Tennessee.)

The states that appeared to provide the best access to applications, which were easy to use, required less verification, and had adequate staff to provide assistance with completing the application

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<sup>7</sup> For more information see "Delays in Modifying Information Systems Contributed to the Decline in Medicaid Enrollment After Welfare Reform," by Mark Ragan, Rockefeller Institute of Government, January 2003.

<sup>8</sup> See "Medicaid Enrollment Trends" Courtney E. Burke and Craig W. Abbey, Rockefeller Institute, August 2002.

**Table 3: Success with Medicaid Application Process Simplification and Enrollment Gain Rank: 1995-2000**

<i>High</i>	<i>Medium</i>	<i>Low*</i>
Missouri – 1	Florida – 4	Arizona – 8
New Jersey – 10	Kansas – 13	Colorado – 9
Maryland – 3	Michigan – 5	New York – na
Utah – 6	Ohio – 14	Texas – 16
	Washington – 3	West Virginia – 12
	Oregon – 15	
	Wisconsin – 11	
	Tennessee – na	
	Georgia – 7	
<b>Average Rank: 5</b>	<b>Average Rank: 9</b>	<b>Average Rank: 11.25</b>

\* This typology is based on point-in-time data from 1995-2000. All states in the “low” category have since implemented measures to improve the simplicity of the application process.

were Missouri, New Jersey, Maryland, and Utah. These states also had less application processes when individuals would transition to work and tended to implement simplification measures earlier than other states. The average ranking of these states in terms of enrollment growth between 1995 and 2000 was 5, the best of the categories. Utah already had processes in place prior to welfare reform to provide better access to applications and appeared to have less trouble with drops in enrollment after welfare reform. Missouri increased enrollment steadily beginning in 1998, perhaps because it was the first state to implement its CHIP program — and aggressively so. Maryland and New Jersey increased access to applications just after Missouri and simplified their application processes largely as a result of CHIP implementation.

Most states were ranked as “medium” because of initial glitches after welfare reform with transitional medical assistance, because of gaps in referral processes between programs, *or* because further improvements seemed plausible. In Washington, it was initial problems (whether perceived or real) that may have caused individuals to lose coverage inappropriately. However, Washington did a good job at providing assistance to individuals with filling out applications as well as making applications more accessible. Ohio was ranked as medium because there

were some discrepancies in the degree of personal assistance depending on the part of the state. Florida was ranked as medium primarily because the ease of application for TMA was slightly more difficult than in other states. Florida’s increase in enrollment was substantial but happened later and appears to have been the result of extensive outreach for CHIP. Wisconsin also experienced initial glitches after welfare reform but eventually undertook extensive outreach late during the study period to make applications more accessible. Kansas and Oregon were ranked as medium because caseworkers appeared to have less time to devote to helping applicants complete applications. Tennessee is ranked as medium because the verification requirements were seen as burdensome. The average ranking of these states in terms of their enrollment increase (or decrease) between 1995 and 2000 was 9 (the second best of the three categories). Oregon was an interesting case. It did not experience a glitch with enrolling Medicaid eligible applicants who went to work after welfare reform. But because the state did not experience the same declines in enrollment that other states were experiencing after welfare reform, it did not invest as much as it could have in improving access to Medicaid applications.

States that were ranked as “low” have all implemented simplification measures — but not until

2000 or later. Arizona implemented significant outreach and simplification measures primarily in response to proposition 204, which expanded eligibility. In fact, the degree of outreach and application process simplification measures that took place in 2001 as the result of proposition 204 *would currently make Arizona rank as “high”* (however this was not the case during the time period studied). This is also true of Colorado, where significant simplification measure were recently implemented. New York’s simplification measures were passed in early 2002 as part of a larger healthcare bill and so the impact has yet to be fully realized. Even though the state will now require these simplification measures, it appears that the staff available at the local level to provide assistance and outreach will decrease in the coming year because county executives are being forced to freeze hiring due to increased Medicaid costs. As mentioned several times in this report, Texas’ simplification measure was implemented in January 2002. West Virginia’s attention to increasing take-up was also more recent and was due to the lack of enrollment in CHIP and not necessarily due to steep declines in Medicaid enrollment.

### ***Challenges for Management***

#### ***Changes Were Required at Multiple Levels of Government***

One of the biggest impediments for states to simplifying their application processes in a timely and comprehensive way appeared to be the fact that policy directives were dependent upon state actions that took time to implement. Many states used advisory groups to assist with determining how the process could be simplified, adding to the time it took to agree upon the simplification actions. It was also the state level where verification requirements were determined and where application processes policies were either successfully (or unsuccessfully) communicated. Communicating change in the verification policies required informing or training workers on the new rules.

Even if states were successful at changing certain aspects of the application process, there were other factors that were dependent upon local ac-

tions. For instance, the degree to which personal assistance and follow-up were provided depended upon the resources and choices of local offices or county government. Some local offices gave staff the option to be “less rigorous” in terms of verifying information on the application. Local offices also had to devote the staff time necessary to ensure the completion and proper use of automated eligibility systems, increasing the importance of frontline workers in assuring a simpler process.

The role of politicians was also important. States that had vocal support from politicians, such as Governor Carnahan in Missouri and Governor Whitman in New Jersey, appeared to impact the degree to which state Medicaid administrators and frontline staff implemented simplification measures. These states noted that take-up became a priority at both the state and local level. Therefore, in order for a state to be fully successful at simplifying the application process overall, all levels of government had to be vested in seeing the application process change.

#### ***Other Aspects of the Process Require Changes***

Simplifying the application process is not the only way to assure that a state enrolls more people. Keeping people who are eligible within the system is also important. In his forthcoming paper titled “Renewal Processes: The Take-Up Challenge and Health Insurance for Children,” Frank Thompson discusses the different policies that states have enacted to promote “inreach” or keeping people enrolled by assuring a simple eligibility renewal process. Interestingly, some of the states that were fairly good at simplifying certain aspects of the application process explored in this paper were not as good at creating a simplified process for eligibility renewal. For instance, Georgia, Florida, and Utah, which made moderate efforts to simplify the application process, were ranked as “lower” in terms of the ease of the renewal process in Thompson’s paper. Other states that ranked as low in this paper (e.g., New York) had moderately easy renewal processes according to Thompson. However, this paper focuses on 1995-2000 while Thompson’s considers more recent state efforts. Merging the analysis of both papers indicates that it is important

for administrators and policy makers to consider changes to all aspects of the application process — from initial application, to TMA, to renewal.

### *Budgetary Constraints and Staffing Shortages*

As part of the take-up study and as part of further research being conducted by the Rockefeller Institute, researchers were asked to gauge the sustainability of take-up efforts during an economic downturn. Given recent data on the declines in state tax revenue, it is likely that many states will target cuts at Medicaid programs.<sup>9</sup> Some researchers were optimistic that their state would maintain efforts to simplify the application process. The parts of the application process that require adequate staffing, such as outreach and personal assistance, may suffer setbacks in the coming year because local capacity has been diminished. The Rockefeller Institute will examine the impact of decreased state revenues and access to Medicaid in a forthcoming paper on sustainability.<sup>10</sup>

### *Further Integration With Other Programs*

Another remaining challenge for Medicaid managers will be administering the program as other social service programs and priorities change. As evidenced by some of the states in the Rockefeller Institute study, changes in eligibility rules that resulted from PRWORA took time to fully implement and many states experienced glitches with ensuring individuals could keep Medicaid when they lost TANF. Consistent support from the federal administration and pressure from advocates was key to remedying this situation. If future changes occur to social service programs, states will need to learn from past experience and develop methods to successfully implement the changes. Administrators will need to make it a priority to hire and properly train frontline staff about the rules and directives of an

array of social programs ranging from TANF to CHIP and from Food Stamps to Medicaid.

### **Conclusion**

States used the flexibility afforded to them under PRWORA and CHIP and successfully simplified the Medicaid application process over time. As expected, some states were more successful at simplifying the application process earlier than others. Federal directives, political support, financing, and publicizing state innovation were all components to assure states could make the process simpler. Indeed, the large majority of states in this study were successful at reforming outreach practices, application processes, and outstationing workers in order to create programs that appeared to be more integrated and accessible to the applicant. A recognition by states that systems did not work as smoothly as planned after welfare reform also contributed to change. Although it took some states until recently to simplify the application process or fix problems with providing TMA to all those who were eligible, most appear to now be more successful. Part of the states' success with reforming the application process may have been the result of efforts to make the CHIP application process easier. One could say that there was not only a "spill-over" from CHIP in terms of Medicaid enrollment but also in terms of administrative tactics. States appear to have learned from each other what tactics worked best to increase enrollment. The reason it took states time to change practices was because there were several choices for how to structure and implement their programs. By studying the range of state choices and their success with implementing policies designed to simplify the application process for Medicaid and CHIP, states can decrease the complexity of the application process and maximize the opportunity afforded through the devolution of social programs.

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<sup>9</sup> "State Budgetary Assumptions in 2002: The Economic Forecast Roller Coaster," *State Fiscal Brief No. 65*, Rockefeller Institute of Government, June 2002.

<sup>10</sup> See "Is Medicaid Retrenching? State Budgets and Medicaid Enrollment in 2002" by Jim Fossett and Courtney Burke, Rockefeller Institute of Government, forthcoming.

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## ***The Nelson A. Rockefeller Institute of Government***

The Nelson A. Rockefeller Institute of Government, the public policy research arm of the State University of New York, was established in 1982 to bring the resources of the 64-campus SUNY system to bear on public policy issues. The Institute is active nationally in research and special projects on the role of state governments in American federalism and the management and finances of both state and local governments in major areas of domestic public affairs.

## ***The American Federalism Group***

The Institute's American Federalism Group was established in 1997 in response to the growing importance of state governments in the American federal system and the devolution of social programs. Despite the ever-growing role of the states, there is a dearth of high-quality, practical, independent research about state and local programs.

The mission of the American Federalism group is to help fill this gap. The Group conducts research on trends affecting states and serves as a national resource on issues such as welfare reform, and Medicaid Managed Care for public officials, the media, public affairs experts, researchers, and others. The Group is directed by Tom Gais, who has spent the last decade analyzing state and local issues with federalism. Jim Fossett oversees research in the area of public health programs.

## ***This Report***

Courtney E. Burke, Senior Research Scientist with the Institute's American Federalism Group, wrote this report. Jim Fossett and Frank Thompson provided valuable feedback to strengthen the report's content. Michael Cooper, the Rockefeller Institute's Director of Publications, did the layout, with assistance from Michele Charbonneau.

## ***For More Information***

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