THE HENRY J. KAISER FAMILY FOUNDATION

the kaiser commission on

Medicaid *and the* Uninsured

Making It Simple:

Medicaid for Children and
CHIP Income Eligibility Guidelines and
Enrollment Procedures

Findings from a 50-State Survey

October 2000

Prepared by
Donna Cohen Ross
Laura Cox

Center on Budget and Policy Priorities
Washington DC

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on medicaid and the uninsured. The Commission is a major initiative of the Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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A companion report, entitled *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Individual State Profiles* (Publication #2191), containing detailed descriptions of eligibility rules and enrollment and redetermination processes for each state, is also available.

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TABLE OF CONTENTS

4A proof

Executive Summary

Recent national and state efforts to expand child health coverage have had dramatic results. Nearly all low-income, uninsured children now qualify for health coverage through Medicaid or the State Children's Health Insurance Program (CHIP). In many states, these eligibility expansions have been accompanied by enthusiastic outreach campaigns to inform families about new health coverage opportunities. Despite these activities, however, millions of eligible children remain uninsured. Raising program awareness is only part of the challenge; removing systemic barriers to getting and staying enrolled is critical to assuring that the Medicaid and CHIP programs reach their full potential for reducing the number of uninsured children. While states have considerable flexibility to streamline enrollment procedures in their Medicaid and CHIP programs—both at the time of the initial application and at redetermination, when eligibility is reviewed—the extent to which they have exercised the options available to them varies widely.

To better understand the actions states are taking to increase health insurance coverage for children, the Kaiser Commission on Medicaid and the Uninsured commissioned the Center on Budget and Policy Priorities to conduct a study of the enrollment process in children's Medicaid and CHIP-financed separate programs (Thirty-two states have opted to create a separate CHIP program). The study was comprised of a nationwide telephone survey of state Medicaid and CHIP officials, a review of state CHIP plans and interviews with state child health advocates. The survey focused on income eligibility guidelines as well as simplified application, enrollment and redetermination procedures for children in state Medicaid and separate CHIP programs, implemented as of July 2000. It is important to note that the procedures used in state child health insurance programs are continually and rapidly evolving. A number of states are planning to further simplify or have new procedures scheduled to take effect later in 2000 or in 2001.

Key Findings

Thirty-six (36) states have expanded income-eligibility for children in families with incomes up to 200 percent of the federal poverty line ($34,100 for a family of 4 in 2000) or higher. While most states have clearly made strides in terms of extending coverage to more children, they differ in the degree to which their eligibility expansions are supported with convenient and straightforward enrollment processes for their Medicaid and CHIP programs (Figure 1, Tables A and B). The federal Health Care Financing Administration (HCFA) has encouraged greater simplification of enrollment procedures by issuing guidance that promotes an array of simplification strategies and assures states that such measures can be implemented without compromising program integrity.

Streamlining Enrollment and Redetermination Procedures

Most states have taken some significant steps to simplify enrollment for their child health coverage programs:

- **Joint Applications.** Of the 32 states that have separate CHIP programs, 28 use joint applications for Medicaid and CHIP.

- **No Asset Test.** Forty-two (42) states, including the District of Columbia, have dropped the asset test in both their Medicaid for children and CHIP programs.

- **No Face-to-Face Interview.** Forty (40) states, including the District of Columbia, have eliminated the face-to-face interview in both their Medicaid for children and CHIP programs, so that families no longer have to apply in person at a welfare or Medicaid office.

- **Annual Redetermination.** Thirty-nine (39) states review eligibility at 12-month intervals in both their Medicaid for children and CHIP programs.

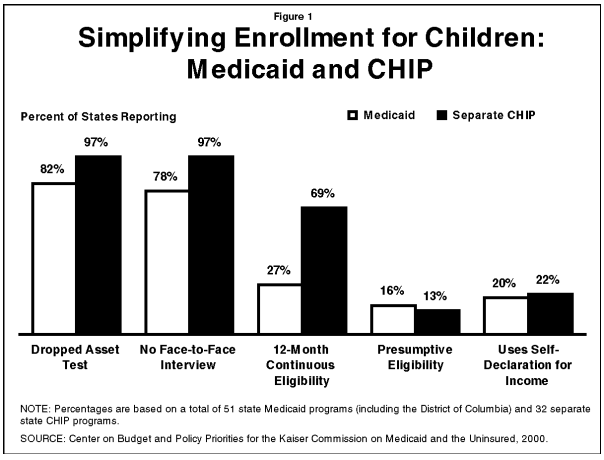
However, states have been slower to implement other streamlining measures:

- **Presumptive Eligibility**. Eight (8) states have adopted presumptive eligibility for children in Medicaid, though only five currently have implemented procedures. Presumptive eligibility enables children who appear income-eligible to enroll temporarily in Medicaid and receive services, giving families time to complete the formal application process.

- **Self-Declaration of Income.** Ten (10) states allow self-declaration of income in both their Medicaid for children and CHIP programs, eliminating the need for the family to provide documentation.

- **12-month Continuous Eligibility.** Thirteen (13) states have adopted 12-

Figure 1



month continuous eligibility in both their Medicaid for children and CHIP programs, guaranteeing enrollment regardless of changes in income or other family circumstances that may occur in the interim.

Not All States Have Aligned Medicaid and CHIP Enrollment Procedures

Simplification efforts have been driven, to a large extent, by the emphasis on designing easy, family-friendly application systems for new CHIP programs, coupled with the federal requirement to coordinate the program with Medicaid. Most of the thirty-two (32) states that have created separate CHIP programs have used enrollment simplification techniques in their CHIP programs and have carried them over to their children's Medicaid programs. Still, a number states could take additional steps to align key simplification strategies in Medicaid and CHIP. For example:

- **Asset Tests.** Six (6) states—Colorado, Montana, Nevada, North Dakota, Texas and Utah—impose an asset test in their children's Medicaid programs, but not for their CHIP-funded separate programs.

- **Face-to-Face Interviews.** Seven (7) states—Alabama, Georgia, Montana, New York, Texas, West Virginia, and Wyoming—require a face-to-face interview for families with children eligible for Medicaid, but not for those with children eligible for the CHIP-funded separate program. Some states waive this requirement for families applying for Medicaid using a joint application, while others allow families to complete the interview outside the Medicaid office at community organizations.

- **Self-Declaration of Income.** Two (2) states—Alabama and Wyoming—allow families to self-declare their income for their CHIP-funded separate programs, but not their Medicaid programs.

- **Redetermination Intervals.** Four (4) states—Georgia, New Jersey, Texas, and Wyoming—require children to have their eligibility reviewed more frequently for Medicaid than for the CHIP-funded separate program.

Policy Implications

Low-income families have reported in surveys and focus groups that a complex and difficult enrollment process is a significant barrier to enrollment. While many states have clearly made progress in removing such obstacles, more can still be done to make it easier for families to enroll their children in health coverage programs.
Continue key application and enrollment simplification efforts. States should continue to revise their application forms to make them easier to understand and fill

out. Eliminating the asset test and face-to-face interview in the few states where these requirements still exist would make it easier for children to qualify and would make the process more convenient, especially for working families. Easing verification requirements or accepting a family's self-declaration of information would increase the likelihood that a family will be able to complete the application process.

Promote greater use of presumptive eligibility and 12-month continuous eligibility. Presumptive eligibility can be an especially valuable way to bring enrollment efforts into the community and to ensure that children receive prompt medical attention. Adopting the 12-month continuous eligibility option is an important tool for streamlining the redetermination process and for promoting retention in health coverage programs.

Apply streamlined procedures to both Medicaid and separate CHIP programs. Aligning eligibility rules and application procedures assures that families have an easier time applying for coverage for all children in the family, regardless of the program for which they qualify, and helps states administer a dual-program system effectively.

Use streamlined children's health insurance programs as a foundation for expanding coverage to low-income parents. Recent research shows that family-based Medicaid expansions that include parents can increase enrollment among uninsured children who already are eligible for Medicaid. States can implement policies such as eliminating asset tests and face-to-face interview requirements in their parent coverage programs so that whole families can obtain coverage more easily. In addition, states that can demonstrate they have designed procedures to promote children's enrollment and retention will have the opportunity to build on their CHIP programs to cover parents.

As policymakers continue to focus attention on reducing the number of uninsured children, there is an unprecedented opportunity to apply the lessons learned from recent efforts to create consumer-friendly, easily navigated child health systems. Taking advantage of the flexibility available under federal law and the strong support for simplification, states can continue to improve their child health systems and transfer innovative procedures to new initiatives, clearing an easy path to coverage for a broader population in need of health insurance.

TABLE A:
States with Medicaid for children or CHIP income eligibility set below 200 percent of the federal poverty line*

Colorado	185%
Idaho	150%
Illinois	185%
Louisiana	150%
Montana	150%
Nebraska	185%
North Dakota	140%
Oklahoma	185%
Oregon	170%
South Carolina	150%
South Dakota	140%
Virginia	185%
West Virginia	150%
Wisconsin	185%
Wyoming	133%

*The other 36 states have set income-eligibility levels at or above 200 percent of the federal poverty line.

TABLE B:
States that have not adopted key simplification strategies in Medicaid for children

No joint application for Medicaid and CHIP	Face-to-face interview required	Asset test required	Frequent redetermination (more than once a year)
Nevada	**Alabama**	Arkansas[5]	Alaska
North Dakota	**Georgia**[1]	**Colorado**	Florida[6]
Texas	**Montana**[2]	Idaho	**Georgia**
Utah	New Mexico[3]	**Montana**	Maine
	New York[4]	**Nevada**	**Minnesota**[7]
	Tennessee	**North Dakota**	**New Jersey**
	Texas	Oregon	Oklahoma
	Utah	**Texas**	Oregon
	West Virginia[2]	**Utah**[5]	**Tennessee**[7]
	Wisconsin		**Texas**
	Wyoming		Vermont
			Wyoming

* States in bold print have adopted simpler enrollment procedures (no face-to-face interview, no asset test and 12-month redetermination periods) for their separate CHIP programs but not for their Medicaid program. See also Notes on next page.

NOTES

1. In Georgia, a face-to-face interview is required when the separate Medicaid application is used, but it can be done outside the Medicaid office. Georgia anticipates eliminating the requirement effective February 2001.

2. In Montana and West Virginia, families using the joint application do not have to complete a face-to-face interview if the child appears to be Medicaid-eligible and the application is transferred for an eligibility determination. Montana will eliminate the Medicaid face-to-face interview requirement for poverty-level groups, effective October 2000.

3. In New Mexico, community-based Medicaid On-Site Application Assistance (MOSAA) providers can help families complete a some what shorter "MOSAA" application; such contact satisfies the interview requirement.

4. In New York, contact with a community-based "facilitated enroller" meets the face-to-face interview requirement.

5. Arkansas and Utah still count assets in determining Medicaid eligibility for some "poverty level" children.

6. Florida provides 12 months of continuous eligibility to children under age 5 enrolled in Medicaid. Children age 5 and older enrolled in Medicaid and all children enrolled in Healthy Kids and MediKids are required to have their eligibility redetermined every 6 months.

7. In Minnesota and Tennessee, children who qualify under waiver programs can redetermine eligibility every 12 months as opposed to every 6 months under "regular" Medicaid.

Introduction

The enactment of the Balanced Budget Act of 1997, the federal law that created the State Children's Health Insurance Program (CHIP), set in motion a wave of activity to expand coverage to uninsured, low-income children. As a result, nearly all—more than 90 percent—of uninsured children in families with incomes below 200 percent of the federal poverty line ($34,100 for a family of four in 2000) are now income-eligible for health coverage under Medicaid, a CHIP-funded Medicaid expansion or a CHIP-funded separate program.[1] Following on the heels of this major step forward, driven in part by requirements built into the CHIP law, states began to undertake ambitious outreach initiatives to inform families about new health coverage opportunities and to help them apply for benefits for their children.

While well-conceived marketing and targeted application assistance can help boost the numbers of insured children, a major challenge is to ensure ongoing, lasting progress. Sustainable improvements will depend on establishing program procedures that remove barriers to enrollment, enable children to retain coverage for as long as they are eligible and minimize gaps in coverage if family circumstances change. Simplifying procedures at the time of initial application, as well as at the time of redetermination, is key to accomplishing these objectives.

Survey and focus group research have shown that families with eligible children lack basic knowledge about Medicaid and CHIP programs and believe the enrollment process is difficult and time-consuming. Many families do not know whether their children qualify for available programs or do not know how or where they can apply. Those who do initiate the process often find the forms confusing, the required documentation difficult to collect and the process long and complicated. These problems may be compounded by language barriers or by perceptions about the program that are vestiges of Medicaid's former link to the welfare system. In a national survey of families with uninsured Medicaid-eligible children, two-thirds reported that they had tried to enroll their children in Medicaid. Among these parents, 57 percent were unsuccessful, often because they could not complete the process. A majority of the families surveyed said they would be "much more likely" to enroll their children in Medicaid if specific steps were taken to make the process easier.[2]

States have considerable flexibility to simplify enrollment procedures in their Medicaid and CHIP-funded separate programs. The Health Care Financing Administration (HCFA) has strongly encouraged states to take advantage of this freedom. In letters to state health officials issued on January 23, 1998 and on September 10, 1998, HCFA promoted an array of simplification strategies including: eliminating asset tests, allowing applications to be submitted by mail without requiring an interview at a welfare office, adopting presumptive eligibility procedures and reducing verification requirements.[3] Most recently, on September 12, 2000, HCFA issued another letter to state officials assuring them that simplification measures can be implemented without compromising program integrity. According to the letter, "... some states have voiced concern that the Federal Medicaid Eligibility Quality Control (MEQC) program is a barrier to their simplification efforts. However, there is no indication that states' simplification procedures have contributed to an increase in errors."[4]

Study Approach

The Kaiser Commission on Medicaid and the Uninsured commissioned the Center on Budget and Policy Priorities to investigate the strategies states were using as of July 2000 to increase health insurance coverage for children through Medicaid and CHIP-financed separate programs. A nationwide telephone survey of state Medicaid and CHIP officials was conducted, as well as a review of state CHIP plans and interviews with state child health advocates. The survey focused on income eligibility guidelines and on simplified application, enrollment and redetermination procedures that apply to children in the Medicaid "poverty level groups," and to children eligible under a state's separate CHIP program. The survey did not explore the eligibility rules and enrollment procedures that come into play when families seek coverage for parents as well as children. Since many children enroll in coverage when the whole family applies, an important route to Medicaid for some children is not presented in these findings.

Information on the following program features was obtained for Medicaid for children in all 50 states and the District of Columbia. In the 32 states that have implemented CHIP-funded separate programs, the Center also collected information on these program features:

- income eligibility guidelines;
- asset tests;
- use of Medicaid/CHIP joint application and redetermination forms;
- face-to-face interview requirements, at initial application and redetermination;
- presumptive eligibility;
- 12-month continuous eligibility;
- selected verification requirements (income, age, residency, deductions);

- enrollment procedures, including "screen and enroll" procedures; and
- redetermination procedures, including methods for transferring children from one program to another.

This report includes state-by-state tables presenting information on selected child health coverage program features for every state and the District of Columbia. The tables include income eligibility guidelines and selected simplification and redetermination strategies, adopted as of July 2000. Many of the technical terms used in the tables and throughout the report are defined in the *Explanation of Terms* section of this report.

It is important to note that the status of state child health insurance programs, with respect to the simplification and coordination criteria investigated, is continually and rapidly evolving. A number of states are developing plans to further simplify or have new simplified procedures scheduled to take effect later in 2000 or in 2001.

A detailed profile has also been prepared for each state and the District of Columbia that describes eligibility rules with respect to income and assets, as well as enrollment and redetermination procedures. These state profiles are available in *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures - Individual State Profiles* (Publication #2191).

Summary of Findings

A number of states have taken significant steps to simplify their child health coverage programs. These activities have been driven, to a large extent, by the emphasis on designing easy, family-friendly application systems for new CHIP programs, coupled with the federal requirement to coordinate these new programs with Medicaid. Nevertheless, there is still room for further efforts to simplify application and enrollment procedures, especially with respect to carrying innovations implemented in separate CHIP programs over to Medicaid. The state-by-state survey found:

Most states have made efforts to expand income-eligibility for children and to simplify eligibility rules.

- Thirty-six (36) states, including the District of Columbia, cover children under age 19 in families with income at or below 200 percent of the federal poverty line. Fourteen (14) of these states cover children in families with income above 200 percent of the federal poverty line.

- Forty-two (42) states, including the District of Columbia, have dropped the asset test in both their Medicaid for children and CHIP programs.

Most states have taken steps to simplify the application process for child health coverage.

- Of the thirty-two (32) states that have separate CHIP programs, twenty-eight (28) use joint applications for Medicaid and CHIP.

- Forty (40) states, including the District of Columbia, have eliminated face-to-face interviews in both their Medicaid for children and CHIP programs.

States vary widely with respect to the verification requirements they impose on families. While some states require only proof of income and the immigration status of non-citizen children, many still require verification of a child's age, allowable deductions and other items.

- Ten (10) states allow self-declaration of income in both their Medicaid for children and CHIP programs. States are required to conduct a check of specific state databases to verify reported income for Medicaid—and they are encouraged to do so for CHIP—but families are not required to produce separate documentation.

States have been slow to adopt the option to conduct presumptive eligibility determinations for children in Medicaid.

- Eight (8) states have adopted the presumptive eligibility option in Medicaid for children, though only five of these states have implemented presumptive eligibility procedures.

- In addition, four (4) states also have adopted a presumptive eligibility procedure in their separate CHIP programs. Three of these states have implemented presumptive eligibility procedures, but the procedures may be somewhat different than those for Medicaid.

More emphasis is now being placed on simplifying the renewal or redetermination process.

- Thirty-nine (39) states, including the District of Columbia, review eligibility at 12-month intervals in both their Medicaid for children and CHIP programs. Families are required to report changes in income and other family circumstances that occur in the interim.

- Thirteen (13) states have adopted the 12-month continuous eligibility option in both their Medicaid for children and CHIP programs. Under this option, families are not required to report changes that occur during the eligibility period.

- Forty-three (43) states, including the District of Columbia, have eliminated a face-to-face interview at redetermination in both their Medicaid for children and CHIP programs.

States with CHIP-funded separate programs could take additional steps to align key simplification strategies in Medicaid and CHIP.

- **Income Eligibility Guidelines.** Thirty-three (33) states have age-based income eligibility standards in their Medicaid programs; of these, seventeen (17) states have three or more standards based on age. Eighteen (18) states have "evened out" the age-based standards in Medicaid, so that all children in a single family are eligible for the same program.

  These variations by age result from the age-based minimum eligibility requirements that have been set by federal law, but these can be eliminated at state option. Some states have taken advantage of the flexibility under Medicaid to eliminate age-based standards; others use CHIP funds to cover children who become eligible for Medicaid when age-based standards are eliminated. The age-based standards can result in one child in a family being eligible for Medicaid and a sibling in the family being eligible for CHIP. Families may find themselves in the position of having to navigate two separate sets of program rules.

Children in the same family may not be able to see the same provider, and a child may have to switch providers when his or her age dictates that Medicaid eligibility ends.

- **Asset Tests.** Six (6) states—Colorado, Montana, Nevada, North Dakota, Texas and Utah—impose an asset test in their children's Medicaid programs, but not for their CHIP-funded separate programs (Utah counts assets for children older than age 6 in Medicaid).

- **Face-to-face Interviews.** Seven (7) states—Alabama, Georgia, Montana, New York, Texas, West Virginia, and Wyoming—require a face-to-face interview for families with children eligible for Medicaid, but not for those with children eligible for the CHIP-funded separate program. In Georgia and New York, interviews can be completed at a community location other than a welfare office. In West Virginia and Montana, families using the joint application to apply for coverage for their children do not have to complete a face-to-face interview if the child appears to be Medicaid-eligible and the application is transferred for a final determination. Effective October 2000, Montana will eliminate the face-to-face interview for Medicaid poverty level groups.

- **Self-declaration of Income.** A number of states have different, usually more burdensome, verification requirements for their Medicaid programs than for their CHIP-funded separate programs. For example, Alabama and Wyoming allow families to self-declare their income for purposes of the CHIP-funded separate program, but not the Medicaid program. States can review the verification requirements of both their Medicaid and CHIP-funded separate programs with the goal of reducing the amount of documents families need to produce and aligning program requirements.

- **Redetermination Intervals.** Four (4) states—Georgia, New Jersey, Texas, and Wyoming—require children to have their eligibility reviewed more frequently for Medicaid than for the CHIP-funded separate program.

- **Section 1115 waivers.** States that have expanded coverage to children under Medicaid section 1115 waivers sometimes impose stricter rules for children eligible under "regular" Medicaid, than for children who qualify under the expansion. For example, Arkansas imposes an asset test on children in "regular" Medicaid (now called ARKids A), but not for children eligible under the expansion (now called ARKids B). This could cause problems similar to those in states with non-aligned Medicaid and CHIP-funded separate programs.

Expanding Eligibility and Simplifying Enrollment: Trends in Children's Health Coverage Programs (July 1997 to July 2000)

Prior to the enactment of CHIP (August 1997), a few states had expanded coverage to children in families with income at or below 200 percent of the federal poverty line using the authority available to them under federal Medicaid law or under Medicaid Section 1115 waivers. At that time, states also had begun to employ Medicaid options to eliminate asset tests and face-to-face interviews for children.

Since the creation of CHIP, the number of states expanding coverage has accelerated and progress has been made with respect to eliminating asset tests and dropping face-to-face interview requirements. Two new Medicaid options — presumptive eligibility for children and 12-month continuous eligibility — were established by the Balanced Budget Act of 1997, though states have been slower to adopt these options. In addition, states could take more steps to simplify their Medicaid programs to align Medicaid enrollment procedures with those used in their CHIP-funded separate programs.

This table does not present data on states' efforts to reduce verification requirements or to simplify and align redetermination processes, since data was not available for July 1997 or November 1998, though these are important aspects of simplification that need to be addressed.

Number of states	July 1997[1]	November 1998[1]	July 2000[2]
Covered children under age 19 in families with income at or below 200 percent of FPL	6*	22	36
Eliminated asset test	36	40 (Medicaid) 17 (CHIP)	42 (Medicaid) 31 (CHIP)
Eliminated face-to-face interview	22**	33*** (Medicaid) not collected (CHIP)	40 (Medicaid) 31 (CHIP)
Adopted the Medicaid presumptive eligilbility option for children	option not available	6 (Medicaid)	8 (Medicaid)
Adopted 12-month continous eligibility option for children	option not available	10 (Medicaid) not collected (CHIP)	14 (Medicaid) 2 (CHIP)
TOTALS:	**51 Medicaid**	**51 Medicaid** **19 CHIP**	**51 Medicaid** **32 CHIP**

1. These data reflect states' eligibility expansions and use of simplification strategies for children's Medicaid (poverty level groups).
2. These data reflect states' eligibility expansions and use of simplification strategies for children's Medicaid (poverty level groups) and CHIP-funded separate programs, as indicated.

* In addition, two states, Massachusetts and New York, financed child health coverage up to 200 percent of the federal poverty line using state funds only.

** Seven states still required telephone interviews; face-to-face interviews were left to county discretion in one state.

*** Thirty-three (33) states had eliminated the face-to-face interview for children applying for Medicaid. Six (6) states eliminated the face-to-face interview only for families using the joint Medicaid/CHIP application to apply for coverage. No data was collected specifically about separate CHIP programs.

Why Simplification Matters

Simplifying both the application form and process makes health coverage programs more consumer-friendly. The following examples from state experiences illustrate the many ways simplified eligibility rules and streamlined enrollment procedures can facilitate the enrollment of eligible children in Medicaid and CHIP.

Simplifying eligibility rules can make it easier for children to qualify for coverage and can reduce the complexity of the application form itself.

For example, in November 1997, when **Oklahoma** expanded the income-eligibility guidelines for pregnant women and children applying for Medicaid, the state also removed the asset test. A separate two-page application was created for these groups to use to apply for Medicaid benefits. The new application no longer contained questions related to assets the family may hold, such as cash, stocks and bonds, livestock and animals, life insurance, trust funds, checking and savings accounts, certificates of deposit, retirement accounts, prepaid burial contracts or tax refunds. Also discarded were questions related to the ownership of cars, boats, trucks, trailers, motorcycles, farm equipment and recreational vehicles, as well as questions about whether assets have been sold, traded or given away within the last 60 days.

Streamlining enrollment procedures encourages more families to apply.

Allowing applications to be submitted by mail without requiring a face-to-face interview at a government office can make the process less intimidating and much more convenient, especially for working parents who are hard-pressed to take time off from their jobs to apply for benefits for their children. A recent survey of health center patients showed that applicants who applied for Medicaid at places other than a welfare office were much less likely to report stigma associated with the Medicaid application process.[7] Reducing verification requirements—or accepting a family's self-declaration of information on the form, including income—makes it more likely that a family will be able to complete the application process. Numerous studies cite the difficulty of gathering all necessary documentation as a major reason families do not complete the application process and are subsequently denied coverage.[8]

Simplifying the application process through presumptive eligibility is a promising approach to enrolling children in health coverage programs.

Under the presumptive eligibility option for children, states can authorize "qualified entities" to enroll children temporarily in Medicaid if they appear to be eligible, based on their family's declaration of income. Qualified entities can include traditional Medicaid providers, such as hospitals and clinics, as well as schools that receive Medicaid payments, WIC clinics, Head Start programs and the agencies that

determine eligibility for subsidized child care. Presumptive eligibility brings the enrollment process into the community, increasing opportunities for families to apply. Children are enrolled right away and can receive prompt attention for medical needs, while families have time to collect the verification required to complete the application process.[9]

A well-designed presumptive eligibility program provides training for staff of qualified entities on how to conduct a careful screening, limiting the possibility that children may turn out not to be eligible. Staff of qualified entities also should provide necessary follow-up help to assist families in completing the application process. Presumptive eligibility procedures need not require families to fill out additional forms. For example, in **Nebraska** the standard Medicaid application also is used as the presumptive eligibility form. When a presumptive determination is made, the case is coded "PE" in the DHHS computer. At that time, the family receives a copy of the PE Medicaid application to use as a temporary enrollment "card," so the child can obtain health services. During the PE period the family is responsible for submitting all required verification to DHHS. If the child is ultimately found eligible, the PE designation is removed and DHHS issues an enrollment card. The system appears to be working, with some qualified entities exhibiting final approval rates up to 86 percent.

Simplifying the renewal or redetermination process is essential to help children retain coverage as long as they are eligible.

Granting continuous eligibility for 12 months relieves families of having to renegotiate the system frequently. Streamlined renewal procedures do not require families to re-submit information already on file. A number of states, including **New Jersey, Vermont** and the **District of Columbia,** send families redetermination forms that contain the information the family submitted at the time of initial application. Families are asked to correct any information that has changed in the interim and return the form by mail. If nothing has changed, the family can sign and return the form to remain enrolled. States vary as to whether they require the family to provide verification of income.

In **Georgia's** CHIP program, PeachCare for Kids, families receive a letter at renewal time summarizing the information they provided at initial application. They can indicate changes in their circumstances by notifying a PeachCare worker by telephone. If nothing has changed, the family is not required to respond, and coverage is continued as long as the family continues to pay the required premium.

In **Washington State** local Community Service Offices (CSO) conduct automatic "ex parte" redeterminations for children on Medicaid in families that have an open case for other benefits such as food stamps. Under an "ex parte" system, the state uses information already in its possession to review eligibility. For example, if the family has been certified for food stamps or has had its food stamp eligibility recertified in the last 12 months, the CSO will use that information to redetermine a child's eligibility for health coverage. So, if a child's 12 months of continuous eligibility ends on February 1st, and the food stamp review completed the previous November 1st indicates the child is still eligible for coverage, health benefits are automatically extended for an additional nine months.

Simplifying the application form and process can make community-based outreach and enrollment efforts more feasible and more effective.

A simple application form and process helps link crucial enrollment activities with traditional outreach strategies to inform families about available benefits. The involvement of community organizations and institutions is an integral part of successful outreach and enrollment efforts, since families with eligible children already have frequent contact and trusting relationships with schools, child care programs, faith-based groups, health care providers and human services agencies. Staff of community organizations will be more inclined to incorporate enrollment activities into their established routine if they feel confident about their ability to help families complete the process easily and accurately.

A more straightforward application form and process also can aid more formal outstationing efforts. Under federal law, states must provide opportunities for pregnant women and children to apply for Medicaid at locations other than the welfare office, such as certain health centers and hospitals that serve low-income patients. Eligibility workers based at outstations in the community not only can assist families with completing the application, but can perform a complete eligibility determination.

Simplification Efforts and Outreach Activities Work in Tandem

Simplification Makes More Effective Outreach Feasible

Simplified application and enrollment procedures in children's health coverage programs have paved the way for community-based organizations and institutions to enrich their outreach efforts by providing application assistance and follow-up help for families seeking health coverage for their children. Some states, such as **Illinois, Indiana** and **New Mexico,** have established enrollment sites in a large number of locations and in a wide variety of settings, such as health clinics, schools, Head Start programs, shelters and elsewhere. Other states, such as **California, Massachusetts, New Jersey, New York,** and **Pennsylvania,** have created grant programs or application assistance fees to community groups to help support these activities.

Community Outreach Experience Fuels States' Efforts to Simplify…

Initial efforts to reach out and enroll children in **Illinois'** KidCare program through a Report Card Pick-Up Day enrollment campaign in the Chicago Public Schools yielded poor results. Of the 4,600 applications received, only about 1,000 were approved. Feedback following the event revealed that families were daunted by the 12-page application that they did not fully understand. In response, the application was reorganized and shortened to three pages, and it was made clear that adults applying for coverage only for their children did not have to provide their own Social Security number.*

… and to Expand Use of Techniques Piloted on a Limited Basis

In November 1998, **Washington State's** Medical Assistance Administration (MAA) signed contracts with 21 counties and 7 tribal authorities to provide outreach to families, pregnant women and children. At the same time, to improve access to health care coverage, the state decided to reduce red tape by eliminating face-to-face interview and income verification requirements for pregnant women and children applying for medical assistance at local Community Service Offices. The streamlined procedures had been piloted at the centralized Medical Eligibility Determination Services unit, which processes medical assistance applications for pregnant women and children (for whom the income limits were relatively high C 185 percent and 200 percent of the federal poverty line, respectively.) A policy memo issued to Community Service Office Administrators and others stated that "... MAA conducted a study on the income declared on Children's Medical Applications. This study concluded that, even when the income was declared incorrectly, the children were eligible for medical benefits." In the memo, the state also acknowledged that concerted outreach efforts would increase the number of medical assistance applications, and the streamlined procedures would help reduce the impact of the increased workload on eligibility staff. Washington State continues to use the simplified application procedures.**

* Presentation by Denise Taylor, Chicago Public Schools, HCFA Technical Advisory Panel Meeting, May 25, 1999.

** Memo to Community Service Office Administrators and others from Steven Wish, Director of Client Support, Washington Department of Social and Health Services, Medical Assistance Administration, December 3, 1998.

Why Program Alignment Matters

Thirty-two (32) states have used CHIP funds to create or expand a child health insurance program that is separate from Medicaid. In states with two programs, the challenge of increasing enrollment in children's health coverage takes on an added dimension—the need to coordinate across programs. Aligning simple procedures in Medicaid and CHIP facilitates a high level of coordination, making the programs less confusing for families and easier for states to administer.[10]

A single program name and joint application are common features of a coordinated child health coverage system.

Many states are using one name to refer to the Medicaid and CHIP coverage components, such as **Connecticut's** HUSKY A (Medicaid) and HUSKY B (CHIP), and **New Hampshire's** Healthy Kids Gold (Medicaid) and Healthy Kids Silver (CHIP). Of the thirty-two (32) states with CHIP-funded separate programs, twenty-eight (28) allow families to apply for health coverage for their children using a single application, creating a single pathway to health coverage; families are not expected to figure out the "right" program for which to apply.

Aligning eligibility rules and application procedures helps states administer a dual-program system effectively.

States have the important responsibility of determining the appropriate coverage program for children applying for benefits. According to federal law, states are required to screen all children who apply for coverage under the CHIP-funded program, and if the child is found to be eligible for Medicaid, enroll the child in that program. (This rule has become known as "screen and enroll.") Effective screen and enroll procedures help prevent children from losing out on coverage if the parent applies to the "wrong" program, and also ensures that children eligible for Medicaid are able to receive the full benefits and cost-sharing protections that program provides.

When a state applies the same rules for counting income and assets in both its Medicaid and separate CHIP programs, it is easy to decide the appropriate program for the child based on whether the child falls below or above a particular income threshold. When procedures in the two programs also are aligned, families do not have to take additional steps or provide additional verification to enroll the child in one of the programs. (Non-aligned programs place extra burdens on some families.) Finally, if the same state agency administers both programs, it is likely that the same eligibility worker can determine eligibility for either program. Several states, such as **Indiana, Kentucky, Massachusetts** and **North Carolina,** meet these criteria and appear to have an efficient system for making determinations about a child's eligibility. Other states, such as **Florida** and **Kansas,** have been able to achieve good coordination by employing mechanisms to screen applications for Medicaid at a

central location and then forward them to the proper place or to a co-located Medicaid eligibility worker for final eligibility determination.

Similar transfer systems are helpful at the time eligibility is to be reviewed so a child who is no longer eligible for CHIP can be easily shifted to Medicaid and vice versa. Effective screen and enroll procedures and smooth transfer systems at renewal help prevent gaps in coverage.

Aligning eligibility rules and procedures assures that families have an easy time applying for coverage for all children in the family.

A key consideration for child health coverage programs is whether all children in a particular family are eligible for the same program. In states that have age-based eligibility requirements for Medicaid—meaning different income-eligibility standards apply to children of different ages—it is common for a younger child to be eligible for Medicaid, but an older child to be eligible for the CHIP-funded separate program.

In states that have age-based eligibility in Medicaid and use different applications, interview and verification procedures, or eligibility review processes for their Medicaid and CHIP programs, families could be placed in the difficult position of having to navigate two sets of program rules. In addition, a child who reaches the age at which Medicaid income-eligibility changes will have to be transferred to the other program even if the family's income or circumstances remains the same. In states that rely on different managed care plans and providers for their Medicaid and CHIP programs, this also means that families may not be able to take all their children to the same provider and that a child's care may be disrupted simply because he or she has reached a particular birthday.

Simplification and coordination can help save on administrative costs.

Simplifying the child health insurance application and enrollment procedures can produce administrative cost-savings. In **Indiana,** for example, a state official reports that the use of a simple, joint application has saved on printing costs and has cut in half the time state workers spend verifying information provided by the applicant. In addition, the state has realized savings associated with marketing its Medicaid and CHIP-funded separate programs as a single, coordinated child health insurance program.[11]

"Opt-in/Opt-out" Boxes May Lead Eligible Children to Miss Out on Health Coverage

A key feature of a well-coordinated child health insurance system is an enrollment process that minimizes any risk that an eligible child who applies for coverage may remain uninsured. In most states with separate CHIP programs, the agency or contractor that screens for Medicaid eligibility automatically transfers applications for children who appear Medicaid-eligible to the right place for a final determination. However, in four states — Alabama, California, Georgia, and Iowa — the application will not be sent to Medicaid unless the family gives permission. (Arkansas and Minnesota, which have expanded Medicaid under Section 1115 waivers, require the family to authorize the transfer to "regular" Medicaid.) In these states, families are asked either to consent to the transfer by checking an "opt-in" box, or to deny permission by checking an "opt-out" box.

"Opt-in/opt-out" boxes are of particular concern since the wording on applications is not always clear that the child will miss out on coverage altogether, if he or she qualifies for Medicaid and the family "opts out." When eligibility rules and application procedures are as simple for Medicaid as they are for separate CHIP programs, families will be less likely to prefer one program over the other.

States with "opt-in/opt-out" boxes should reconsider using them due to the risk they impose. Medicaid and separate CHIP programs can be promoted as one health coverage system, in which eligibility for the appropriate program is determined automatically.

> **Florida's** application explains that several programs are offered, and "when you apply for the insurance, the KidCare office will check which program your child may be eligible for."

However, if "opt-in/opt-out" boxes are used, states should ensure:

- **Application forms contain clear language that helps the family weigh its decision.**

- ***Montana*** is removing the "opt-out" box from its application; however, the box formerly read: "All applications will be screened for Medicaid eligibility. Medicaid provides more benefits than other programs, does not require an enrollment fee or copayment and may pay past medical bills. If your children are eligible for Medicaid they cannot be enrolled in CHIP."

- **A system is in place to contact families to ensure they understand the benefits of Medicaid and the implications of "opting out." Follow-up limits the number of eligible children in danger of remaining uninsured.**

  In **Georgia,** the application for the separate CHIP program, PeachCare, also can be used for Medicaid. The family must check a box to indicate whether it wants the child to be considered for Medicaid. Families with children who appear to be eligible for Medicaid, but who have "opted out" receive a personal call from a state Right From the Start Medicaid (RSM) eligibility worker who explains the benefits of Medicaid. According to RSM, between March and July 2000, only 460 families out of 7,425 applying for PeachCare—about one in 17—had checked the Medicaid "opt-out" box. After the call from an RSM worker, 260 of these families decided to apply for Medicaid for their children. Ultimately, more than 97 percent of the families decided to complete the application process.

Most states with separate CHIP programs have designed systems that do not use "opt-in/opt-out" boxes. HCFA has encouraged states to "make every effort to ensure that a decision by a family not to apply for Medicaid or not to complete the application process is an informed one" and to simplify the Medicaid application process so families will not be discouraged from completing it.*

* Sally Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, *Letter to State Health Officials,* November 23, 1998.

Policy Implications

Continuing aggressive efforts to simply and align eligibility rules, as well as application, enrollment, and redetermination procedures in Medicaid and CHIP-funded separate programs is central to reducing the number of uninsured low-income children. Taking these steps also will have an impact on efforts to insure other low-income groups, including working parents.

Take additional steps to eliminate asset tests, face-to-face interview requirements and onerous verification rules.

Most often, in states that have not addressed these issues, the greater burden falls on families with children eligible for Medicaid, as opposed to those with children eligible for CHIP-funded separate programs. More stringent eligibility rules and more demanding application procedures in Medicaid create barriers to enrollment and contribute to the stigma families associate with Medicaid application process. Waiving these requirements would enable more children to qualify, make the process more convenient, and increase the likelihood that a family will be able to complete the application process.

Ease verification requirements in Medicaid and CHIP-funded separate programs.

Under federal law, the only documentation the family must provide for Medicaid or CHIP is proof of the immigration status of a non-citizen child. While many states have reduced the amount of verification they require families to provide—and several allow families to self-declare most information, including income—most families still are asked to submit a host of documents with their application. A number of states continue to require families to provide proof of a child's age in the form of a birth certificate. These can be difficult and costly to obtain and proof of age is not necessary to determine eligibility.

States that accept self-declaration of income have not reported problems with the practice. These states still can request verification when information reported on the application seems questionable. For Medicaid, states are required to conduct a post-eligibility check of state databases to verify the applicant's income and resources, to the extent that is useful. For CHIP, there are no federal income verification requirements, but HCFA encourages states to adopt procedures to assure program integrity is being maintained.

HCFA's September 12, 2000 letter to state officials strongly encouraged them to simplify application and enrollment processes. The letter also described the opportunity for states to conduct Medicaid Eligibility Quality Control (MEQC) pilot projects to evaluate the impact of simplification strategies, such as reducing verification requirements. Such pilot projects can help assure a state that its simplification efforts do not jeopardize program integrity. Information about the MEQC pilots can be found at http://www.hcfa.gov/medicaid/regions/mqchmpg.htm.

Promote greater understanding and more widespread use of the presumptive eligibility option for children.

Presumptive eligibility can be an especially valuable way to bring enrollment efforts into the community. Through presumptive eligibility, children can get prompt medical attention at the same time their families apply for coverage. Very few states are currently exercising the option to conduct presumptive eligibility determinations, and the practice is still relatively new in states that have established procedures. Early reports from active qualified entities in states that have adopted the option suggest that presumptive eligibility can be a useful tool for enrollment. More can be done to promote the design of effective presumptive eligibility procedures that build in sufficient follow-up efforts so families get the help they need to complete the process, ensuring that children are enrolled for a full period of eligibility.

Promote more extensive use of the 12-month continuous eligibility option.

The 12-month continuous eligibility option is an important tool for promoting retention in health coverage programs. Because income fluctuations are common, especially for families with workers that earn hourly wages, work overtime or work irregularly, children often wind up cycling on and off Medicaid from month to month. Continuous eligibility makes it more likely that children will fully benefit from the preventive services Medicaid provides and reduces the chances that medical treatment a child needs will be disrupted. It also reduces paperwork for families and can save on administrative and outreach costs for states.

Coordinate with other benefit programs to identify and enroll eligible children in coverage.

Programs that provide benefits to low-income children can open important channels for identifying children eligible for health coverage and helping them enroll. According to a recent analysis conducted by the Urban Institute, the school lunch, WIC and food stamp programs are serving millions of uninsured children who qualify for Medicaid and CHIP. For example, the study indicates that 3.9 million low-income, uninsured children are members of families in which one or more children participate in the school lunch program.[12]

States and local school districts are implementing strategies for using the school lunch application to identify families with children eligible for health coverage and to target application assistance to them. Others are experimenting with ways to use data from the school lunch application to begin eligibility determination for Medicaid and CHIP. Differences in the application and enrollment procedures for the school lunch and child health coverage programs present challenges to coordination, but simplification of Medicaid and CHIP procedures can make it easier to take advantage of the school lunch program as a source of children eligible for health coverage.[13]

The Agricultural Risk Protection Act of 2000, signed into law on June 20, 2000, will give states and school districts the option to more easily share information from the school lunch application with Medicaid and CHIP for the purpose of enrolling eligible children, while still protecting families' confidentiality. To take advantage of the new option, states must have a written agreement in place between school food authorities and state or local child health agencies to assure that shared information actually facilitates enrollment, an assurance that does not exist now.

Apply lessons learned about the value of simplification in children's Medicaid and CHIP programs to health coverage expansions to parents.

Expanding coverage to working parents provides much-needed benefits to a vulnerable group. Recent research also indicates that family-based Medicaid expansions that include parents can increase enrollment among children who already are eligible for Medicaid, but are not enrolled.[14] Judging from experience with children's health coverage programs, expanding eligibility for parents will not guarantee they get insured; simplifying the application process will be critical to boosting enrollment.

States have the authority to take steps such as eliminating assets tests and face-to-face interviews for parents applying for coverage. A few states, such as Rhode Island and the District of Columbia, have implemented such measures. Aligning eligibility rules and application procedures for parents with those already in place for children can make it easier to design an application form that can be used for the whole family. Moreover, having different application procedures for parents and children could negate the simplification measures put in place for children. For example, requiring a face-to-face interview for a parent to get enrolled confounds the advantage of having removed this requirement for children when both parents and children are applying.

Further simplification of children's health coverage programs can advance efforts to cover parents under CHIP waivers.

In a letter issued on July 31, 2000 to State Health Officials, the Health Care Financing Administration (HCFA) described the circumstances under which it will consider states' requests for CHIP waivers.[15] According to the letter, states may be able to secure waivers to use their CHIP funds to cover parents, a policy not otherwise allowed under the CHIP statute, except in very narrow circumstances. Waivers will be considered only for states that have expanded coverage to children under age 19 in families with incomes up to 200 percent of the federal poverty line. The state also must demonstrate that its application and redetermination processes for Medicaid and CHIP promote enrollment and retention of eligible children.

To this end, a state must adopt *at least three* of the following policies and procedures in its Medicaid and CHIP programs:

- Use of a joint mail-in application and common application procedure—for example, applying the same verification and interview requirements for CHIP and Medicaid;
- Elimination of the asset test for children;
- Presumptive eligibility for children;
- 12-month continuous eligibility for children; and
- Simplified redetermination procedures that allow families to establish their child's continuing eligibility by mail, and in states with separate CHIP programs, by establishing procedures that allow children to be transferred between Medicaid and CHIP without a new application or a gap in coverage when the child's eligibility status changes.

As this report indicates, many states already have met these criteria and are in a position to apply for a CHIP waiver to cover parents. Others, however, will need to make additional improvements before they will be able to seek authorization to use CHIP funds to provide health coverage for parents.

It has become clear that expanding eligibility to children and other groups is only the first step to assuring that they gain coverage. Removing the barriers to enrollment by simplifying application rules and procedures must occur concurrently to bring the newly eligible into the programs. As policymakers continue to focus attention on extending health insurance coverage more broadly, there is no better time to apply these simplification efforts to support expansions to the nation's vulnerable and low-income populations.

NOTES

1. Matthew Broaddus and Leighton Ku, *More Than 9 out of 10 Low-Income Uninsured Children Are Now Income-Eligible for Child Health Coverage,* Center on Budget and Policy Priorities, forthcoming.
2. Michael Perry, Susan Kannel, R. Burciaga Valdez, and Christina Chang, *Medicaid and Children: Overcoming Barriers to Enrollment*, The Kaiser Commission on Medicaid and the Uninsured, January 2000.
3. Nancy-Ann Min DeParle, Administrator, HCFA and Claude Earl Fox, Acting Administrator, HRSA, US Department of Health and Human Services, *Letter to State Health Officials*, January 23, 1998; and Sally Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration. *Letter to State Health Officials*, September 10, 1998.
4. Timothy Westmoreland, Director, Center for Medicaid and State Operations. Health Care Financing Administration, *Letter to State Quality Control Directors*, September 12, 2000. http://www.hcfa.gov/medicaid/regions/mqchmpg.htm.
5. Information on these issues can be obtained from the National Conference of State Legislators at www.ncsl.org.
6. Information on this topic can be obtained from the Center on Budget and Policy Priorities.
7. Jennifer Stuber, Kathleen Maloy, Sara Rosenbaum and Karen Jones, *Beyond Stigma: What Barriers Affect the Decisions of Low-Income Families to Enroll in Medicaid?,* Center for Health Services Research and Policy, School of Public Health and Health Services, The George Washington University, July 2000.
8. Michael Perry, Susan Kannel, R. Burciaga Valdez, and Christina Chang, *Medicaid and Children: Overcoming Barriers to Enrollment*, The Kaiser Commission on Medicaid and the Uninsured, January 2000. Jennifer Stuber, Kathleen Maloy, Sara Rosenbaum and Karen Jones, Beyond Stigma: *What Barriers Affect the Decisions of Low-Income Families to Enroll in Medicaid?*, Center for Health Services Research and Policy, School of Public Health and Health Services, The George Washington University, July 2000. Sarah Shuptrine, Vicki Grant and Genny McKenzie, *Southern regional initiative to improve access to benefits for low income families and children,* Southern Institute on Children and Families, 1998.
9. Donna Cohen Ross and Wendy Jacobson, *Free and Low-Cost Health Insurance: Children You Know Are Missing Out,* Center on Budget and Policy Priorities, December 1998; and Vicki Pulos, *Presumptive Eligibility for Children,* Families USA, April 2000.
10. For more information on coordinating Medicaid and CHIP, see Cindy Mann, Donna Cohen Ross and Laura Cox, *Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children,* Center on Budget and Policy Priorities, February 1, 2000.
11. Telephone interview with Nancy Cobb, Director, Children's Health Insurance Program, Indiana.
12. Genevieve M. Kenney, Jennifer M. Haley and Frank Ullman, *Most Uninsured Children Are in Families Served by Government Programs,* The Urban Institute, December 1999.
13. For more information on this topic see, Donna Cohen Ross, *Fostering a Close Connection: Report to Covering Kids on Options for Conducting Child Health Insurance Outreach and Enrollment Through the National School Lunch Program*, Center on Budget and Policy Priorities, January 2000. Also see Dawn Horner, Wendy Lazarus and Beth Murrow, *Express Lane Eligibility: How to Enroll Large Groups of Children in Medicaid and CHIP,* The Children's Partnership, December 1999.
14. Leighton Ku and Matthew Broaddus, *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms*, Center on Budget and Policy Priorities, September 2000.
15. Timothy Westmoreland, Director, Center for Medicaid and State Operations. Health Care Financing Administration, *Letter to State Health Officials,* July 31, 2000.

Explanation of Terms

A number of technical terms used throughout the report and in the following state tables are defined below:

Income-eligibility guidelines: The income-eligibility guidelines for Medicaid for children and for the state's separate CHIP program, if one exists, are presented as a percentage of the federal poverty line. In some states, income eligibility guidelines for Medicaid vary according to the age of the child, meaning children in the same family may be eligible for different programs. In addition to income, some states also consider a family's assets (discussed below) in determining eligibility for child health coverage programs.

Income-counting rules (including deductions and assets tests): In general, Medicaid allows families to deduct from the family's monthly income, a portion of work-related expenses, out-of-pocket child care costs, and child support received. These deductions can help children qualify for health coverage. States' separate CHIP programs may apply the same Medicaid income-counting rules or they may use other rules. For example, a number of states' separate CHIP programs determine a child's eligibility based on gross income, with no deductions allowed. The profiles also indicate whether the state's Medicaid or CHIP programs take into account a family's assets, such as the value of a car or bank account, in determining eligibility.

Household composition rules: The basic rule for determining whose information is relevant and whose income counts when assessing whether a child qualifies for Medicaid is determined by looking at the income of the child seeking coverage and the income of legally responsible relatives in the home, meaning the parent(s) of a minor child applying for benefits if the parent is living with the child. The income of unrelated adults who may be living in the home and the income of other relatives, such as a grandparent or step-parent, who have no legal responsibility to support the child applying for coverage generally does not count. Similarly, a child's own income (e.g. child support payments from an absent parent) counts only for that child, not for other children in the family. The profiles state whether the Medicaid household composition rules are used also to determine eligibility for the separate CHIP program, or whether other rules are apply. For example, a number of states count step-parent income in determining eligibility for the separate CHIP program.

Poverty level groups: This refers to groups of children who are eligible for Medicaid based on their family income, as opposed to their eligibility for other benefit programs, such as Supplemental Security Income (SSI) or the former Aid to Families with Dependent Children (AFDC) programs. According to federal law, states must provide Medicaid to children under age six (and pregnant women) in families with income at or below 133 percent of the federal poverty line. In addition, states must provide Medicaid to children age six and older, up to age 19, in families with income at or below 100 percent of the federal poverty line. These

income guidelines are federal minimums; states have the option to cover these groups at higher income levels. In addition, states have the option to eliminate asset tests for these groups.

Presumptive eligibility: The Balanced Budget Act of 1997 created a Medicaid presumptive eligibility option for children. Presumptive eligibility allows children whose family income appears below the state's Medicaid income-eligibility guidelines to enroll temporarily in Medicaid, giving families time to complete the formal application process. In the meantime, children can receive prompt attention for their health care needs and providers can be paid for Medicaid services delivered. "Qualified entities" including Medicaid providers (e.g. physicians, health clinics, hospitals, and schools that receive Medicaid payments), Head Start programs, WIC agencies and agencies that determine eligibility for subsidized child care are allowed to make presumptive eligibility determinations. Presumptive eligibility enhances opportunities for families to apply for coverage for their children in community-based settings.

States can implement procedures to provide services to children under their separate CHIP programs prior to a final eligibility determination. How presumptive eligibility determinations are made and how coverage is financed in the presumptive period are addressed differently than they are under Medicaid.

12-months continuous eligibility: Under the Balanced Budget Act of 1997, states were given the option to enroll children in Medicaid for up to 12 months, without regard to changes in their family income. The 12-month continuous eligibility option differs from a 12-month redetermination period in that under the new option, families are not obliged to report changes in their circumstances that may occur before the end of the 12-month enrollment period.

Verification rules: Federal Medicaid rules require states to verify information on the application form through various data exchanges with other agencies (for example, the Social Security Administration and the state agency that administers unemployment insurance). Federal law, however, does *not* require *families* to supply third-party verification of information provided in the application, except in one situation—when the person seeking coverage is not a citizen, documentation of the non-citizen's immigration status is required. Otherwise, states have the flexibility to determine documentation requirements and can design systems for their Medicaid and CHIP programs that avoid burdensome verification requirements, including allowing self-declaration of income and assets.

tables

TABLE 1 • STATE INCOME ELIGIBILITY GUIDELINES

Medicaid for Children and CHIP-funded Separate State Programs

(Percent of Federal Poverty Line) • July 2000

STATE	Medicaid Infants (0-1)[1]	Medicaid Children (1-5)[1]	Medicaid Children (6-16)[2]	Medicaid Children (17-19)[2/7]	Separate State Program[3]
Alabama	133	133	100	100	200
Alaska	200	200	200	200	-
Arizona	140	133	100	50	200
Arkansas[5/6]	200	200	200	200	-
California	200	133	100	100	250
Colorado[6]	133	133	100	43	185
Connecticut	185	185	185	185	300
Delaware	185	133	100	100	200
D.C.	200	200	200	200	-
Florida[8]	200	133	100	100	200
Georgia	185	133	100	100	235
Hawaii	200	200	200	200	-
Idaho	150	150	150	150	-
Illinois[10]	200	133	133	133	185
Indiana	150	150	150	150	200
Iowa	200	133	133	133	200
Kansas	150	133	100	100	200
Kentucky	185	150	150	150	200
Louisiana	150	150	150	150	-
Maine	200	150	150	150	200
Maryland	200	200	200	200	-
Massachusetts[4/9]	200	150	150	150	200 (400+)
Michigan	185	150	150	150	200
Minnesota[5]	280	275	275	275	-
Mississippi	185	133	100	100	200
Missouri[5]	300	300	300	300	-
Montana[6]	133	133	100	71	150
Nebraska	185	185	185	185	-
Nevada[6]	133	133	100	89	200
New Hampshire	300	185	185	185	300
New Jersey	185	133	133	133	350
New Mexico	235	235	235	235	-
New York	185	133	100	100	250
North Carolina	185	133	100	100	200
North Dakota[6]	133	133	100	100	140
Ohio	200	200	200	200	-
Oklahoma	185	185	185	185	-
Oregon[6]	133	133	100	100	170

STATE	Medicaid Infants (0-1)[1]	Medicaid Children (1-5)[1]	Medicaid Children (6-16)[2]	Medicaid Children (17-19)[2/7]	Separate State Program[3]
Pennsylvania[4]	185	133	100	71	200 (235)
Rhode Island[5]	250	250	250	250	-
South Carolina	185	150	150	150	-
South Dakota	140	140	140	140	-
Tennessee[4/5]	N/A	N/A	N/A	N/A	-
Texas[6]	185	133	100	100	200
Utah[6]	133	133	100	100	200
Vermont[5]	300	300	300	300	-
Virginia	133	133	100	100	185
Washington	200	200	200	200	250
West Virginia	150	150	100	100	150
Wisconsin[5]	185	185	185	185	-
Wyoming	133	133	100	67	133

1. To be eligible in the infant category, a child is under age 1 and has not yet reached his or her first birthday. To be eligible in the 1-5 category, the child is age 1 or older, but has not yet reached his or her sixth birthday. Minnesota covers children under age 2 in the infant category.
2. As required by federal law, states provide Medicaid to children age six or older who were born after September 30, 1983 and who have family incomes below 100 percent of the poverty line. By October 1, 2002 all poor children under age 19 will be covered. If the state covers children in this age group who have family incomes higher than 100 percent of the poverty line, or the state covers children born before September 30, 1983, thereby accelerating the phase-in period, it is noted in this column. States that have taken such steps have done so either through Medicaid waivers or the 1902(r)(2) provision of the Social Security Act.
3. The states noted use federal child health block grant (CHIP) funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may provide benefits similar to Medicaid or they may provide a limited benefit package. They also may impose premiums or other cost-sharing obligations on some or all families with eligible children.
4. Massuchusetts and Pennsylvania provide state-financed coverage to children with incomes above CHIP levels. Eligibility is shown in parenthesis. Eligibility under the Tennessee waiver is based on the child's lack of insurance; there is no upper income limit.
5. The Medicaid programs in AR, MN, MO, RI, TN, VT and WI may impose some cost-sharing-premiums and/or co-payments for some children-pursuant to federal waivers. Children covered under Arkansas's Medicaid expansion receive a reduced benefits package.
6. The states noted count assets in addition to income in determining Medicaid eligibility for children under Medicaid poverty level guidelines; Utah counts assets for children age 6 and older. Arkansas counts assets only for children who qualify under pre-expansion guidelines. Oregon counts assets in addition to income in determining eligibility for Medicaid and its separate child health insurance programs.
7. To be eligible in this category, a child is born before September 30, 1983 and has not yet reached his or her 19th birthday. States are required to provide Medicaid coverage to these children if their families would have qualified for AFDC under rules in effect in their state in July 1996. These standards typically require families to meet three income tests. First, they must have net income below the state's "standard of need," a measure of the amount of income determined by the state to be essential for a minimum standard of living. Second, they must have net income below the state's "payment standard," the maximum amount of assistance the state would grant a family with no income.In most states, the payment standard falls below the need standard. Finally, the family must pass a gross income test which requires that gross income (net of up to $50 in child support payments, EITC payments, and optional exclusions of a dependent child's income) fall below 185 percent of the state's standard of need.
8. Florida operates two CHIP-funded separate programs. Healthy Kids covers children age 5 through 19; Medi-Kids covers children age 1 through age 4.
9. Children between ages 1 and 19 in families with income between 150 and 200 percent of the federal poverty line will receive either slightly reduced MassHealth benefits or assistance paying premiums for employer-based plans.
10. Illinois covers infants in families with income at or below 200 percent of the federal poverty line who are born to mothers enrolled in Medicaid. Illinois covers other infants in families with income at or below 133 percent of the federal poverty line.

Center on Budget and Policy Priorities, July 1, 2000

TABLE 2
Selected Simplification Criteria:
Medicaid for Children (Poverty Level Groups) and CHIP-funded Separate State Programs (SSP) • July 2000

	Joint Application	Eliminated Face-to-Face Interview	Eliminated Asset Test	Presumptive Eligibility	12-month Continous Eligibility[10]
Total Medicaid (51)*	N/A	40	42	8	14
Total SSP (32)*	N/A	31	31	**	22
Aligned Medicaid & SSP*	28	40	42	**	13
Alabama[1]	Yes	-	✔	-	✔
Alabama SSP		✔	✔	-	✔
Alaska	N/A	✔	✔	-	-
Arizona	Yes	✔	✔	-	-
Arizona SSP		✔	✔	-	✔
Arkansas [2/ 3]	N/A	✔	-	-	-
California	Yes	✔	✔	-	-
California SSP		✔	✔	-	✔
Colorado	Yes	✔	-	-	-
Colorado SSP	-	✔	✔	-	✔
Connecticut[4]	Yes	✔	✔	✔	✔
Connecticut SSP		✔	✔	-	✔
Delaware	Yes	✔	✔	-	-
Delaware SSP		✔	✔	-	✔
District of Columbia	N/A	✔	✔	-	-
Florida[4]	Yes	✔	✔	✔	✔ (under age 5)
Florida SSP[5]		✔	✔	-	-
Georgia [6]	Yes	-	✔	-	-
Georgia SSP	-	✔	✔	-	-
Hawaii[1]	N/A	✔	✔	-	-
Idaho	N/A	✔	-	-	✔
Illinois	Yes	✔	✔	-	✔
Illinois SSP		✔	✔	-	✔
Indiana	Yes	✔	✔	-	✔
Indiana SSP		✔	✔	-	✔
Iowa	Yes	✔	✔	-	-
Iowa SSP		✔	✔	-	✔
Kansas	Yes	✔	✔	-	✔
Kansas SSP		✔	✔	-	✔

	Joint Application	Eliminated Face-to-Face Interview	Eliminated Asset Test	Presumptive Eligibility	12-month Continous Eligibility[10]
Kentucky	Yes	✔	✔	-	-
Kentucky SSP		✔	✔	-	-
Louisiana	N/A	✔	✔	-	✔
Maine	Yes	✔	✔	-	-
Maine SSP		✔	✔	-	-
Maryland	N/A	✔	✔	-	-
Massachusetts	Yes	✔	✔	✔	-
Massachusetts SSP		✔	✔	✔	-
Michigan	Yes	✔	✔	-	-
Michigan SSP[4]		✔	✔	✔	✔
Minnesota	N/A	✔	✔	-	-
Mississippi	Yes	✔	✔	-	✔
Mississippi SSP		✔	✔	-	✔
Missouri[7]	N/A	✔	✔	-	-
Montana[8]	Yes	-	-	-	-
Montana SSP		✔	✔	-	✔
Nebraska	N/A	✔	✔	✔	✔
Nevada	No	✔	-	-	-
Nevada SSP		✔	✔	-	✔
New Hampshire	Yes	✔	✔	✔	-
New Hampshire SSP		✔	✔	-	-
New Jersey	Yes	✔	✔	✔	-
New Jersey SSP		✔	✔	✔	-
New Mexico[6]	N/A	-	✔	✔	✔
New York[4/6]	Yes	-	✔	✔	✔
New York SSP		✔	✔	✔	-
North Carolina	Yes	✔	✔	-	✔
North Carolina SSP		✔	✔	-	✔
North Dakota	No	✔	-	-	-
North Dakota SSP		✔	✔	-	✔
Ohio[2]	N/A	✔	✔	-	-
Oklahoma	N/A	✔	✔	-	-
Oregon	Yes	✔	-	-	-
Oregon SSP		✔	-	-	-

	Joint Application	Eliminated Face-to-Face Interview	Eliminated Asset Test	Presumptive Eligibility	12-month Continous Eligibility[10]
Pennsylvania[9]	Yes	✔	✔	-	-
Pennsylvania SSP		✔	✔	-	✔
Rhode Island	N/A	✔	✔	-	-
South Carolina	N/A	✔	✔	-	✔
South Dakota	N/A	✔	✔	-	-
Tennessee	N/A	-	✔	-	-
Texas	No	-	-	-	-
Texas SSP		✔	✔	-	✔
Utah[1/3]	No	-	-	-	-
Utah SSP		-	✔	-	✔
Vermont	N/A	✔	✔	-	-
Virginia	Yes	✔	✔	-	-
Virginia SSP		✔	✔	-	-
Washington	Yes	✔	✔	-	✔
Washington SSP		✔	✔	-	✔
West Virginia[8]	Yes	-	✔	-	-
West Virginia SSP		✔	✔	-	✔
Wisconsin[11]	N/A	-	✔	-	-
Wyoming[1]	Yes	-	✔	-	-
Wyoming SSP		✔	✔	-	✔

A check mark (✔) indicates that a state has eliminated the face-to-face interview; dropped the asset test; adopted presumptive eligibility; or implemented the 12-month continuous eligibility option in its children's health coverage programs.

* "Total Medicaid" indicates the number of states that have adopted a particular enrollment simplification strategy for their children's Medicaid program (for "poverty level" children). All 50 states and the District of Columbia operate such programs.

* "Total SSP" indicates the number of states that have adopted a particular enrollment simplification strategy for their CHIP-funded separate state program. The following 32 states operate such programs: AL, AZ, CA, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, ME, MA, MI, MS, MT, NV, NH, NJ, NY, NC, ND, OR, PA, TX, UT, VA, WA, WV, and WY. (The remaining 18 states and DC use their CHIP funds to expand Medicaid, exclusively.)

* "Aligned Medicaid & SSP" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children's Medicaid program (for "poverty level" children) and their CHIP-funded separate state program. States that have used CHIP funds to expand Medicaid, exclusively, are considered "aligned" if the simplified procedure applies to children in the Medicaid "poverty level" groups and the CHIP-funded Medicaid expansion group.

** *While several states have adopted a presumptive eligibility procedure for their CHIP-funded separate state programs, the rules under the Medicaid presumptive eligibility option do not necessarily apply. While states that have adopted presumptive eligibility procedures are noted in the table, an assessment of "alignment" between Medicaid for children and CHIP-funded separate programs has not been made.*

1. These states require an interview for families applying for Medicaid for their children, however the interview may be conducted by telephone. In Alabama and Hawaii, the interview is usually done by telephone. In Utah and Wyoming a face-to-face interview is required, but families are permitted to do the interview by telephone. In Utah, an interview also is required for the CHIP-funded separate program. In Alabama and Wyoming, no interview is required for the CHIP-funded separate program.
2. In Arkansas and Ohio, applicants eligible under the expansion components receive 12 months of continuous eligibility.
3. Arkansas and Utah still count assets in determining Medicaid eligibility for some "poverty level" children.
4. Connecticut, Florida, and New York have adopted Medicaid presumptive eligibility for children, but have not yet implemented the procedures. Connecticut anticipates implementing presumptive eligibility procedures in October 2000. Michigan has adopted presumptive eligibility for its CHIP-funded separate program, but has not yet implemented procedures.
5. Florida operates two CHIP-funded separate state programs. Healthy Kids covers children age 5 through 19; Medi-Kids covers children age 1 through age 4.
6. In Georgia a separate Medicaid application is still in use; a face-to-face interview is required when the separate Medicaid application is used, but it can be done outside the Medicaid office. Georgia is currently piloting an elimination of the face-to-face interview requirement and anticipates eliminating the requirement effective February 2001. In New Mexico a face-to-face interview is required, however community-based Medicaid On-Site Application Assistance (MOSAA) providers are available to help families complete a somewhat shorter "MOSAA" application; contact with a MOSAA provider satisfies the interview requirement. In New York, a contact with a community-based "facilitated enroller" will meet the face-to-face interview requirement.
7. Missouri has eliminated the asset test for applicants eligible under pre-expansion guidelines. Children in the Medicaid expansion group are subject to a "net worth"test of $250,000.
8. In West Virginia and Montana, families that apply for coverage for their children using the joint application do not have to complete a face-to-face interview if the child appears to be Medicaid-eligible and the application is transferred for an eligibility determination. (Families that submit the application directly to Medicaid would be subject to an interview.) Montana will eliminate the Medicaid face-to-face interview requirement for poverty-level groups, effective October 2000.
9. Pennsylvania has separate applications for Medicaid and its separate state program. Families are allowed to use either application to apply for Medicaid or the separate state program. A joint application is being developed.
10. A child is enrolled for 12 months, regardless of changes in family income or circumstances.
11. In Wisconsin, all families are asked to provide information about assets so that eligibility for Medicaid eligibility categories that include an asset test can be determined. If the family does not provide information about assets, or if the asset limit is exceeded, children will be reviewed for Medicaid eligibility categories that do not count assets.Eligibility determination can be delayed if a family's assets are not verified.

Center on Budget and Policy Priorities, July 2000

TABLE 3
States Allowing Self-Declaration of Income:
Medicaid for Children (Poverty Level Groups) and CHIP-funded Separate State Programs (SSP) • July 2000

	Self-declaration of Income
Total Medicaid (51)	10
Total SSP (32)	7
Aligned Medicaid & SSP	10
Alabama	-
Alabama SSP	✔
Alaska	-
Arizona	-
Arizona SSP	-
Arkansas	✔
California	-
California SSP	-
Colorado	-
Colorado SSP	-
Connecticut	-
Connecticut SSP	-
Delaware	-
Delaware SSP	-
District of Columbia	-
Florida	✔
Florida SSP	✔
Georgia	✔
Georgia SSP	✔
Hawaii	-
Idaho	✔
Illinois	-
Illinois SSP	-
Indiana	-
Indiana SSP	-
Iowa	-
Iowa SSP	-
Kansas	-
Kansas SSP	-
Kentucky	✔
Kentucky SSP	✔
Louisiana	-
Maine	-
Maine SSP	-
Maryland	✔
Massachusetts	-
Massachusetts SSP	-
Michigan[1]	✔
Michigan SSP	✔
Minnesota	-

	Self-declaration of Income
Mississippi	-
Mississippi SSP	-
Missouri	-
Montana	-
Montana SSP	-
Nebraska	-
Nevada	-
Nevada SSP	-
New Hampshire	-
New Hampshire SSP	-
New Jersey	-
New Jersey SSP	-
New Mexico	-
New York	-
New York SSP	-
North Carolina	-
North Carolina SSP	-
North Dakota	-
North Dakota SSP	-
Ohio	-
Oklahoma	✔
Oregon	-
Oregon SSP	-
Pennsylvania	-
Pennsylvania SSP	-
Rhode Island	-
South Carolina	-
South Dakota	-
Tennessee[2]	-
Texas	-
Texas SSP	-
Utah	-
Utah SSP	-
Vermont	✔
Virginia	-
Virginia SSP	-
Washington	✔
Washington SSP	✔
West Virginia	-
West Virginia SSP	-
Wisconsin	-
Wyoming	-
Wyoming SSP	✔

A check mark (✔) indicates that the state allows self-declaration of income in its children's health coverage programs.

* "Total Medicaid" indicates the number of states that allow self-declaration of income for their children's Medicaid program (for "poverty level" children). All 50 states and the District of Columbia operate such programs.
* "Total SSP" indicates the number of states that allow self-declaration of income in their CHIP-funded separate state program. The following 32 states operate such programs: AL AZ, CA, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, ME, MA, MI, MS, MT, NV, NH, NJ, NY NC, ND, OR, PA, TX, UT, VA, WA, WV and WY. (The remaining 18 states and DC use their CHIP funds to expand Medicaid exclusively.)
* "Aligned Medicaid & SSP" indicates the number of states that allow self-declaration of income in both their children's Medicaid program (for "poverty level" children) and their CHIP-funded separate state program. States that have used CHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the Medicaid "poverty level" groups and the CHIP-funded Medicaid expansion group.

1. In Michigan, applicants may self-declare family information on the joint MIChild / Healthy Kids application effective August 2000. Families will be able to self-declare family information for Medicaid on the combined program application effective February 2001.
2. In Tennessee, applicants for the expansion program may self-declare all family information. No verification is required.

Center on Budget and Policy Priorities, July 2000

TABLE 4
Selected Aspects of the Redetermination Process:
Medicaid for Children (Poverty Level Groups) and CHIP-funded Separate State Programs (SSP) • July 2000

	Frequency	12-month Continuous Eligibility	Eliminated Face-to-Face Interview	Joint Form Used at Redetermination
Total Medicaid (51)*	39**	14	43	N/A
Total SSP (32)*	29**	22	32	N/A
Aligned Medicaid & SSP*	39**	13	43	14
Alabama	12 months	✔	-	No
Alabama SSP[1]	12 months	✔	✔	
Alaska	6 months	-	✔	N / A
Arizona[2]	12 months	-	✔	No
Arizona SSP[2]	12 months	✔	✔	
Arkansas [1/ 3]	12 months	-	✔	N / A
California[4]	12 months	-	✔	No
California SSP	12 months	✔	✔	
Colorado[5]	12 months	-	✔	No
Colorado SSP	12 months	✔	✔	
Connecticut	12 months	✔	✔	No
Connecticut SSP	12 months	✔	✔	
Delaware	12 months	-	✔	Yes
Delaware SSP	12 months	✔	✔	
District of Columbia	12 months	-	✔	N/A
Florida[1]	12 months (under age 5) 6 months (over age 5)	✔ (under age 5)	✔	No
Florida SSP[1]	6 months	-	✔	
Georgia [1/6]	6 months	-	-	No
Georgia SSP[1]	12 months	-	✔	
Hawaii	12 months	-	✔	N/A
Idaho[1]	12 months	✔	✔	N/A
Illinois	12 months	✔	✔	No
Illinois SSP	12 months	✔	✔	
Indiana[2]	12 months	✔	✔	Yes
Indiana SSP	12 months	✔	✔	

	Frequency	12-month Continuous Eligibility	Eliminated Face-to-Face Interview	Joint Form Used at Redetermination
Iowa[4]	12 months	-	✔	No
Iowa SSP	12 months	✔	✔	
Kansas	12 months	✔	✔	Yes
Kansas SSP	12 months	✔	✔	
Kentucky[1]	12 months	-	✔	Yes
Kentucky SSP[1]	12 months	-	✔	
Louisiana	12 months	✔	✔	N/A
Maine	6 months	-	✔	Yes
Maine SSP	6 months	-	✔	
Maryland[1]	12 months	-	✔	N/A
Massachusetts	12 months	-	✔	Yes
Massachusetts SSP	12 months	-	✔	
Michigan[1]	12 months	-	✔	No
Michigan SSP[1]	12 months	✔	✔	
Minnesota[3]	6 months	-	✔	N/A
Mississippi	12 months	✔	✔	Yes
Mississippi SSP	12 months	✔	✔	
Missouri	12 months	-	✔	N/A
Montana[6]	12 months	-	-	No
Montana SSP	12 months	✔	✔	
Nebraska	12 months	✔	✔	N/A
Nevada	12 months	-	✔	No
Nevada SSP	12 months	✔	✔	
New Hampshire	12 months	-	✔	Yes
New Hampshire SSP	12 months	-	✔	
New Jersey	6 months	-	✔	Yes
New Jersey SSP	12 months	-	✔	
New Mexico	12 months	✔	✔	N/A
New York[7]	12 months	✔	-	Yes
New York SSP	12 months	-	✔	
North Carolina	12 months	✔	✔	Yes
North Carolina SSP	12 months	✔	✔	
North Dakota	12 months	-	✔	No
North Dakota SSP	12 months	✔	✔	
Ohio[3]	12 months	-	✔	N/A

	Frequency	12-month Continuous Eligibility	Eliminated Face-to-Face Interview	Joint Form Used at Redetermination
Oklahoma[1]	6 months	-	✔	N/A
Oregon	6 months	-	✔	Yes
Oregon SSP	6 months	-	✔	
Pennsylvania	12 months	-	✔	No
Pennsylvania SSP	12 months	✔	✔	
Rhode Island	12 months	-	✔	N/A
South Carolina[5]	12 months	✔	-	N/A
South Dakota	12 months	-	✔	N/A
Tennessee[3]	6 months	-	-	N/A
Texas	6 months	-	-	No
Texas SSP	12 months	✔	✔	
Utah[8]	12 months	-	✔	No
Utah SSP	12 months	✔	✔	
Vermont[1]	6 months	-	✔	N/A
Virginia	12 months	-	✔	Yes
Virginia SSP	12 months	-	✔	
Washington[1]	12 months	✔	✔	Yes
Washington SSP[1]	12 months	✔	✔	
West Virginia	12 months	-	✔	No
West Virginia SSP	12 months	✔	✔	
Wisconsin	12 months	-	-	N/A
Wyoming	6 months	-	✔	No
Wyoming SSP[1]	12 months	✔	✔	

A check mark (✔) indicates that a state has adopted 12-month continuous eligibility or eliminated the face-to-face interview at redetermination in its children's health coverage programs.

* "Total Medicaid" indicates the number of states that have adopted a particular enrollment simplification strategy for their children's Medicaid program (for "poverty level" children). All 50 states and the District of Columbia operate such programs.

* "Total SSP" indicates the number of states that have adopted a particular enrollment simplification strategy for their CHIP-funded separate state program. The following 32 states operate such programs: AL, AZ, CA, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, ME, MA, MI, MS, MT, NV, NH, NJ, NY, NC, ND, OR, PA, TX, UT, VA, WA, WV, and WY. (The remaining 18 states and DC use their CHIP funds to expand Medicaid, exclusively.)

* "Aligned Medicaid & SSP" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children's Medicaid program (for "poverty level" children) and their CHIP-funded separate state program. States that have used CHIP funds to expand Medicaid, exclusively, are considered "aligned" if the simplified procedure applies to children in the Medicaid "poverty level" groups and the CHIP-funded Medicaid expansion group.

** If the frequency of redetermination is every 12 months as opposed to six months or more frequently, the procedure is considered "simplified" for purposes of this table. States that previously imposed frequent reporting requirements have either eliminated those requirements or are scheduled to do so.

1. Families may self-declare most family information, including income at redetermination.
2. In Indiana the child health coverage programs require families to complete a telephone interview at redetermination. The Medicaid program in Arizona requires families to complete a telephone interview at redetermination.
3. In Arkansas, Minnesota, Tennessee and Ohio, redetermination procedures differ for families with children enrolled in Medicaid, depending on whether they are eligible under pre-expansion rules ("regular Medicaid") or under expansions pursuant to Medicaid section 1115 waivers or CHIP-funded Medicaid expansions. In Minnesota and Tennessee, children who qualify under waiver programs can redetermine eligibility every 12 months as opposed to every 6 months under "regular" Medicaid. In Arkansas and Ohio, children who qualify under expansion rules receive 12 months of continuous eligibility as opposed to a 12 month redetermination period.
4. Iowa plans to eliminate the Medicaid monthly reporting requirement, effective October 2000.
   California plans to eliminate Medicaid quarterly reporting effective January 2001.
5. In Colorado, South Carolina, and Wisconsin, redetermination procedures vary by county. In South Carolina and Wisconsin, county offices may require a face-to-face interview.
6. In Georgia, a face-to-face interview is required at every other Medicaid redetermination. In Montana, families referred to Medicaid by the CHIP-funded separate program do not have to be interviewed. Montana plans to eliminate the Medicaid face-to-face interview requirement effective October 2000.
7. In New York, a contact with a community-based "facilitated enroller" will meet the face-to-face interview requirement. A joint application can be used with the "facilitated enroller" at redetermination.
8. In Utah, children enrolled in Medicaid whose family income is close to the income eligibility limit are required to have their eligibility redetermined more frequently.

Center on Budget and Policy Priorities, July 2000

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