CONNECTING KIDS TO COVERAGE:

Steady Growth, New Innovation

2011 CHIPRA ANNUAL REPORT

EXECUTIVE SUMMARY

Three years ago, on February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA) into law. CHIPRA has provided states new financial resources and options to expand and improve health coverage for children through Medicaid and the Children's Health Insurance Program (CHIP). States have taken advantage of the new tools and added federal support, notwithstanding the economic downturn and recovery that has taken place over the last several years.

CHIPRA offered a wide range of policy and programmatic "tools" to enable states to move their coverage efforts forward. In addition to providing new federal funding dedicated to outreach and enrollment efforts, the law authorized several new policy options – like Express Lane Eligibility, coverage of pregnant women in CHIP, deeming all newborns whose mothers are covered by Medicaid or CHIP to be eligible for coverage without need for an application, and removing the 5-year waiting period for legal immigrant children and pregnant women to enroll in Medicaid and CHIP. All of these tools have enhanced states' ability to improve access and boost enrollment.

HHS Secretary Kathleen Sebelius has continued to stress the importance of ongoing outreach efforts and simplification strategies through the *Connecting Kids to Coverage Challenge*, calling upon leaders at all levels of government and the private sector to find and enroll all uninsured children who are eligible for Medicaid and CHIP, and keep them covered for as long as they qualify.

This report reviews the progress achieved during federal fiscal year (FFY) 2011 and highlights the ongoing gains in children's coverage, as well as the new innovations being tested at the state, federal, and community levels to bring the nation closer to ensuring that all children in America have high quality, affordable health coverage. Highlights include:

- **More than 1.5 million children gained Medicaid or CHIP coverage during federal fiscal year 2011 (October 1, 2010 – September 30, 2011). In total, Medicaid and CHIP served more than 43.5 million children last year.** This steady increase in enrollment is evidence of the important role that Medicaid and CHIP play for children, especially during economic downturns. Together, these programs are credited with significant increases in the number of children who have health coverage as compared to before CHIPRA was enacted in 2009. The enrollment growth also reflects states' continued efforts to incorporate innovative strategies, new technologies and additional streamlining of their programs in order to identify more children who are eligible for coverage and get them enrolled. On average, 85 percent of eligible children participate in Medicaid and CHIP, a further indication that these programs are fulfilling the role for which they are intended. Participation rates vary from more than 95 percent in Massachusetts and the District of Columbia to a low of 63 percent of eligible children enrolled in Nevada in 2009.[1]

- **Eight states implemented eligibility expansions in 2011 and many others simplified their enrollment and renewal procedures.**[2] Forty-seven states and the District of Columbia now cover children with incomes up to 200 percent of the federal Poverty Level (FPL) in Medicaid and CHIP; with 18 of those states covering children at or above 300 percent of the FPL. Twenty-three states and the District of Columbia now offer coverage to lawfully residing immigrant children and/or pregnant women without a five-year waiting period and six states have received approval to provide CHIP coverage to eligible children of state employees.[3]

- **CHIPRA performance bonuses continue to be a great incentive for states to improve their Medicaid and CHIP programs.** Twenty-three states qualified for nearly $300 million in performance bonuses for FFY 2011, a significant increase over 2010 where 16 states received bonuses totaling over $167 million (See appendix 1). These bonuses provide additional federal financial support each year to states that successfully boost enrollment in Medicaid above target levels. To qualify, a state not only has to enroll more children, but must also have implemented program features that are designed to promote enrollment of eligible children. The bonuses were designed to help offset the cost of covering the additional children that are enrolled as a result of these efforts to streamline the enrollment and renewal process.

- **Maximizing the use of technology to facilitate enrollment and renewals emerged as a key strategy.** Nearly two-thirds of states (34) now have an on-line application that can be submitted electronically; and five states enhanced their on-line application capabilities in 2011.[4] Eight states have received approval to enroll children through the "Express Lane Eligibility" (ELE) option created by CHIPRA; and three states are using ELE for Medicaid renewals. Thirty-four states and the District of Columbia are successfully utilizing the CHIPRA data matching process provided by the Social Security Administration to confirm U.S. citizenship for children, saving time and lowering costs for administering agencies.

- **A second round of CHIPRA outreach and enrollment grants has renewed focus on advancing coverage among the hardest to reach children.** On August 18, 2011, HHS announced the second round of $40 million in grants for efforts to identify and enroll children eligible for Medicaid and the Children's Health Insurance Program (CHIP). The two-year grants were awarded to 39 state agencies, community health centers, school-based organizations and non-profit groups across 23 states. The grant amounts range from $200,000 to $2.5 million. Projects emphasize the use of technology and activities aimed at addressing disparities in health coverage. The Cycle II grants will build on the successes and benefit from lessons learned from the first round of grants (Cycle I) that were awarded in 2009.

- **Improving quality of care continues to be a priority for the federal government and the states**. With access to data on a comprehensive set of performance measures for children and efforts underway to improve the stability of coverage for children in Medicaid and CHIP, CMS now has a greater capacity to work toward its goal of achieving a first class system of coverage and care for all children. In the first year of reporting, 42 states and DC voluntarily reported one or more quality measures and 15 states reported on at least half of the measures.

The accomplishments continue to grow, but our collective work is not complete. The wide variation in progress across states remains a challenge, with several states achieving amore than 95 percent participation rate among children who are eligible for Medicaid and CHIP while other states continue to reach less than 80 percent of their eligible children. The efforts underway for 2012 will be designed to focus on the children who are disproportionately uninsured – like older children, Latinos and American Indians – by meeting them in their communities and making enrollment easier than ever before. As always, partnerships at the federal, state and community level will be critical to the success of these efforts.

INTRODUCTION

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This legislation launched a new era in children's coverage by providing states with significant new funding and a range of new opportunities for covering children eligible for Medicaid and the Children's Health Insurance Program (CHIP). By making available policy options and financial incentives, CHIPRA has supported states in their efforts to simplify and streamline program rules and procedures, to boost enrollment and improve continuity of coverage and care.

These efforts have paid off. The National Center for Health Statistics released new data in December 2011 to show that in 2008 (prior to the enactment of CHIPRA) 91 percent of all children had health insurance coverage. In 2011, this number had increased to nearly 93 percent, corresponding to an additional 1.2 million children receiving health coverage. The report attributed this increase in children's coverage entirely to Medicaid and CHIP.[5]

Other studies support these findings. According to an analysis of Census data by the Urban Institute, between 2008 and 2009 the number of children eligible for Medicaid and CHIP but not enrolled declined from 4.7 million to 4.3 million. This achievement is especially significant considering that, during this period, 2.5 million additional children became eligible for the programs due to the difficult economic circumstances their families were facing. The research attributes these gains to state simplification efforts and to outreach.[6] On average, nationally 85 percent of eligible children participate in Medicaid and CHIP, a further indication that these programs are fulfilling the role for which they are intended. Participation rates vary from more than 95 percent in Massachusetts and the District of Columbia, to a low of 63 percent of eligible children enrolled in Nevada in 2009.[7]

Building on efforts that began in early 2009, HHS has continued to work closely with states, other federal departments and agencies, and a broad array of private and public leaders and organizations interested in children's coverage to implement CHIPRA. This report highlights federal and state activities over the course of the three years since CHIPRA was enacted, and charts the collective progress that has been achieved.

CHIPRA IN 2011: STEADY GROWTH, NEW INNOVATION

CHIPRA goals remained a priority in 2011, with robust federal and state activity continuing around efforts to enroll eligible children in health coverage. States proceeded to implement program improvements for children, even as the focus on implementing the Affordable Care Act intensified and attention has shifted to the historic expansion of the Medicaid program that is approaching in 2014. The Centers for Medicare & Medicaid Services (CMS) continued its work with states, consumer advocacy groups and the health policy community to advance the goal of HHS Secretary Kathleen Sebelius' *Connecting Kids to Coverage Challenge* – to find and enroll all children who are eligible for coverage through Medicaid or CHIP.

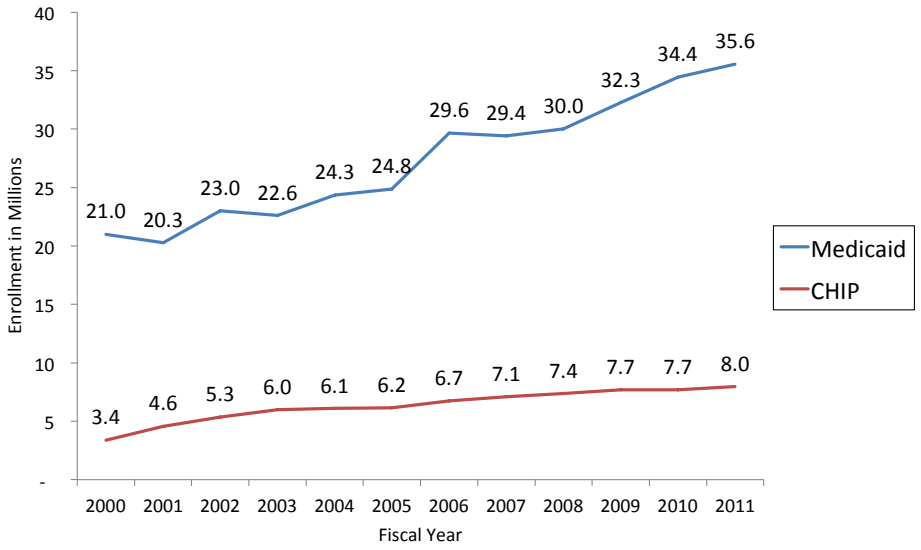
State progress continued at a steady pace in 2011. The Affordable Care Act requirement that states maintain their eligibility levels played a role in assuring stability, but states continued to show leadership and innovation as their children's coverage programs grew and matured. States have continued to embrace policy and procedural changes that make their programs smarter and more

accessible to the families who need them. According to an annual survey released in January 2012 by the Kaiser Family Foundation, prepared jointly with the Georgetown Center for Children and Families, nearly all states maintained or made improvements to their Medicaid and CHIP eligibility and enrollment procedures. According to the study, eight states expanded eligibility for children and 29 states made improvements in enrollment and renewal procedures in Medicaid and/or CHIP.[8] One state, Arizona, implemented an enrollment freeze on January 1, 2010, which has resulted in a decline in enrollment of more than 23,600 ever enrolled children as of the end of FFY 2011.

ENROLLMENT GAINS. Children's enrollment in Medicaid and CHIP increased by more than 1.5 million between federal Fiscal Year (FFY) 2010 and 2011. Together, these programs served more than 43.5 million children over the course of the year (See Appendix 2). In particular, Michigan and Oregon achieved significant enrollment increases, undoubtedly as a result of their commitment to innovation in outreach and enrollment strategies. These enrollment gains reflect the critical role Medicaid and CHIP play in ensuring that low-income children get the health care coverage they need. They also reflect states' continued efforts to incorporate new technologies, efficiencies, and improvements into their programs, facilitating their efforts to reach children who are eligible for Medicaid and CHIP but remain uninsured.

Michigan, for example, attributes the enrollment gains in its CHIP program in part to the development of an electronic interface with the state's Department of Human Services that electronically refers MIChild (CHIP) applications to children whose income qualifies them for the program. Oregon attributes its large gains in Medicaid and CHIP enrollment (over 100,000 children) to strong outreach efforts. In addition, Michigan and Oregon were two of the 23 states that received FFY 2011 CHIPRA performance bonuses for simplifying their enrollment and renewal processes and for increasing enrollment of uninsured children in the Medicaid program. (More information about performance bonuses can be found later in this report.)

TRENDS IN MEDICAID AND CHIP ENROLLMENT FOR CHILDREN, FY 2000-2011



Source: CHIP Statistical Data Enrollment System (SEDS) forms CMS-21E, CMS-64.21E, and CMS-64EC. Data as of 2/1/12.

Figure 1

These Medicaid and CHIP enrollment increases continue to be credited with the decline in the uninsurance rate for children.[9] The U.S. Census Bureau reported that in 2010, 7.3 million children were uninsured, remaining at the lowest rate since 1983.[10] These findings demonstrate the value of the program and policy improvements as well as the importance of the federal funding that has been made available, including:

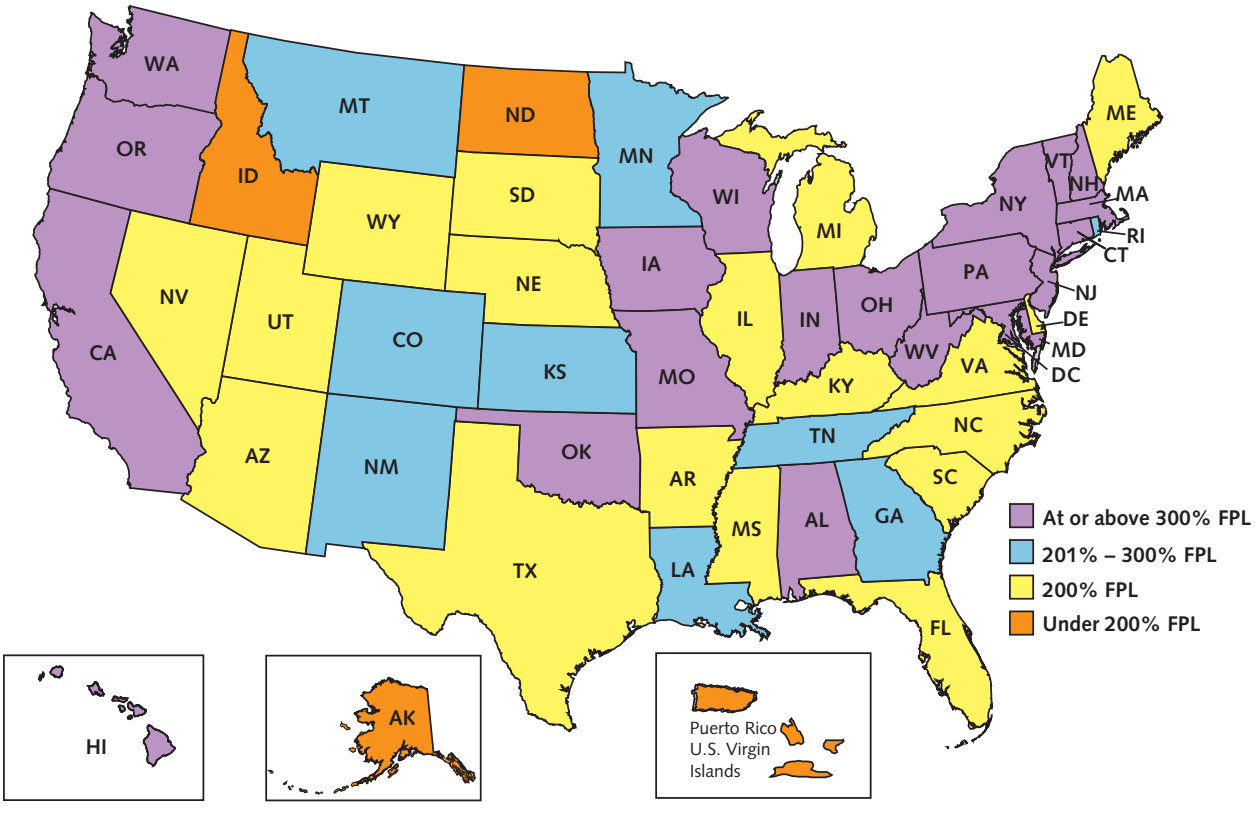
- A fully funded CHIP program through 2015
- Performance bonuses designed to reward enrollment of eligible children in Medicaid
- Support provided by the Recovery Act in the form of an increased federal Medicaid matching rate for all states through June 2011.

ELIGIBILITY: COVERAGE BROADENS FOR CHILDREN. States have continued to broaden the scope of children's coverage programs by using CHIPRA options to extend Medicaid and CHIP to children unable to enroll in the past: 18 states cover children at or above 300 percent of the FPL; 23 states and DC now offer coverage to lawfully residing immigrant children and/or pregnant women; and six states have received approval to provide coverage to children of state employees who are eligible for CHIP.

Figure 2

MEDICAID/CHIP

Upper Income Limits as of January 1, 2012



TOWARD 2014: THE SIMPLE, SEAMLESS PATH TO HEALTH COVERAGE. States and community organizations have continued to improve enrollment and renewal strategies, increase their use of technology, and reduce procedural barriers for families. States' experience with strategies to ensure access for children will provide a strong foundation for taking the next step – implementing the expansion of Medicaid coverage to low-income adults in 2014. For example:

- 48 states and the District of Columbia have a 12 month eligibility period for Medicaid and CHIP; and 23 states offer 12 months of continuous eligibility for both programs – keeping children enrolled for a full year regardless of changes in circumstances;
- 37 of 39 states that operate a separate CHIP program have a single joint application that can be used to apply for and renew both Medicaid and CHIP coverage;
- 34 states now have an on-line application that can be submitted electronically. Five states enhanced their online application capabilities during 2011.
- 34 states and the District of Columbia are utilizing the data matching process provided by the Social Security Administration to confirm U.S. citizenship for children in Medicaid/CHIP, which both reduces costs and results in improved beneficiary access.
- Eight states have adopted Express Lane Eligibility to facilitate enrollment in their Medicaid and/or CHIP programs and three states are using ELE for Medicaid renewals. Massachusetts became the first state in 2011 to receive a waiver to provide ELE to low-income parents.

SPOTLIGHT ON TECHNOLOGY:

Oklahoma—Online Enrollment

Oklahoma's online application for SoonerCare (Medicaid) has transformed the enrollment process. The system allows Oklahomans to complete an application, manage their information and enroll in real-time. Data exchanges are used for many verifications.Those who qualify are enrolled and can access services immediately. About 35,000 applications are processed each month, with 45 percent submitted online by home users and almost a quarter of them being received outside traditional business hours. Paper applications (about 10 percent) are still accepted and are processed with optical character recognition and minimal data entry. Funding from the CHIPRA Cycle I outreach grant helped Oklahoma build a sustainable, statewide infrastructure for SoonerCare outreach and enrollment, working collaboratively with more than 700 community partners from the public, private and nonprofit sectors. Partner agencies have access to a condensed version of the on-line application and can assist consumers, as well as enter documentation, comments, and updates to their file. The web application process takes minutes rather than days or weeks. Efforts to increase efficiency continue to move forward. SoonerEnroll conducted a telephonic re-enrollment pilot which, at its peak, was averaging more than 3,000 children being recertified for SoonerCare each month. The process generally took less than five minutes. For more information, see *http://www.insurekidsnow.gov/professionals/events/2011_conference/oklahoma_health_care_authority_online_enrollment_508.pdf.pdf*

FFY 2011 PERFORMANCE BONUSES. CHIPRA established Performance Bonuses to promote enrollment of eligible children and to help states cover the costs associated with covering those children, particularly in Medicaid. The bonuses provide additional federal funding for qualifying states that have taken specific steps to simplify Medicaid and CHIP enrollment and renewal procedures and have also increased enrollment of children in Medicaid above a baseline level.

Figure 3 **PERFORMANCE BONUSES FOR FY 2011**

The chart below summarizes the States that received performance bonuses for FY 2011 and highlights the program features in place for each State.

State	Program Features								Enrollment**	FY 2011 Performance Bonus Amount
	Continuous Eligibility	Liberal-ization of Asset Require-ments	Elimination of In-Person Interview	Same App and Renewal Form	Auto/ Admin. Renewal	PE	Express Lane	Premium Assistance Subsidies	Tier 2 enrollment reached?	
AL	X	X	X	X	X				Yes	$19,758,656
AK	X	X	X	X	X				Yes	$5,660,544
CO		X	X	X		X		X	Yes	$26,141,052
CT*		X	X	X	X	X			No	$5,209,262
GA*		X	X	X			X	X	No	$4,965,887
ID	X	X	X	X	X				No	$1,302,552
IL	X	X	X	X	X	X			No	$15,069,869
IA	X	X	X	X		X	X		Yes	$9,575,525
KS	X	X	X	X		X			Yes	$5,862,957
LA	X	X	X	X	X				No	$1,929,692
MD		X	X	X	X		X		Yes	$28,301,384
MI	X	X	X	X		X			No	$5,902,731
MT*	X	X	X	X		X			Yes	$6,473,416
NJ		X	X	X	X	X	X		Yes	$16,822,537
NM	X	X	X	X	X	X			Yes	$4,971,028
NC*	X	X	X	X	X				Yes	$21,135,087
ND*	X	X	X	X	X				Yes	$3,195,768
OH	X	X	X	X		X			Yes	$21,036,616
OR	X	X	X	X	X		X		Yes	$22,493,771
SC*	X	X	X	X			X		No	$2,383,837
VA*		X	X	X	X			X	Yes	$26,729,489
WA	X	X	X	X				X	Yes	$16,987,468
WI		X	X	X	X			X	Yes	$24,541,778
Total	16	23	23	23	14	10	6	5	16	$296,450,906

* State is receiving a bonus for the first time in FY 2011.

**The enrollment target is based on FY 2007 Medicaid child enrollment and adjusted based on a formula that accounts for population growth and for increases in enrollment during an economic recession. States that exceed their enrollment target have increased enrollment above what would have been expected without expanded outreach efforts. States that exceed their enrollment target by more than 10% qualify for a "Tier 2" performance bonus payment, in which additional enrollment is rewarded at a higher rate. This enrollment data and the related bonus amounts are considered preliminary and subject to reconciliation after States' Medicaid enrollment numbers are finalized in early 2012.

On December 28, 2011, CMS awarded $296 million in FFY 2011 performance bonuses to 23 states. The total bonus amount increased by $129 million over 2010, indicating that states have continued to make significant progress simplifying their programs and covering more children. All states that received a performance bonus in 2010 qualified again for 2011, and seven of the states receiving bonuses this year are qualifying for the first time.

Performance bonuses have been one of the most effective financial incentives that CHIPRA offered. The bonuses have not only motivated states to increase enrollment – 16 states received "tier 2" bonuses this year – but they have served as a catalyst for streamlining enrollment and renewal procedures. Five states (IL, IA, NJ, NM, and OR) have adopted six simplified program features, going beyond the five needed to qualify for the bonus. Oregon and Iowa, which had both met the criteria and received bonuses in the past, implemented their sixth feature, Express Lane Eligibility, in FFY 2011.

EXPRESS LANE ELIGIBILITY: TICKET TO NEXT YEAR'S PERFORMANCE BONUS. One of the most exciting new program options included in CHIPRA is Express Lane Eligibility (ELE), which involves using eligibility findings from other public programs (like SNAP, school lunch, WIC and tax information) to facilitate enrollment in Medicaid and CHIP. In 2011, many states forged ahead in implementing or improving Express Lane Eligibility for children in both Medicaid and CHIP. A total of eight states are now using ELE, with five states newly adopting ELE strategies in 2011. As noted above, ELE is one of the eight "program features" that states can adopt to qualify for a CHIPRA performance bonus. The Express Lane Eligibility option provides a variety of opportunities for states to improve children's enrollment and retention. Following are some examples of states' recent experience:

- South Carolina implemented ELE with SNAP and TANF in 2011. Prior to implementing ELE, the state found that 42 percent of children losing coverage at renewal were returning to Medicaid within one month. State staff calculated that by using income data from SNAP and TANF at children's annual Medicaid renewals, the state would prevent enough needless terminations of coverage to save 50,000 hours of worker time and $1 million per year. During the first six months of the program, South Carolina renewed 65,000 children using Express Lane Eligibility.

- In 2011, Georgia became the first state to implement ELE with the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Using WIC as the Express Lane agency is a logical approach for Georgia since individuals are often referred back and forth between the two programs, and preexisting rules draw the two programs together. For example, since Georgia WIC uses the same income verification standards as Medicaid and CHIP, there would be no need to ask a family with a child in WIC to resubmit proof of income for Medicaid.

- Louisiana first implemented ELE in 2010 by connecting all children receiving SNAP with Medicaid in one data exchange. In October 2011, the Medicaid agency began a daily match with SNAP that replaced the manual applicant-by-applicant review, adding roughly 1,000 children to Medicaid in both November and December. Similar improvements are underway in Alabama, where a new memorandum of understanding with SNAP and TANF partner agencies allow them to move from manual data matches conducted by an eligibility worker to automated matches.

- Oregon and New Jersey established ELE connections with the National School Lunch Program. Both states have overcome barriers related to the differences between NSLP and Medicaid/CHIP processes, and are beginning to see the results of their hard work.

Finally, in late 2011, the Office of the Secretary of HHS began an evaluation of Express Lane Eligibility for a Report to Congress as required by CHIPRA. Results from the evaluation are expected in Fall, 2012.

SPOTLIGHT ON TECHNOLOGY:

Insure New Mexico Enrollment Kiosks

The New Mexico Human Services Department used its Cycle I CHIPRA outreach grant to install enrollment kiosks around the state to make the Medicaid application process more accessible to people in remote and rural areas. The kiosks are stand-alone Medicaid enrollment units which include a full-functioning printer, scanner and signature pad. The kiosk units house everything that is needed to successfully complete and submit an electronic version of the Medicaid application, but no personal information is stored. Verification documents can be scanned and uploaded and the built-in signature scan allows for the application to be populated with an electronic version of the client's original signature. The built-in printer allows the client to receive a completed application "packet" at the end of the process. The kiosks also have the ability to accept recertification information. Applications submitted through the traditional paper process can take up to 45 days to process. Electronic applications supplied via kiosks are processed, on average, within 5 days of submission. One of the most successful kiosk placements was in a county eligibility office, where their kiosk received immediate and consistent use. New Mexico received a cycle II CHIPRA outreach grant to continue its work modernizing its online application with web-based technology to reduce paperwork, speed processing, and increase overall efficiency. For more information: *http://www.insurekidsnow.gov/professionals/events/2011_conference/new_mexico_human_services_department_insure_new_mexico_enrollment_kioks_508.pdf.pdf*

CONNECTING KIDS TO COVERAGE

The Secretary's Connecting Kids to Coverage Challenge has become the umbrella theme for the national children's health coverage outreach and enrollment campaign. Launched in 2010, Secretary Sebelius called upon leaders in government, community and faith-based organizations, health care providers, schools, and others to identify and enroll all children who are eligible for Medicaid and CHIP, and momentum has continued to build. Sixty-five organizations have formally "stepped up" and more than 261 organizations and individuals are tracking the progress on Challenge.gov.[11]

SCHOOLS: HIGH-LEVEL SUPPORT FOR A LONGSTANDING PARTNERSHIP. Schools can play a central role in the effort to reach out and enroll eligible children in Medicaid and CHIP. In August 2011 HHS Secretary Kathleen Sebelius and Education Secretary Arne Duncan sent a *joint letter* to the nation's Governors urging them to engage school districts in their states to "undertake children's health coverage outreach and enrollment activities when classes begin this fall."[12] The letter suggests promising strategies such as enlisting school athletic coaches to help promote enrollment. To stimulate these efforts, HHS released a strategy guide to states, schools, community

groups, and other stakeholders as part of the *"Get Covered, Get in the Game"* initiative CMS conducted in 2010 with CHIPRA funding. The strategy guide was released in August 2011 and is available on the InsureKidsNow website.[13]

CHIPRA OUTREACH GRANTS: CLOSING THE GAPS. As noted above, CHIPRA and the Affordable Care Act together made a total of $112 million in outreach grant funds available between FFY 2009 and FFY 2013. CMS awarded the first $40 million in grant awards (Cycle I) to 68 grantees across 42 states and the District of Columbia in September 2009. These grants, to states, nonprofit groups, school-based programs and provider organizations, came to a close at the end of September 2011. An evaluation of the Cycle I experience found that in the first year of operation the Cycle I grantees documented that they collectively enrolled or renewed coverage for over 63,000 eligible children. Considering that many of the grantees were new to the task of helping to enroll children in Medicaid and CHIP and all grantees needed to conduct at least some start-up activities (hiring staff, forming partnerships, formulating agreements with state programs to collect data, etc.) these results are encouraging.

The grantees reported lessons learned for establishing meaningful partnerships and employing effective strategies for reaching vulnerable populations. The outreach infrastructure and skill development made possible by the CHIPRA grants will position grantee organizations to continue to assist families beyond the duration of the grant period. Moreover, the grants contributed to the overall progress on children's health coverage achieved in a number of states. For example:

- The Oregon Healthy Kids program has made significant progress on enrolling eligible children in Medicaid and CHIP. Oregon's efforts include a full complement of strategies: simplifying the enrollment process, instituting Express Lane Eligibility procedures, providing support to community application assistors throughout the state and conducting outreach through schools. A CHIPRA Cycle I grant helped to support these efforts. In less than two years the program enrolled over 100,000 eligible children and cut the percentage of uninsured children in half—from 11.3 percent to 5.6 percent.

- Florida Healthy Kids, a Cycle I Outreach Grantee, has spearheaded a statewide effort to engage, train and support 16 local, all volunteer community coalitions covering 30 Florida counties that are focusing on reducing the number of uninsured children. Activities to get eligible children enrolled in Medicaid and CHIP – the Florida KidCare Program – range from school-based activities, working with the children's hospitals, providing one-on-one application assistance to families, partnering with both small and large businesses and enlisting municipal governments in outreach activities. Under a CHIPRA Cycle I grant, such efforts helped obtain and renew coverage for more than 11,000 eligible Florida children.

- A new analysis of the American Community Survey shows that between 2008 and 2010, over 40,000 children have gained health insurance in Colorado. Public coverage programs, including Medicaid and Child Health Plan Plus provide 23.4 percent of all children in Colorado with health insurance coverage. The state has increased income eligibility, and adopted an array of simplified enrollment procedures. These policy choices, combined with outreach, including activities organized by the CHIPRA Cycle I grantee, the Colorado School-Based Health Association have contributed to the increase in enrollment.

CYCLE II OUTREACH AND ENROLLMENT GRANTS. On August 18, 2011, HHS announced the second round of $40 million in grants for efforts to identify and enroll children eligible for Medicaid and CHIP. The two-year grants were awarded to 39 state agencies, community health centers, school-based organizations and non-profit groups in 23 states. The grant amounts range from $200,000 to $2.5 million. Projects emphasize the use of technology and activities aimed at addressing disparities in health coverage. The Cycle II grantees will be conducting projects in the following focus areas:

- Using technology to facilitate enrollment and renewal (approximately $20 million to ten grantees)
- Retaining eligible children in coverage (approximately $3 million to four grantees)
- Engaging schools in outreach, enrollment and renewal activities (approximately $5 million to seven grantees)
- Reaching children who are most likely to experience gaps in coverage (approximately $10 million to fourteen grantees)
- Ensuring eligible teens are enrolled and stay covered (approximately $3 million to four grantees).

A full list of the grantees and a summary of the projects is available on InsureKidsNow.gov.[14]

TRIBAL OUTREACH GRANTS. In April 2010, CMS awarded nearly $10 million in grant funds to 41 Tribal health providers, Indian Health Service providers, and other health providers in urban areas across 19 states. These grants are available for tribal outreach and enrollment efforts for a three-year period.

SPOTLIGHT ON TECHNOLOGY:

Utah–myCase

In August 2011, Utah launched myCase, an easy-to-use website that provides Department of Workforce Services customers with 24/7 access to their case information and creates new avenues for communication with the Medicaid agency. Utah's myCase allows customers to interact with the eligibility system by reporting changes online and completing recertifications. The system can also verify some information electronically, precluding the need for customers to supply paper documentation. Electronic notices are available to customers who "opt in," permitting myCase to alert them that a new notice is waiting on the secure website and enabling them to get the information they need without a mailing delay. As of October 5, 2011, 32,022 customers had elected this service, representing 18 percent of the total caseload. As of that date, the state had sent 176,441 eNotices. Overall, myCase allows the state to increase the speed and accuracy of decisions, reduce manpower and related costs, and improve eligibility process efficiency. For more information: *http://www.insurekidsnow.gov/professionals/events/2011_conference/utah_department_of_workforce_services_mycase_508.pdf.pdf*

2ND NATIONAL CHILDREN'S HEALTH INSURANCE SUMMIT

The *Connecting Kids to Coverage: Second National Children's Health Insurance Summit* held in Chicago from November 1 – 3, 2011 was the seminal event that set our new CHIPRA outreach grantees on the path to meeting their enrollment goals. The Summit focused on sharing strategies and techniques for reaching out, enrolling and retaining eligible children in Medicaid and CHIP. For two and a half days, attendees from all over the country participated in a wide range of substantive workshops and communications skill-building sessions designed to share effective and innovative approaches to outreach and enrollment. Highlights from the Summit include:

RELEASE OF A NEW MEDICAID AND CHIP CONSUMER SURVEY. To understand parents' perceptions of Medicaid and CHIP and the care their children receive once they are enrolled, CMS engaged Lake Research Partners, a respected research firm with longstanding experience on health coverage issues related to low-income individuals. The researchers surveyed 1,936 parents with family incomes below 250 percent of the federal poverty level (FPL), including parents of uninsured children, children with Medicaid or CHIP, and children covered under employer-based insurance.

The results, presented in a new CMS report, *"Parents' Views of CHIP and Medicaid: Snapshot of Findings from a Survey of Low-Income Parents"* found that the programs earned high consumer satisfaction ratings:

- *Parents have positive views:* Seven in ten of the low-income parents surveyed (both those with and without children enrolled) say that Medicaid and CHIP are good programs.
- *The vast majority of parents are happy with coverage and quality of care:* More than nine in ten parents with children covered under Medicaid and CHIP (93 percent) say they are satisfied with the coverage their children receive and that they are satisfied with the quality of care; two-thirds (66 percent) say they are "very satisfied."
- *The majority also finds easy access to care:* Almost nine in ten parents with children covered under Medicaid and CHIP say they are satisfied with the ease of finding a doctor who takes their child's insurance (87 percent) and how quickly they can get an appointment to see a doctor (89 percent). Most are "very satisfied" with these aspects of the program – 62 percent and 57 percent, respectively – but concerns about access to providers like dentists remain a challenge and a priority for CMS.

The survey findings also shed light on the factors that encourage families to enroll their children, the methods parents prefer for completing applications, and the settings in which outreach messages are most likely to be effective.

- *Peace of mind and affordability encourage parents to enroll their children:* Parents say "getting peace of mind" is a very motivating factor for enrolling a child in Medicaid or CHIP (71 percent), Of parents whose children were enrolled in the programs at the time of the survey, 70 percent said finding out that the coverage was something they could afford was also very motivating.
- *The opportunity to enroll online would make parents more likely to apply:* In general, parents say they would be more likely to apply if they could do so online (62 percent). Parents who were Spanish-speaking (58 percent) or who had income below the federal poverty line (56 percent) were somewhat less interested in applying on-line.

- *Parents trust doctors when it comes to advice about signing up.* The majority of parents (57 percent) said they trust doctors "a lot" about whether to enroll their children. Nurses, social workers and other parents with Medicaid and CHIP experience also were trusted by at least 40 percent of parents, in general, with teachers and child care providers also being trusted by at least 40 percent of Spanish-speaking parents.

These and additional survey findings have provided a great deal of insight into how to shape outreach messages and methods to encourage and support families with eligible children.

"WALK IN MY SHOES." Conference participants had an opportunity to experience "Walk in My Shoes" – an engaging activity designed by the national non-profit organization Community Catalyst to provide insight into the challenges confronting uninsured, low-income families seeking health coverage. "Walk in My Shoes" was tailored for the National Children's Health Insurance Summit to reflect the perspectives of families whose children are likely to be eligible for Medicaid and CHIP.

A group of 63 conferees, composed of a mix of state, federal, and non-profit staff, assumed the roles of a family with a specified ethnicity, language, immigration status, set of health problems, employment situation, and insurance coverage. For 60 minutes participants attempted to obtain the health care 'their family' needed. As they visited any of a dozen 'stations,' including state agencies, a health plan, a community health center, private doctors' offices, a pharmacy and the ER, participants gained new perspectives on the barriers families face and the choices they are sometimes compelled to make.

Later, participants joined together for an in-depth discussion of the experience. Participants said they gained a better understanding of the barriers families face and the choices they must sometimes make between being on time for work and making a medical appointment, or between filling a prescription and buying new shoes for their child. Participants shared the frustrations they felt in trying to navigate the system, and related the activity to real-life experiences including their own outreach work.

TECHNOLOGY FAIR. The conference featured CMS's first-ever Children's Health Coverage Technology Fair, in which innovators from across the country highlighted how they are using information technology to break new ground and advance outreach and enrollment efforts. For example, the Michigan Primary Care Association demonstrated its use of 2-1-1 and Google® Maps to target outreach efforts more effectively; the state of New Mexico showcased one of its kiosks that allows families to complete applications online in community settings; and the Healthy Mothers Healthy Babies coalition showcased "text4baby," a

mobile health service that provides public health messages to pregnant women and new mothers via a free text messaging service.

Putting technology to work to enroll and retain eligible children is a particularly important strategy and a priority for the second round of CHIPRA outreach grants, as noted above. The presentations at this technology fair sparked interest about supporting the modernization of eligibility systems and enrollment and renewal procedures to ensure they are efficient, data-driven, and deliver the best customer service possible. The presentations focused on how technology is making systems more efficient and is improving consumer service. The full description of all of the featured *presenters' promising tools* is available on the InsureKidsNow website.

ECHOE HONORS. The National Children's Health Insurance Summit also featured the first presentation of the Excellence in Children's Health Outreach and Enrollment (ECHOE) honors[15] — recognizing 10 individuals or organizations that have displayed leadership and innovation in Medicaid and CHIP outreach, enrollment and retention. The honorees are well known and respected among their peers and each has made a unique contribution toward advancing children's coverage.

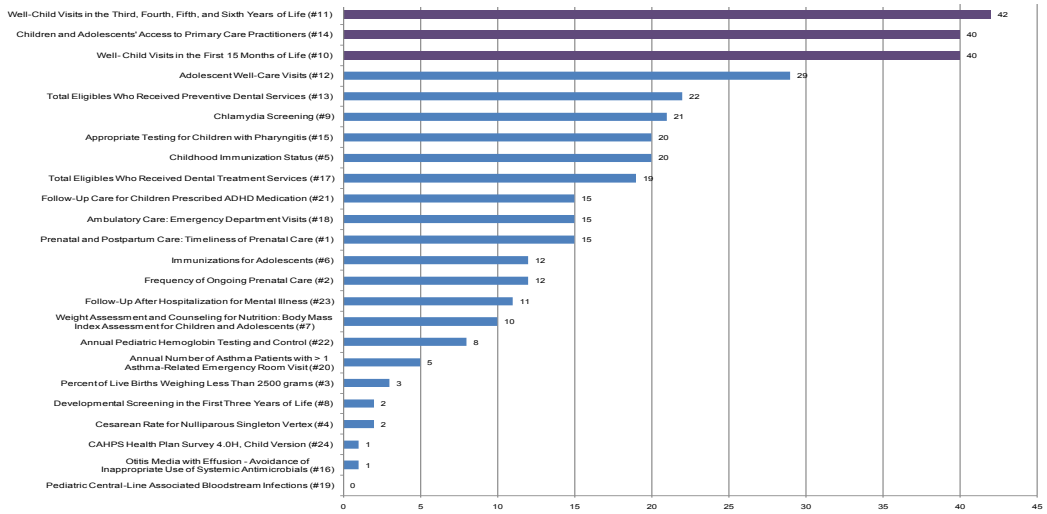
MEDICAID.GOV. Because success in providing health coverage to all eligible uninsured children requires joint focus and collaboration with Medicaid and CHIP, new resources about states' progress with children's coverage are also available on the new CMS website *www.medicaid.gov*, which launched in December 2011. Medicaid.gov provides another opportunity for CMS to drive users to information about children's coverage. In many cases, the site will provide links to the materials on InsureKidsNow, which remains the key policy and consumer resource for children's coverage information and highlighting state and federal activities in this arena.

ACCESS TO QUALITY CARE FOR CHILDREN

While enrolling children in health coverage and keeping them enrolled for as long as they are eligible is a critical priority, perhaps even more important is ensuring that coverage translates into high quality health care that leads to positive health outcomes for all children. 2011 was a banner year for CMS in terms of the process made in assessing the quality of care for children in Medicaid and CHIP. With access to data on comprehensive set of performance measures for children and efforts underway to improve the stability of coverage for children in Medicaid and CHIP, CMS now has a greater capacity to work toward its goal of achieving a first class system of coverage and care for all children.

INITIAL CORE SET OF CHILDREN'S HEALTH CARE QUALITY MEASURES. 2011 served as the first year of voluntary state reporting on the initial core set of 24 children's health care quality measures. The core set, which was identified and finalized by the Secretary of HHS in early 2011, includes measures from domains of care including prevention and health promotion, management of acute and chronic conditions, and family experiences of care. In this first year of reporting, forty-two states and the District of Columbia voluntarily reported one or more of the children's quality measures for FFY 2010 (see Figure 4). The median number of measures reported was 7 and 15 states reported at least half of the measures, reflecting a strong first-year effort by states. Full results on first year of reporting of the core set of children's health care quality measures and other efforts to measures and improve the quality of care provided to children and Medicaid and CHIP can be found in the Secretary's 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP available on Medicaid.gov.[16]

42 STATES AND DC REPORTED 1 OR MORE CHILD HEALTH CARE MEASURES IN FFY 2010



Notes: Measure number in parentheses. Delaware did not submit a CARTS Report for FFY 2010. Arkansas, Hawaii, Idaho, Kansas, Massachusetts, Oregon, and Texas submitted FFY 2010 CARTS Reports, but did not submit data on any of the core CHIPRA quality measures.
Source: Mathematica analysis of FFY 2010 CARTS Reports, as of June 30, 2011.

Figure 4

CMS expects to build on this progress and to see increased state reporting on the core set measures during the upcoming year.

FIRST ANNUAL MEDICAID AND CHIP QUALITY CONFERENCE. In August 2011, CMS convened the first national Medicaid and CHIP Quality Conference, "Improving Care, Lowering Costs" in Baltimore, MD. The conference brought together over 240 representatives from states and stakeholder organizations to share experiences and receive technical assistance on how to collect and use the children's core set of quality measures to drive quality improvement. The Quality Conference opened with a poster session with the CHIPRA Quality Demonstration Grantees, and included sessions on health information technology, collecting data on the children's core quality measures, and improving access to oral health services. For more information about the conference, visit Medicaid.gov.

CHIPRA TECHNICAL ASSISTANCE AND ANALYTIC SUPPORT PROGRAM. To support states' child health care quality measurement and improvement efforts, CMS announced the launch of its CHIPRA Technical Assistance and Analytic Support Program and a contract with Mathematica Policy Research – teamed with the National Committee for Quality Assurance, the Center for Health Care Strategies and the National Initiative for Children's Healthcare Quality – in August 2011. The contract will be a partnership with CMS and states to: (1) provide information and support to states in their effort to uniformly collect, calculate, and report the core measures; (2) ensure that program managers and health care providers use the data collected to inform decisions about policies, programs, and practices to improve quality of care; and (3) share emerging best practices and lessons learned.

CHIPRA QUALITY DEMONSTRATION GRANTS. On February 22, 2010, CMS awarded the first $20 million of a total of $100 million in CHIPRA Quality Demonstration Grants to 10 states: Colorado, Florida, Maine, Maryland, Massachusetts, North Carolina, Oregon, Pennsylvania, South Carolina, and Utah. Projects focusing on four areas are underway and will be conducted over a five-year period and include both single-state projects and multi-state collaborations; 18 states will participate in these projects.

The Grantees are approaching completion of the second year of the grants, and are moving from the planning phase to implementation of their quality improvement projects. In 2012, CMS will have even more opportunities to understand and share how these grants will be used to measure and improve children's health care quality across 18 states. Following are some highlights from the demonstration projects:

- Colorado, in partnership with New Mexico, has begun to form an Interstate Alliance of School-Based Health Centers (SBHCs) to integrate school-based health care into a medical home approach designed to improve the care of underserved school-aged children and adolescents. The states plan to utilize the SBHCs to improve the delivery of care within school settings and to improve screening, preventive services, and management of chronic conditions.

- Maryland, in partnership with Georgia and Wyoming, is focusing on improving the health and social outcomes for children with serious behavioral health needs. The three states have begun to implement or in some cases, expand upon a Care Management Entity (CME) provider model to improve the quality of care and control the cost associated with children with serious behavioral health needs enrolled in Medicaid/CHIP.

- Oregon, in partnership with Alaska and West Virginia, is testing a patient-centered medical home model and will use health information technology to improve the quality of children's health care. The states will also collect the initial core set of quality measures and launch various learning collaboratives focused on oral health and children with special health care needs.

A full summary of all grantee activities can be found in the Secretary's 2011 Annual Report available on Medicaid.gov.[17]

CONCLUSION: LEADERSHIP AND INNOVATION

During the three years since CHIPRA was enacted, the number of uninsured children has continued to decline as states have refined and also augmented their enrollment and renewal practices in ways that truly maximize coverage among eligible children. The lessons learned in states and communities are already being heralded as models for successful implementation of the Affordable Care Act in preparation for the coverage expansions that will take place through Medicaid and the new Affordable Insurance Exchanges beginning in January 2014.

State efforts to improve these programs and the corresponding results show that it is possible to ensure that eligible children are enrolled, but challenges remain. While some states have achieved participation rates above 95 percent in Medicaid and CHIP coverage, a dozen states still have less than 80 percent of eligible children enrolled in these programs, and one state has stopped enrolling

children in CHIP due to State budget constraints. States in all regions of the country and with very different systems of coverage have all made progress in recent years, evidence that augmented and targeted efforts can bring any state to the tipping point where a culture of coverage for all eligible children can be achieved. Partnerships and the ongoing commitment to innovation at the federal, state and community level will continue to be critical to achieving the goal of ensuring that adults and children alike are enrolled in the health coverage that best suits their needs.

APPENDICES

Appendice 1: CHIPRA Performance Bonus History (FFY 2009 – FY 2011) Chart

Appendice 2: FFY 2011 Children's Enrollment in Medicaid and CHIP by state

Appendix 3: Children's Health Coverage Upper Income Limits

APPENDIX 1:
CHIPRA PERFORMANCE BONUSES: A HISTORY
(FY 2009—FY 2011)

State	FY 2009 Bonus Payment Amount (if applicable)	Enrollment	FY 2010 Bonus Payment Amount (if applicable)	Enrollment	"FY 2011 Bonus Payment	Enrollment
		Tier 2 Enrollment Reached in 2009?		Tier 2 Enrollment Reached in 2010?		Tier 2 Enrollment Reached in 2011?
AL	**$1,468,033	No	**$5,687,952	No	$19.768,656	Yes
AK	$707,253	No	$4,913,942	Yes	$5,660,544	Yes
CO	n/a	No	$18,203,273	Yes	$26,141,052	Yes
CT	n/a		n/a		$5,209,262	No
GA	n/a		n/a		$4,965,887	No
ID	n/a		$876,171	No	$1,302,552	No
IL	$9,460,312	No	$15,325,041	No	$15,069,869	No
IA	n/a	No	$7,702,644	Yes	$9,575,525	Yes
KS	$1,220,479	No	$5,461,248	No	$5,862,957	Yes
LA	$1,548,387	No	$3,661,104	No	$1,929,692	No
MD	n/a	No	$11,445,344	Yes	$28,301,384	Yes
MI	$4,721,855	No	$8,436,607	No	$5,902,731	No
MT	n/a		n/a		$6,473,416	Yes
NJ	$3,131,195	No	$8,765,386	No	$16,822,537	Yes
NM	$5,365,601	Yes	$8,967,885	Yes	$4,971,028	Yes
NC	n/a		n/a		$21,135,087	Yes
ND	n/a		n/a		$3,195,768	Yes
OH	n/a		$13,127,633	No	$21,036,616	Yes
OR	$1,602,692	No	$10,567,238	Yes	$22,493,771	Yes
SC	n/a		n/a		$2,383,837	No
VA	n/a		n/a		$26,729,489	Yes
WA	$7,861,411	No	$20,649,662	Yes	$16,987,468	Yes
WI	n/a		$23,432,822	Yes	$24,541,778	Yes
Total	**$37,087,218**	**1**	**$167,223,952**	**8**	**$296,450,906**	**16**

Performance Bonus amounts are subject to change based on revised or corrected data from States.

* Note that some FY 2009 and FY 2010 performance bonus amounts have been revised based on final enrollment figures.

** A preliminary audit conducted jointly by CMS and the State of Alabama revealed an error in the monthly average unduplicated qualifying children included in the State's original Performance Bonus application for FY 2009. The error in calculation was carried over to FY 2010, which resulted in Alabama's bonus amount being inflated for those two years. Alabama is verifying other aspects of its MSIS data to ensure accuracy; therefore, the bonus amounts may be adjusted at the conclusion of this analysis.

APPENDIX 2:
FY 2011 NUMBER OF CHILDREN EVER ENROLLED IN MEDICAID AND CHIP

State and Program Type	Number of Children Ever Enrolled by Program Type						Percent Growth over 2010
	CHIP		Medicaid		CHIP and Medicaid		
	FY 2010	FY 2011	FY 2010	FY 2011	FY 2010	FY 2011	
Alabama (S)	100,530	109,255	846,766	866,094	947,296	975,349	3.0%
Alaska (M)	12,614	12,787	78,894	79,286	91,508	92,073	0.6%
Arizona (S)	39,589	20,043	951,092	946,977	990,681	967,020	-2.4%
Arkansas (C)	100,770	103,693	404,307	410,602	505,077	514,295	1.8%
California (C)	1,731,605	1,763,831	4,457,183	4,565,016	6,188,788	6,328,847	2.3%
Colorado (S)	106,643	105,255	424,271	453,719	530,914	558,974	5.3%
Connecticut (S)	21,033	20,072	282,100	301,545	303,133	321,617	6.1%
Delaware (C)	12,852	15,348	83,857	93,598	96,709	108,946	12.7%
District of Columbia (M)	8,100	8,675	89,402	106,500	97,502	115,175	18.1%
Florida (C)	403,349	431,717	1,915,980	2,019,075	2,319,329	2,450,792	5.7%
Georgia (S)	248,268	248,536	1,098,937	1,168,338	1,347,205	1,416,874	5.2%
Hawaii (M)	27,256	30,584	114,736	140,150	141,992	170,734	20.2%
Idaho (C)	42,208	42,604	169,216	178,249	211,424	220,853	4.5%
Illinois (C)	329,104	336,885	2,080,461	2,178,950	2,409,565	2,515,835	4.4%
Indiana (C)	144,178	158,138	685,966	698,383	830,144	856,521	3.2%
Iowa (C)	63,985	75,133	293,103	306,158	357,088	381,291	6.8%
Kansas (S)	56,384	60,431	201,038	215,703	257,422	276,134	7.3%
Kentucky (C)	79,380	84,551	471,940	478,670	551,320	563,221	2.2%
Louisiana (C)	157,012	152,404	662,861	671,651	819,873	824,055	0.5%
Maine (C)*	32,994	32,994	142,931	142,931	175,925	175,925	0.0%
Maryland (M)	118,944	119,906	437,840	465,409	556,784	585,315	5.1%
Massachusetts (C)	142,279	144,767	488,191	500,534	630,470	645,301	2.4%
Michigan (C)	69,796	83,004	1,188,936	1,205,449	1,258,732	1,288,453	2.4%
Minnesota (C)	5,164	4,461	482,352	495,509	487,516	499,970	2.6%
Mississippi (S)	89,942	91,470	451,809	468,183	541,751	559,653	3.3%
Missouri (C)	91,376	96,014	558,056	566,293	649,432	662,307	2.0%
Montana (C)	25,231	24,365	70,175	76,514	95,406	100,879	5.7%
Nebraska (M)	47,922	52,852	164,435	166,277	212,357	219,129	3.2%
Nevada (S)	31,554	29,760	212,426	236,360	243,980	266,120	9.1%
New Hampshire (C)	10,630	10,801	94,531	96,625	105,161	107,426	2.2%
New Jersey (C)	187,211	198,283	617,895	639,764	805,106	838,047	4.1%
New Mexico (M)	9,654	9,635	372,989	380,373	382,643	390,008	1.9%
New York (S)	539,614	552,068	2,080,412	2,124,322	2,620,026	2,676,390	2.2%
North Carolina (C)	253,892	254,460	1,243,785	1,194,999	1,497,677	1,449,459	-3.2%
North Dakota (C)	6,657	7,112	48,112	48,486	54,769	55,598	1.5%
Ohio (M)	253,711	280,650	1,150,356	1,214,287	1,404,067	1,494,937	6.5%
Oklahoma (C)	122,874	120,501	477,181	507,378	600,055	627,879	4.6%
Oregon (S)	93,366	112,165	352,718	385,131	446,084	497,296	11.5%
Pennsylvania (S)	273,221	272,492	1,228,017	1,300,042	1,501,238	1,572,534	4.7%
Rhode Island (C)	23,253	24,815	108,321	110,208	131,574	135,023	2.6%
South Carolina (C)	73,438	72,084	485,322	501,025	558,760	573,109	2.6%
South Dakota (C)	15,872	16,623	46,994	47,469	62,866	64,092	2.0%
Tennessee (C)	89,302	96,028	781,567	792,302	870,869	888,330	2.0%
Texas (S)	928,483	972,715	3,279,846	3,471,310	4,208,329	4,444,025	5.6%
Utah (S)	62,071	59,698	237,125	247,298	299,196	306,996	2.6%
Vermont (S)	7,026	7,054	72,891	72,826	79,917	79,880	0.0%
Virginia (C)	173,515	182,128	603,166	625,438	776,681	807,566	4.0%
Washington (S)	35,894	43,364	705,950	764,662	741,844	808,026	8.9%
West Virginia (S)	37,539	37,631	247,953	249,203	285,492	286,834	0.5%
Wisconsin (C)	161,469	172,451	520,003	537,093	681,472	709,544	4.1%
Wyoming (S)	8,342	8,586	58,277	59,142	66,619	67,728	1.7%
TOTALS	**7,707,096**	**7,970,879**	**34,322,672**	**35,571,506**	**42,029,768**	**43,542,385**	**3.6%**

S – Separate child health programs. M – Medicaid expansion programs. C – Combination programs. NR – Not Reported.

Data Source – CHIP Statistical Enrollment Data System (SEDS) forms CMS-21E, CMS-64.21E, CMS-64.EC (2/1/12)
Data are reported by individual States and are representative of children ever-enrolled in Medicaid and CHIP as of February 1, 2012. States may subsequently revise their current and/or historical data. *Data for Maine for FY 2011 are represented as data from FY 2010 due to technical issues present at time of publication of this document.

APPENDIX 3: CHILDREN'S HEALTH COVERAGE UPPER INCOME LIMITS

All figures based on the 2012 federal poverty level for a family of four ($23,050); 200 percent of the FPL for a family of four is $46,100; 250 percent of the FPL for a family of four is $57,625; 300 percent of the FPL for a family of four is $69,150.

Note: Alaska's FPL for a family of four is $28,820 and Hawaii's FPL for a family of four is $26,510.

STATE	% FPL
Alabama	300%
Alaska	175%
Arizona	200%
Arkansas	200%
California	300%
Colorado	250%
Connecticut	300%
Delaware	200%
District of Columbia	300%
Florida	200%
Georgia	235%
Hawaii*	300%
Idaho	185%
Illinois	200%
Indiana	300%
Iowa	300%
Kansas	241%
Kentucky	200%
Louisiana	250%
Maine	200%
Maryland	300%
Massachusetts	300%
Michigan	200%
Minnesota	275%
Mississippi	200%

STATE	% FPL
Missouri	300%
Montana	250%
Nebraska	200%
Nevada	200%
New Hampshire	300%
New Jersey	350%
New Mexico	235%
North Dakota	160%
Ohio	300%
Oklahoma	300%
Oregon	300%
Peurto Rico	<200%
Pennsylvania	300%
Rhode Island	250%
South Carolina	200%
South Dakota	200%
Tennessee	250%
Texas	200%
Utah	200%
Vermont	300%
Virginia	200%
Virgin Islands	<200%
Washington	300%
West Virginia	300%
Wisconsin	300%
Wyoming	200%

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