

I. Project Purpose

The Problem: In Massachusetts, as in other states, a principal barrier to timely, consistent health care for low- and moderate-income residents is the amount of time it takes to enroll in MassHealth—Massachusetts' Medicaid and SCHIP program that covers over 926,000 residents.¹ It currently takes an average of four to six weeks from the time a paper application is mailed to MassHealth to the time applicants are informed via postal mail that they are eligible and covered.² If the outreach workers (OWs) who help them apply don't know about recent procedural or eligibility changes, or submit erroneous data on behalf of their clients, the time lag can increase. This delay in access to care can do serious harm to the health of clients and their families; it can also have devastating financial consequences.

In 2003, 28% of uninsured Massachusetts residents reported delaying or forgoing care due to cost.³ During the weeks in which clients don't know whether they are eligible for MassHealth, they will likely delay getting care for themselves or their families until they are sure of their coverage status. This delay can have life-threatening consequences: those waiting may forgo preventative health care such as immunizations for children, treatment for pre-existing conditions like diabetes, or may become sick or injured and go without treatment.⁴ The delay can also take a serious financial toll. Employed family members may lose workdays or their jobs due to an untreated illness or injury. Or they may go to the doctor anyway, running up bills they cannot afford to repay that may not be covered retroactively by insurance. Unpaid health care bills are a leading cause of bankruptcy in America.⁵ The time lag between application and receipt of care may be even longer than the four-to-six-week application wait period; clients who find they are *not* eligible for MassHealth must endure another waiting period when their OWs help them apply to other programs in the patchwork system of alternative resources for the uninsured.

These delays in securing coverage also affect the state. If a sick person becomes sicker while uninsured, the cost of future care will be higher. Uninsured residents will often seek services covered by the state's Uncompensated Care Pool in the Emergency Room; this is far more costly to the state than primary and preventative care services offered by practitioners who participate in the state's Medicaid program.⁶

Our Communities. Many of Western Massachusetts' 26,000 uninsured residents⁷ apply for MassHealth and other coverage and care programs through outreach workers in community-based health access programs. OWs offer vital guidance; the application processes are very confusing, time-consuming, and off-putting, even to well-educated clients.⁸ Eligibility requirements and application procedures are complex and constantly changing.⁹ OWs must stay continually informed of changes in the MassHealth program and in the availability of services through other avenues. Any missing piece of knowledge may delay enrollment processing.¹⁰

Most enrollment assistance happens in OWs' offices, often located in community hospitals or health centers. But in the most rural communities of western Massachusetts, OWs must leave their offices to reach people who need coverage most: people without transportation or phones, homeless people, migrant workers in the fields, people with inflexible work schedules, and people too sick to leave their homes.¹¹ The recent economic downturn has left OWs with less time to do a more challenging job. Increased unemployment has led to an increase in uninsured clients¹² just as many health access programs have had to lay off OWs or cut their hours. State budget cuts have forced early retirements among state agency workers, so there are fewer state employees to answer OWs' questions and process paper applications.¹³ (For more about our region, see Appendix F, p. 17.)

The Solution: The Portable Electronic Enrollment Project (PEEP)—a three-year pilot program in rural western Massachusetts—will give OWs portable access to the Internet. This will enable OWs to conduct streamlined electronic screening and enrollment for MassHealth and alternative programs, and to access updated information and peer technical assistance, *while in the field with clients*. PEEP will increase OWs' efficiency and effectiveness so they can secure coverage and care faster and more successfully for their clients, **reducing the potentially dangerous time lag between application and receipt of care**. PEEP will help OWs enroll residents who are eligible for MassHealth and *find alternative resources for ineligible residents*. (See Appendix E, p. 16.)

PEEP will equip each of seven outreach workers from six sites in rural western Massachusetts with: a PC Tablet; the hardware and software to access the Internet in the field; a license for RealBenefits (Massachusetts' new online screening and enrollment application for MassHealth); a handheld scanner; and Community Partners' health access web site. CP's health access site—developed with OWs and designed for use in the field—will be a quickly-accessible, centralized source of timely, accurate information on MassHealth and alternative programs. It will also offer message boards and email forums that will help OWs connect with their peers. CP is the process of planning this site and expects to launch it within the first four months of PEEP. (Please see Appendix O for more details.) PEEP will also provide OWs with training as needed in the use of the PC Tablets, portable handheld scanners, RealBenefits, and CP's web and email resources.

The seven outreach workers selected for the PEEP pilot currently serve approximately 3000 clients per year (See *User Group*, p 5.).¹⁴ They will continue seeing clients where they do now: in their offices, in clients' homes, at hospital bedsides, in libraries and community settings, and on farms. Rather than interviewing clients and filling out paper forms on their behalf, OWs will: (1) use their PC Tablets to connect to the Internet through a wireless cellular modem or wi-fi broadband connection, or a dialup landline modem where wireless access is not available (see Appendix O, p. 28). (2) Their browsers' homepages will be set to Community Partners' health access website. There they will check for MassHealth procedural and eligibility updates. This ability to check for contextual information *while in the field with their clients* is key, as it is often a lack of knowledge about MassHealth program changes that delays applications and coverage. (3) Once updated, OWs will click from Community Partners' site directly to RealBenefits—Massachusetts' new online screening and enrollment application for MassHealth—and log in. The RealBenefits site will walk OWs through the application process. OWs will interview their clients and enter their information into the online form using either a stylus or a keyboard. (4) Likely eligibility for coverage is determined immediately by RealBenefits. The next steps depend on clients' MassHealth eligibility status.

Eligible Residents. If RealBenefits confirms a client's likely eligibility for MassHealth, the client's information will be instantly and automatically transmitted into the MassHealth database, eliminating the need for time-consuming data entry by the state. The application will immediately be queued for electronic determination of coverage and notice of eligibility or denial. The application will immediately be date-stamped; an earlier date-stamp means retroactive coverage starts sooner for eligible clients. The OW will receive instantaneous confirmation of the submission. Instead of obtaining necessary income verification documents from clients (pay stubs, court orders, identification cards, etc.) and driving them back to their offices for photocopying—a process that further delays applications—OWs will be able to use portable handheld scanners to capture document images. The electronic images can be immediately downloaded onto the PC Tablets via a USB cable and can be sent to the state while OWs are still in the field with clients.

Electronic submission will shorten clients' wait time from several weeks to a few days, dramatically decreasing the time lag between application and receipt of care.

Ineligible Residents. When applicants are determined ineligible for MassHealth, the OW will click back to Community Partners' health access website. The site will be a central source of resources for connecting ineligible clients to needed care, including: information and tools for applying for alternative state- or privately-funded coverage programs; information on accessing community or free resources; and forms for obtaining immediate services, such as emergency prescriptions. OWs will be able to use CP's message boards and email lists to get technical assistance from peers, ask questions, or seek follow-up for particular care needs. Again, the ability to connect to CP's health access website *while in the field, still with their clients*, will help OW's connect their clients to these alternatives more quickly.

Finally, OWs will ask their clients to fill out a short, voluntary exit survey on the PC Tablet via CP's website at the close of each enrollment transaction. The survey will allow clients to share their opinions of the enrollment experience, and offer their contact information if they wish to participate in future follow-up surveys.

Outcomes: The primary aim of the Portable Electronic Enrollment Project is to **reduce the time lag between application and receipt of care** for rural western Massachusetts residents by helping OWs be more efficient and effective, enroll more eligible residents in MassHealth in less time, and help more ineligible clients find other health coverage and care resources more quickly and successfully. Throughout the life of the project we will engage an evaluator to assess measurable outcomes for the two groups involved in meeting this aim: outreach workers (the end-users) and their clients (the beneficiaries). Please see Appendix L, p. 24-25.

1. RESIDENTS/CLIENTS

a. Fewer Days to Coverage and Care. ELIGIBLE RESIDENTS served by participating OWs will receive MassHealth coverage more quickly.¹⁵ The ability to check for contextual information via CP's health access website *while in the field with their clients* is key, as a lack of knowledge about MassHealth program changes often delays applications and coverage. INELIGIBLE RESIDENTS: Because likely ineligibility will also be determined upon screening, ineligible clients can start working with their OWs *immediately* to find alternative coverage and care options. OWs' ability to connect to CP's health access website *while in the field, still with their clients*, will help them connect clients to programs more quickly.

b. More People Served. A greater number of people will get coverage and care faster. More will enroll in MassHealth, or find alternatives to MassHealth if ineligible.

c. Improved Enrollment Experience. We anticipate that clients will have an improved opinion of and feel less daunted by the state's Medicaid/SCHIP application process because it will be made quicker and more accessible.¹⁶

2. OUTREACH WORKERS

a. Increased Efficiency. The streamlined screening/application process, combined with immediate access to updates, forms, and information, will enable OWs to serve more clients better in less time.¹⁷ They will be able to do all application work—as well as document collection and submission—electronically in one sitting, saving much follow-up time.

b. Increased Effectiveness. Outreach workers will be able to serve their clients more effectively because they will have portable, immediate access to information and forms for MassHealth and alternative coverage and care resources in the field. They will also be able to consult with peers

about complex cases via email and online message boards.

c. More Accurate and Readily Available Data. Outreach workers will have a single piece of hardware—the PC Tablet—on which they will collect their data in the field and work in their offices, leading to better data integration, more accurate data, and fewer errors in the application process.¹⁸ The Tablet will also allow OWs to offer follow-up support to clients more easily, as they will have their data with them at all times. This consolidation of data will also improve OWs' ability to report their service statistics (number of people served, nature of transactions, etc.) to their funders and/or parent organizations.

d. Improved Adaptability in a Changing Work Environment. Massachusetts is like other states¹⁹ in that its health and human service systems are increasingly moving toward electronic, Internet-based interfaces.²⁰ PEEP will provide participating OWs with training and skills to increase their ability to use the Internet and other new technologies. This will help them to stay on the leading edge of the workforce and to assist their peers in regions that are underserved by job training programs, have high levels of unemployment and few new job opportunities, and where the work of outreach workers is especially needed.

2. Innovation

There is a distinct national trend toward electronic enrollment for health and human service programs: several states are in the process of implementing electronic systems.²¹ Only one state we know of, however, has combined electronic enrollment with wireless mobility. In April 2004, we spoke with the California Health Care Foundation (CHCF) about Health-e-app, their online Medicaid and SCHIP application for children and pregnant women.²² In December 2002, CHCF partnered with California wi-fi provider Ricochet Networks to conduct mobile enrollment in San Diego using Health-e-app. OWs screened and enrolled children and pregnant women in malls and at Little League games. CHCF reported that the streamlined enrollment process reduced the time lag in receipt of coverage, made applying easier and more accessible, reduced enrollment transaction time and the number of data errors, and improved clients' opinions of the application process.²³ CHCF was not and is not focused on mobile enrollment; they stopped tracking portable enrollment in 2003 after financial problems at Ricochet caused wi-fi service to become unreliable. CHCF has no plans at this time to focus on supporting mobile enrollment.²⁴ As of this writing, we know of no mobile enrollment programs being planned or conducted in the U.S.

The proposed Portable Electronic Enrollment Project differs from CHCF mobile enrollment activities in five areas of innovation and sustainability. First, PEEP will equip outreach workers with the potential to do mobile screening and enrollment for *all Massachusetts residents*. Second, PEEP will increase the likelihood of connecting residents to care faster, *whether they are eligible for Medicaid/SCHIP or not*. Because PEEP integrates mobile screening and enrollment with access to a consolidated knowledge base via CP's health access website, OWs will be able to access essential resources in the field. Third, to promote sustainability the PC Tablets will be able to connect to the Internet in three ways, rather than depending on one type of connection or vendor: cellular wireless (works where there is cell phone coverage; only stable, major vendors will be used), wi-fi (wi-fi is available in hospitals and other public places; hotspots are increasing in rural regions), and a dialup landline modem for areas with holes in wireless coverage. CHCF reported that the Health-e-app was too graphics-heavy to be accessed using a landline dialup modem, but CP has determined that our health access website and RealBenefits are fully accessible over a 56K landline connection. Please see Appendix O, p. 28.

Fourth, PEEP OWs will use portable handheld scanners to capture images of necessary docu-

ments (pay stubs, birth certificates, identification cards, etc.) so they can be sent electronically during the enrollment transaction, reducing follow-up time. Finally, to promote sustainability and expandability, we are choosing PC Tablets instead of notebooks because of their superior portability and versatility. Why PC Tablets? See page 6.

3. Community Involvement

Partnerships. Community Partners will engage nine other organizations as partners in the Portable Electronic Enrollment Project; each is legally unaffiliated with the others. For a list of PEEP Partner Organizations, see Appendix H, p. 19.

User Group. Six of the partner organizations will be directly involved in the activities of PEEP. These organizations were chosen for the PEEP pilot because they are the primary health access providers for the most rural areas of western Massachusetts; all are not-for-profit organizations. Seven OWs from these organizations will use portable electronic enrollment to help clients get coverage and care. All seven will meet quarterly with appropriate CP staff as the PEEP User Group to discuss implementation issues and lessons learned. CP has long-term, ongoing, collaborative relationships with all six of the User Group partner organizations. All six partner organizations have been consistently represented at CP's monthly health access meetings, four of the organizations since 1998 (see Appendix J, p. 21 for more details). User Group members conduct their work in a broad variety of settings and serve a diverse range of clients. One OW does outreach to migrant workers in farm fields; another serves clients in the substance abuse and mental health units of the regional hospital; another goes from bed to bed seeing in-patients at a community hospital. Several travel to screen and enroll seniors, homeless people, and recent Latino immigrants in their communities.

The long-term, strong relationships Community Partners has with User Group partners have given us a broad and deep understanding of the challenges they face, and we have solicited feedback from them throughout the development of the PEEP model. CP conducted a comprehensive Key Informant phone interview—developed with input from proposed PEEP evaluator Summit Collaborative—with outreach staff from User Group partner organizations in April 2004. OWs responses to this interview, in addition to previous ongoing discussions, have been central to the design of the PEEP model (see Appendix B, p. 10-13). CP and Summit Collaborative will develop similar feedback tools to deploy at different points over the course of the project.

Advisory Group. The other three organizational partners offer their expertise about state-level systems and issues to the project. These organizations include Community Catalyst, the national health access non-profit that offers RealBenefits in Massachusetts; the Massachusetts State Medicaid agency (oversees the MassHealth program); and Whalley Computer Associates, a large, locally-based private computer and wireless consultant and retailer. We have worked with Whalley since 1999, and they have existing contractual relationships with several public sector entities in our communities including public schools, police departments, and municipalities. Representatives from these three organizations, along with representatives from the six User Group organizations and appropriate CP staff, will meet semi-annually as an Advisory Group to offer guidance, discuss sustainability and institutionalization of the project, and consider strategies for disseminating lessons learned to interested state and national parties.

Support for End Users. Whalley Computer Associates will provide two PC Tablet and Internet mobile connectivity trainings for OWs in Year 1 (Appendix S, p. 35). Community Catalyst will provide an initial training on the RealBenefits program, annual follow-up trainings, and will be available for one-on-one training as needed (Appendix R, p. 34). CP's Technology Manager will

provide training on the use of CP's health access website, handheld scanners, as well as ongoing support for use of PC Tablets, scanners, and mobile connectivity.

Stakeholder Involvement. Since 1998, CP has been holding monthly health access meetings in western Massachusetts, resulting in an ongoing six-year conversation with OWs, state agencies, advocates, and other health access stakeholders about OWs' needs. The Portable Electronic Enrollment Project is a natural outgrowth of this conversation, addressing OWs' most consistently articulated needs.²⁵ All PEEP User Group organizations, as well as the state Medicaid agency and RealBenefits provider Community Catalyst, are long-term, active members of our health access network. We expect those relationships to continue during and after the grant, ensuring continued collaboration and involvement from PEEP participants.

Demonstrating Sustained Commitment. Community Partners has an excellent record of developing model health access programs with partner community organizations and of achieving long-term sustainability, integration, and involvement. (For a brief history, see Appendix D, p. 15.) Again, because the PEEP participants attend monthly health access meetings in which collaboration about best practices—including online enrollment—is ongoing, we expect that to continue throughout the grant period and beyond.

4. Evaluation

Evaluation Strategy. We will focus on answering important questions about the use of mobile and wireless technology to improve the timeliness of health coverage and care. During the startup phase, PEEP partners will work with CP and our evaluator, Summit Collaborative, to refine tracking tools. Next, OWs will collect data for a three-month baseline period (months 4 to 6 of Year 1) before actual portable electronic enrollment begins (see Appendix G, p. 18). During both the startup and implementation periods of the project, we will use a combination of quantitative methods (i.e., numbers and timeliness of enrollments and program connections, statistics tracking the use of the CP website), and qualitative methods (i.e., interviews with workers and clients, follow-up surveys) to answer evaluation questions.

Evaluation Questions. Please see the PEEP Logic Model, Appendix L, p. 24-25.

Data Collection, Analysis Plans, Final Evaluation Report, Funds for Evaluation, Evaluator. Please see the PEEP Evaluation Plan, Appendix K, p. 22-23.

5. Project Feasibility

Technical Approach. Why PC Tablets? We have chosen to use PC Tablets instead of notebooks because of their versatility and portability. While they are similar in price, PC Tablets can be used for note-taking, accessing the web, and filling out forms both as a tablet with a stylus (much like a large, powerful handheld PDA), or as a notebook with a keyboard. The state's websites and other web resources are not yet formatted to be easily viewed on a PDA screen. PC Tablets offer many of the advantages of a PDA but with a full-sized screen: users can jot notes and input data with a stylus (RealBenefits' form can be easily completed with a stylus); they have easy-to-access data ports (for scanner data); they are well-designed for wireless Internet use; and they are lighter, and more compact and portable than many notebooks. (Please see Appendix O, p. 29.)

Connecting in the Field. OWs participating in PEEP will be trained to connect to the Internet using the service(s) that provide(s) the best coverage in their region: cellular wireless connection (we will use a combination of the region's largest cellular providers to achieve the best coverage in each area) or wi-fi. In extremely rural areas where coverage is currently partial or unavailable, OWs can connect via a landline dialup modem from phone jacks in clients' homes or community

sites (see Appendix O, p. 28). We expect holes in wireless broadband coverage to shrink over the three-year project, as cellular vendors and wi-fi solutions are aggressively expanding in those areas (see Appendix O).

Expanding the Model. Community Partners is well positioned to expand the PEEP program model statewide and make it sustainable beyond the three-year pilot period. As described below, we support a strong statewide network of health access stakeholders. The seven PEEP OWs are involved in our monthly health access meetings and will help spread the portable enrollment model throughout western Massachusetts, and we have both statewide and regional partners whom we will engage to expand the program model to other parts of the state. We expect that several of the PEEP OWs may be willing to help train others in the next, post-TOP generation of the project. The Office of Medicaid is a project partner and we will have strong relationships in place to help us institutionalize PEEP into state government systems.

Applicant Qualifications. Community Partners has been developing and disseminating collaborative program models for 19 years. Since 1997, we've coordinated two federal grants that developed model community-based health access programs (see Appendix D, p. 15).

Our Statewide Network. For six years Community Partners has been facilitating a statewide network of 600 health access stakeholders, including outreach workers, health care advocates, and state agency employees. From 1998 to 2003 we held 60 monthly meetings *per year* in six regions throughout Massachusetts. Through these physical meetings, postal mailings, email bulletins, and our website, we promote the exchange of information and peer networking, and provide regular updates to network participants. Over the past six years, our network members have come to depend on us as a trusted source of information and support.

Technology Planning. Over the last two years, budget cuts have made it increasingly difficult for network members to attend physical meetings. But members still need the information and look to CP to provide it. To solve this problem we have increased our use of the Internet to disseminate updates and information. CP has already begun the planning, developing, and increasing our email and web presence with a strategic technology consultant—proposed PEEP evaluator Summit Collaborative—and we redesigned our organizational website in early 2004. We have included planning for a health access website in this process and are well positioned to launch it within the first four months of PEEP (see Appendix O, p. 28). Visits to our organizational website (www.compartners.org) have nearly doubled in the last year, from an average of 850 visits per month last year to an average of 1600 visits per month since January 2004.²⁶

Staff & Partners. Community Partners has five full-time staff members onsite; all will be involved in running PEEP. Anne Rosen, CP's Health Access Programs Coordinator, will be the Project Manager for PEEP. She will maintain weekly communication with PEEP participants, manage incoming data, and work with Summit Collaborative to coordinate ongoing and final evaluations. Johanna Bates, CP's Technology Manager, will oversee technology-related aspects of PEEP, including development and maintenance of the health access website, implementation of hardware and software, and ongoing technology training and support for PEEP participants. The project will also be supported by Michael DeChiara, CP's Executive Director; Carol Lewis, Finance and Administrative Director; and Jeanine Abarno, Health Access Programs Assistant.

The PEEP User Group will be made up of seven staff members from six sites as follows: (1) Community Health Center of Franklin County, Turners Falls; (2) Hilltown Community Health Centers, Worthington and Huntington; (3) Community Health Center of the Berkshires, Great

Barrington; (4) Hampshire Health Connect, Cooley-Dickinson Hospital, Northampton; (5) Advocacy for Access, Berkshire Medical Center, Pittsfield and Great Barrington; (6) Healthy Connections, Franklin Community Action Corporation, Athol. The Advisory Group will include representatives from User Group organizations, plus the Massachusetts Office of Medicaid, Community Catalyst (RealBenefits), and Whalley Computer Associates. (See Appendices H; J; P-S).

Project Implementation and Completion. Please see the PEEP Timeline, Appendix G, p 18.

Privacy and Security. All data collected through RealBenefits' website will be protected in transit over the Internet and on their server by RealBenefits' security safeguards (see Appendix O, p. 28). Data gathered from clients by OWs will be treated by their host organizations—like all client records—in a HIPAA-compliant manner. Statistics and data reported to CP for PEEP will be anonymous, with each individual assigned a unique identifier. Clients may *voluntarily* identify themselves and provide contact information for follow-up surveys for evaluation purposes through the exit interviews. *All data collected by CP will be used solely for the purposes of evaluating the Portable Electronic Enrollment Project.*

Sustainability. PEEP partners in western Massachusetts have worked for years to improve health care access, sharing the collaborative framework of CP's health access network. CP expects User Group partners will be willing to integrate certain functions and costs of PEEP into their organizations as improved ways of doing business: PEEP costs will only be a small percentage of their total cost of doing business, and by 2006 online electronic enrollment will likely be the state norm. Elsewhere in the state, many other members of our network have long-standing interests in improving care and coverage; as the lessons learned from PEEP are disseminated, we expect statewide interest in expanding the model. The Massachusetts Office of Medicaid is actively developing online electronic enrollment for Medicaid/SCHIP, and will likely support certain PEEP key functions and costs beyond the grant period. CP will explore opportunities for transitional funding for the User Group organizations with Massachusetts health care funders as it has done with past model programs (see Appendix D, p. 15). When portable electronic screening and enrollment activities and costs are successfully absorbed by partner organizations and the state, CP's role and PEEP-related operational costs will diminish. Our remaining responsibility will be to maintain and continue to improve our health access website.

Dissemination. As Community Partners has successfully done with past health access program models (see Appendix D), we will share information from PEEP with Massachusetts state officials, other states, and key national organizations. Information will be disseminated throughout the project; the bulk of dissemination will occur in Year 3. Activities will include:

- Creation of PEEP practical tools and summaries of lessons learned for OWs and/or organizations interested in the PEEP practices; dissemination: free download from CP's health access website, as well as hardcopy via postal mail (free of charge as is reasonable).
- Presentations at relevant health access and community-oriented technology conferences to share the model and lessons learned; we will request presentations at the New England Rural Health Roundtable (Oct. 2005), Families USA (Jan. 2006), and the Nonprofit Technology Enterprise Network (N-TEN - Mar. 2006).
- Fielding of phone/email inquiries from interested parties in Massachusetts and other states; we will share information and materials free of charge as is reasonable.
- Distribution of interim and final evaluator reports to key people interested in the issue of portable electronic enrollment, both in Massachusetts and nationally.

¹ "Enrollment for Selected Public Assistance Programs in Massachusetts" Health Care For All Feb. 2004

² See Key Informant Interview (p. 1), Appendix B, p. x.

³ Carol Pryor and Deborah Gurewich. "Getting Care But Paying the Price: How Medical Debt Leaves Many in Massachusetts Facing Tough Choices." The Access Project: Boston, February 2004, p. 5. See also Key Informant Interview (pp 1, 4), Appendix B, p. x.

Deleted: "The Uninsured: A Primer" Kaiser Commission on Medicaid and the Uninsured. December 2003 p. 1.

⁴ Research has repeatedly shown that people without health care coverage are more likely to be diagnosed in the late-stages of disease and are hospitalized for health problems that could have been avoided had they had access to preventative care. From "The Uninsured: A Primer" Kaiser Commission on Medicaid and the Uninsured. December 2003 p. 5.

⁵ Time. May 15th 2000. p. 64.

⁶ According to a 1996 New England Journal of Medicine article, "The Costs of Visits to Emergency Departments," the national average cost for an Emergency Room visit is \$383; a 2001 report from the American Medical Association entitled "Physician Socioeconomic Statistics" found the national average cost for a doctor's office visit to be approximately \$60.

⁷ Massachusetts Division of Health Care Finance and Policy. "Health Insurance Status of Massachusetts Residents" 3rd ed. Boston: 2003.

⁸ See Key Informant Interview, Appendix B, p. xx.

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⁹ Massachusetts Law Reform Institute. "Chronology of Massachusetts Health Access Cutbacks: 2002-2004." November 2003. See also Key Informant Interview, Appendix B, p. x.

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¹⁰ See Key Informant Interview (p. 2, 3), Appendix p. x

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¹¹ See Key Informant Interview (p. 3), Appendix p. x

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¹² Kaiser Commission on Medicaid and the Uninsured. "Health Insurance Coverage in America: 2002 Data Update." December, 2003, p. 14.

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¹³ Letter of March 6, 2002 from Massachusetts Medicaid Agency Assistant Commissioner of Member Services to MassHealth providers and outreach partners; minutes of Western Health Access Network meeting March 1, 2002, Amherst MA

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¹⁴ The 3,000 figure is an average derived from a conservative estimate of volume based on past performance.

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¹⁵ Supported by findings of The Lewin Group for the CHCF. "Business Case Analysis of Health-e-App: Executive Summary." p. 3-4. June 2001.

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¹⁶ Supported by findings of The Lewin Group for the CHCF. (See above.) p. 2. June 2001.

¹⁷ Supported by findings of The Lewin Group for the CHCF. (See above.) p. 34. June 2001.

¹⁸ Supported by findings of The Lewin Group for the CHCF. (See above.) p. 4. June 2001.

¹⁹ National Academy for State Health Policy. "Public Access to Online Enrollment for Medicaid and SCHIP." May 2003.

²⁰ In 2000, the Massachusetts Executive Office of Human Services received a TOP grant to develop an online referral and screening tool called BATON. While this project was not ultimately implemented statewide, it did build momentum within state government to move toward what is now called the "Virtual Gateway"—a single online electronic screening/application tool for all public benefits. As of April 2004, development is still underway, with implementation several years off. At present, RealBenefits is the only electronic screening tool available, but we know that ultimately, expanded online electronic enrollment will be offered—if not required—by Massachusetts state government.

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²¹ National Academy for State Health Policy. "Public Access to Online Enrollment for Medicaid and SCHIP." May 2003.

²² This was *not* a TOP-funded project.

²³ The Lewin Group. "Business Case Analysis of Health-e-App: Executive Summary." June 2001.

²⁴ Phone calls with Claudia Page, CHCF Program Officer, 4/1/2004 and 4/23/2004.

²⁵ See Key Informant Interview, Appendix B, p. x.

²⁶ Web statistics for http://www.compartners.org, April 2003 - April 2004.