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Covering Kids & Families[®] Evaluation

*Lasting Legacies of Covering Kids & Families:
Medicaid and SCHIP Officials in 46 States
Share Their Perspectives in the 2008 Follow-Up
Telephone Survey*

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About the *Covering Kids & Families*[®] Evaluation

Since August 2002 Mathematica Policy Research, Inc., and its partners, the Urban Institute and Health Management Associates, have undertaken an evaluation to determine the impact of the Robert Wood Johnson Foundation's (RWJF) investment in the *Covering Kids & Families* (CKF) program, as well as to study factors that may have contributed to, or impaired, its efforts.

The evaluation focuses on these key issues:

- documenting and assessing the strategies and actions of CKF grantees and their coalitions aimed at increasing enrollment of children and families and the barriers to their implementation;
- assessing the effectiveness of CKF grantees and their coalitions in conducting outreach; simplifying the application and renewal process; and coordinating efforts by existing health insurance programs to expand coverage;
- measuring progress on CKF's central goal—expanding enrollment and retention of all eligible individuals into Medicaid and the State Children's Health Insurance Program (SCHIP); and
- assessing the sustainability of CKF after RWJF funding ends.

Findings from the evaluations can be found at www.rwjf.org/special/ckfeval.

Executive Summary

The Covering Kids & Families (CKF) initiative of the Robert Wood Johnson Foundation (RWJF) had two goals: to reduce the number of uninsured children and adults eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) who remain uninsured, and to build the knowledge, experience, and capacity necessary to sustain the enrollment and retention of children and adults on those programs after the CKF program ends (Grant and Ravenell 2002).

As a condition of funding, RWJF required grantees in its CKF program to include state Medicaid and SCHIP officials in their coalitions, so that grantees might develop relationships with state officials that would lead to increases in Medicaid and SCHIP enrollment and policies that made it easier to access these programs.

Methods and Data. In May and June of 2008 Health Management Associates (HMA) conducted a telephone survey with 59 Medicaid and SCHIP officials in all 46 states in which there were CKF grantees. This survey was structured as a follow-up to a similar survey that HMA conducted in late 2006 and early 2007, and that Mathematica Policy Research, Inc. (MPR) and HMA conducted in 2005. The 2005 survey asked state officials to identify the three most important policy or procedural changes since January 2002 that CKF had directly influenced. Researchers grouped these changes into five major categories:

1. Simplified Enrollment
2. Renewal/Retention
3. Coordination
4. Eligibility
5. Outreach

The purpose of the follow-up interviews in 2006–2007 was to learn the status of these policy and procedural changes and to capture information concerning up to three additional changes that CKF might have influenced which had not been identified previously. Over the course of these two surveys, state Medicaid and SCHIP officials identified 183 unique policy and procedural changes that CKF had influenced since 2002 (Duchon, Ellis and Gifford 2008). The 2008 survey was designed to learn to what extent these changes were still in effect or had been reversed, and whether any changes previously reversed had been restored.¹

Findings. Key findings of the telephone survey with state officials in May through June 2008 include:

Policy and Procedural Changes CKF Influenced

- Over the course of two previous surveys, Medicaid and SCHIP officials in 46 states that participated in CKF reported 183 policy or procedural changes that CKF influenced, of which *simplified enrollment changes* were the largest category (36%), followed by *renewal/retention* (18%), *eligibility* (17%), *outreach* (14%), *coordination* (11%) and *other* (4%).
- Among the policy and procedural changes that state officials associated with CKF's influence, 74 percent were described as still completely in effect or fully restored at the time of the 2008 survey. Coordination changes were most likely (90%) and outreach changes least likely (36%) to be completely in effect by mid-2008.
- Of the changes completely in effect, 91 percent were considered permanent, that is, state officials expected them to remain in effect for at least two more years.
- State officials were most likely to consider eligibility and outreach changes at risk of reversal (12% and 11%, respectively).
- Among the changes reported as partially or completely reversed or at risk of reversal at the time of the 2008 survey, Medicaid and SCHIP officials—given the option to choose multiple reasons for a change being at risk or reversed—most frequently cited funding constraints, political considerations, and new leadership, as well as federal policy and internal agency decisions.

CKF's Legacy Through the Eyes of State Officials

- State officials were overwhelmingly positive about the benefits of CKF when asked to make any final comments about CKF's influence in their state.
- Several themes emerged from opened-ended responses of state officials:
 - CKF's legacy manifests itself through many different avenues, including the continuation of coalition activities, through new skills and tools state officials continue to apply, and the continuation and expansion of the many policy and procedural changes CKF helped states achieve.

- During the active grant period, CKF provided valuable assistance on legislation, policy changes and program improvements that otherwise might not have occurred. Officials were grateful for CKF’s resources and support.
- State officials highly valued the training and professional development CKF provided as well as the exposure to other states’ activities and networking opportunities at the national level.
- Some officials expressed disappointment that CKF had ended and some officials believe their program would benefit from continued CKF support, particularly regarding outreach efforts.

Conclusions. Nearly three-quarters of policy and procedural changes that CKF influenced in Medicaid and SCHIP programs since January 2002 were in effect in 2008 and about 90 percent of those were expected to remain so, according to state officials. The results suggest that CKF’s involvement with Medicaid and SCHIP programs may have been most productive in supporting procedural changes compared with policy changes. State agencies have the most internal control over procedural changes related to simplified enrollment, renewal and coordination, for example, which comprised two-thirds of all the CKF-influenced changes state officials cited. Eligibility expansion and outreach changes, which were more likely to be reversed or considered at risk of reversal, may be more subject to external political influence and budget constraints and federal policies that coalitions may find difficult to overcome.

CKF has advanced the state-of-the-art of Medicaid and SCHIP program operations and statewide communications networks across the country. The efforts of CKF grantees not only led to 183 policy or procedural changes but gave state officials new skills and tools to continue experimenting with improvements to their programs and to continue collaborating with community stakeholders to support effective state health policies for children.

Background

The Covering Kids & Families (CKF) initiative of the Robert Wood Johnson Foundation had two goals: to reduce the number of uninsured children and adults eligible for Medicaid or SCHIP programs who remain uninsured, and to build the knowledge, experience, and capacity necessary to sustain the enrollment and retention of children and adults on those programs after the CKF program ended (Grant and Ravenell 2002). CKF expanded on its predecessor, *Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children* (CKI), which operated from 1999 to 2002. RWJF phased in its funding of CKF grantees in 46 states beginning in 2002. The grants were phased out between December 2005 and July 2007, with most projects (70%) ending during the 2006 calendar year.

CKF worked through state and local coalitions to maximize enrollment and retention in public health insurance programs for eligible uninsured low-income children and adults. CKF grantees employed three primary strategies to increase enrollment and retention of eligible uninsured children and families:

- **Outreach** to encourage enrollment in SCHIP and Medicaid;
- **Simplification** of SCHIP and Medicaid policies and procedures to make it easier for families to enroll their children and keep them covered; and
- **Coordination** between SCHIP and Medicaid to ensure the easy transition of families between programs if they apply for the wrong program or their eligibility changes subsequently.

One component of the evaluation was a series of telephone surveys of state officials to assess the influence of CKF on targeted policies and procedures of Medicaid and SCHIP programs in each state, and the sustainability of the efforts implemented as a result of CKF's influence. The evaluation team conducted telephone interviews with state officials in 2003 (Ellis, Morgan and Longo 2005), in 2005 (Morgan, Ellis and Gifford 2005), during December 2006–January 2007 (Duchon, Ellis and Gifford 2008), and most recently in mid-2008.

Methods

Survey Design. Beginning with the 2005 interviews, the evaluation team administered a telephone survey to Medicaid and/or SCHIP officials in all 46 states with CKF projects. The 2005 survey asked state officials to identify the three most important policy or procedural changes since January 2002 that CKF had directly influenced. Responses to open-ended questions led researchers to develop a set of six categories of policy and procedural changes that CKF sought to influence:

1. **Simplified Enrollment** included changes that make the enrollment process easier, such as limiting documentation, removing a face-to-face interview requirement, implementing presumptive eligibility, shortening or simplifying application forms, or training enrollment workers to better assist applicants.
2. **Renewal/Retention** included policy or procedural changes that are intended to make the renewal or re-enrollment process easier and retain enrollment of those eligible for coverage (e.g., pre-printed or individualized renewal application).
3. **Eligibility** included policy changes to Medicaid and/or SCHIP that affect who is eligible for the program (e.g., expanding income limits or offering 12-month continuous eligibility²). CKF's effect on eligibility policy could include promotion of policies that expand eligibility or efforts to prevent the implementation of policies that would reduce eligibility.
4. **Outreach** included policy or procedural changes designed to make uninsured families more aware of their potential eligibility for coverage in Medicaid and/or SCHIP, and increase the opportunities for families to enroll in Medicaid, SCHIP or other public health programs for which they may be eligible (e.g., advertising campaign, enrollment facilitators in a hospital emergency room).
5. **Coordination** included policy and procedural changes that help to create a seamless enrollment process across public programs such as Medicaid, SCHIP or any state or locally funded programs, regardless of the particular program for which an individual or family members may be eligible. Examples include joint Medicaid and SCHIP applications; integration of information systems between Medicaid and SCHIP; and training eligibility workers to screen individuals for multiple health insurance programs.

6. **Other** included efforts mentioned outside the scope of the five areas described above. Examples include staff training, restoring benefits or preventing benefit cuts, review of proposed regulatory changes, and raising awareness of Medicaid/SCHIP programs among legislators.

Follow-Up Questionnaires. In December 2006 and January 2007, HMA conducted follow-up interviews with officials in each of the 46 states with CKF projects³ to learn to what extent the changes that CKF had influenced were still in effect. We also gave officials an opportunity to identify up to three additional changes that CKF had influenced since 2002 and asked about their current status. Thus, up to six changes per program were possible for inclusion in our analysis.

In May and June of 2008, HMA conducted follow-up interviews with state officials to learn the status of the policy and procedural changes named in the 2005 or 2006–2007 surveys. We analyzed these changes by the five major categories, excluding “other,” described above.

If a state official responded in the 2006–2007 survey that a change was still in effect, we asked in the 2008 survey whether it was still in effect or had been reversed. If still in effect, we asked about its permanence, that is, whether the official expected the change to be in effect in two years. If a change was no longer in effect, or if in effect but the official thought the change was at risk of reversal within two years, we asked the reasons why.

If we learned during the 2006–2007 survey that a change already had been reversed, either partially or completely, we asked in the 2008 survey whether this was still the case or whether the change had been restored, partially or in full. Unless otherwise noted, the findings presented are from the 2008 survey ([Appendix A](#)).

Survey Participants. HMA interviewed 59 state Medicaid and SCHIP officials in 46 states ([Appendix B](#)). If a single official was responsible for both a Medicaid program and a SCHIP program (whether SCHIP is a Medicaid expansion or separate SCHIP program or a combination of the two), we interviewed one state official. If two officials were separately responsible for a Medicaid program and a SCHIP program, we attempted to interview both officials. In 29 states, we interviewed a single official representing both Medicaid and SCHIP. In 13 states, we interviewed one official from the Medicaid program and one official from SCHIP. For three additional states with a separate SCHIP, only a SCHIP official was available. In one state for which we sought to interview both a Medicaid and SCHIP official, as we had in the previous survey, only a Medicaid official was available in mid-2008.

Table 1 shows the number of unique states represented in the 2008 survey and the number of state officials interviewed by the type of program(s) administered. The table also indicates how many officials interviewed in the 2008 survey were the same or a different person than was interviewed in 2006–2007. All but seven of 59 officials interviewed in 2008 were the same person interviewed in the previous survey.

TABLE 1

Number of States Represented and Officials Interviewed in the 2008 Survey

| | One official interviewed about both Medicaid and SCHIP | Separate officials interviewed about Medicaid and SCHIP | | Total |
|---|--|---|-------|-------|
| States | 29 | 17 | | 46 |
| | | MEDICAID | SCHIP | |
| Officials interviewed in 2008 | 29 | 14 | 16* | 59 |
| Same official interviewed in 2006–2007 | 26 | 13 | 13 | 52 |
| Different official interviewed in 2006–2007 | 3 | 1 | 3 | 7 |

* In one state, there was no SCHIP official available to interview in 2008 because of a position vacancy. In three states, only a SCHIP official was available to participate in the 2008 and earlier surveys.

Source: 2008 CKF Survey of State Officials

Findings

Policy and Procedural Changes CKF Influenced and Their Status Today

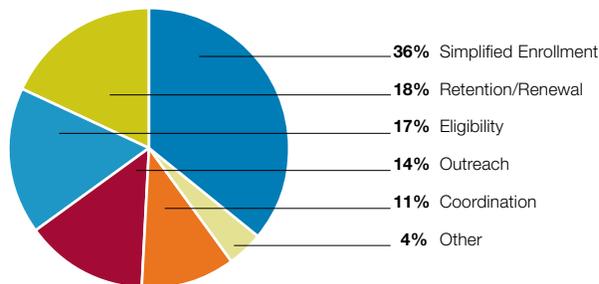
CKF influenced a variety of policy areas; just over half of the policy changes named related to either simplified enrollment or renewal/retention.

Over the course of two previous surveys, in 2005 and 2006–2007, Medicaid and SCHIP officials in the 46 states that participated in CKF⁴ reported 183 unique policy or procedural changes that CKF had influenced (Duchon, Ellis and Gifford 2008).⁵ State officials most often reported changes to simplify enrollment and renewal/retention, followed by changes in eligibility, outreach and coordination (Figure 1).

FIGURE 1

Types of Policy or Procedural Changes Medicaid and SCHIP Officials Identified That CKF Influenced

N=183 policy or procedural changes



Source: 2005 CKF Survey of State Officials and 2006–2007 CKF Survey of State Officials

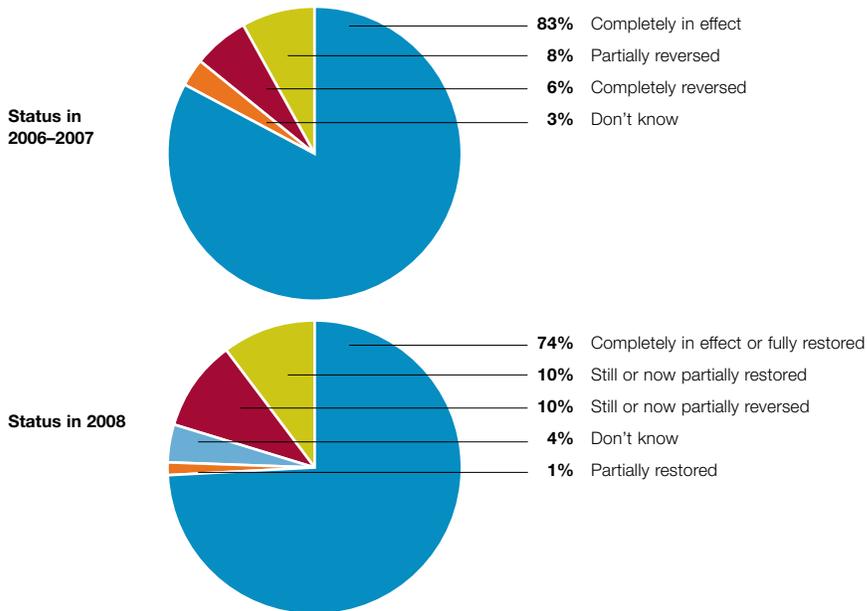
As of mid-2008, nearly three-quarters of the policy and procedural changes CKF influenced since 2002 were still completely in effect, representing a slight decline from 2007.

Taking into account that some changes officials reported as partially reversed in 2007 had been fully restored by mid-2008; 74 percent of the 183 policy and procedural changes that CKF influenced were completely in effect (Figure 2). (See [Appendix C](#) for details on how the status of some policies and procedures that CKF influenced had changed between the time of the 2006–2007 and 2008 surveys.)

FIGURE 2

Status of Policy and Procedural Changes CKF Influenced, as Reported by Medicaid and SCHIP Officials

N=183 Policy or Procedural Changes



Source: 2006–2007 CKF Survey of State Officials and 2008 CKF Survey of State Officials

Sustainability of Changes by Type of Policy or Procedure

Between 2007 and 2008, states maintained or restored coordination and simplified enrollment changes, but some eligibility, renewal, and outreach policy or procedural changes were discontinued or repealed, including half of the outreach changes in place at the time of the 2006–2007 survey.

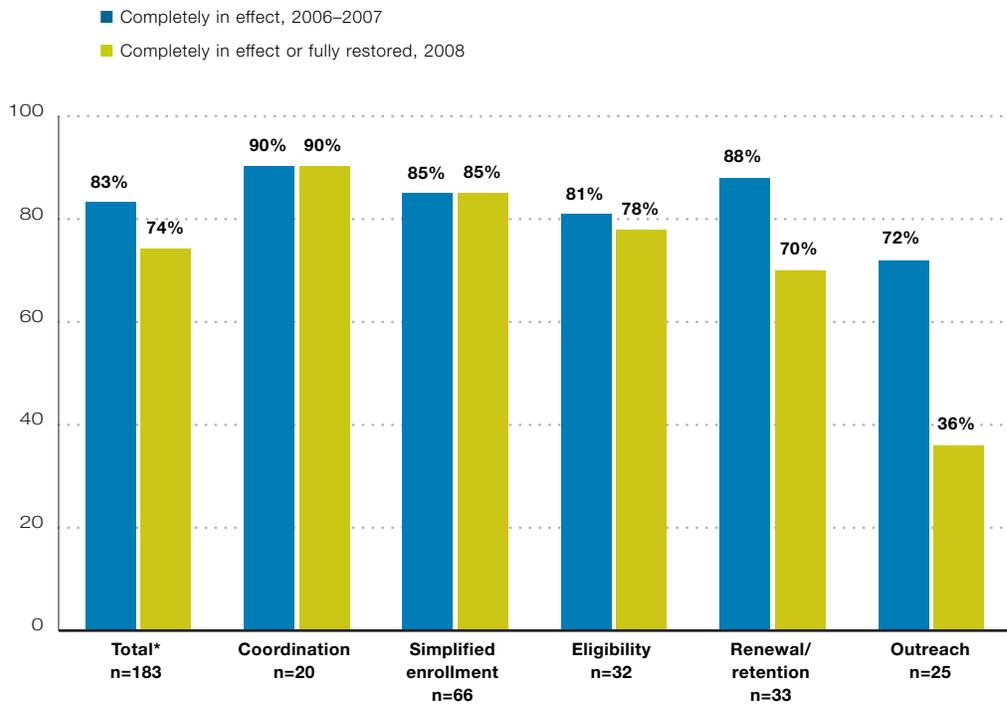
Ninety percent of coordination changes that CKF influenced were permanent through mid-2008, with no changes in status since the 2006–2007 survey (Figure 3). We speculate that the benefits to the state from improved coordination likely contributed to the sustainability of coordination policies and procedures. A Medicaid official from one state commented: “The joint application results in better ongoing communication and collaboration between Medicaid and SCHIP.”

Simplified enrollment. Among the large number of changes to simplify enrollment, 85 percent were completely in effect in 2008, the same percentage as in 2007. A number of officials’ remarks echoed this comment: “We continue to improve the streamlining process, and build on the efforts of CKF.” As an example, one official noted that her Medicaid program is adding an e-signature feature to the online application that CKF helped put in place. “We are finding that clients are starting to use the internet more frequently than the phone to contact our agency. The libraries and health department clinics have set up internet kiosks to facilitate access.”⁶

Three simplified enrollment changes reported as partially reversed in the 2006–2007 survey had been completely restored by mid-2008, and three other changes in effect at the time of the last survey had since been partially or completely reversed. For example, an official from a combined Medicaid/SCHIP program reported in the 2005 survey that CKF had helped the program shorten its application. At the time of the 2006–2007 survey, the official reported that although this change “appeared to be effective in getting people to apply,” it had been partially reversed due to “a lot of follow-up required because the application was too short.” They returned to a lengthier application.⁷ By the time of the 2008 survey, however, the official reported that the program had returned to a shorter application: “Making it longer was a mistake. The size of it discouraged people from applying.” Although the net effect was no change in the rate of permanence of procedures related to simplifying enrollment, such transitions indicate some fluctuation in the status of these types of procedures.

FIGURE 3

Percentage of Changes CKF Influenced That Are Completely in Effect, as Reported by Medicaid and SCHIP Officials



*Includes “other” category

Source: 2006–2007 CKF Survey of State Officials and 2008 CKF Survey of State Officials

Eligibility. Seventy-eight percent of changes to eligibility that CKF influenced were in effect in mid-2008, compared with 81 percent in early 2007. Only one eligibility change that had been in effect in 2007 was no longer in effect in 2008. In some cases, however, CKF's original efforts had expanded. For example, CKF helped one Medicaid program introduce presumptive eligibility for children as a pilot program in four children's hospitals that later expanded to one federally qualified health center (FQHC) and one rural health center (RHC). The official reported that, "In 2008, funding was provided to allow all interested FQHCs and RHCs to have presumptive eligibility if they wish."

In 2005 a Medicaid/SCHIP official described how CKF had "worked with [our] Department, the legislature, and the governor's office to ensure that Medicaid and SCHIP remain as they were at the start of the grant period—so that there weren't large cuts in eligibility." In reporting that their efforts with CKF were sustained, the official said during his 2008 interview, "In fact, we are still expanding eligibility."

Renewal/retention. While 88 percent of the 33 changes to simplify renewal and improve retention were still in effect at the time of the 2006–2007 survey, according to the 2008 survey results, this rate had dropped to 70 percent, with five changes reported as partially or completely reversed.⁸ In most cases, these were pilot programs that "didn't get off the ground" or "didn't work." (See next section for more discussion.) In one of these instances, however, a state official said that the partial reversal she was reporting had been temporary. The state had worked with CKF to introduce calls to clients prior to termination. After the 2006–2007 survey, "We had a staff shortage so had to discontinue the calls for a while," but now the practice is in effect again.⁹

Most renewal or retention changes were still in effect, and among these, several Medicaid and SCHIP officials described how they were building on CKF's efforts. A SCHIP official said their program is working with a third party administrator to enhance a disenrollment survey that CKF helped launch. "Instead of surveying 30 percent of dropped cases, we will survey 100 percent." A Medicaid official in the same state reported that CKF's support of retention efforts now includes "pre-populating" renewal applications. Another Medicaid/SCHIP official reported that her state has "just rolled out a huge express renewal initiative" that is web-based. "This was a project that CKF was instrumental in creating; it has been under development for some time." Another state official volunteered the following about the continuation of the retention efforts CKF worked on in her state: "We have added a second letter, so now the members get two reminder letters."

Outreach. The attrition of outreach efforts continued. By mid-2008, only nine of the 25 outreach efforts that CKF influenced, as reported by state Medicaid and SCHIP officials, were still in effect. A relatively high reversal rate of outreach activities may reflect a history of states associating outreach activities with direct funding from external sources, including CKF and other time-limited grants (Duchon, Ellis and Gifford 2008). As one state official described in the most recent survey: “We have a smaller budget and one paid staff person, whereas under the CKF grant we had a large outreach team.”

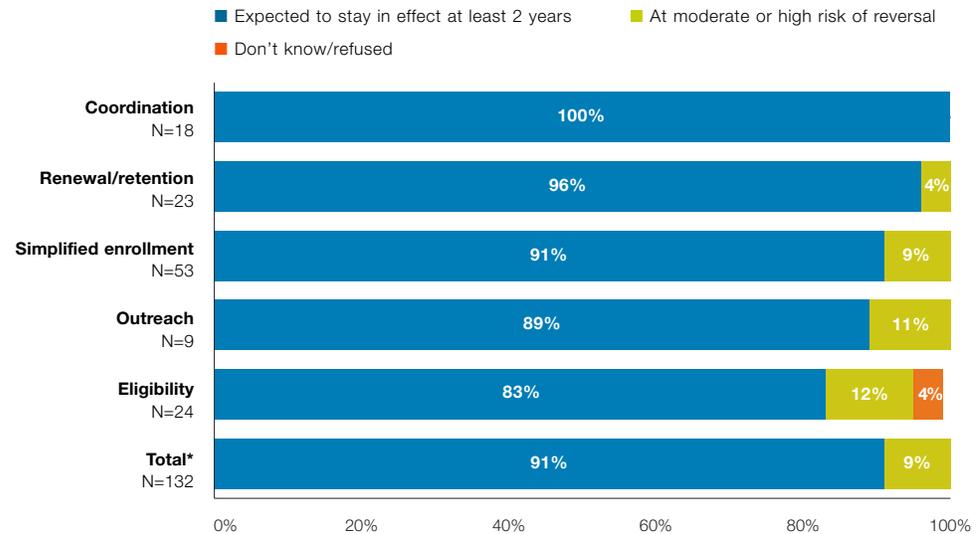
A few program officials, nevertheless, described how they are sustaining CKF’s outreach legacy, or are determined or hopeful to see CKF’s outreach efforts continue or even expand. “Since the [CKF] grant ended, our agency now has a lot more staff out in the community and in provider settings doing outreach and application assistance,” stated one Medicaid/SCHIP official. Another official said that, “CKF helped improve outreach policies and processes, but our funding was cut,” and then went on to add that, “Some counties may have been able to partially continue outreach work using other funding sources.” Another official said that the former CKF grantee is currently a participant in state outreach “mini-grants” and has a “major coordination role in statewide outreach efforts.” The official added, “We are looking for FTEs to expand this effort.”

Nine out of ten policy and procedural changes that Medicaid and SCHIP officials reported were still completely in effect through mid-2008 were expected to remain in effect for at least two years.

Among the 132 changes that state officials said were in effect at the time of the 2006–2007 survey and reported in the 2008 survey as still completely in effect, only 11 policies or procedures (9%) were considered at risk of reversal within the next two years (Figure 4).¹⁰ Expectations of permanence were highest for coordination changes (100%) that CKF influenced, and lowest for changes related to eligibility (83%) and outreach (89%). The vast majority of all changes reported in effect in mid-2008—across all categories—were expected to be permanent.

FIGURE 4

Expected Sustainability of Policy and Procedural Changes Still in Effect According to State Officials



* Some numbers may not add to 100% due to rounding. Total includes "other" category.
Source: 2008 CKF Survey of State Officials

State Officials' Reasons That Policy or Procedural Changes Were Reversed or Could Be at Risk of Reversal

State officials named budget constraints, new state leadership, "political/philosophical" reasons and concerns about the direction of federal policies as the main reasons policies and/or procedures that CKF influenced were overturned or might be overturned in the future.

Among the 158 policy and procedural changes that state officials reported were still in effect (n=152) at the time of the 2006–2007 survey or for which the official did not know the status (n=6), state officials reported in 2008 that 22 had been partially or completely reversed. In each case, we asked state officials why the reversal had occurred. We used the same approach in asking state officials the reasons they considered a change that was still in effect to be at risk of being reversed (n=11).¹¹ For each question, state officials had an opportunity to choose multiple reasons (Table 2). They gave more reasons for changes that had been reversed than changes at risk of reversal.

TABLE 2

Reasons State Officials Said Policy or Procedural Changes That CKF Influenced Were Reversed or Considered at Risk of Reversal*

| | Changes partially or completely reversed (N=22) | Changes still in effect but at risk of reversal (N=11) | Total changes reversed or at risk of reversal (N=33) | Percentage of total (N=33) reversed or at risk of reversal |
|--|---|--|--|--|
| Budget constraints | 8 | 8 | 16 | 48% |
| Other political/philosophical reasons | 2 | 7 | 9 | 27% |
| New leadership | 5 | 3 | 8 | 24% |
| Concerns over CMS policy interpretations or actual changes in federal requirements | 2 | 5 | 7 | 21% |
| Fraud, abuse, other program integrity concerns | 2 | 3 | 5 | 15% |
| Effort was ineffective or unnecessary | 4 | 0 | 4 | 12% |
| Grant ended or effort had a planned time or budget limit | 4 | 0 | 4 | 12% |
| DRA citizenship verification | 2 | 1 | 3 | 9% |
| Staffing issues | 3 | 0 | 3 | 9% |

* Among 158 changes that were in effect at the time of the 2006–2007 survey, or for which the respondent did not know the status
 Note: Respondents could choose multiple reasons.

Source: 2008 CKF Survey of State Officials

Financial constraints and state politics. “Budget constraints or lack of funding” was the most common reason state officials gave as to why a policy or procedural change CKF influenced had been reversed or was at risk of reversal. Financial concerns were sometimes intertwined with a new administration that changed priorities or with uncertainties about actions the legislature may take due to budget cuts or its ideological bent. One official explained why his program may lose support for outreach efforts that CKF helped implement: “Because this is a marketing—an outreach—effort, it will be the first thing to go in a new administration (next year) if it’s looking for ways to cut costs. When you reduce outreach, it will lead to less coverage, which will save the state money.” Another Medicaid/SCHIP official said that CKF outreach was severely curtailed after the grant ended and that the state has not been able to “...shake loose any state funding to replace it. It’s always the first thing to go.”

Eligibility changes also may be more dependent upon legislative authorization and the state budget process compared with other procedural changes over which the executive branch may be able to exercise more control (Duchon, Ellis and Gifford 2008). Responses volunteered from a few state officials support this notion. For example, a Medicaid/SCHIP official explained how one of CKF’s efforts was successful in advocating a grandfather clause to protect the coverage of undocumented children from proposed legislative cuts, but was later reversed. In the 2008 legislative session, state-only funding for coverage of undocumented children was completely eliminated.

Federal-level decisions and policies. Several state officials said that federal policies and decisions by the Center for Medicare and Medicaid Services (CMS) were the reason a change was no longer in effect or could affect whether changes they had implemented with CKF’s involvement would be permanent. A Medicaid official described the impact of the new Payment Error Rate Measurement (PERM) audit requirements on her program’s simplification efforts: “We can no longer do a totally passive renewal—where the client can be re-enrolled if he or she does not report any changes.” The official explained that, “In order to avoid having the CMS auditor make a finding of ‘ineligible,’ there needs to be something in the file during the previous 12 months showing that eligibility was verified—even if it is an attestation.” Stated another official: “The risk is low, but if a PERM report comes back with lots of errors, then that could have an effect on the self-declaration of income policy.”

One state official was uncertain of the risks to the state's eligibility expansion of its SCHIP program: "We're having to respond to the federal requirements around anti-crowd out assurances."¹² Another described how CMS had overturned the state's waiting period exemptions. "We had an agency discretion exemption and CMS made us get rid of that." A Medicaid/SCHIP official said that her agency dropped its attempt at simplification through phone-in applications because of concerns that, "Not having a signed application did not have legal standing with CMS."

Agency-level decisions. Some enrollment or renewal simplification efforts that CKF supported were discontinued because agency staff decided they simply did not work. In one state, officials piloted an initiative for agency staff to attempt to complete the renewal process by phone when required renewal forms had not arrived by the deadline. The Medicaid program discontinued the practice in late 2007 because, "It became ineffective and proved to be a burden for workers." In another instance, an official claimed that her agency undertook a process improvement collaborative (PIC) initiative because, "The CKF grantee was convinced that language barriers were a problem for enrollees...There really was no evidence to support this hypothesis. So the whole effort died on the vine." In some cases a good idea was poorly implemented. CKF had worked with a Medicaid/SCHIP program to set up an automated, Web-based eligibility system. But during the most recent interview, an official from the program characterized the effort as partially reversed. "We had to terminate the contract with the vendor for poor performance...We are currently in a project recovery phase...We still intend to do it, but our timeline is uncertain."

State Officials' Reflections on Covering Kids & Families

At the end of each interview, we gave state officials an opportunity to offer any additional information about CKF and its influence in their state. Forty-four of 59 officials from 31 states volunteered additional comments. Overall, as we had found in previous surveys, state officials were positive about their experiences with CKF and appreciative of the contributions of the CKF coalition in their state. Officials described CKF as "a beneficial collaboration," a "very effective partnership," a "model of collaboration," and a "valuable outreach arm to the state."

Below, we summarize state officials' comments along four themes. First, many officials described ways that CKF's legacy continues—through coalition activities sustained after the grant period; through new skills, tools and a new "mindset" they continue to apply to simplification and outreach efforts even if the CKF coalition is no longer present; and through the changes in policy and operations that remain in effect.

Second, most officials responding talked about the many valuable accomplishments of CKF during the active grant period. From the perspective of some officials, however, the benefits of CKF have diminished since the grants ended, and they would like to see various aspects of CKF reactivated. And finally, a minority of state officials focused on the shortcomings of CKF, which in several cases was related to the CKF grantee's performance. The following is a summary of state officials' concluding comments about Covering Kids & Families.

CKF offered state officials a foundation upon which to build and enhance their community partnerships on policy and outreach, and to continue to simplify and coordinate their Medicaid and SCHIP programs.

One state official's remarks captured the theme of CKF's legacy this way: "The grant really did make a change in how we approach simplification, outreach and enrollment, and how we work with community organizations on these efforts. We are continuing to do that even though we are no longer working with the CKF state coalition."

Some officials reported that the work of the CKF coalition in their state continues. One official said, "While [the coalition] hasn't continued formally, the ideas and connections made through CKF continue informally and continue to have an impact." Another official was more emphatic: "You can't really tell that the grant has ended because everything is continuing to run the way it was before." Coalitions remain active in many states in various configurations (Hoag and Stevens 2008). One official noted that CKF has been "very active sending letters and advocating in other ways recently" to get CMS's August 17, 2007, SCHIP policy letter reversed (Smith 2008). "CKF has not slowed down a bit since the end of the grant. In fact, it may have picked up a bit." In a few states, officials noted that CKF proved so valuable, that state funds were appropriated to support coalitions and direct outreach. "We just got \$200,000 in outreach funding for SCHIP enrollment. This helps us continue some of the outreach CKF used to do."

CKF provided valuable assistance on legislation, policy changes and program improvements that might not have otherwise occurred.

Officials cited CKF's effect in the legislative arena to assist with development of better coverage policies. "Our state has tried to improve its programs for children, and CKF has been there every step of the way. They've helped with legislation, stakeholder support and have been a major player in reform efforts." Another official credited CKF with providing information that led the state legislature to pass a law that eliminated an enrollment cap. One official said their state's CKF grant "moved a mighty elephant" and that the coalition was the "most beneficial partnership I've been a part of in my entire career."

State officials also cited CKF as the impetus behind policies such as the addition of application assisters and use of insurance agents in SCHIP enrollment, with one noting that many steps her program undertook “may not have been considered without CKF input.” Said one official: “I’m absolutely convinced that the online application would not have happened without CKF. We just can’t get things like that done easily.” Another official said that SCHIP would not have been as successful as it was without CKF. “The CKF grant was instrumental in reaching out and getting the word out about SCHIP.” Another official remarked that, “CKF did a good job of providing tools to help providers get people enrolled. When CKF was active, we did see more people getting coverage.”

CKF also served as a valuable resource on best practices in other states. Several officials cited training opportunities, publications, and the CKF Web site as heavily relied-upon information sources. Officials said the training resources were the “best ever” and were “used on the job every day.”

Some state officials expressed a need for continued foundation support.

Several officials would like to see RWJF continue to convene meetings and offer training to their agency staff. “A key item missing without CKF is the opportunity to take an in-depth look at what other states are doing.” One official said, “It would be good to reactivate CKF. CKF provided professional training that state agency staff don't usually receive, such as training in public speaking and how to ‘defend your cause.’”

Other officials, mostly from states with relatively low population density, were more concerned about losing ground without CKF, especially on outreach. “We had people in the field that would get out the word, and current state staff just can't do it. The simplification and coordination we were able to continue. But the outreach has been difficult to continue.” Another official suggested that, “RWJF should find a way to continue funding—even at a reduced level—those CKF programs that were successful in [our state].” Said another: “I wish their efforts could be ongoing... Some states still need assistance.”

For several state officials, there was room for improvement.

A few officials commented on occasional “tensions” between their agency and the CKF coalition in their state, but considered these minor compared to the overall successes. However, one state official who expressed appreciation for CKF funding that “helped promote” SCHIP was particularly critical of the CKF grantee for being “possessive” and “territorial” about its activities. “The grantee didn't understand how to lead a coalition and they didn't have any training or guidance about how to do so.” (This coalition no longer exists.)

Another state official who had “nothing negative to say about the grantee” criticized a “lack of coordination” between the national CKF office and the states regarding media buys for Insure Kids Now and Back to School campaigns. “States were excluded, and this undermined our own campaign efforts, especially in ‘bleed-over’ markets” (metropolitan areas that encompass more than one state). According to the official, the state had to purchase media time in two states, which resulted in “inefficiency” and “frustrated callers” from the other state who had phoned their hotline to sign up for coverage. Those callers had to be referred to the other state’s program.

Conclusions

The Covering Kids & Families program has been highly valued by state officials. Nearly three-quarters of the policy and procedural changes that CKF influenced in Medicaid and SCHIP programs since January 2002 were completely in effect as of mid-2008; of those, about 90 percent were expected to be permanent. The volume of policy and procedural changes that state officials identified is sizable, although varied by state, and may not fully be captured in this report due to a limit on the total number of changes about which the survey inquired, and turnover in program administration. The results suggest that CKF’s involvement with Medicaid and SCHIP programs may have been most productive in supporting procedural changes compared with policy changes. We offer one cautionary note in their interpretation. In 13 states, two respondents participated in the surveys; thus the 183 policy and procedures analyzed may somewhat overrepresent these 13 states.

Our analysis of the 2008 survey of state Medicaid and SCHIP officials demonstrates that Covering Kids & Families has provided valuable support to states, particularly in initiating and implementing strategies designed to simplify enrollment, improve renewal/retention procedures, and facilitate coordination, which together comprised two-thirds of the changes that Medicaid and SCHIP officials cited. Beyond the permanence of most policies and procedures, CKF provided a foundation upon which state officials continue to build and enhance their community partnerships and apply acquired skills and new tools.

From the results of our surveys with state officials, CKF appears to have had less success in creating sustainable outreach efforts, which officials often attributed to the loss of CKF funding, or as the first place an administration looks to trim in a budget shortfall. The long-term success of sustaining some of the eligibility expansions that CKF influenced was questionable in the minds of a number of state officials because of uncertainties about future legislative or administrative decisions at the state level, or CMS's interpretation of federal policies. Other strategies states adopted in the name of simplification were also discontinued because of CMS rules, or may be at risk of being overturned, depending on future CMS policy interpretations. The DRA, PERM, and SCHIP enrollment requirements each represent examples of federal policy that work against CKF's goals of enhancing states' abilities to expand health insurance coverage for children and families, and enroll and retain every child and adult eligible.

Regardless of the external challenges Medicaid and SCHIP face at a federal or state level, CKF has advanced the state-of-the-art of program operations and statewide communications networks across the country. This progress continues in many states (Hoag and Stevens, 2008). The efforts of CKF grantees not only inspired hundreds of policy and procedural changes but gave state officials new skills and tools—and confidence—to continue experimenting with improvements to their programs and collaborating with community stakeholders to support effective state health policies for children and their families.

Endnotes

1. As part of the follow-up interviews, both the 2006–2007 and 2008 surveys also queried state officials about the actual or expected effects of the identity and citizenship documentation requirements of the Deficit Reduction Act (DRA) of 2005 (Ellis and Duchon 2007, Ellis and Duchon 2008).
2. This policy allows individuals the option to retain Medicaid eligibility for 12 months even if changes in income or other circumstances would otherwise make them ineligible.
3. The CKF initiative included 45 states and the District of Columbia. Five states—Kansas, Montana, South Carolina, South Dakota, and Vermont—received “liaison” grants that provided opportunities to participate in the national CKF initiative. These states were excluded from the survey. Appendix B lists the 46 states surveyed for this report.
4. In one state, neither a Medicaid nor SCHIP official identified any changes in policies or procedures—in either the 2005 or 2006–2007 survey—that they attributed to CKF’s influence.
5. In four cases for which a Medicaid and SCHIP official in the same state identified the same change (three were related to coordination and one to outreach), we used only the responses of the Medicaid official.
6. The official also mentioned their program was relying on a RWJF “retention” grant to help with this effort.
7. This state also had new questions to include because of the citizenship and identity documentation requirements contained in the Deficit Reduction Act of 2005, as well as due to other new state requirements.
8. Five of 29 changes in effect in 2006–2007 were reported partially or completely reversed by mid-2008 and one was reported as “don’t know” the status, which brought the total still in effect in 2008 to 23.
9. This change, reported as completely in effect during the 2006–2007 interview, was partially reversed and completely restored between the dates of the 2006–2007 and 2008 interviews. The official chose to respond to the change as partially reversed because for a time it had been—even though it was completely in effect at the time of the mid-2008 interview.
10. This follow-up question applied only to changes that had been reported “still completely in effect” at the time of the 2006–2007 survey.
11. For the single change that an official reported as partially reversed in 2006–2007 and completely reversed by mid-2008, we did not ask the reason the complete reversal had occurred.

12. The Center for Medicare and Medicaid Services (CMS) released a letter to State Health Officials on August 17, 2007, regarding concerns that offering public coverage for children at higher incomes (above 250% FPL) could “crowd-out” private coverage. The letter indicated that CMS expects states to provide assurances that they have adopted prevailing crowd-out strategies if they expand eligibility for SCHIP coverage above 250 percent of FPL. States also should have enrolled at least 95 percent of children below 200 percent of FPL in the state in either SCHIP or Medicaid before expanding SCHIP coverage to this higher income level (Smith 2008).
13. Ninety-one percent of state officials stated that they were very or somewhat familiar with CKF activities since 2002, similar to results for 2006–2007.

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Appendix A

2008 Survey Questions

Survey questions are summarized below by topic, with coded answers shown in italics. “Don’t know” and “refused” were potential answers for any question.

Familiarity and Involvement with CKF

All state officials who participated in the survey were asked the following questions:

1. How familiar would you say you are with CKF activities that have focused on your program since January 2002? Would you say...
 - very familiar;
 - somewhat familiar;
 - not too familiar; or
 - not at all familiar?

Policy and Procedural Changes that CKF Influenced, Their Current Status and Expected Permanence

For each change (up to six) influenced by CKF since January 2002, as reported by a state official (or predecessor) in either of two previous surveys, the interviewer read the appropriate statement that represented the status of that change based on the response at the time of the 2006–2007 interview:

1. At the time of our last interview...
 - We learned that this change was still completely in effect
 - We learned that this change was partially reversed.
 - We learned that this change was completely reversed.
 - We were not able to learn whether this change was still in effect or reversed.

For each change that was *still in effect* at the time of the 2006–2007 interview, or for which the status had not been determined, officials were asked:

2. As far as you know, is this change...
 - still completely in effect;
 - partially reversed; or
 - completely reversed?

If the change was still in effect, respondent was asked the following:

3. Please tell me which of the following three statements best represents your opinion about the sustainability of this change over the next two years...
- You expect it to stay in effect for at least two years;
 - You consider it at moderate risk of full or partial reversal; or
 - You consider it at high risk of full or partial reversal.

If the change was A) still in effect and the state official said the change is at risk (moderate/high) for (partial/full) reversal; or B) if the change had been reversed (partially/fully), the state official was asked to answer “yes” or “no” to each of eight possible reasons the change was at risk of reversal or why the change had been reversed.

- a. Would you say this change is at risk of a partial or complete reversal because of...
- b. Would you say this change was partially or completely reversed because of...
- Budget constraints or lack of funding;
 - New leadership;
 - Other political or philosophical reasons;
 - DRA citizenship documentation requirements;
 - New CMS SCHIP enrollment requirements;
 - Other changes in federal requirements;
 - Fraud, abuse, or other program integrity issues; or
 - Some other reason? (Please describe.)

If an official had stated at the time of the 2006–2007 interview that a change had been *partially reversed*, the official was asked:

4. As far as you know, is this change...
- Still partially reversed; or has it been
 - Completely reversed;
 - Partially restored; or been
 - Completely restored?

If an official had stated at the time of the 2006–2007 interview that a change had been *completely reversed*, the official was asked:

5. As far as you know, is this change...
 - Still completely reversed; or has it been
 - Partially restored; or been
 - Completely restored?

The following open-ended question completed the survey:

6. Do you have any final thoughts you would like to share about CKF that you think would be helpful to the Foundation?

Appendix B

Officials Interviewed, by State and Type of Program

In May and June of 2008, staff from Health Management Associates conducted telephone interviews with 59 state officials representing Medicaid or SCHIP, or representing both Medicaid and SCHIP in the 46 states with CKF grants.

TABLE B-1

States and Programs of Officials Interviewed

| Medicaid (N=14) | SCHIP (N=16) | Medicaid/SCHIP (N=29) | |
|----------------------------|-------------------------|----------------------------------|----------------|
| Alabama | Alabama | Alaska | New Jersey |
| Arizona | Arizona | Arkansas | New Mexico |
| California | California | Connecticut | North Carolina |
| Florida* | Colorado** | Delaware | Ohio |
| Georgia | Georgia | District of Columbia | Oklahoma |
| Iowa | Iowa | Hawaii | Rhode Island |
| Massachusetts | Massachusetts | Idaho | Tennessee |
| Mississippi | Mississippi | Illinois | Texas |
| Nevada | Nevada | Indiana | Utah |
| New Hampshire | New Hampshire | Kentucky | Virginia |
| New York | New York | Louisiana | Washington |
| Oregon | North Dakota* | Maine | Wisconsin |
| Pennsylvania | Oregon | Maryland | |
| Wyoming | Pennsylvania | Michigan | |
| | Wyoming | Minnesota | |
| | West Virginia** | Missouri | |
| | | Nebraska | |

*In previous surveys, both a Medicaid and SCHIP official participated in interviews.

**Only an official from SCHIP participated in each of the CKF surveys.

Source: 2008 CKF Survey of State Officials

Appendix C

Status of Changes CKF Influenced, 2006–2007 and 2008

In a 2005 survey, state Medicaid and SCHIP officials identified 126 policy and procedural changes that CKF had influenced since 2002. In a follow-up survey in December 2006/January 2007 state officials identified an additional 57 policy and procedural changes CKF helped bring about. In total, officials identified 183 unique policy or procedural changes associated with CKF's influence.

The table below shows the status of the 183 changes at the time of the first follow-up interview (2006–2007), and the status of these changes at the time of the second follow-up interview (mid-2008), according to state Medicaid and SCHIP officials. The last row of the table shows the status of each change as of mid-2008.

In the time between the 2005 survey with state officials and the 2006–2007 survey, the status of 25 policy or procedural changes had shifted, with the status of another six changes unknown.

In the time between the 2006–2007 survey and the 2008 survey, the status of at least 27 policy and procedural changes had shifted (see shaded cells). Among those changes CKF influenced that state officials said were in effect (n=152) or for which they did not know the status (n=6) at the time of the 2006–2007 survey, 21 (or 14%) had been partially or completely reversed by mid-2008. For two changes, the status was unknown at either point in time.

TABLE C-1

Status of 183 Policy and Procedural Changes CKF Influenced

| Status of Changes 2006–2007 | | Status of Changes: mid-2008 | | | | |
|--------------------------------|------|-----------------------------|-----------------------|-----------------------|------------------------|---------------|
| | | Completely in effect | Partially restored | Partially reversed | Completely reversed | Don't know |
| Completely in effect | 152 | 129 | N/A | 13 | 8 | 2 |
| Partially reversed | 14 | 4 | N/A | 6 | 1 | 3 |
| Completely reversed | 11 | 0 | 1 | N/A | 9 | 1 |
| Don't know | 6 | 3 | N/A | 0 | 1 | 2 |
| Total | 183 | 136 | 1 | 19 | 19 | 8 |
| Percentage of Total | 100% | 74% | 1% | 10% | 10% | 4% |

N/A: Not applicable

Source: 2006–2007 CKF Survey of State Officials and 2008 CKF Survey of State Officials



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