APRIL 2009

Covering Kids & Families® Evaluation

Synthesis of 10 Case Studies: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice

Mathematica Policy Research, Inc.

Judith Wooldridge, *senior vice president*

Christopher Trenholm, *associate director of Health Research*

Angela Gerolamo, *nurse researcher*

Credits

Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
Tel: (609) 799-3535
Fax: (609) 799-0005

Judith Wooldridge,
senior vice president
Christopher Trenholm,
associate director of Health Research
Angela Gerolamo,
nurse researcher

Design and Layout
Landesberg Design
Pittsburgh, PA

Robert Wood Johnson Foundation

Route 1 and College Road East
P.O. Box 2316
Princeton, NJ 08543-2316

This publication is available for downloading from the Foundation's Web site at *www.rwjf.org/goto/ckfsynthesis0509*

Acknowledgments

This synthesis draws on 10 case studies written by the following staff from Mathematica Policy Research Inc., Health Management Associates, and the Urban Institute: Ben Cook, Brigette Courtot, Eileen Ellis, Kathy Gifford, Ian Hill, Embry Howell, Bridget Lavin, Donna Marks, Gaylee Morgan, Whitney Schott, Jennifer Sullivan, Christopher Trenholm, Jenna Walls, and Judith Wooldridge. Without their work this synthesis would not have been possible. We would also like to acknowledge the state SCHIP and Medicaid staff and CKF grantee staff who talked to us about enrollment and retention trends and the policies and procedures affecting them.

APRIL 2009

Covering Kids & Families Evaluation

Synthesis of 10 Case Studies: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice

Contents

Tables

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 effect of RWJF's investment in the *Covering Kids & Families* (CKF) program, as well as to study factors that might have contributed to, or impaired, its efforts.

The evaluation focuses on the following 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 to meet CKF's central goal—expanding enrollment and retention of all eligible individuals in Medicaid and the State Children's Health Insurance Program (SCHIP).**
- **Assessing the sustainability of CKF activities after Robert Wood Johnson Foundation (RWJF) funding ends.**

Findings from the evaluation can be found at *www.rwjf.org/coverage/product.jsp?id=20929.*

Background

After Congress established SCHIP in 1997 in response to large numbers of uninsured children in low-income working families, states took this unique opportunity to expand children's coverage and introduce program innovations. To build on this opportunity, RWJF funded the national *Covering Kids Initiative* (CKI) in 1999 to increase children's enrollment in SCHIP and Medicaid. In 2002 RWJF extended CKI to families, as well as children, and renamed it *Covering Kids & Families* (CKF).

RWJF funded 46 state CKF grantees, which included community-based organizations, service agencies, government agencies, academic institutions and health care providers. In turn, these state grantees funded 152 local grantees–at least two in each state–using half of their grants (the average state grant was $828,215). Local grantees were intended to be local laboratories for innovation that could report to state grantees on barriers to enrollment and the most effective types of outreach. The four-year grants began in 2002.

CKF required its grantees to use three strategies RWJF believed to be crucial for increasing enrollment of eligible, uninsured children and families in SCHIP and Medicaid:

- **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 in the programs;
- **Coordination** between SCHIP and Medicaid to ensure that families transition easily between programs if they apply for the wrong program or their eligibility changes. CKF also encouraged community commitment by requiring every grantee to be embedded in a community coalition and it encouraged collaboration between grantees and state officials.

During the CKF evaluation, the study team selected 10 states as case studies to examine the interplay between children's coverage in Medicaid and SCHIP, the state economic and political environment, the state's policy and procedures related to coverage, and the activities of the state's CKF grantees. Our goal was to assess the most important factors contributing to the coverage of children and to suggest the most effective ways of increasing enrollment of eligible children and families in Medicaid and SCHIP. The case study site visits, which took place between 2005 and 2007, included meetings with state officials, CKF state grantee staff and selected local project staff.

Before the visits, we prepared graphs showing trends in new enrollment in SCHIP and Medicaid. During the visits, we asked state officials and CKF state grantee staff members what they thought were the reasons for certain directions in these trends. For example, we might inquire about a sharp and sustained rise in new enrollment that had been evident among only some eligibility groups. Combined with our statistical analysis of these trend data, we used the information provided by interview respondents to identify the factors that had contributed to these changes. When we reached a consensus about these factors, we described them in a site visit report using the statistical analysis to further explore their credibility. (Each case study resulted in a written report described in the references.) What follows is a brief summary of the overarching findings from the resulting 10 case study reports.

Findings

In many states, CKF and state staff collaborated effectively on outreach and simplification. CKF state grantees were required to build a coalition that included state administrative staff and, in several states, the two staffs subsequently collaborated closely. In New Jersey, for example, the state grantee undertook extensive outreach and trained state staff to do outreach. When staff members worked together on simplification (such as simplified application forms) and coordination (including developing a joint Medicaid and SCHIP application form), they often developed a new respect for each other. Furthermore, the state CKF grantees collected information from the local grantee projects about difficulties families had with the enrollment and renewal process and brought that information to the state. Although it was not always comfortable for the states to learn about these problems, the availability of such information was helpful as the states considered policy and procedural changes.

Many CKF projects adopted aggressive outreach, at both the local and state levels. CKF-supported outreach typically began as a supplement to state-funded outreach. However, as many states reduced their outreach budgets over the course of the grants, the CKF-supported outreach sometimes became the only major source of outreach in the state. Case study findings suggest that outreach in and around schools holds significant promise for increasing enrollment of children and families. This is particularly true when outreach is conducted one-on-one rather than through less direct approaches, such as sending flyers home in the backpacks of school children. Some of the most promising school-based examples of outreach observed through case studies include:

- *Use of School-Based Service Centers* (Kentucky). The state CKF grantee demonstrated the importance of coalitions in mobilizing resources and securing support for children's coverage from key grassroots organizations. The support of the school-based Family Resource Youth Services Centers (FRYSCs), entities created to promote the well-being of school-aged children in the state, appears to have been important to state coverage. Staff at the FRYSCs functioned as local outreach workers who identified uninsured children in local schools and helped families apply for SCHIP and Medicaid. In the face of state policy changes that might otherwise have curtailed program growth, the FRYSCs and other local groups maintained the momentum for children's coverage in Kentucky, contributing to sustained growth in the numbers of children enrolled in public coverage.
- *Use of Volunteer Networks* (Missouri). A local CKF project–Local Investment Commission (LINC)–used a site-council outreach approach that included an existing network of school volunteers and site coordinators in a comprehensive, school-based strategy. The approach was built on the experiences of site council members who had enrolled family members in the program. They identified eligible children and educated families about enrolling and staying enrolled in the program. The local area served by LINC sustained enrollment despite restrictive statewide policy changes.
- *Partnerships Between Community-Based Organizations and Schools* (Virginia). A local organization, the Fairfax County Partnership for Healthier Kids, was not funded by the CKF project, but had close ties to the state grantee organization and pursued similar goals. It emphasized reaching families with the help of other organizations, especially local schools. It worked with schools to identify uninsured children, referred them to coverage, and followed up on them when they did not apply. This project was championed by the superintendent of Fairfax County schools, who believed in using the school setting to enroll children.

Each year of the CKF program there was a Back-to-School campaign funded by RWJF with significant media support for national and local events. All of the CKF grantees took part in the campaigns to some degree. In North Carolina, in 2002 and 2003, the state budget was tight and there was concern that the state might freeze enrollment as it had done in 2001. In response, the CKF grantee felt it best not to promote Back-to-School, and instead supported lower-profile efforts in schools, such as using school lunch program records to identify low-income, uninsured children. New enrollments in North Carolina continued to increase during this period, suggesting no major loss from shifting away from a larger-scale, media-based approach.

States adopted numerous policies during the grant period aimed at simplifying program procedures and coordinating SCHIP and Medicaid. All states, including the case study states in the CKF evaluation, took numerous steps to simplify enrollment and renewal procedures and improve coordination between Medicaid and SCHIP. Table 1 highlights several steps taken among the 10 case study states.

Some of the key steps identified across the case states were:

- **Simplified forms** were designed to reduce the time needed for families to complete application and/or renewal procedures and to reduce confusion and mistakes in filling out forms. Illinois, for example, developed a one-page form for use when a parent was added to an existing KidCare case. CKF grantees advocated for such forms, and states often received technical assistance from the CKF program on wording and organization of forms for families with lower education levels or whose first language is not English. For example, the New Jersey CKF grantee worked with the state to create a one-page application, which could draw on data already in state computer systems.
- **Joint forms** were designed to ensure that a child eligible for one coverage program is not dropped because his or her family applied for the other coverage program, or, in some cases, applied for another public program for low-income families, such as food stamps. Arkansas, for example, developed a joint application for its Medicaid and SCHIP programs, in part as an effort to reduce the stigma of Medicaid. Arkansas also brought its Medicaid and SCHIP programs under a common umbrella program (ARKids) to further reduce program stigma and confusion over program coverage and eligibility.
- **Eliminating face-to-face interviews** is seen by many children's advocates as an essential step to encourage families to apply for coverage. These interviews can make it particularly difficult for working families to enroll their children in public coverage, both because of the potential stigma associated with applying for coverage at a local welfare office and because of the time required to do so. Over the course of the grant period, a number of case study states abandoned face-to-face applications for some or all eligibility groups, and allowed applications to be submitted by mail (for example, in Arkansas), or, in some cases, online (Illinois and Michigan).

TABLE 1

Simplification and Coordination Changes in the 10 Case Study States, 1999–2005

Type of Simplification or Coordination Change	Arkansas	California	Illinois	Kentucky	Michigan	Missouri	New Jersey	North Carolina	Oregon	Virginia
Simplified and Joint Applications	X	X	X	X	X	X	X	X	X	X
Umbrella Program for SCHIP and Medicaid	X									X
No Face-to-Face Interviews for Medicaid or SCHIP Enrollment	X	[c]	X[a]	X[b]	X	[c]	[c]	[c]	[c]	[c]
More Centralized Eligibility			X		X					X
Self-Declared Income	X			X	X					
Presumptive Eligibility		X	X		X		X			

[a] Illinois allowed on-line applications starting in 2005.

[b] Kentucky eliminated face-to-face interviews, but subsequently reintroduced them for both Medicaid and KCHIP applicants.

[c] By January 2008 all of these states had eliminated face-to-face interviews for both initial applications and renewals (Ross DC, Horn A and Marks C 2008).

- **Centralized eligibility processing** can improve the quality and efficiency of the application and renewal processes, which may be uneven across local offices. During the period of the grant, three case study states (Illinois, Michigan and Virginia) adopted such procedures, processing some or all forms through a state-based system.[1] As discussed later, this program feature was strongly associated with increased enrollment in Virginia.

- **Self-declaration of income** eliminates the need for families to produce and submit proof of income through pay stubs or other means. For example, in Arkansas and Kentucky, the state adopted this approach to reduce the burden of applying for Medicaid and SCHIP. (Illinois reduced the number of pay stubs to one but did not go as far as self-declaration of income.)

- **Presumptive eligibility** allows community-based providers and organizations to grant short-term coverage to children who appear to be eligible for Medicaid or SCHIP so that they can receive services immediately. During the period of presumptive eligibility, parents must submit an application for coverage. For example, Illinois incorporated presumptive eligibility during the grant period for its SCHIP and Medicaid programs.

In addition to these changes in enrollment, states made changes in renewal procedures partly in response to concerns that many children left Medicaid and SCHIP only to return to these programs after a short period of time (an outcome commonly referred to as churning). Often in concert with CKF grantees, states tried different ways of reaching out to families before and around the renewal date using reminders. Another popular approach was to prepopulate renewal forms with information from state files and mail these forms to families to make it easier for them to reapply if nothing in their situation had changed. North Carolina was one such state.

CKF grantees (and their partners) influenced many of these policies. Several of the grantees in case study states developed close and trusting relationships with state staff. For example, in both Virginia and Arkansas, the grantees worked closely with the state to modify Medicaid and SCHIP enrollment and renewal policies. The state CKF grantee in Virginia was an organization founded by then-Governor Mark Warner, and he supported their application to be the state grantee. The grantee worked closely with state officials on simplification and coordination, and also coordinated statewide outreach. In Arkansas, the organization that subsequently became the state grantee was actively involved in promoting important policy changes: it worked collaboratively with the state to develop ARKids First, and promoted and monitored the program once it was in place. Later, as the CKF grantee, it continued to monitor ARKids First and to provide the state with constructive feedback.

The statewide CKF coalitions also played an important role in many of the changes taking place. As summarized by Duchon and Ellis (2008), these coalitions often informed state staff, the legislature and the governor about barriers to public coverage, and helped shape the policies and procedures to overcome the barriers. For example, among the case study states, the Illinois grantee oversaw a statewide coalition that recommended coordination and simplification of enrollment and retention policies to the state throughout the CKF period. The Virginia grantee identified enrollment barriers and ways to overcome them by describing cases of families who did not complete an enrollment application or were denied, and then communicated with the governor and legislature to shape policy changes to reduce barriers. Similarly, the Arkansas grantee had direct access to the governor and state policy-makers and the Michigan grantee created a State Steering Committee to communicate information from local projects to policy-makers. Without this type of access to state policy-makers, it was harder for CKF grantees to have an effect on policy.

Budget and other challenges slowed progress in many states, though political/public support for children's coverage offered a potential counterweight. Many states faced budget problems soon after the CKF program began in 2002. They responded to budget cuts in various ways that had the potential to, and in some cases, did, reduce new enrollment. They cut back on outreach, froze enrollment, reversed previous enrollment or renewal simplifications, introduced tests of availability of other affordable coverage, and restricted benefits and added cost sharing. For example:

- California ended its payments to application assistants in 2003 and Oregon and Kentucky ended their statewide outreach programs. California's enrollment dropped after its outreach cutbacks.
- North Carolina put a cap on enrollment in January 2001, but lifted it nine months later.
- Kentucky reversed itself on face-to-face applications, reintroducing them in 2002.
- Missouri enforced annual eligibility checks beginning in 2005 rather than allowing the de facto, passive renewal process to continue (the state had a staff shortage and had not been doing full annual reviews of eligibility). Missouri also introduced premiums for families with incomes of more than 150 percent of the federal poverty level and an "affordability test" (families had to show no access to affordable health insurance).

- Oregon's budget crisis began in 2003. Its response was not to implement its Oregon Health Plan 2 (OHP2) initiative for adults. Subsequently, it cut back on its OHP standard plan for adults by introducing cost sharing, penalties for premium nonpayment and a reduced benefit package.

Strong political support for children's coverage limited program cutbacks in at least three case study states that also experienced budget problems:

1. In Virginia, the governor's steady support for children's coverage led to a simplified application process and improvements in SCHIP and Medicaid coordination, suspension of premium payments, and institution of a "no wrong door" policy, which allowed children's applications to be submitted either at local offices of the Department of Social Services or to the central processing unit. These policies were all designed to increase children's coverage and took place in spite of a weak economic environment in the state. New enrollment increased markedly after each change.
2. In Arkansas, the governor was likewise a strong supporter of children's coverage and of coverage expansion. Despite critical budget problems in 2002 and 2003, the state pursued significant steps to destigmatize public coverage and experienced significant growth in new enrollment.
3. In Illinois, the new governor in 2003 faced numerous fiscal challenges but strongly supported expansions in children's coverage. Through his leadership, the state expanded eligibility in both 2003 and 2005, resulting in a universal coverage program for children in Illinois.

Major enrollment increases were evident in many states, some with close links to policy. A formal analysis of enrollment data across the 10 case study states reveals significant evidence of gains in new enrollment during the grant period, often with close links to major policy changes. Examples of enrollment gains with close links to policy include:

- Arkansas' rebranding of SCHIP and Medicaid (under the common ARKids program brand), together with the abandonment of face-to-face interview requirements and the introduction of a mail-in application, was associated with a sharp increase in Medicaid enrollment (and a smaller increase in enrollment in the separate SCHIP program).

- California showed large gains in enrollment associated with expansion of its presumptive eligibility program. However, much of this enrollment proved temporary, as many families never completed the application subsequent to seeking care (and gaining presumptive eligibility) for their children.
- Kentucky conducted an unprecedented level of statewide outreach during the launch of its SCHIP component. This outreach aimed to raise awareness about *all* public health insurance coverage and appears to have contributed to sustained gains in Medicaid that continued long after the outreach ended.
- Michigan's adoption of self-declaration of income in 2000 was associated with large increases in enrollment in the Medicaid and SCHIP Medicaid expansion programs.

Summary

Over the course of the CKI and CKF programs (1999–2006) there were widespread changes in SCHIP and Medicaid policies and procedures related to eligibility, enrollment and renewal of coverage, some intended to make it easier for families to enroll and some not. Many changes were intended to reduce the barriers to enrollment and increase coverage of low-income families. However, when states experienced budget problems, they always looked at changes in SCHIP and Medicaid policies that might save them money; and they sometimes acted on those changes. The case study findings summarized in this brief provide evidence for links in some states between the CKF grant program and policy changes; the findings also provide substantial evidence across states for links between the policy changes and enrollment. A forthcoming paper will present the findings from a formal analysis across the 10 case study states of the effects of specific policy changes (such as elimination of face-to-face interviews and the implementation of a joint application form) on enrollment, singly and in combination with other policy changes (Trenholm and Zutshi, forthcoming).

Endnotes

1. California has a centralized vendor that reviews all applications and processes Healthy Families (SCHIP) applications, but sends MediCal applications back to the relevant county.

References

Ross DC, Horn A and Marks C. *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles, Kaiser Commission on Medicaid and the Uninsured.* Washington: Kaiser Family Foundation, 2008. Available at *www.kff.org/medicaid/upload/7740_ES.pdf*.

Duchon L and Ellis E. *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*. Princeton, NJ: Robert Wood Johnson Foundation, 2009. Available at *www.rwjf.org/files/research/3663.pdf*.

Trenholm C and Zutshi A. "Increasing Children's Enrollment and Retention in Medicaid and SCHIP: Which Policies Really Work?" (Forthcoming 2009).

Some of the CKF reports drawn on in preparing this synthesis are:

Cook B, Schott W and Trenholm C. *Covering Kids & Families Evaluation: Case Study of Missouri: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice.* Princeton, NJ: Mathematica Policy Research, Inc., 2007. Available at *www.rwjf.org/files/research/052208ckfmissouri0807.pdf*.

Courtot B, Hill I and Trenholm C. *Covering Kids & Families Evaluation: Case Study of Oregon: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice.* Washington: The Urban Institute and Mathematica Policy Research, Inc., 2007. Available at *www.rwjf.org/files/research/052208ckforegon0807.pdf*.

Ellis E, Walls J, Marks D and Trenholm C. *Covering Kids & Families Evaluation: Case Study of Michigan: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice.* Washington: Health Management Associates and Mathematica Policy Research, Inc., 2007. Available at *www.rwjf.org/files/publications/other/CKFcaseStudy0507.pdf*.

Gifford K, Morgan G, Marks D and Trenholm C. *Covering Kids & Families Evaluation: Case Study of Illinois: Exploring Links Between Policy, Practice and the Trends in New Medicaid/ SCHIP Enrollments.* Washington: Health Management Associates and Mathematica Policy Research, Inc., 2008. Available at *www.rwjf.org/files/research/052208ckfillinois0108.pdf*.

Howell E, Courtot B and Trenholm C. *Covering Kids & Families Evaluation: Case Study of North Carolina: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice,* 2007.

Howell E, Trenholm C, Gifford K and Lavin B. *Covering Kids & Families Evaluation: Case Study of Virginia: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice. Final Report*. Princeton, NJ: Mathematica Policy Research, Inc., The Urban Institute and Health Management Associates, 2006. Available at *www.rwjf.org/files/research/CKF_VA_case_study-final%20report.pdf*.

Sullivan J, Hill I and Trenholm C. *Covering Kids & Families Evaluation: Case Study of California: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice. Final Report*. Princeton, NJ: The Urban Institute and Mathematica Policy Research, Inc., 2006. Available at *www.rwjf.org/files/research/CA-CaseStudy-rep%20(Revised%207-26-06).pdf*.

Trenholm C and Lavin B. *Covering Kids & Families Evaluation: Case Study of Kentucky: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice. Final Report.* Princeton, NJ: Mathematica Policy Research, Inc., 2008.

Trenholm C, Lavin B and Wooldridge J. *Covering Kids & Families Evaluation: Case Study of New Jersey: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice. Final Report.* Princeton, NJ: Mathematica Policy Research, Inc., 2006. Available at *www.rwjf.org/files/research/CKF_NJ_case_study-final%20report.pdf*.

Walls J, Lavin B, Gifford K and Trenholm C. *Covering Kids & Families Evaluation: Case Study of Arkansas: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice. Final Report.* Princeton, NJ: Mathematica Policy Research, Inc. and Health Management Associates, 2006. Available at *www.rwjf.org/files/research/AR%20case%20study.final1(Revised%207-26-06).pdf*.

Robert Wood Johnson Foundation

Route 1 and College Road East
P.O. Box 2316
Princeton, NJ 08543-2316
www.rwjf.org

This report is part of the Covering Kids & Families evaluation. For more information on this and other RWJF national program evaluations please visit *www.rwjf.org*.

Our Committment to Evaluation

The Robert Wood Johnson Foundation is committed to rigorous, independent evaluations like this one. Evaluation is the cornerstone of our work and is part of the Foundation's culture and practice. Our evaluation efforts often include varied approaches to gather both qualitative and quantitative data. These evaluations are structured to provide insight, test hypotheses, build a knowledge base for the field, and offer lessons learned to others interested in taking on similar efforts.