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Covering Kids & Families Evaluation

Sustaining the Effects of Covering Kids & Families on Policy Change: Results of a Follow-Up Telephone Survey of Medicaid and State Children's Health Insurance Program (SCHIP) Officials in 46 States

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Contents

Tables and Figures

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.

The literature indicates that "forced" collaborations–those required by funders–might be partnerships on paper only (Lasker, Weiss and Miller 2001; Lewin Group 2000). However, survey findings from interviews with 60 state Medicaid and SCHIP officials in 46 states in late 2006 and early 2007 suggest that these partnerships were effective collaborations, culminating in permanent policy and procedural changes in Medicaid and SCHIP programs. This report summarizes the survey results.

Methods and Data. In December 2006 and January 2007 Health Management Associates (HMA) conducted a telephone survey with 60 Medicaid and SCHIP officials in all 46 states in which there were CKF grantees. This survey was structured as a follow-up to a 2005 survey conducted by Mathematica Policy Research, Inc. (MPR) and HMA. The earlier 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:

- Simplified enrollment
- Renewal/retention
- Coordination
- Eligibility
- Outreach

The purpose of the follow-up interviews was to learn the status of these policy and procedural changes and to capture information about any additional changes that CKF might have influenced which had not been identified previously. As part of these follow-up interviews, the survey 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).

Findings. Key findings of the telephone survey with state officials in December 2006 and January 2007 include:

State Officials' Familiarity and Involvement With CKF

- Ninety percent of state officials stated that they were very or somewhat familiar with CKF activities since 2002, and nearly 80 percent reported that they were very or somewhat involved with CKF activities since 2005.

Policy and Procedural Changes CKF Influenced

- In 45 out of 46 states with a CKF grant, state officials reported at least one type of policy or procedural change implemented since 2002 as a result of CKF's influence; 29 states simplified enrollment as a result of CKF.
- State Medicaid and SCHIP officials 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%).
- For almost half (45%) of all policy and procedural changes identified with CKF's influence, state Medicaid and SCHIP officials indicated that the change would not have occurred without CKF. For all other changes, state officials indicated that the change would have occurred anyway, without CKF, but more slowly (36%) or would have occurred anyway, at the same pace (12%).
- Among the policy and procedural changes that state officials associated with CKF's influence, 83 percent were described as still completely in effect at the time of the follow-up survey. Of those changes still completely in effect, 88 percent were considered permanent, that is, state officials expected them to remain in effect for at least two more years.

- For the 20 percent of changes reported as partially or completely reversed or at risk of reversal, Medicaid and SCHIP officials–given the option to choose multiple reasons for the reversal–most frequently cited "budget constraints" (54%), followed by "political or philosophical" reasons (32%) and "new leadership" (22%).
- Changes that state officials said would have occurred without CKF (at the same pace or more slowly), were more likely still to be in effect (90%), and more likely expected to be permanent if still in effect (84%) than changes that officials said would have occurred only with CKF's involvement (76% and 61%, respectively).

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:
  - Many officials noted the professionalism and effectiveness of CKF grantees.
  - State officials praised the communication networks that CKF coalitions formed in their states. Many, if not most, of these coalitions continue in some capacity and are considered an important legacy of CKF.
  - State officials valued highly the training and professional development CKF provided as well as the exposure to other states' activities and networking opportunities at the national level.
  - Many officials expressed disappointment that CKF had ended. Some officials were concerned that progress made with CKF's support might erode over time.

Conclusions. State officials highly valued the Covering Kids & Families program. Most policy and procedural changes that CKF influenced in Medicaid and SCHIP programs since January 2002 are still in effect and 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 that coalitions may find difficult to overcome.

The efforts of CKF grantees and coalitions not only inspired many procedural and policy changes but a greater sense of confidence and leadership among state officials. The program's legacy includes an extensive set of state communication networks of local organizations and government agencies dedicated to children's health and coverage. This largely permanent presence may indirectly improve coverage over the long run by raising the profile of public health programs among state legislative leaders, whose influence has such enormous sway over the direction of Medicaid and SCHIP policies.

Background

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 SCHIP programs who remain uninsured, and to build the knowledge, experience and capacity necessary to sustain the enrollment and retention of children and adults in those programs after the CKF program ends. 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 funded CKF grantees in 46 states beginning in 2002.[1]

CKF works 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 is 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), 2005 (Morgan, Ellis and Gifford 2005), and most recently in December 2006 and January 2007. The team designed these surveys to identify, from the perspective of state officials, the most important policy or procedural changes that CKF influenced; how important CKF was to the implementation of identified policy or procedural changes; to what extent the changes that CKF influenced are still in effect; and to what extent state officials expect changes to be permanent.

Methods

Survey Design. In 2005 the evaluation team administered a telephone survey to Medicaid and/or SCHIP officials in all 46 states with CKF projects. The survey asked officials to identify the three most important policy or procedural changes since January 2002 that CKF had directly influenced (Ellis, Morgan and Longo 2005). 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** includes 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** includes policy or procedural changes that are intended to make the renewal or re-enrollment process easier and retain enrollment of those eligible for coverage.

3. **Eligibility** includes policy changes to Medicaid and/or SCHIP that affect who is eligible for the program (e.g., expanding income limits, offering 12-month continuous eligibility[2]). CKF's effect on eligibility policy could include promotion of policies that expand eligibility and efforts to prevent the implementation of policies that would reduce eligibility.

4. **Outreach** includes policy or procedural changes designed to make uninsured families more aware of their potential eligibility for coverage in Medicaid and/or SCHIP, and to increase the opportunities for families to enroll in Medicaid, SCHIP or other public health programs for which they may be eligible.

5. **Coordination** includes 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 program, regardless of the particular program for which an individual or family member 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** includes 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 Questionnaire. In December 2006 and January 2007, HMA conducted follow-up interviews with officials in each of the 46 states with CKF projects to learn the status of changes Medicaid and SCHIP officials identified in the 2005 interviews. We also asked respondents to identify up to three additional changes in enrollment, eligibility, renewal, coordination and/or outreach that the CKF initiative had influenced since 2002 that had not been captured in the 2005 survey.

Combining the results from the two surveys, State Medicaid and SCHIP officials collectively identified 183 unique policy or procedural changes that CKF influenced.[3] Up to six changes per program (and a maximum of 12 in states with a Medicaid and separate SCHIP program) were possible. We analyzed these changes by the five major categories described above. If a change was still in effect, we asked about its permanence, that is, whether the official expected the change to be in effect in two years. If the 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 queried as to the reasons for this. Unless otherwise noted, the findings presented here are from the follow-up 2006/2007 survey (see Appendix A for the 2006/2007 survey questionnaire).

Survey Participants. In December 2006 and January 2007 HMA interviewed 60 state Medicaid and SCHIP officials in 46 states. Our basis for selecting state officials to interview was the administrative structure of the Medicaid and SCHIP programs within their respective state agencies.[4] Thus, if a single official is 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 a single official. If two officials are separately responsible for a Medicaid program and a SCHIP program, we attempted to interview both officials.

For 29 states, we interviewed a single official for both the Medicaid and SCHIP program. In 14 states, we interviewed one official from the Medicaid program and one official from the SCHIP program. For three additional states with a separate SCHIP program, only a SCHIP official was available for this survey.

Table 1 shows the number of unique states represented and the number of state officials interviewed by the type of program(s) administered. The table also indicates how many officials interviewed in the follow-up survey were the same or a different person interviewed in 2005. (See Appendix B for a list of 46 states with CKF grantees.)

TABLE 1

Number of States Represented and Officials Interviewed in the 2006–2007 Survey

	One official interviewed about both Medicaid and SCHIP	Separate officials interviewed about Medicaid and SCHIP		Official interviewed about SCHIP only	Total
States	29	14		3	46
		MEDICAID	SCHIP		
Officials interviewed in 2006–2007	29	14	14	3	60
Same official interviewed in 2005	21	11	7	2	41
Different official interviewed in 2005	8	3	6*	1	18*

* In one state, no SCHIP official was interviewed in 2005.
Source: 2005 and 2006–2007 CKF Survey of State Officials

Findings

Familiarity and Involvement of State Officials with CKF Activities

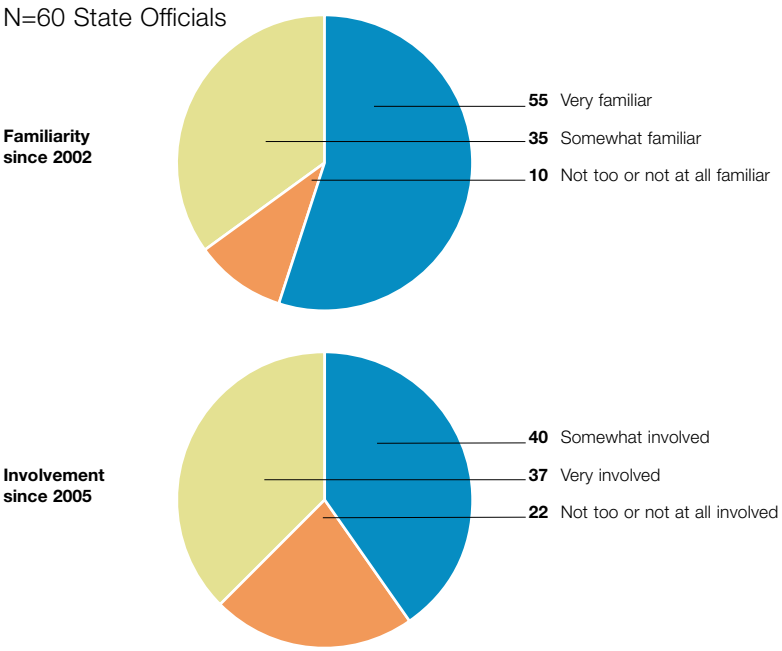
Most state officials were very or somewhat familiar with the CKF initiative in their state and very or somewhat involved with CKF activities in the last 18 months.

Interviewers asked state program officials about their familiarity with CKF activities since 2002–the first year of the program–and their involvement in CKF activities since the time of the mid-2005 survey.[5] Ninety percent of state officials stated that they were very or somewhat familiar with CKF activities since 2002 and more than half said they were very familiar. Nearly 80 percent of state officials reported they were very or somewhat involved with CKF activities since 2005, with more than one-third indicating they were very involved (Figure 1).

In 28 states (61%), at least one official indicated that he or she was very familiar with CKF activities, and in 21 states (46%), at least one official indicated that he or she was very involved with CKF activities since 2005.

FIGURE 1

Familiarity and Involvement of State Medicaid and SCHIP Officials with CKF Activities



Source: 2006–2007 CKF Survey of State Officials

Officials who were interviewed in both the 2005 survey and the 2006–2007 follow-up survey (N=41) were more likely to say that they were very familiar and very involved compared to officials who were relatively new to their current position (N=18). This is not surprising, as the CKF grant period officially ended during 2006 for all but two participating states. Officials from several state agencies that served as the CKF grantee voluntarily mentioned that they have continued CKF activities beyond the grant period.[6]

Policy and Procedural Changes CKF Influenced

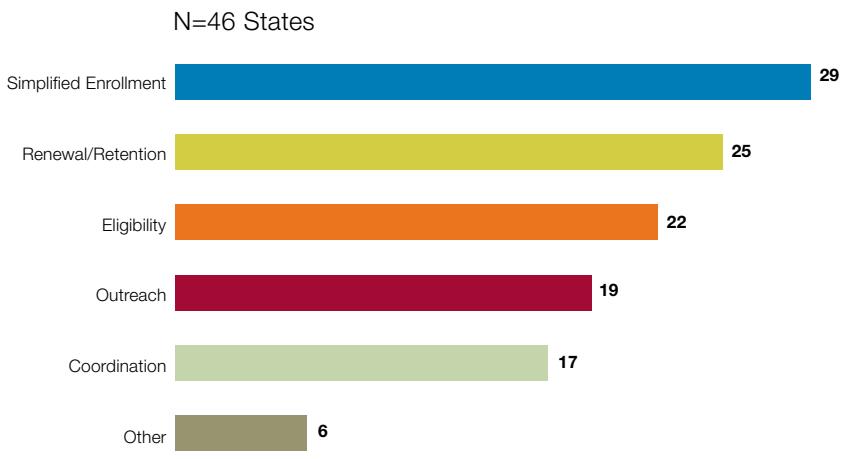
Almost all participating states implemented at least one policy or procedural change that CKF influenced; simplified enrollment was the type of change most broadly implemented across the 46 states.

All but one participating state identified at least one policy or procedural change that had been implemented since 2002 as a result of CKF's influence. Officials from 10 states identified six or more changes, and one state identified 10 changes. The average was four changes per state.

Officials from 29 of the 46 participating states (63%) identified at least one enrollment simplification change that was implemented because of CKF's influence (Figure 2). Twenty-five or just over one-half of participating states adopted at least one renewal/retention policy or procedure influenced by CKF activities, and 22 states (48%) credited CKF with influencing at least one change in eligibility policy since 2002.

FIGURE 2

Number of States Where Officials Identified at Least One Type of Policy or Procedural Change that CKF Influenced



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

Only 17 states reported a coordination change, typically implementation of a joint application for Medicaid and SCHIP (but also including coordination with other public programs–such as the Food Stamp Program). The fact that 29 of the 46 states surveyed operate Medicaid and SCHIP programs that are administered by the same staff may partially explain the relatively smaller number of states reporting coordination activities. It is also possible that coordination efforts may have occurred before CKF began (and perhaps through CKI efforts).

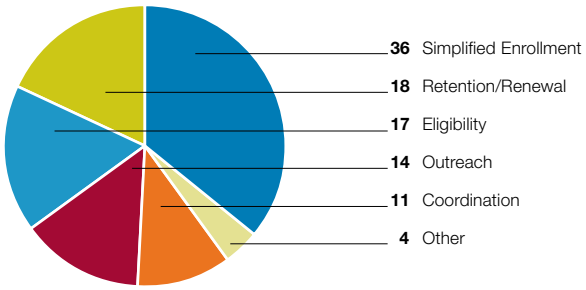
Among the 183 unique policy and procedural changes that Medicaid and SCHIP officials identified as being influenced by CKF activities, efforts to simplify enrollment processes comprised the largest category (36%).

State officials most often mentioned efforts to simplify enrollment in reference to CKF's influence on policies and procedures in Medicaid, SCHIP, or combination programs (Figure 3). Renewal/retention changes and eligibility changes were a distant second (18% and 17%, respectively). Outreach activities made up 14 percent of all reported changes influenced by CKF and coordination efforts made up 11 percent.

FIGURE 3

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

N=183 policy or procedural changes



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

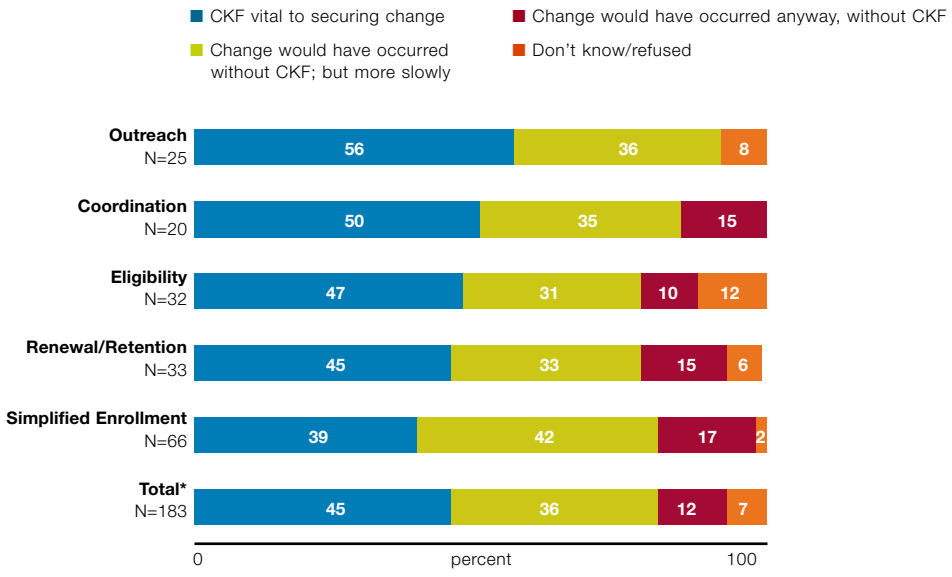
While most state officials indicated that CKF played either a vital or facilitating role in the policy and procedural changes they cited, the level of CKF's influence varied somewhat by the type of change pursued.

For almost half (45%) of all policies and procedures that CKF influenced, state officials indicated that the change would not have occurred without CKF; that is CKF was considered "vital to securing this change." This response ranged from 39 percent for simplified enrollment changes to 56 percent for changes related to outreach (Figure 4). For more than a third (36%) of changes CKF influenced, state officials indicated that the initiative played a facilitating or catalyzing role; that is, the change would have occurred without CKF's involvement, but more slowly. State officials described 12 percent of changes as those that would have occurred without CKF's involvement, at the same pace.

Compared with all other changes, state officials were somewhat more likely to indicate that efforts to simplify enrollment would have occurred without CKF (at the same pace or more slowly). Some of CKF's effect in this area may have been to facilitate or accelerate changes that states were predisposed to make, such as changes that were relatively uncontroversial, simple to implement or valued for improving operational efficiency.

FIGURE 4

CKF's Influence on Procedural and Policy Changes Identified by Medicaid and SCHIP Officials



* Includes "other" category.

Note: Some totals may not add up to 100 due to rounding.

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

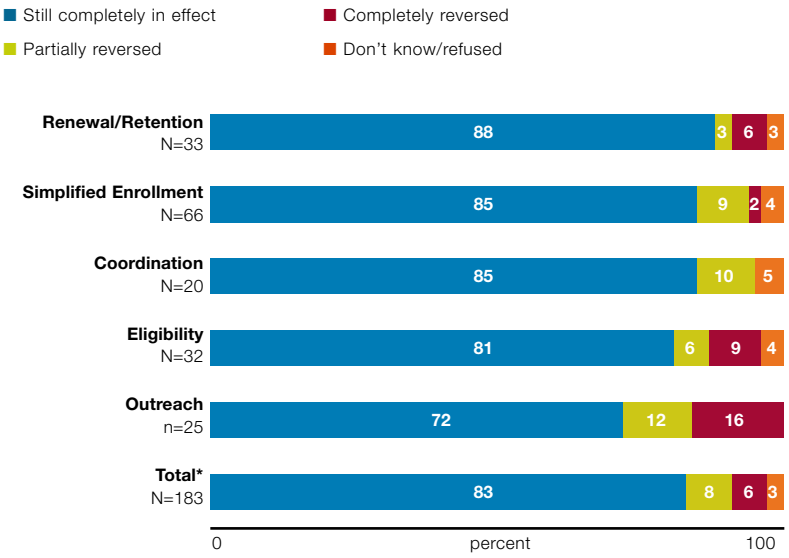
Permanence and Expected Sustainability of Policy and Procedural Changes that CKF Influenced

Most policy and procedural changes that CKF influenced were still in effect at the time of the follow-up survey.

The changes most likely still to be completely in effect at the time of the follow-up survey were those related to renewal/retention (88%), simplified enrollment (85%) and coordination (85%) (Figure 5). For many of these types of changes, it may be impractical to reverse a change once in effect. Changes in procedures–compared with changes in policy–may also be less controversial in terms of their budget implications and therefore may be more "protected" from legislative decision-making.

FIGURE 5

Status of Policy and Procedural Changes Identified by Medicaid and SCHIP Officials



* Includes "other" category.

Source: 2006–2007 CKF Survey of State Officials.

State officials were most likely to say that outreach activities had been partially or completely reversed.

While CKF's influence on outreach changes was more often than other types of changes considered "vital" in the eyes of state officials, outreach changes were also the most likely to be partially (12%) or completely (16%) reversed. On average, 8 percent of the changes from all categories were partially reversed, and 6 percent were reported as completely reversed.

Outreach activities, according to state officials, comprised 14 percent of all policy and procedural changes. This result, combined with both the need for greater CKF effort to implement state outreach activities and the higher reversal rate suggest that there may be ambivalence about or resistance to outreach activities in some states. Remarks in the National Governors' Association SCHIP Policy Position HHS-09 (NGA 2007) regarding the fiscal ramifications of outreach offer an example:

> *"Any new outreach program must be designed so that it does not create fiscal problems for states or create expectations that cannot be met. Any new outreach funds must be coordinated by or through the states and must be accompanied by adequate funding for coverage, since it is counterproductive to encourage eligible individuals to enroll if the resources are not available to cover the cost of health care coverage."*

A relatively higher reversal rate of outreach activities may also reflect a history of states associating outreach activities with direct funding from external sources, including CKF and other time-limited grants. For example, when SCHIP was implemented, some states funded outreach efforts by using a one-time grant related to welfare reform that was originally appropriated to ensure that children and families would be aware that they may be eligible for Medicaid even if they were ineligible for cash assistance (Avetti, Maloy and Schott 2002). This "delinking" grant was used to fund SCHIP-related outreach efforts, such as media campaigns, which otherwise might not have occurred.[7]

There is also some evidence to suggest that when states face an economic downturn, as occurred several years ago, outreach efforts may be reduced or eliminated as "nonessential" services (Smith, et al. 2007). This type of environment also may have limited some states' ability to sustain outreach efforts influenced by CKF, particularly after the grants ended. Additionally, within the political context and budget constraints of public programs, outreach activities have often lacked a dedicated and ongoing funding source.

Our survey also found that state officials from 17 (40%) of the 43 Medicaid or Medicaid and SCHIP programs indicated that their state does not fund outreach directly or indirectly.[8] The large portion of states without outreach programs combined with the relatively low volume and higher reversal rate of CKF-influenced outreach efforts, as identified by Medicaid and SCHIP officials, highlight the challenges of both promoting and sustaining state outreach activities.

Eighty-eight percent of policy and procedural changes still completely in effect were expected to stay in effect "at least two years," as reported by state officials.

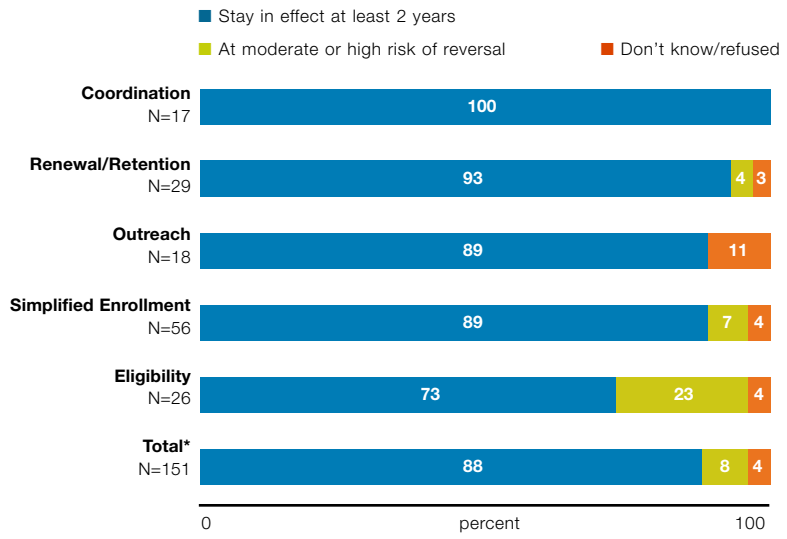
The sustainability, or expectation of permanence, for changes still in effect ranged from 100 percent for coordination efforts to 73 percent for eligibility policies (Figure 6). Among the changes expected to be permanent, state officials indicated 96 percent of the time that they were "very" (71%) or "somewhat" (25%) confident that these changes would be in effect for four more years. (Data not shown.)

State officials were more likely to say an eligibility policy that CKF influenced was at risk of reversal (23%) compared with the other types of policy and procedural changes CKF influenced overall (8%).

Compared with procedural changes that affect the enrollment or renewal process or program coordination, for example, policy changes that expand eligibility may be more subject to budget constraints, changes in administration or changing political priorities. These were the key reasons given for reversals, as described below. Eligibility changes may also be more dependent upon legislative authorization and the state budget process. Therefore, the responses of state officials may reflect a greater sense of *uncertainty* about the permanence of eligibility expansions compared with other procedural changes over which the executive branch may be able to exercise more control. Successes that CKF had in the area of eligibility policy may also be relatively at greater risk of reversal once CKF support stops, if this results in a coalition or advocates having fewer resources to help prevent a reversal.

FIGURE 6

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



* Includes "other" category.

Source: 2006–2007 CKF Survey of State Officials.

Primary Reasons a Change Was Reversed or Considered at Risk of Reversal

Among the changes CKF influenced that were reversed or that state officials considered at risk of reversal, budget constraints and other "political/philosophical" reasons were most often cited as the reasons.

For each change that an official stated had been partially or completely reversed (n=25) and for each change an official said was still in effect but identified as at risk for a full or partial reversal (n=12), we asked about six specific reasons and about any other reasons behind the reversal or risk of reversal outcome. For each of these 37 changes, officials had an opportunity to identify multiple contributing factors.

"Budget constraints" were identified as the reason in more than half the reversal or at risk of reversal cases (54%) (Table 2). Other "political or philosophical" reasons were the second most frequently cited reason (32%), while "new leadership" was indicated for 22 percent of changes reversed or at risk of reversal. CKF grantees also identified "environmental" barriers, including limited state funding, policy changes, the political climate or Medicaid/SCHIP bureaucracy as the greatest barriers to achieving CKF goals (Hoag and Paxton 2007).

CKF's level of influence in producing a policy or procedural change, as perceived by state Medicaid and SCHIP officials, may also be associated with the reversal or permanence of a change.

We explored whether state officials' perceptions about CKF's role in producing a policy or procedural change were associated with the status of a change and their perceptions about the permanence of a change. We were interested in whether a predisposition to make a change, as measured by state officials' perceptions that a change would have occurred without CKF, may serve as a "protective" factor in sustaining it.

TABLE 2

Reasons Policy or Procedural Changes that CKF Influenced Were Reversed or Considered at Risk of Reversal, as Perceived by State Officials

	Changes partially or completely reversed (N=25)	Changes still in effect but at risk of reversal (N=12)	Total changes reversed or at risk of reversal (N=37)	Percent of total (N=37) reversed or at risk of reversal
Reasons for partial or complete reversal or for being considered at risk of reversal*				
Budget constraints	13	7	20	54%
Other political/philosophical reasons	6	6	12	32%
New leadership	5	3	8	22%
DRA citizenship verification	6	0	6	16%
Other changes in federal requirements	2	1	3	8%
Fraud, abuse, other program integrity concerns	1	1	2	5%
Some other reason**	13	4	17	46%

* Respondents could choose multiple reasons.

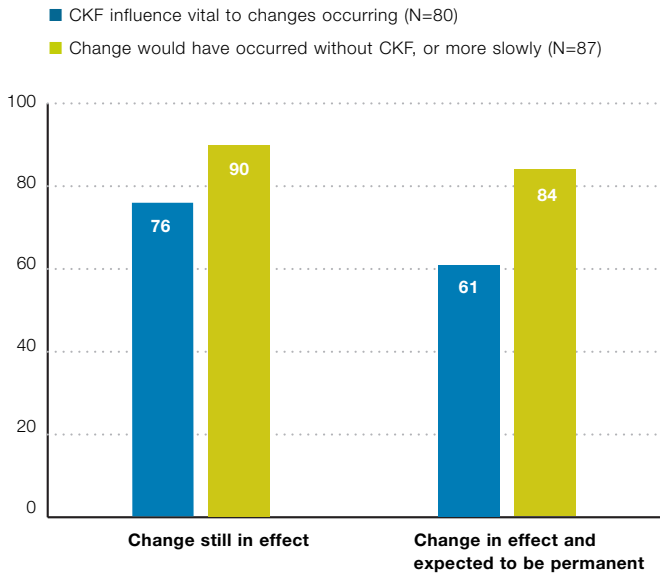
** Other reasons included: Activity or change ceased with end of grant or departure of grantee staff; priorities changed at administration or legislative level; the change never fully went into effect.

Source: 2006–2007 CKF Survey of State Officials

We found that for the five main categories of policy and procedural changes combined, those changes that state officials said would have occurred without CKF (more slowly or at the same pace) were more likely to be in effect (90%) at the time of the follow-up interview than changes that officials stated would not have occurred without CKF's involvement (76%) (Figure 7). Of those changes still in effect at the time of the follow-up survey, the changes that officials said would have occurred anyway, without CKF, were more likely to be considered permanent (84%) than changes that officials indicated occurred only because of CKF's role (61%). These patterns generally held up across individual categories of change, but the denominators for each are small (see Appendix C). In a separate analysis of all changes combined, we also found a statistically significant inverse relationship between CKF's level of involvement in producing a change and its likelihood of still being in effect at the time of the follow-up survey.[9]

FIGURE 7

Percentage of Changes Still in Effect, and Expected to be Permanent, at Time of Follow-Up Survey, by CKF's Influence on the Change, According to State Officials



Source: 2006–2007 CKF Survey of State Officials.

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 the CKF project and its influence in their state. Forty of 60 officials from 31 states chose to make additional comments. Overall, state officials were highly positive about their experiences with CKF and the contributions of the CKF coalition in their state. Officials described CKF as "very beneficial," "effective," "critical to our program," a "good collaboration," "wonderful advocates," a "vital partnership," and as a program that was a "worthwhile endeavor" whose "impact was felt."

Officials also expressed appreciation for the communication networks that CKF coalitions created and the technical assistance and professional development CKF provided. These are important legacies of CKF in many states, in addition to the changes in policies and procedures that remain in effect. A number of officials also expressed disappointment that the grants had ended, as well as a desire for CKF's continuation to sustain the progress made. The following is a summary of state officials' concluding comments about Covering Kids & Families.

Many Officials Described the Influence of the CKF Program in Concrete Ways

One official attributed the "significant reduction in uninsured" in her state directly to the work of CKF. Another official commended CKF grantees for "safeguarding eligibility" in her state's Medicaid program. Several officials praised CKF's involvement in outreach activities, and one mentioned that "the greatest impact has been on improving coordination."

Several officials specifically mentioned the benefits of the "Process Improvement Collaborative" (PIC). One official credited the results of a PIC with increasing application and retention rates. Another described their PIC as "a tremendous amount of work, but we would never have gotten things done without it (Hoag and Woodridge 2007)."

A number of state officials gave examples of efforts underway (e.g., Web-based application) or under consideration by the legislature (e.g., continuous eligibility) and thus not captured by the survey, but which they attributed to CKF's continued influence. One state official noted that although outreach activities declined after CKF funding ended, CKF's influence is associated with the state budgeting $1 million to expand state-funded outreach activities.

The communication infrastructure that CKF coalitions established across states is an important legacy of the program.

A number of officials praised the communication networks that CKF coalitions established between the Medicaid and/or SCHIP program and its stakeholders, including advocates, community organizations and other state agencies. For some, the exposure to a greater diversity of viewpoints has improved policy deliberations. CKF's communication efforts in the political realm were also valued. Several officials praised CKF grantees for their active role in "getting the message out" about children's health issues, particularly to their state legislature. "CKF really made a difference getting state policy-makers and legislators to pay attention," stated one official.

Fourteen officials spoke specifically about ways that CKF's efforts continue, mainly through regular meetings with stakeholders. One official's comments represented the sentiments of several: "CKF's legacy is this communication infrastructure that helps to inform, improve and fine-tune our decision-making process, rather than directly influence policy decisions." In one state, an official noted that its program "has incorporated CKF into its mission and activities." Another official, in noting that the state began contracting with organizations to "continue the CKF-type work" after funding ended, said the network of community groups CKF established "provided a great foundation."

In another state, an official described the value of having the Medicaid/SCHIP program itself serve as the CKF grantee. "Everyone involved with CKF was a state employee, so we didn't have to rely on external funding. CKF is part of the infrastructure of state government. This has likely contributed to the sustainability of the changes we've made to our program." Yet, another official noted that even though the state's coalition no longer exists, local coalitions do exist, and are still working on issues such as an electronic application. "Any outcomes they (local coalitions) continue to have will be part of CKF's legacy in [our state]."

The value of the training and exposure to other states' efforts that CKF facilitated was a broad theme of officials' appraisal of CKF, and another part of its legacy.

One official said that the skill-building activities CKF provided around partnering with other organizations were "the best training of my professional career." A few expressed appreciation for networking activities at the national level. "Knowing what other states were doing was a real advantage," said one official. In noting these experiences, a number of officials described CKF grantees and program staff in terms such as "smart," "professional," "analytical," "respectful," and "well-organized." One official exclaimed that CKF "made my job easier and made me more confident about what we do." In only a few instances were officials critical. One described the CKF grantee as "lacking awareness" about the uninsured. Another official described the agency's relationship with the CKF grantee as "not always comfortable, but very important."

Some state officials expressed concerns over discontinuation of CKF.

While many officials noted ways that CKF's influence continues in their state, more than a half-dozen sounded a note of "disappointment" and concern over the program's completion. One official stated that since CKF funding ended, "there is not as much information flowing." A few officials expressed sentiments similar to the following about the program's end: "A lot of good things have happened and it would be a shame if we were to take steps backwards."

Conclusions

The Covering Kids & Families program has been highly valued by state officials. On the whole, the policy and procedural changes that CKF influenced in Medicaid and SCHIP programs since January 2002 were still in effect and 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.[10] In any case, CKF's legacy includes new and enhanced communication networks and partnerships, greater awareness about children's health issues among state legislators and a higher attainment of professional training and technical skills among state officials and program staff.

Our analysis of the survey of state Medicaid and SCHIP officials demonstrate that Covering Kids & Families has provided valuable support to states, particularly in initiating and implementing strategies designed to simplify enrollment and renewal/retention procedures and facilitate coordination, which together comprised two-thirds of the changes that Medicaid and SCHIP officials cited. From the results of our surveys with state officials, CKF appears to have had somewhat limited long-term influence on outreach efforts (although CKF's influence on those changes was more likely to be considered vital in the eyes of state officials). However, coalition leaders most often cited outreach as their highest priority for expanding coverage (Lavin, et al. 2004). This survey outcome could also indicate a lack of awareness among state officials about outreach activities that CKF generated, particularly at the local rather than state level. CKF also appears to have had relatively less of an effect in promoting eligibility expansions, which was not an explicit goal of CKF.

Overall, the results suggest that CKF's involvement with Medicaid and SCHIP programs may have been most productive in supporting changes and activities that state agencies had the most internal control over and likewise, were least subject to external political influence and budget constraints. Although small numbers dictate caution in interpretation, the findings may also suggest that state officials were more likely to view changes as permanent when CKF's efforts helped to accelerate or otherwise support changes that state officials were predisposed to undertake, rather than when CKF's role was considered critical to a change occurring.

Finally, the efforts of CKF grantees not only inspired policy and procedural changes but a greater sense of confidence and leadership among state officials. The largely permanent presence of state communication networks of local organizations and government agencies dedicated to children's health and coverage–that is a part of CKF's legacy–may indirectly improve coverage over the long run by raising the profile of public health programs among state legislative leaders, whose influence has such enormous sway over the direction of Medicaid and SCHIP policies.

Endnotes

1. 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.

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. 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 the responses of the Medicaid official.

4. The organizational structure of Medicaid and SCHIP within state agencies is distinct from, but may overlap with, a state's SCHIP program structure relative to its Medicaid program. See *statehealthfacts.org* for a list of SCHIP program structures.

5. For the follow-up interviews, we attempted to contact and interview each person surveyed in 2005. In many cases, the individual had left the agency or changed positions. In such cases, we interviewed a different person for the follow-up interview. In a few states, a separate SCHIP program had combined with the Medicaid program, making it appropriate to interview one rather than two officials.

6. The survey did not ask state officials about the status of the CKF coalition in their state. However, early results from an online grantee and coalition survey indicate that a few coalitions have stopped entirely, but most are continuing by meeting less frequently, merging with another group, or changing focus slightly.

7. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) overhauled the welfare system and severed the link between eligibility for cash assistance—now called Temporary Assistance for Needy Families (TANF)—and automatic eligibility for the Medicaid program. To address the concern that the delinking of eligibility for cash assistance and eligibility for Medicaid might deter some families from applying for Medicaid, PRWORA authorized $500 million in federal Medicaid matching funds for administrative activities to ensure that children and families would be aware that they may be eligible for Medicaid even if they are ineligible for cash assistance.

   Grant funds could be used to inform potential enrollees of Medicaid coverage and facilitate their enrollment in Medicaid. States were permitted to claim the entire costs of outreach activities primarily intended to address Medicaid eligibility even if the activities had the effect of increasing enrollment for other eligibility categories, such as SCHIP.

   Also see "Dear State Medicaid Director Letter," Center for Medicare and Medicaid Services, January 6, 2000. Available at *www.cms.hhs.gov/smdl/downloads/smd010600.pdf.*

8. The survey included questions about whether and how Medicaid outreach is conducted as part of the question set related to the DRA citizenship documentation requirements.

9. We used a Chi-square correlation analysis of a two by two contingency table that included CKF's level of influence (CKF was "vital" to securing the change versus the change would have happened without CKF either at the same pace or more slowly) and the status of the change (change is still completely in effect versus change is partially or completely reversed). The test yielded a p-value of 0.016.

10. The 14 states for which two surveys contributed to the 183 policy and procedures analyzed may be somewhat overrepresented, to the extent that both officials identified more than the average number of changes that CKF influenced.

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Smith V, Cooke J, Rousseau D, et al. *SCHIP Turns 10: An Update on Enrollment and the Outlook on Reauthorization from the Program's Directors.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2007 (Report #7642). One SCHIP Director stated, "Funding for outreach has definitely been constrained in the last four years; funding for outreach efforts essentially dried up.", p.16.

Appendix A

2006–2007 Survey of State Officials: 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?
2. How involved have you been with CKF activities since July 2005? Would you say…
    - very involved;
    - somewhat involved;
    - not too involved; or
    - not at all involved?

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

For each change (up to six) that a state official identified in either 2005 or in the follow-up interview, the following set of questions was asked:

1. Please tell me which of the following three statements best represents your opinion about CKF's influence on this change…
    - The change would have occurred anyway, without CKF working on this issue
    - The change would have occurred without CKF, but more slowly; or
    - CKF was vital to securing this change.

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.

4. How confident are you that this change will still be in effect four years from now? Would you say that you are…

    - very confident;
    - somewhat confident; or
    - not too confident?

5. 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 six possible reasons that the change was at risk of reversal or 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;
    - other changes in federal requirements;
    - fraud, abuse, or other program integrity issues; or
    - some other reason? (Please describe):

6. Is there any additional information you would like to share with me about the CKF project and its influence in your state before we complete this interview?

Appendix B

Officials Interviewed, by State and Type of Program

In December 2006 and January 2007, staff from Health Management Associates conducted telephone interviews with 60 state officials representing Medicaid or SCHIP programs, or representing both Medicaid and SCHIP programs in the 46 states with CKF grants.

TABLE B-1

States and Programs of Officials Interviewed

Medicaid (N=14)	**SCHIP* (N=17)**	**Medicaid/SCHIP (N=29)**	
Alabama	Alabama	Alaska	New Jersey
Arizona	Arizona	Arkansas	New Mexico
California	California	Connecticut	North Carolina
Florida	Colorado*	Delaware	Ohio
Georgia	Florida	District of Columbia	Oklahoma
Iowa	Georgia	Hawaii	Rhode Island
Massachusetts	Iowa	Idaho	Tennessee
Mississippi	Massachusetts	Illinois	Texas
Nevada	Mississippi	Indiana	Utah
New Hampshire	Nevada	Kentucky	Virginia
New York	New Hampshire	Louisiana	Washington
Oregon	New York	Maine	Wisconsin
Pennsylvania	North Dakota*	Maryland	
Wyoming	Oregon	Michigan	
	Pennsylvania	Minnesota	
	Wyoming	Missouri	
	West Virginia*	Nebraska	

* In Colorado, North Dakota and West Virginia, only an official from the SCHIP program and not the Medicaid program was available to participate in the survey.

Appendix C

Compilation of Figures 3–7

TABLE C-1

Numbers and Percentages of Survey Outcomes by Type of Change, Figures 3–7

	FIGURE 3		FIGURE 4A		FIGURE 4B		FIGURE 5		FIGURE 6		FIGURE 7							
Type of Change	Number of changes identified	Percentage	CKF's influence was "vital"	Percentage[1]	Would have occurred w/o CKF or occurred more slowly	Percentage[1]	Change still completely in effect	Percentage[1]	Change likely to stay in effect for two years	Percentage[2]	CKF influence vital and change still in effect	Percentage[3]	Change would have occurred w/o CKF or more slowly and still in effect	Percentage[4]	CKF influence vital *and* change still in effect and expected to stay in place for two years	Percentage[3]	Change would have occurred w/o CKF or more slowly and still in effect and expected to stay in place two years	Percentage[4]
Simplified Enrollment	66	36%	26	39%	39	59%	56	85%	50	89%	21	81%	35	90%	17	65%	33	85%
Renewal/ Retention	33	18%	15	45%	16	48%	29	88%	27	93%	12	80%	15	94%	11	73%	14	88%
Eligibility	32	17%	15	47%	13	41%	26	81%	19	73%	12	80%	10	77%	6	40%	9	69%
Outreach	25	14%	14	56%	9	36%	18	72%	16	89%	9	64%	8	89%	8	57%	7	78%
Coordination	20	11%	10	50%	10	50%	17	85%	17	100%	7	70%	10	100%	7	70%	10	100%
Combined	176		80		87		146		129		61	76%	78	90%	49	61%	73	84%
Total (includes other)	183	100%	83	45%	88	48%	151	83%	133	88%								

[1] Denominator is corresponding number in Figure 3 column.

[2] Denominator is corresponding number in Figure 5 column.

[3] Denominator is corresponding number in Figure 4(A) column.

[4] Denominator is corresponding number in Figure 4(B) column.

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