

MAY 2007

Covering Kids & Families Evaluation

*Case Study of Michigan: Exploring
Medicaid and SCHIP Enrollment Trends
and their Links to Policy and Practice*

Health Management Associates

Eileen Ellis, *principal*

Jenna Walls, *senior consultant*

Donna Marks, *research assistant*

Mathematica Policy Research, Inc.

Chris Trenholm, *senior economist*

Credits

Health Management Associates

120 N. Washington, Suite 705
Lansing, MI 48933
Tel. (517) 482-9236
Fax (517) 482-0920

Eileen Ellis, *principal*
Jenna Walls, *senior consultant*
Donna Marks, *research assistant*

Mathematica Policy Research, Inc.

P.O. Box 2393
Princeton, NJ 08543-2393
Tel. (609) 799-3535
Fax (609) 799-0005

Chris Trenholm, *senior economist*

Design and Layout

Landesberg Design
Pittsburgh, PA



Robert Wood Johnson Foundation

Copyright 2007 Robert Wood Johnson Foundation

Route One and College Road East
P.O. Box 2316
Princeton, NJ 08543-2319

This publication is available for downloading
from the Foundation's Web site at
www.rwjf.org/pdf/CKFcaseStudy0507.pdf.

This content may be reproduced for educational or nonprofit purposes in print or electronically, free of charge without prior permission provided that it is credited properly using the following statement:

"Courtesy of Covering Kids & Families Evaluation Materials, Robert Wood Johnson Foundation, Princeton, New Jersey."

Acknowledgements

We acknowledge the time and assistance of the people interviewed for this case study. From the Michigan Department of Community Health (MDCH) we spoke with Logan Dreasky, manager of the Eligibility Policy Section in the Michigan Medical Services Administration; Mary Ann Tribble, policy specialist in the Eligibility Policy Section in the Medical Services Administration; and Linda Loeffler, departmental analyst in the Education, Training and Outreach Unit of the Health Promotions Section of the Communications, Training and Performance Support Division of the Bureau of Resource Services. From the Michigan Department of Human Services we met with Kim Shinabery, assistance payments supervisor. Bob Stampfly, with Michigan State University's Institute for Health Care Studies, also agreed to participate in our interview process. He had previously been employed by MDCH and had the lead responsibility for implementation of SCHIP in Michigan.

From the Michigan Public Health Institute (MPHI), which served as Michigan *Covering Kids & Families* (CKF) state grantee, we acknowledge the contribution of Cynthia Cameron, senior program director, who served as CKF project director. We also talked with Ann McMillan, former Michigan CKF project coordinator who, although no longer with MPHI, generously agreed to share her perspective related to the earlier time frame of the study.

Additional statewide input was provided by Bob Engels, manager, Quality Assurance, Systems and Training; and Tara Clark, data processing manager, both with MAXIMUS, the eligibility determination and enrollment contractor for Michigan's SCHIP program.

Dianne Bohl and Laura Fitzpatrick, former project directors of the Muskegon CKF initiative within the Muskegon Community Health Project, were instrumental in providing the perspective of a local CKF project for this study.

We appreciate also the assistance of Amy Wiles, Health Management Associates, in recording interview notes.

Covering Kids & Families Evaluation

*Case Study of Michigan: Exploring Medicaid
and SCHIP Enrollment Trends and Their Links
to Policy and Practice*

Contents

- 1 Background**
- 2 Introduction**
- 3 State Policy Context**
- 8 History and Design of the
CKI/CKF Program in Michigan**
- 11 Qualitative Findings**
- 13 Enrollment and
Retention Findings**
 - 13** Trends in Number of Children
that are New Entries to Medicaid
or M-SCHIP
 - 14** Trends in Enrollment Retention
in Michigan
 - 18** Enrollment Data from the State
of Michigan
- 20 Conclusions and Key Findings**
- 21 Endnotes**
- 22 Appendix A: New Entry
Analysis for Counties with
Local CKF Projects**
- 25 Appendix B:
Online Applications**
- 26 Sources**

Tables and Figures

- 5 TABLE 1**
Key Events in Michigan's Child &
Family Health Insurance History
(1998–2006)
- 7 TABLE 2**
Current Michigan Medicaid/
SCHIP Program for Children
and Families
- 7 TABLE 3**
Enrollment Policies and Procedures
- 15 FIGURE 1**
Total New Entries to Children's
Health Coverage (Medicaid
and M-SCHIP) Michigan,
October 1999–September 2003
- 15 FIGURE 2**
Total New Entries and
Unemployment Rate: Michigan,
October 1999–September 2003
- 16 FIGURE 3**
New Entries to Children's Health
Coverage, by Program Type:
Michigan, October 1999–
September 2003
- 17 FIGURE 4**
Retention of Children's Health
Insurance Coverage: Michigan
Percentage of New Entries that
Disenroll within 6 Quarters of
Enrollment and then Re-enroll
within 4 to 10 Months
- 18 FIGURE 5**
Michigan Medicaid Enrollment
of Children
- 19 FIGURE 6**
MIChild Enrollment
- 23 FIGURE A-1**
Total New Entries to Children's
Health Coverage (Actual vs.
Predicted), Detroit/Wayne
County Child Health,
October 1999–September 2003
- 23 FIGURE A-2**
Total New Entries to Children's
Health Coverage (Actual vs.
Predicted), Muskegon
Community Health Project,
October 1999–September 2003
- 24 FIGURE A-3**
Total New Entries to Children's
Health Coverage (Actual vs.
Predicted), Marquette General
Hospital/Catholic Social Services,
October 1999–September 2003
- 24 FIGURE A-4**
Total New Entries to Children's
Health Coverage (Actual vs.
Predicted), Michigan Center for
Rural Health, October 1999–
September 2003
- 25 FIGURE B-1**
MIChild/Healthy Kids
Internet Applications

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 RWJF's 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 State Children's Health Insurance Program (SCHIP).
- Assessing the sustainability of CKF after RWJF funding ends.

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

Background

The *Covering Kids & Families*® (CKF) initiative of the Robert Wood Johnson Foundation (RWJF) has two goals: to reduce the number of 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 in those programs after the CKF program ends. RWJF issued four-year CKF grants to 46 states, beginning in 2002. CKF expanded on its predecessor, the RWJF *Covering Kids Initiative* (CKI), which operated from 1999 to 2002.

CKF works through state and local coalitions to maximize enrollment in public health insurance programs for uninsured, low-income children and adults. CKF grantees employed three 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.

This is one of 10 case studies that examine the link between enrollment trends and policy and practice at the state and local levels. The case studies look particularly at the role of outreach, simplification and coordination in changing levels of new enrollment over time. The case studies are the work of Mathematica Policy Research, Inc., and its subcontractors, the Urban Institute and Health Management Associates, the team entrusted with evaluating the CKF program.

Introduction

This case study looks at enrollment trends in Michigan for children in Medicaid and in the Medicaid expansion portion of SCHIP from 1999 through late 2003. It also examines the activities of the CKF project and its interaction with state agency policy through early 2006, when the Michigan CKF grant ended. In particular, the study examines the potential relationship between new enrollments that occurred during these periods and the specific activities and efforts associated with Michigan's CKF grant. Ideally, we would examine such links through a formal impact analysis that estimates the effect of individual policy changes or outreach efforts on the number of children enrolling in Medicaid or SCHIP. However, because many of the outreach efforts and policy changes occurred at or near the same time, such analysis is not possible. In addition, no state or other geographic area is a defensible comparison group for a rigorous analysis. The use of a case study approach, which combines exploratory data analysis with in-depth interviews, allows us to ascertain where and how CKF's influence was most likely a factor.

The primary source of data used in the study was enrollment data from the Medicaid Statistical Information System (MSIS), obtained from the Centers for Medicare & Medicaid Services (CMS). Using these data, we developed a measure indicating the number of new entries into Medicaid or Medicaid expansion SCHIP from October 1999 through September 2003. A *new entry* was defined as any enrollment, into either program, of a person who had not been enrolled in either program within the past 12 months, which thus excluded people transferring between programs or re-entering the programs within a 12-month period. This definition supports the CKF objective of expanding program enrollments. In addition, we asked state staff and grantee staff about data they used to measure internally the effectiveness of their efforts and policies.

The SCHIP program in Michigan includes both: (1) a Medicaid expansion component, Healthy Kids;¹ and (2) a separate SCHIP program, MICHild. Michigan's MICHild data were not available through the MSIS and were therefore not included in the analysis of new entries. However, the evaluation team did review MICHild enrollment data provided by the state. The MICHild program is relatively small: as of June 2006, there were 34,210 MICHild enrollees, compared with 431,740 in Healthy Kids.²

New entries in Michigan increased, especially in the early quarters we analyzed. While the increasing trend in new entries was statewide, no areas with CKF local projects had enrollment trends that varied significantly from the predicted trend, once the analysis accounted for the demographic and economic variables between counties. (These data are presented in Appendix A.)

We still wanted to examine the role of the local projects in the development of statewide policies and procedures. For this purpose, we selected one local project, the Muskegon Community Health Project (MCHP), for inclusion in this study. The most interesting changes in the Michigan data occurred during the CKI period, and Muskegon was part of both CKI and CKF, with generally consistent MCHP staff. The data available for the new entry analysis included only one year of the CKF period and three years for the CKI period.

In the late summer and early fall of 2006, we conducted detailed interviews with the CKF state grantee, a CKF local grantee and state officials and state contractors working within the Medicaid and SCHIP programs in Michigan. We asked them about the status of the programs, policy changes, CKF activities and other factors that might have affected Medicaid and SCHIP enrollments. We gained additional insight from other sources, including pertinent state and project Web sites, CKF Online Reports and other program documents. To identify common themes and qualitative explanations for data trends, we compared and analyzed interview responses, program information, and new enrollment data.

State Policy Context

In 1997, before the SCHIP program began, Michigan's Medicaid program provided coverage to pregnant women and infants up to age 1 in families at or below 185 percent of the federal poverty level (FPL), to all children ages 1–15 in families with income up to 150 percent of the FPL, and to children ages 16–18 at or below 100 percent of the FPL. Application for Medicaid for these groups was cumbersome, based on a 28-page “common application” used for all assistance programs. Also in 1997, additional ambulatory care coverage was provided through Blue Cross Blue Shield of Michigan's “Caring Program for Children,” which provided limited health benefits to low-income children as early as 1992.³

In 1998, Michigan created the Healthy Kids program by using the newly created SCHIP to expand Medicaid services for children ages 16–18 in families with income up to 150 percent of the FPL. (The Healthy Kids program included pregnant women and infants with family income below 185 percent of the FPL and all children with family income below 150 percent.) In addition, the state created a separate SCHIP program called MICHild, for children ages 1–18 with family income between 150 percent and

200 percent of the FPL, and for children under 1 year of age with family income between 185 percent and 200 percent. Counties were phased into these programs between May 1998 and October 1998. The “Caring Program for Children” was incorporated into the newly established MICHild program in December 1998.⁴ At the same time the new programs began, the state introduced a new short joint application form for Medicaid and SCHIP for children and pregnant women, which simplified the enrollment process for both programs. The new form was only four pages long, including instructions. To encourage and facilitate enrollment, the state initiated a media campaign, including TV, radio and posters, and contracted with community-based organizations for program outreach.

Beginning in 2000 Michigan’s public health insurance programs underwent a number of policy changes, which sometimes included competing goals. State officials, including legislators and governors, sought to expand coverage and enhance accessibility for health care coverage for children. At the same time, the state’s financial difficulties, a result of the economic downturn of 2000–2001, led to efforts to maximize federal funding, contain costs and cut budgets.

The state encouraged access to Medicaid and SCHIP services through a number of policy changes. As one component of its outreach, the state paid local health departments an incentive fee for each person they enrolled beginning in 2000. This was also the year the state adopted one of its most important changes: self-declaration of income for MICHild and Healthy Kids (Michigan’s SCHIP and Medicaid programs for children and pregnant women). This was followed by the implementation of 12-month continuous eligibility and the implementation of an online application process in 2002, and more recently, the elimination of a 6-month lockout for nonpayment of SCHIP premiums and implementation of presumptive eligibility for children and pregnant women in 2005.⁵

The economic downturn that began during 2000 and 2001 continued long-term for Michigan. Declining state revenues were insufficient to support funding at existing levels for the current services provided or funded by the state. This budget deficit forced the state to implement a number of cost-cutting measures. Although Michigan had bipartisan support for expanded health care coverage for children, some budget cuts affected the children’s health care programs. For example, the local incentive fee for enrollments was eliminated in December 2002. In addition, the state’s budget tightening included an early-retirement initiative in 2002, which led to cuts in state staff and significant turnover within the staff of the Medicaid and SCHIP programs.

Table 1 outlines the key events relevant to children and families that occurred within Michigan’s Medicaid and SCHIP programs from 1997 through 2006. This historical summary provides the framework within which the CKF program was operating during the time period covered by this study.

Table 2 describes the elements of the children and families components of Michigan’s Medicaid and SCHIP programs as they currently exist.

TABLE 1

Key Events in Michigan's Child & Family Health Insurance History (1998–2003)

1998

May through September: SCHIP phased in by county.

- New Healthy Kids program includes poverty-level Medicaid children and pregnant women and Medicaid Expansion SCHIP (100%–150% of the FPL for children ages 16–18).
- Separate SCHIP program called MICHild created for children through age 18 in families with income at or below 200% of the FPL. MICHild provides 12-month continuous eligibility.
- Single short application (four pages including instructions) implemented for use by both programs. Mail-in applications accepted.

December: Blue Cross Blue Shield “Caring Program for Children” incorporated into MICHild.

1999

February: CKI three-year grant for Covering Michigan's Children.

June: Applications, brochures and posters are available in various languages (Spanish, Arabic).

2000

March: State institutes \$25 incentive fee to local health departments for every person enrolled.

April:

- SCHIP enrollment contractor MAXIMUS assumes centralized processing role for mail-in applications.
- MAXIMUS and state eligibility agency agree to share each other's income eligibility determinations (April). MICHild Renewal Form (described by Michigan officials as a “passive” renewal process because the form was pre-filled when sent to family) accepted as a Healthy Kids application when ineligible for MICHild.
- Medicaid enrollment process simplified for most eligibility groups; in-person interviews dropped.

August: State institutes self-declaration of income for MICHild and Healthy Kids.

September: Co-location of state eligibility workers at the SCHIP enrollment contractor's office.

TABLE 1 (CONTINUED)

2001	July: SCHIP premium exemption for American Indians/Alaska Natives.
2002	January: Major state budget cuts affect Medicaid outreach and state agency budgets. February: RWJF CKF initiative, Covering Michigan's Kids & Families. June: Implementation of online application process (piloted in February). October: 12-month continuous eligibility for children under Medicaid. December: Outgoing governor issues Executive Order (2002-22), scaling back outreach activities for Medicaid and MICHild due to budgetary constraints; ended \$25 incentive payments to local health departments.
2003	April: • Healthy Kids' and MICHild's 12-month continuous eligibility policy effective regardless of income changes. • Extend MICHild coverage to unborn children in families with income at or below 185 percent of the FPL and not eligible for Medicaid.
2004	January: HIFA Section 1115 Adult Benefits Waiver expands SCHIP coverage to childless adults up to 35% of the FPL.
2005	January: Institute presumptive eligibility for children and pregnant adults in Medicaid/SCHIP. November: Eliminate 6-month "lockout" from SCHIP for failure to pay premiums.
2006	January: Eliminate "passive" renewal for MICHild. May: Implement an asset limit (\$3,000) for caretaker relatives and medically needy persons under age 21 (same as that required previously for low-income families). July: • HIFA Section 1115 Family Planning Demonstration Waiver "Plan First!" provides Medicaid funding for family planning services to women. • MI RWJF CKF grant officially ends.

TABLE 2

Current Michigan Medicaid/SCHIP Program for Children and Families

	Medicaid	SCHIP Medicaid Expansion (Healthy Kids)	Separate SCHIP (MICHild)
Unborn children			Families with income to 185% of the FPL and not eligible for Medicaid
Pregnant women and infants up to age 1	Families with income at or below 185% of the FPL		Non-Medicaid-eligible children up to 200% of the FPL
Children ages 1–15	Up to 150% of the FPL		Non-Medicaid-eligible children up to 200% of the FPL
Children ages 16–18	Up to 100% of the FPL	Up to 150% of the FPL	Non-Medicaid-eligible children up to 200% of the FPL
Parents	Up to 50% of the FPL		
Family-planning services for women ages 19–44	Up to 185% of the FPL		

TABLE 3

Enrollment Policies and Procedures

- Joint application used, including online completion, for children and pregnant women in Medicaid or SCHIP.
- MI Assistance and Referral Service pre-application screening tool used for Medicaid, SCHIP, Food Stamps, TANF, Child Care, State Disability Assistance, WIC and other medical assistance.
- No asset test, face-to-face interview or income verification required for children and pregnant women for Medicaid or SCHIP.
- Twelve-month continuous eligibility for Medicaid and SCHIP children.
- \$5-per-month-per-family premiums for separate SCHIP.
- Six-month uninsured waiting period for SCHIP with prior employer-sponsored insurance.
- Separate Medicaid application and \$3,000 asset limitation for parents/adults.
- Co-pays for parents/adults.
- Recent elimination of fully passive renewal for separate SCHIP program.

History and Design of the CKI/CKF Program in Michigan

The initial phase of the CKI in Michigan, called Covering Michigan's Kids, was launched in February 1999 and served as the foundation for the Covering Michigan's CKF project, which operated from February 2002 through July 2006. A State Steering Committee was created as part of the CKI project to serve as its required coalition. This group of nearly 50 people included representation from a wide variety of constituencies, including health care provider associations, community-based organizations, state and local Medicaid and eligibility agencies, advocacy organizations, faith-based organizations, local CKI grantees and the education community. This group included people in leadership roles within organizations that constitute Michigan's health care provider and health care policy communities. The State Steering Committee guided the CKI and CKF projects and also served as a forum to discuss strategies related to simplification, outreach and coordination.

At the beginning of the CKF grant, the Center for Advancing Community Health (CACH) served as the state grantee, providing oversight and technical assistance to the local projects and to the State Steering Committee. In early 2003 CACH closed its doors as a result of funding constraints, and the state grantee responsibilities were transferred to the Systems Reform Section of the Michigan Public Health Institute (MPHI-SR).

The three CKF-grant-funded local projects were carried forward from the earlier CKI initiative: Detroit-Wayne County Child Health Care Coalition (Detroit area), Muskegon Community Health Project (western lower Michigan), and Catholic Social Services of the Upper Peninsula. During the CKF program a fourth project was added through the Michigan Center for Rural Health in northeastern Michigan. Brief descriptions of the four projects follow:

1. **Detroit/Wayne County Child Health Care Coalition.** Under MI CKF, this coalition represented a partnership of four organizations, each targeting a specific population within the Detroit/Wayne County area. The Community Health and Social Services Center conducted bilingual outreach to a primarily Latino population on Detroit's southwest side. Oakwood Teen Health Centers, consisting of three different facilities, focused on reaching at-risk teens through school-based or school-linked outreach. The Arab American Center for Economic and Social Services (ACCESS), a community-based health and mental health program, served Arab-American kids and families in the metro Detroit area. The fourth organization, Eastside Access Partnership, through the University of Michigan's School of Public Health, employed a cadre of trained community workers to increase Medicaid and SCHIP enrollment of children and families on the city's east side.

2. **Muskegon Community Health Project.** Increasing Medicaid and SCHIP enrollment and retention of families throughout Muskegon, Oceana and Newaygo counties in the southwestern part of the state was the focus of this local project. The primary targets were the Latino and migrant communities. Interventions included outreach to provider clinic sites, community-based organizations and schools. The Muskegon project also enhanced enrollment opportunities for children of working-poor families through a locally based coverage program called Access Health, which targeted small businesses.
3. **Catholic Social Services of the Upper Peninsula.** This local project employed a coalition of outreach workers to identify eligible children in the Upper Peninsula, paying special attention to developing ways to reach homeless or displaced families and to connect with the Native-American community. Strategies included outreach through employers, tribes and schools. Efforts also included linkages with the Medical Care Access Coalition and the Marquette General Hospital to identify eligible families in the Marquette area.
4. **Michigan Center for Rural Health.** This project, the last local initiative to be incorporated during the MI CKF grant, undertook outreach in rural communities in northeastern Michigan. MCRH particularly focused on families in the rural towns of Pigeon and Standish, as well as on those residing in four primarily rural counties. Their activities included educating hospital intake workers, school personnel, small businesses and farmers about program details and enrollment opportunities. They engaged community “encouragers” in small towns to convene problem-solving forums and to work one-on-one with people to identify and remove barriers to enrollment.

Michigan’s CKI/CKF program experienced some administrative turnover during its seven years of operation. Over this period, the program had two project directors and three project coordinators. The person who wrote and served as project coordinator for the original CKI grant for CACH left the agency and was replaced in January 2001. Shortly thereafter, the new project coordinator wrote and submitted the CKF grant application. In 2003, administrative personnel changed again when the project director left the agency to become the Governor’s Health Policy Advisor, and the State Grantee responsibilities were transferred to MPH. Then in 2005 the project coordinator once again resigned, which required that a third staff person be brought in to coordinate the project for the duration of the grant. The staff that left the project did so because they were moving or had new job opportunities. Even though these changes did not reflect job dissatisfaction, they were still disruptive.

State Grantee activities at the state level consisted primarily of:

- convening and staffing the State Steering Committee;
- presenting information about Medicaid and SCHIP programs to various groups to reach potentially eligible persons; and
- providing feedback to state staff about the impact of policy changes at the local level.

State Grantee support for local projects consisted primarily of:

- sharing ideas and materials from national meetings and other states;
- providing information and guidance with respect to state policy;
- working with local projects to customize effective strategies for enrolling hard-to-reach populations;
- encouraging local ownership and initiatives to promote sustainability after the grant ended; and
- providing a forum for local projects to communicate with state officials regarding effective and ineffective policies and procedures.

Most of the CKF case studies have included a review of trends for at least one of the local CKF initiatives. In Michigan there was no local CKF program with enrollment trends that differed greatly from statewide trends. As a result, there was no need to look at a local project to examine special tactics that enhanced the impact of CKF. However, the Michigan case study still includes a local site to provide the local perspective on the success or lack of success of Michigan's CKF initiative and to probe the role that the local initiatives played in the statewide Covering Michigan's Kids effort. The MCHP was selected for this purpose. MCHP, founded in 1993 with funding from the W.K. Kellogg Foundation to undertake a countywide effort to make health care more available, had since its inception been involved in a number of initiatives relating to health care disparities, access to health care and community health improvement. MCHP's involvement with the CKF initiative was a natural extension of its ongoing mission. The Muskegon project targeted enrollment of children from Latino migrant communities as well as the working poor and their children. Project staff included two outreach workers and the primary outreach strategies included utilization of small local business contacts, community-based organizations, provider/clinic sites and schools. MCHP offered flexible, nontraditional work hours at nontraditional enrollment sites. A key relationship was established with Michigan Works! (the state's workforce development system) to help identify unemployed and underemployed families. In 2001, 2003 and 2005 MCHP collaborated with local school districts on direct mailings to all families receiving free or reduced-price lunches.

Qualitative Findings

Political and Economic Factors. The political environment in Michigan was seen as generally supportive of health care coverage for children and the Medicaid and SCHIP programs throughout the CKI/CKF period. Economic factors within the state, however, were seen by those interviewed as more influential. Michigan suffered prolonged economic challenges during the 2000–2001 economic downturn which resulted in significant budget constraints by 2002. While the state was forced to make budget cuts, including some limited cuts in Medicaid, Medicaid and SCHIP eligibility for children was not affected. Eligibility for caretaker relatives and medically needy young adults (19 and 20 years of age) was also not affected until May 2006 when an asset test was added for these two groups.

In real terms, the primary effects of Michigan’s state budget woes were staff cuts and turnover, as well as limitations on funding for local outreach efforts within the Medicaid and SCHIP programs. The early retirement budget-cutting initiative in 2002 reportedly challenged the ability of CKF grantees to communicate effectively with state staff, as many seasoned and knowledgeable contacts were lost, at both the central agencies and the local units of state agencies. Local communities lost state grant funds for outreach staff, materials and events. Further, a state budget line item for paying a \$25 incentive “bounty” per enrollment to local public health agencies was eliminated. While some projects reportedly relied heavily on these performance dollars to supplement CKI/CKF and other outreach efforts, others did not, which made the impact of their elimination unequal across local projects.

State Steering Committee. One common observation from all interviews was the reported importance of the CKF State Steering Committee, which included state staff along with other stakeholders, with respect to influencing Medicaid and SCHIP enrollment. A “Policy Tracking Matrix” included in a report by the Center of Collaborative Research in Health Outcomes and Policy, the entity engaged to evaluate the CKI project, outlines a number of issues that were raised at Steering Committee meetings between 1998 and 2001 and led to state policy and procedural changes. According to this matrix, the specific issues directly influenced by the Steering Committee included the elimination of application backlogs; the adaptation of brochures and communication tools for non-English-speaking persons; the updating and revising of the Medicaid/SCHIP application, including the development of multilingual applications; the movement toward self-declaration of income on applications; the co-location of staff processing both Medicaid and SCHIP applications; and the piloting of the online application and eligibility verification processes.

Interview comments further supported the critical role of the Steering Committee in developing policy. Local staff from the Muskegon project recalled that the joint

application used for Medicaid and SCHIP had, based upon local input to the Steering Committee, undergone three major revisions so that it would be more user-friendly. Complicated language was simplified, confusing terms were clarified, and its unmanageable length was reduced. (The shortened joint Medicaid/SCHIP application for children and pregnant women replaced a 28-page common application used for other Medicaid categories.)

The environment in which the Steering Committee operated was seen as a key factor in its success. State staff and policy-makers seemed to be receptive to ideas for change raised by local projects and other stakeholders. The policy change to allow 12-month continuous eligibility, initiated at the suggestion of local CKF staff, serves as a concrete example of the state's receptivity. One interviewee observed that the state seemed to appreciate the Committee as a catalyst for change as much as did local projects. For example, although state staff began developing an online application, the local CKF sites provided an invaluable sounding board for piloting this initiative. The synergy created by the Steering Committee's membership proved mutually positive, with local projects enjoying a receptive audience for their input and state staff finding a fresh array of advocates who could move ideas forward.

Further, local projects, and even locally stationed state staff, found that the Steering Committee was a highly valuable and effective communication source to keep abreast of all the policy and procedural changes taking place. Steering Committee conversations seemingly kept energy and commitment levels to program goals higher than they might otherwise have been, given budget constraints and funding problems.

All Outreach is Local. Interviewees indicated that the use of local projects in the CKF model contributed to the understanding of the importance of grassroots involvement in reaching children and their families. They indicated that local folk, rather than outsiders, can relate better to other local folks. The use of locally customized printed materials illustrated this point well. In Muskegon, a local program critique of printed state and national Medicaid and SCHIP outreach materials revealed that a "glitzy" presentation is not as important as a locally relevant message, from the literacy level of the text to the use of a local rather than an "800" phone number to call for information. This was particularly true for culturally specific outreach efforts. The Muskegon project employed a Hispanic outreach staff member on a full-time basis to assist with translation, enrollment and advocacy for non-English-speaking clients. In addition to benefits relative to obvious language barriers, the project found outreach workers who were considered part of the community to be generally more effective.⁶

Along these same lines, interviewees emphasized the importance of conducting outreach and enrollment in community settings where families in need of assistance frequently go. Prior to the CKI/CKF initiative, out-stationed workers were not widely

utilized. In contrast, over the course of the grant period, local staff accessed families at local clinics, schools, pharmacies and faith-based events.

Following suit, workers from the state eligibility agency that processes Medicaid applications (the Family Independence Agency, or FIA, which became the Department of Human Services, or DHS) were co-located at the office of the state's enrollment contractor for SCHIP applications, MAXIMUS, which processes mailed or electronically filed SCHIP applications. When MAXIMUS staff determines that families that applied for SCHIP coverage have lower income and should be considered for Healthy Kids, the applications can be reviewed by the onsite eligibility staff rather than mailed to a county office of Department of Community Health (DHS). Representatives of DHS, DCH and MAXIMUS all indicated that co-location of staff made the application process seamless for applicants that applied for Medicaid or SCHIP using the mail-in or online options and improved the level of communication and coordination between the programs.

Enrollment and Retention Findings

A key goal of the case study was to document quantitatively any relationships between the number of children enrolled in Medicaid and SCHIP in Michigan and CKF activities and policy changes.

Trends in Number of Children that are New Entries to Medicaid or M-SCHIP

Of particular interest in this study are changes in the number of new entries to the Medicaid and SCHIP program. The new entry analysis⁷ for Michigan was limited to Medicaid and Medicaid expansion SCHIP since Michigan does not submit the data for the separate SCHIP program to the MSIS⁸ database.

The graph in Figure 1 shows that in the last quarter of 1999 the state added roughly 33,000 newly enrolled children to Medicaid or Medicaid expansion SCHIP. This level climbed to around 38,000 children per quarter for the first two quarters of 2000. The 1999–2000 period correlates to the CKI grant period, the implementation of the \$25 incentive fees, the removal of the in-person interview requirement for Medicaid, and the streamlining of the process for mail-in applications. The state also initiated administrative changes, such as co-locating Medicaid and SCHIP eligibility staff to increase efficiency and implementing other simplifications in the process. From the first quarter of 2000 to the last quarter of 2000, the number of new entries per quarter increased from 38,000 to well above 46,000. This increase corresponds to the implementation of self-declaration of income in August 2000. Most of those interviewed for this report identified this policy as the most important factor in increasing enrollments. From the fourth quarter of 2000 forward to the third quarter of 2003, the average number of new entries remained steady at about 45,000 per quarter.

Figure 2 tracks the same information against the unemployment rate in Michigan. The data show that in the early part of the period, as the unemployment rate increased in Michigan, the number of children entering the public health insurance programs also increased. However, Figure 2 also shows that the unemployment rate does not totally explain entry of children into Medicaid and M-SCHIP in Michigan, as the period of greatest expansion of new enrollments, the latter part of 2000, precedes the period of the most rapid expansion in unemployment (from the fourth quarter of 2000 through the fourth quarter of 2001).

The analysis of new entries also looked at the trends in enrollment of children by component of the Medicaid and M-SCHIP programs. As shown in Figure 3, most of the growth in the number of new entries occurred in the largest component of the program, Healthy Kids, which includes the poverty-level group and Medicaid expansion SCHIP. These are low-income children who are eligible independent of other members of their families and who are not disabled.

The beginning of the third quarter in 2002 marked the beginning of the CKF grant period. While new enrollment levels did not increase over the next year, new enrollments did not decrease in spite of continued budget constraints during some of this period. Lack of data for the end of 2003 and beyond prevents comprehensive analysis of the impact of some major initiatives, such as the electronic application process that was piloted in February 2002 and expanded to statewide availability by June 2002.

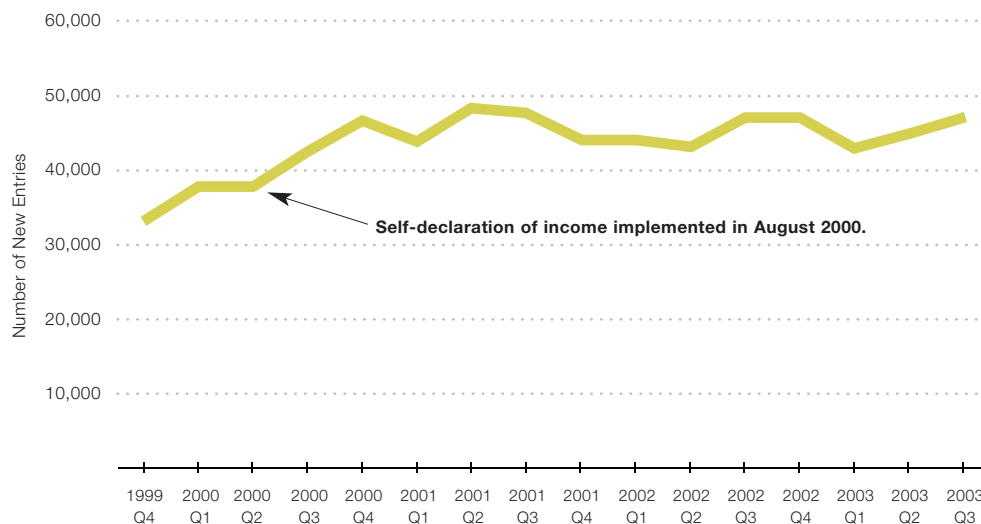
Trends in Enrollment Retention in Michigan

CKI and CKF throughout the nation focused initially on strategies to increase the number of children who enrolled in Medicaid or SCHIP. After a time, they found that some eligible children left the Medicaid or SCHIP rolls at the point when their eligibility was “redetermined,” perhaps 6 or 12 months later. While some of these children no longer qualified for assistance, others were still eligible. Grantees reported at CKF national meetings and in other forums that they often found themselves assisting families with reapplications for children who had previously been enrolled.

As a result, grantees and their state agency partners focused on initiatives that would increase the retention of enrollment. While data on retention rates (discussed below) indicate that Michigan already had a high retention level, several new initiatives in Michigan focused on increasing these rates.

FIGURE 1

Total New Entries to Children's Health Coverage (Medicaid and M-SCHIP): Michigan, October 1999–September 2003

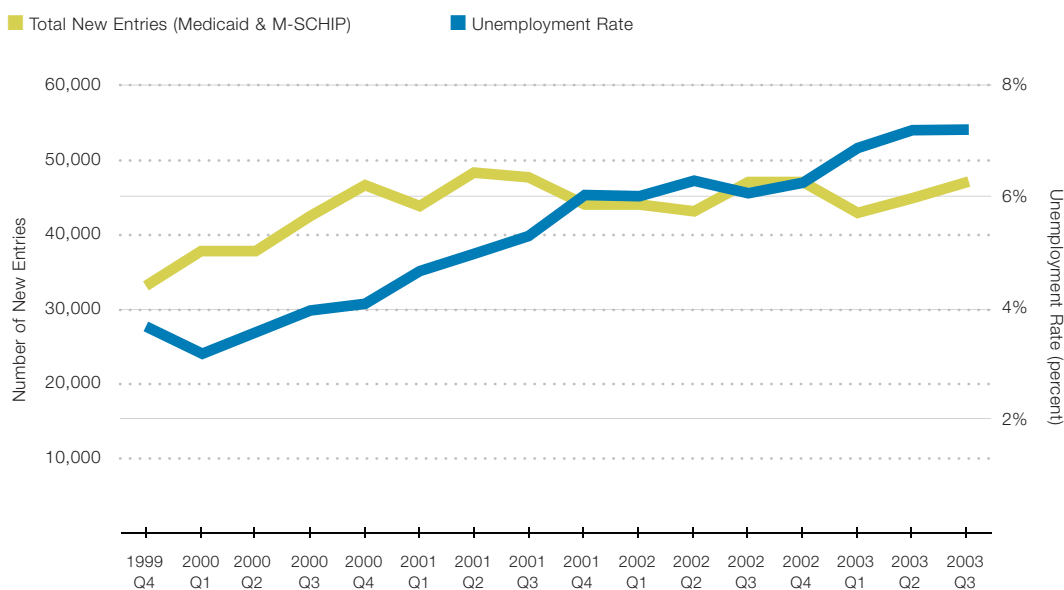


Source: Medicaid Statistical Information System

Note: It appears that a reporting anomaly caused an understatement of new entries in the fourth quarter of 2001 and a corresponding overstatement of new entries in the first quarter of 2002. To adjust for this, in Figures 1, 2 and 3 and also in Appendix Figures A.1 through A.5b the average of the data for the fourth quarter of 2001 and the first quarter of 2002 is reported as the value for each of those quarter.

FIGURE 2

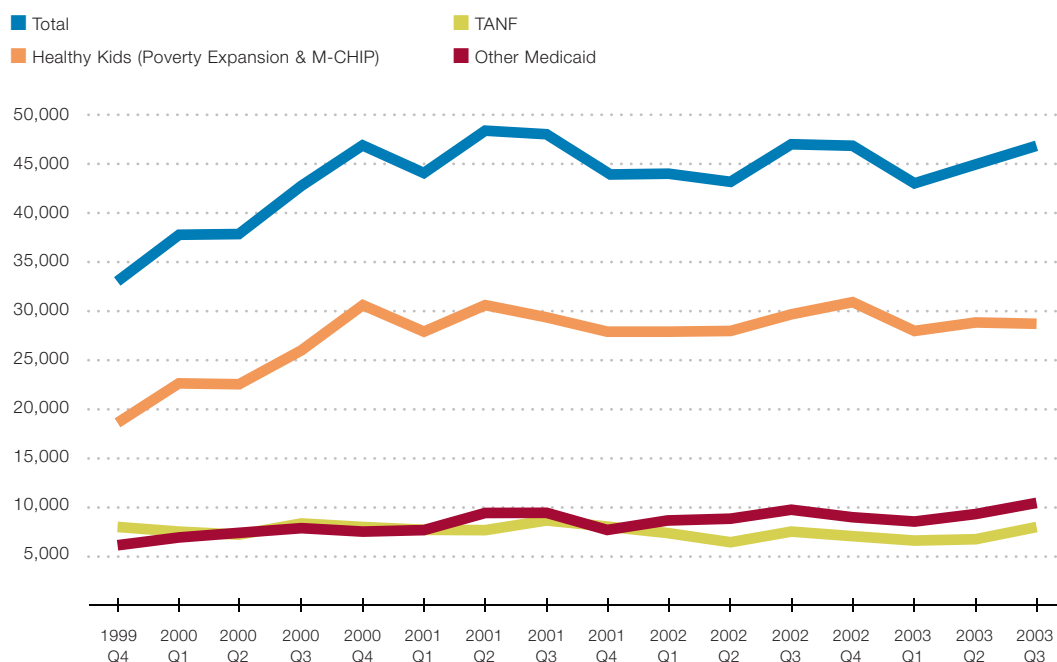
Total New Entries and Unemployment Rate: Michigan, October 1999–September 2003



Source: Medicaid Statistical Information System

FIGURE 3

New Entries to Children's Health Coverage by Program Type: Michigan, October 1999–September 2003



Source: Medicaid Statistical Information System

Michigan Retention Initiatives

- As of April 2000, a MICHild renewal request was considered an application for Healthy Kids. In that way, children no longer eligible for MICHild because their family income was too low for SCHIP could be seamlessly enrolled in Medicaid.
- The state implemented passive re-enrollment for MICHild in April 2000. Families no longer had to fill out the full application but could simply verify information as correct.⁹
- Twelve-month continuous eligibility (which was implemented for the MICHild program in June 1998) was implemented for Medicaid children in October 2002. Redetermination of eligibility had previously been required at six-month intervals. Under this change, families were not required to fill out another form for 12 months, but they were still expected to notify the state if there was a change that would affect eligibility, such as a change in income.
- The definition of *12-month continuous eligibility* was expanded in June 2003 to apply even with a change in income. Children remain eligible for 12 months even if family income increases to an extent that would otherwise make them ineligible.

FIGURE 4

Retention of Children's Health Insurance Coverage: Michigan Percentage of New Entries that Disenroll Within Six Quarters of Enrollment and then Re-enroll within 4–10 Months (New Entries Between 2000 Q1 and 2001 Q4)

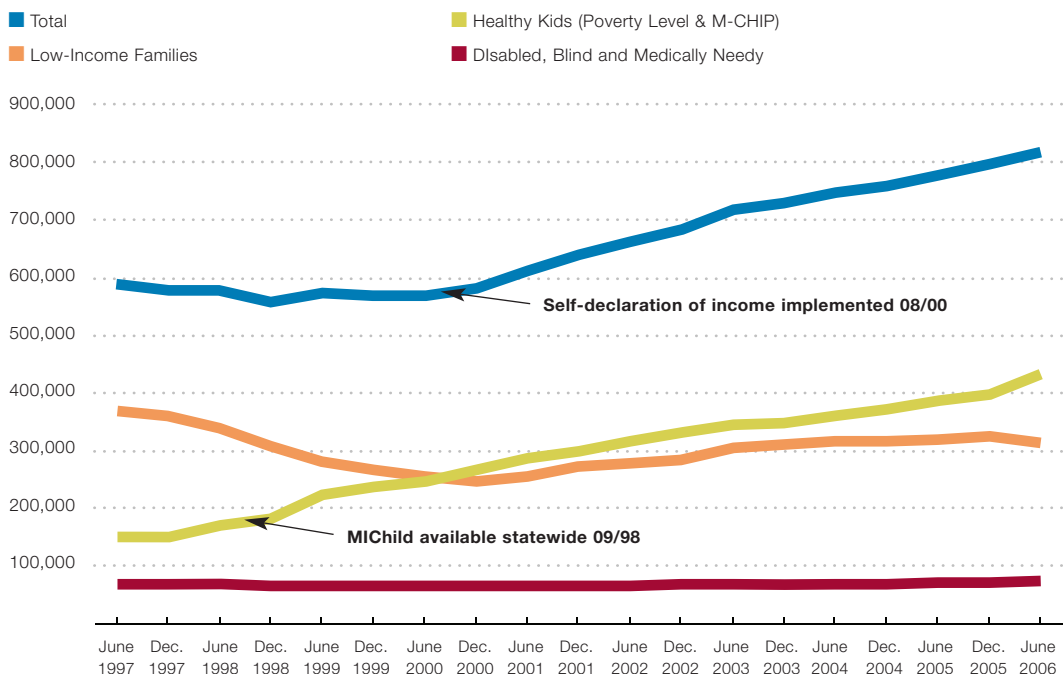


Figure 4 shows one potential measure of appropriate retention of enrollment in children's health insurance coverage. The measure is the proportion of children who disenroll from coverage within six quarters (18 months) of their initial enrollment date and then re-enroll within 4–10 months of being disenrolled. The hypothesis is that this is a cohort that includes children who are eligible to remain covered but who were dropped from coverage because they failed to meet administrative requirements. The analysis covers children who enrolled in Medicaid and/or SCHIP between January 2000 and December 2001. The MSIS data file that was used for this analysis included only four years of data, from the fourth quarter of 1999 to the third quarter of 2003. As a result, new entries could be measured beginning in the first quarter of 2000. To allow sufficient time for the disenrollment and re-enrollment parameters noted above, the latest cohort that could be analyzed were new entries in the fourth quarter of 2001. As a result, data for only eight quarterly cohorts could be measured. Because of limits on the months of data available for analysis, the study of retention rates does not indicate what happened in Michigan after active state outreach activities ended.

This and other measures of retention have been used in several of the CKF case studies. Of the study states, Michigan has the lowest incident of “recycling” or “churning” represented by this data, and as shown in Figure 4, Michigan showed improvement in this measure for children who enrolled in Medicaid or SCHIP during 2000 and 2001.

FIGURE 5

Michigan Medicaid Enrollment of Children



Since the MSIS data do not include the separate SCHIP program in Michigan, the aggregate retention rate may be even greater. Some children move between the Healthy Kids program and the MICHild program as changes in family income or family size result in changes in eligibility.¹⁰

Enrollment Data from the State of Michigan

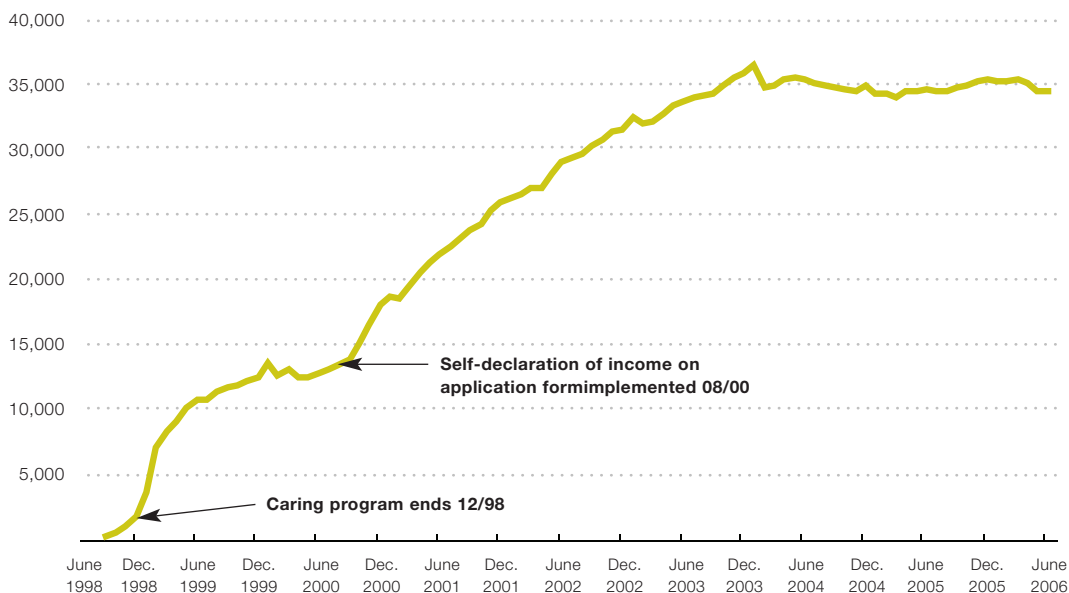
While the MSIS data used for the analysis of new entries and retention were available only through the third quarter of 2003, state staff were able to provide enrollment data through June 2006. This more recent data show that the increase in enrollment of children in Medicaid in Michigan continues. Figure 5 shows the substantial increase in the number of children enrolled in Michigan's Medicaid and Medicaid-expansion SCHIP programs from June 1997 through June 2006, in total and by category of enrollment.

In particular, the number of children enrolled in the Healthy Kids program, which includes poverty-level Medicaid and the Medicaid expansion SCHIP program, increased dramatically during this period, as seen in Figure 5.

Enrollment data for Michigan's separate SCHIP program, MICHild, were not available in the MSIS database and were therefore not subject to analysis of new entries. The state's enrollment contractor, MAXIMUS, provided MICHild enrollment information from the beginning of the program through June 2006.

FIGURE 6

MiChild Enrollment



Source: MAXIMUS

As seen in Figure 6, the aggregate enrollment trends for MiChild were similar to those for Healthy Kids until early in 2004. As discussed above, interviewees indicated that a significant portion of the children who apply for re-enrollment in the MiChild program are found to be eligible for the Healthy Kids program as a result of changes in family income or circumstances. As a result, MiChild enrollment has declined from its January 2004 peak.

The Medicaid and SCHIP enrollment data from Michigan agencies indicate that the number of children covered by Medicaid and SCHIP continues to increase. Though SCHIP enrollment has declined slightly in recent years, the increase in Medicaid enrollment has more than made up for the decrease. From June 1997 to June 2006 the total number of children covered by Medicaid or SCHIP increased from 589,130 to 819,278, a rise of 45 percent in nine years. The enrollment data indicate strong growth in the number of children covered by Medicaid or SCHIP in Michigan.

Conclusions and Key Findings

Among the states that have been analyzed by the CKF evaluation team, Michigan has had a high rate of success in increasing enrollment levels in children's health insurance through Medicaid and SCHIP. Michigan has taken several steps to make the process of enrollment in Medicaid and SCHIP as easy as possible for low-income families.

All interviewees agreed that CKF was instrumental in creating a broad base of support for children's health insurance in Michigan. The State Steering Committee in particular was cited as a place where key stakeholders came together to support increased enrollment in Medicaid and SCHIP.

CKF, especially the State Steering Committee, facilitated state-level policy changes that had a positive effect on enrollment (both new enrollment and retention). The State Steering Committee provided a framework where local grantees, providers and advocates could collectively voice and pursue new ideas. From their vantage points and access, the State Steering Committee and its members could move ideas forward where, perhaps, state staff could not. State staff relied on the State Steering Committee as a mechanism to bolster their change initiatives. Even when the original impetus to change was from state agency staff, the State Steering Committee was helpful in moving ideas forward.

Among specific new initiatives, self-declaration of income, which was implemented in August 2000, had the single most significant impact on new enrollments into both Medicaid and SCHIP. In addition, implementation of an online application option and a centralized eligibility processing system contributed to Michigan having one of the nation's fastest turnaround times for processing and determining eligibility. The initiation of 12-month continuous eligibility for Medicaid and SCHIP also contributed to retention of enrollment in Healthy Kids.

This study found that Michigan has low "churning" of children off and back on to Medicaid and M-SCHIP when compared with other states, and that this retention rate has improved over time.

The right people were present to make changes possible, which likely would not have been the case without CKF. While the end of the CKF grant brought an end of the State Steering Committee, a successor stakeholder organization is expected to continue support of children's health insurance initiatives in Michigan. Even if local projects do not survive intact, they will leave the legacy of a much-streamlined application process and a set of guiding principles for effective outreach, including institutionalized partnerships with key agencies.

Endnotes

1. Michigan's Healthy Kids program includes both the Medicaid expansion component of the SCHIP program and low-income children enrolled in Michigan's Medicaid program based on family income below a particular percentage of the FPL.
2. The state estimates that 10,000 of the Healthy Kids enrollees were Medicaid-expansion SCHIP enrollees. The rest were poverty-level Medicaid enrollees.
3. The Caring Program for Children covered children through age 18 in families with incomes below 185 percent of the FPL.
4. The families of these "Caring Program for Children" enrollees were given 90 days to complete an actual application for the SCHIP program. Most did so and were retained as part of the MICHild or Healthy Kids program.
5. While Michigan had been very successful in enrolling more children in Healthy Kids and MICHild, very few of the new enrollees were in families in the narrow income band covered by SCHIP. As a result, the state had a surplus SCHIP allotment. The state chose to use surplus SCHIP funds to provide limited benefits to 62,000 childless adults with incomes up to 35 percent of the FPL through a Section 1115 HIFA waiver, the Adult Benefits Waiver. In addition, SCHIP coverage was expanded to cover unborn children in families with income below 185 percent of the FPL when Medicaid non-financial criteria were not met but SCHIP criteria were. One example would be a pregnant woman who was a legal U.S. resident but had been in the country for less than five years and would otherwise receive emergency Medicaid only for delivery.
6. While local grantees found these strategies to be more effective than statewide strategies, the quantitative data in this report indicate that results for counties that were not local grantees were similar to those for counties that were CKF local grantee sites. See Appendix A.
7. As noted in the introduction, the definition of a *new entry* was considered to be any enrollment into either program of a person who had not been enrolled in either program within the past 12 months; thus, people transferring between programs or re-entering the programs are excluded. This definition supports the CKF objective of expanding program enrollments.
8. MSIS is the Medicaid Statistical Information System of CMS.
9. This policy has since been reversed. As of January 2006, the state eliminated the passive renewal process and now requires applicants to supply information on a renewal form rather than verify a pre-filled application.
10. The monthly MICHild Executive Summary reports prepared by MAXIMUS indicate that at the time of an annual eligibility renewal, a significant proportion of MICHild enrollees are found to be eligible for Healthy Kids Medicaid rather than MICHild because their income is too low for the separate SCHIP program. Reports from June to August 2003 indicated that about 21 percent of MICHild renewals were determined to be eligible for Healthy Kids rather than MICHild. Reports from March to May 2006 indicate that at the time of renewal, more than one-third of MICHild enrollees are now referred to Healthy Kids.

Appendix A: New Entry Analysis for Counties with Local CKF Projects

We analyzed data on new entries, comparing actual with expected enrollment data for the counties with local CKF projects. No local project counties had enrollment trends that varied significantly from the predicted trend, once the analysis was adjusted for demographic and economic variables. Unlike several other states for which the CKF evaluation team has done case studies, there was no significant variation in the trends for new entries between the statewide trends and the individual counties. The county-specific data in Michigan seem to indicate that statewide changes in policy and procedures drove changes in enrollment levels.

The following figures show that the pattern of new entries into Medicaid and Medicaid-expansion SCHIP in Michigan at local CKF project sites did not vary significantly from the predicted level of new entries based on statewide trends adjusted for local demographic and economic variables.

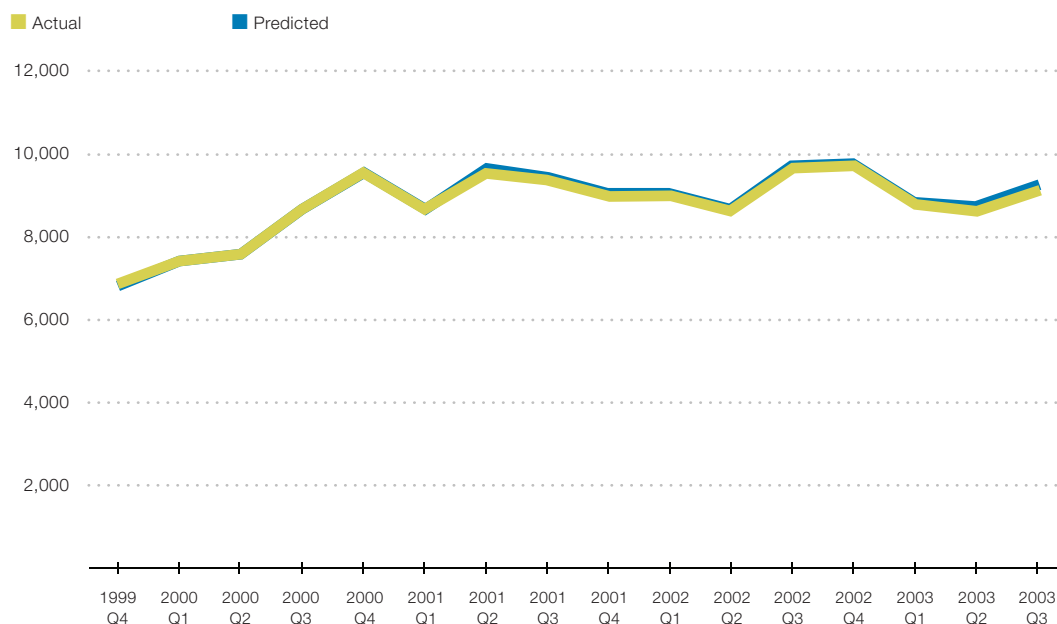
Figures A-1 through A-4, using MSIS data, show the difference between predicted and actual numbers of new entries to children's health coverage for the geographic areas that were covered by local CKF grantees. Figure A-1 shows that Wayne County (Detroit), which has about 20 percent of the statewide new entries, has a pattern of actual new entries that mirrors the predicted number.

Figures A-2 and A-3 show that for the other two local grantees that were part of both CKI and CKF, the number of actual new entries was similar to or lower than the predicted level.

As noted earlier, the Michigan Center for Rural Health was a new local grantee in 2002 as part of CKF. Figure A-4 shows that the actual new entries were below the predicted level for the counties covered by the Michigan Center for Rural Health in early months of the CKF grant. Since this represents data from a combination of very small counties, and since the data do not continue through the end of the grant cycle, this does not necessarily indicate that the local grantee was ineffective.

FIGURE A-1

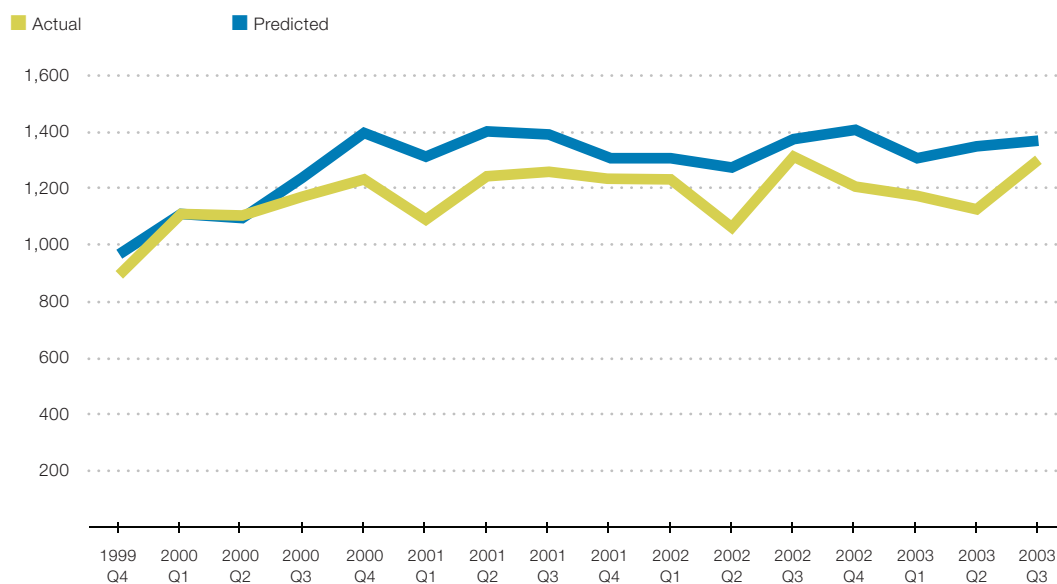
Total New Entries to Children's Health Coverage (Actual vs. Predicted): Detroit/Wayne County Child Health, October 1999–September 2003



Source: Medicaid Statistical Information System

FIGURE A-2

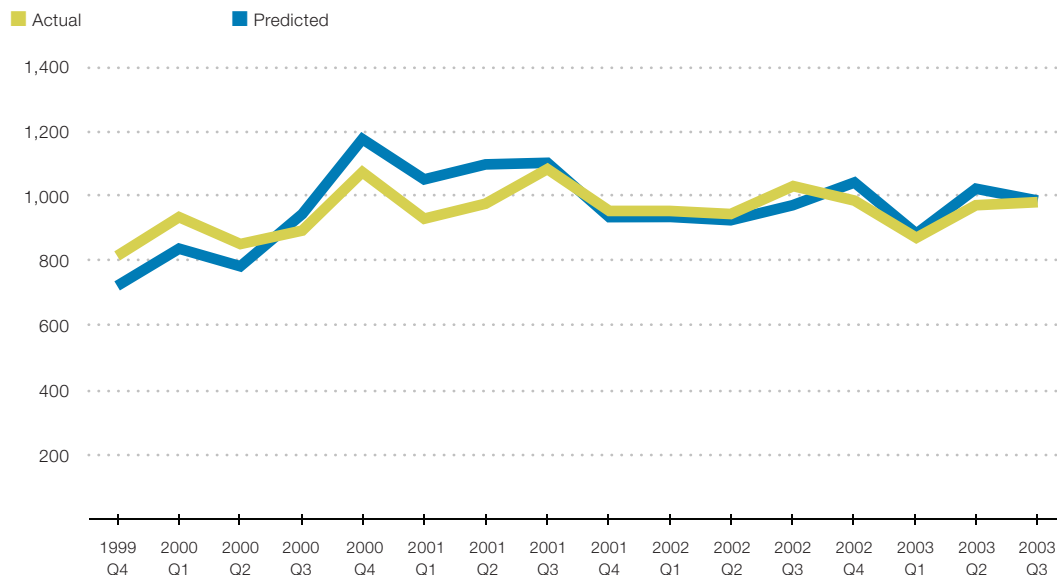
Total New Entries to Children's Health Coverage (Actual vs. Predicted): Muskegon Community Health Project, October 1999–September 2003



Source: Medicaid Statistical Information System

FIGURE A-3

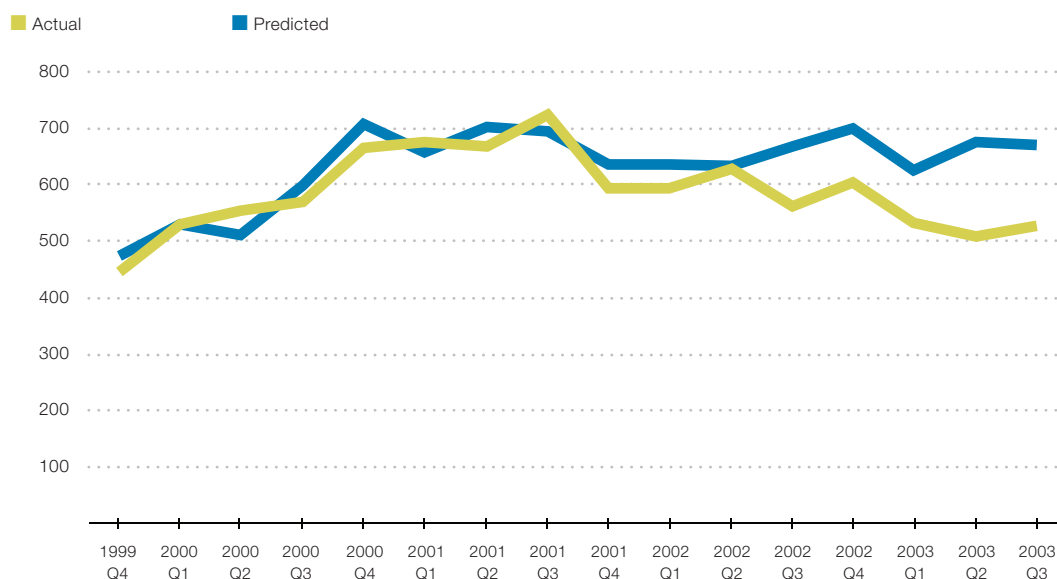
Total New Entries to Children's Health Coverage (Actual vs. Predicted): Marquette General Hospital/Catholic Social Services, October 1999–September 2003



Source: Medicaid Statistical Information System

FIGURE A-4

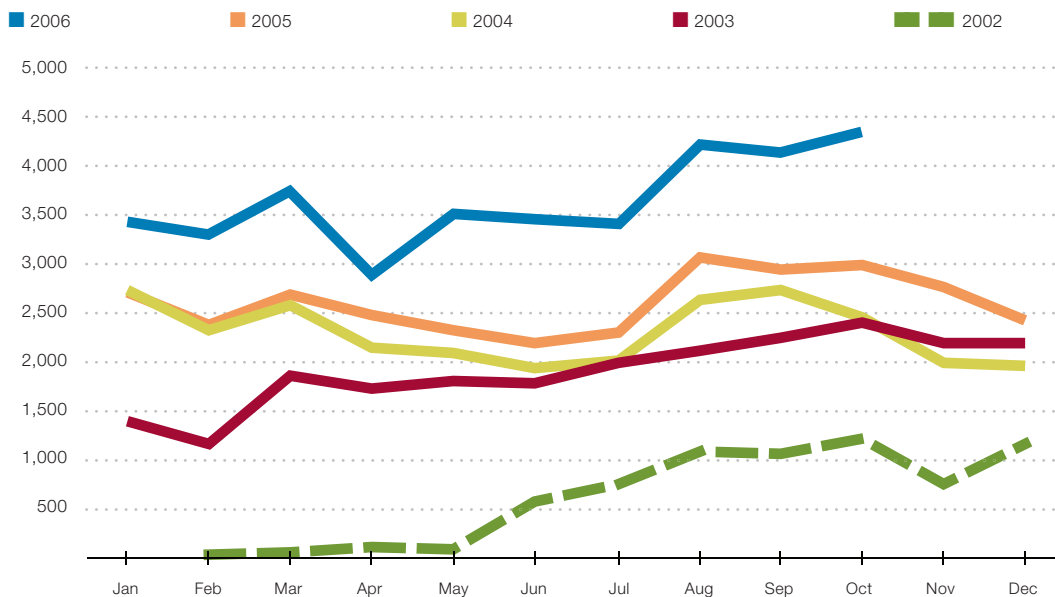
Total New Entries to Children's Health Coverage (Actual vs. Predicted): Michigan Center for Rural Health, October 1999–September 2003



Source: Medicaid Statistical Information System

FIGURE B-1

MiChild/Healthy Kids Internet Applications



Source: MAXIMUS

Appendix B: Online Applications

Online applications became available on a pilot basis in February 2002 and were extended to all counties in June 2002. Online applications have increased over time as a vehicle for enrollment of children and pregnant women into Medicaid or SCHIP in Michigan, with a total of 124,649 such applications completed between February 2002 and October 2006. Of these, 36 percent were completed through community agencies, and 64 percent directly by the families. As Figure B-1 shows, the number of online applications continues to grow each year. On average, each application represents 1.5 children.

The state's SCHIP enrollment contractor, MAXIMUS, also provided information about the disposition of the online applications. From January 2005 through October 2006, on average 70 percent of applicants were enrolled in Healthy Kids (mostly as Medicaid enrollees, with a few as Medicaid-expansion SCHIP enrollees), 12 percent were enrolled in MiChild, and 18 percent were determined to be ineligible for both programs. Implementation of the online application has significantly reduced processing times. The turnaround time is extremely fast, 20 minutes or less, and while the national requirement for application processing for Medicaid is 45 days or less, Healthy Kids applications in Michigan are processed, on average, in about 10 days. State agency staff indicate that Michigan's extremely rapid processing time for completed applications has been recognized by CMS as a "best practice."

Sources

Center for Advancing Community Health. *Covering Michigan's Kids & Families*.

Center for Advancing Community Health Projects.

Covering Kids & Families. *Michigan Covering Kids & Families Initiative*.

Available at: <http://coveringkidsandfamilies.org/projects/index.php?StatelD=MI>.

Covering Kids & Families. *State Projects*. Available at: <http://coveringkidsandfamilies.org/projects/>.

Covering Kids & Families Online Reporting System. *Michigan Online Reports*. 2002–2005.

Covering Michigan's Kids Initiative. Interviews with staff from MAXIMUS, Inc., the Michigan Department of Community Health, the Michigan Public Health Institute, and the Muskegon Community Health Project. [Included interviews with other staff who worked with the initiative as well.]

Muskegon Community Health Project. *Covering Kids and Families Project: Summary of Project*. March 2, 2006.

State of Michigan, Department of Community Health. *Medicaid Policy Bulletins*.

Available at: <http://www.michigan.gov/mdch>.

State of Michigan, Department of Community Health. *Provider Updates*.

Available at: <http://www.michigan.gov/mdch>.

State of Michigan, Department of Human Services. *Key Statistics*.

Available at: <http://www.michigan.gov/dhs>.

State of Michigan, Department of Human Services. *Program Policy Bulletins*.

Available at: <http://www.michigan.gov/dhs>.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Medicaid Waivers and Demonstration Projects*. Available at: <http://www.cms.gov>.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *SCHIP State Plan Amendments*. Available at: <http://www.cms.gov>.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *SCHIP State Plan and Summary Information*. Available at: <http://www.cms.gov>.

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *State Plan Amendments*. Available at: <http://www.cms.gov>.



Route One and College Road East
P.O. Box 2316
Princeton, NJ 08543-2319
www.rwjf.org

**A message about evaluation from the
Robert Wood Johnson Foundation**

The Robert Wood Johnson Foundation believes in supporting programs that have measurable impact on the health of Americans and the quality of care they receive. For more than 35 years we've worked with dedicated, diverse partners who strive for meaningful and timely change.

Learning from what grantees do and documenting the impacts of these efforts are strategic parts of our work and key to measuring the effectiveness of our strategy—not individual grantee performance. Evaluation of the impact of this work is not only part of our grantmaking, but 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.

We are passionate about our responsibility to share information and foster understanding of the impact of our grantmaking—what works, what doesn't and why. When it comes to helping Americans lead healthier lives and get the care they need, we expect to make a difference in your lifetime.

For more information visit www.rwjf.org.