COVERING KIDS AND FAMILIES EVALUATION

Influence of Covering Kids and Families on Medicaid and SCHIP

A Report on a Telephone Survey of State Officials in Thirty-six States

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I. INTRODUCTION

Following the enactment of the State Children's Health Insurance Program (SCHIP) in 1997, states moved aggressively to expand health care coverage for children. In addition to expanding eligibility, states implemented unprecedented outreach efforts and simplified enrollment processes to improve enrollment rates. In many cases, states partnered with local governments, community organizations, providers, and advocacy organizations to accomplish their enrollment goals. As a result, enrollments grew rapidly and states quickly found that most newly enrolled children were eligible for traditional Medicaid but had not previously enrolled.

The Robert Wood Johnson Foundation (RWJF) began "Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children" in 1997, the same year that SCHIP was enacted. Its goal was to enroll more eligible children into Medicaid and SCHIP through outreach, enrollment simplification and health insurance program coordination strategies. Covering Kids began with a plan to award $13 million in grants to 15 states but ended with $47 million in grants to 50 states and the District of Columbia, and 170 local community projects. The RWJF "Covering Kids and Families" (CKF) initiative began in January 2002 as a four-year, $55 million grant program with goals similar to Covering Kids except that it provides an opportunity for grantees to seek to increase enrollment of uninsured adults as well as uninsured children. In each of 46 states, including the District of Columbia, CKF state grantees contract with two or more local projects to perform many of the tasks of the initiative.[1]

To help assess the effectiveness of the CKF initiative, Mathematica Policy Research, Inc. and its partners The Urban Institute and Health Management Associates began a multi-faceted evaluation in 2002. One component of that evaluation was a telephone survey of state officials in 36 states designed to assess the perceived impact of CKF on the policies and procedures of Medicaid and SCHIP programs in each state. The survey process allowed researchers to gather information about how CKF staff and state officials interact and how CKF projects impacted state programs. This report summarizes the findings of this survey.

[1] Small "liaison" grants allow groups in the other five states opportunities to participate in the national CKF initiative events and activities.

II. METHODOLOGY

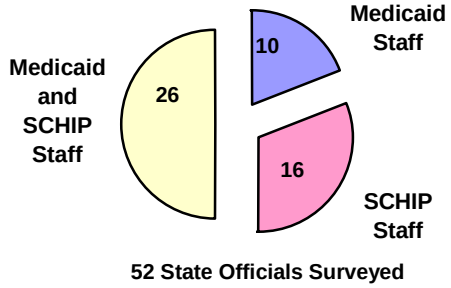
In November and December 2003, trained interviewers conducted telephone interviews with 52 Medicaid and/or SCHIP officials in the following 36 states (including the District of Columbia):

Alabama	Idaho	Missouri	Oregon
Arizona	Indiana	Nebraska	Pennsylvania
Arkansas	Iowa	Nevada	Rhode Island
Connecticut	Kentucky	New Hampshire	Tennessee
Delaware	Louisiana	New Jersey	Utah
District of Columbia	Maine	North Carolina	Washington
Florida	Maryland	North Dakota	West Virginia
Georgia	Michigan	Ohio	Wisconsin
Hawaii	Mississippi	Oklahoma	Wyoming

The ten states that participated in the site visit component of the CKF evaluation were not included in the telephone survey of state officials.[2] Also, five states (Kansas, Montana, South Carolina, South Dakota, and Vermont) with small "liaison grants" were excluded from the telephone survey process.

In some states with Medicaid-expansion SCHIP programs, a single official was interviewed. In other states, the interviews included one official from the Medicaid program and one official from the SCHIP program. The 52 state officials in 36 states who participated in the survey held a variety of program responsibilities including one director of a state human services department, one Medicaid director, six SCHIP directors, other high-level Medicaid staff, eligibility and policy staff, and others. Half of the respondents (26) worked for both the Medicaid and SCHIP programs, 16 worked only on SCHIP and 10 worked only on Medicaid. (Figure 1) A single state official was interviewed in 19 states and two officials were interviewed in 16 states. In New Jersey, a large group was convened to answer survey questions.

Figure 1
"What is your role in the Medicaid or SCHIP Program?



[2] Site visit states were Arkansas, California, Colorado, Illinois, Massachusetts, Minnesota, New Mexico, New York, Texas and Virginia. While state Medicaid and SCHIP officials were interviewed as part of the site visits, there was not a common set of questions to allow inclusion of the ten site visit states in this analysis.

Whether one or two officials in the state were interviewed, both programs were represented in all but three states. In Florida, Iowa and Kentucky (three states with combination programs[3]), only SCHIP officials were interviewed.

The interview consisted of 37 mostly closed-ended questions that had specific response choices. There were also a few open-ended questions that allowed officials to expand on their responses. The interview questions are included in this report as Appendix B.

In this report, responses are often grouped by state. For states with two respondents, responses for multiple-choice questions were combined since each official might be aware of different aspects of CKF's interaction with state programs. For "yes / no" questions, the response for a state is coded as "no" if both respondents answered "no" and "yes" if one or both of the respondents answered "yes". In cases where one state respondent answered "yes" and one answered "no", it is assumed that one state official had more contact with CKF than the other and therefore the single "yes" answer accurately reflects the overall perspective of state officials on the impact of CKF. For the other forced choice questions, the response for a state was coded as "mixed" if two state respondents gave different responses.

[3] Combination states have implemented SCHIP in two ways, as a Medicaid expansion and as a separate state program.

III. FINDINGS

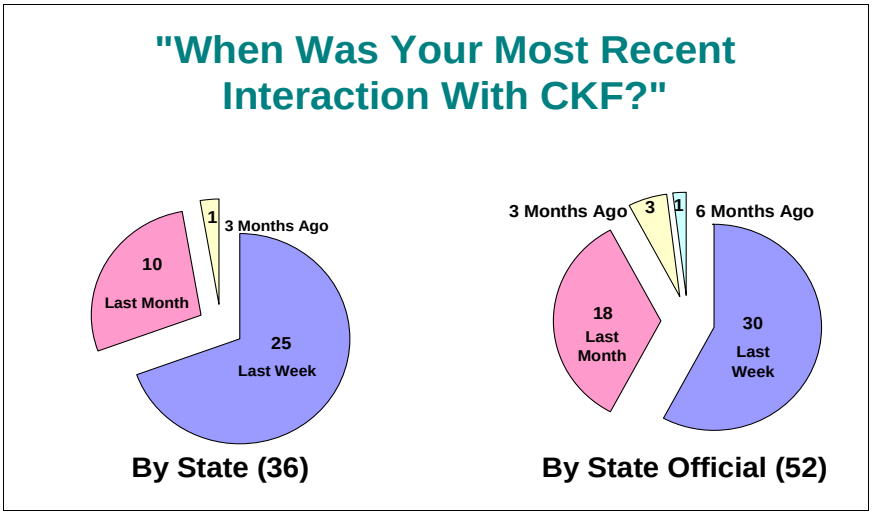
A. State Official Awareness of and Involvement in CKF

The CKF program is well known to state officials in both the Medicaid and SCHIP programs. All state officials reported being aware of, and involved with, the CKF initiative in their state. The types of involvement varied by state and the level of involvement varied by program. State officials who worked only on Medicaid were less likely to participate with CKF in multiple ways compared to officials who worked only on SCHIP or on both Medicaid and SCHIP. The types of CKF involvement most often reported by state officials include:

- interacting with CKF staff (28 states);
- participating as a CKF Coalition member (28 states);
- serving on a CKF Steering Committee or Governing Board (20 states);
- participating in a CKF workgroup (23 states); and
- participating in other activities with CKF (10 states).

Most state officials (90%) reported recent interactions with CKF. All respondents had interacted with CKF within at least the last six months and 30 of the 52 state officials interviewed reported interaction within the past week. When responses are considered by state, officials in 35 of 36 states reported interaction with CKF within the past month and 25 reported interaction within the past week. (Figure 2.)

Figure 2



Officials who worked on SCHIP alone were most likely to report contacts within the last week and officials who worked on Medicaid alone were the least likely to report contacts within the last week. Two out of 10 officials who worked with Medicaid alone reported that their most recent interaction with CKF occurred more than one month ago. (Table 1.)

Table 1

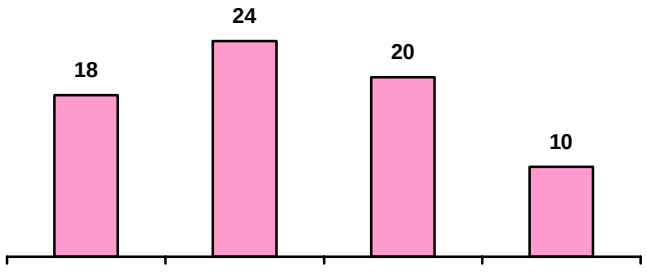
Q4. When was your most recent interaction with CKF?

Medicaid and/or SCHIP Role	Within the past:						
	Week		Month		1 – 6 Months		Total
Medicaid staff	4	40%	4	40%	2	20%	10
SCHIP staff	11	69%	4	25%	1	6%	16
Both	15	58%	10	38%	1	4%	26
Total	30	58%	18	34%	4	8%	52

B. Program Changes

Almost all of the surveyed states (34 of 36) reported recent program changes impacting the enrollment of children in Medicaid and/or SCHIP. The most common were changes to application and renewal processes (24 states) followed by changes in cost-sharing requirements (20 states). Benefit changes were the least common (10 states). (Figure 3) While it was more common for states to report that changes made application and renewal processes "easier " (in 14 of 26 states), it was more common for changes in eligibility, cost-sharing and benefits to be negative (i.e., increases in cost-sharing or reductions in benefits).

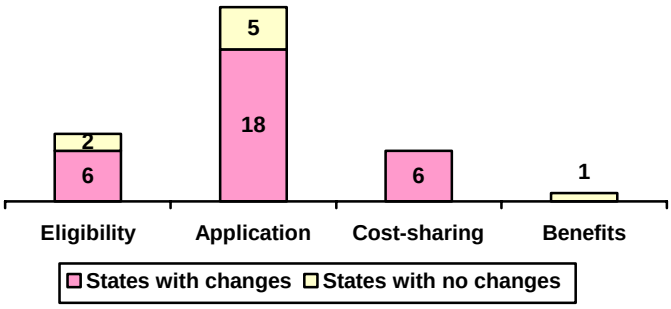
Figure 3
Types of Program Changes
(Some states have more than one type of change)



States were asked if CKF had played a significant role in encouraging or challenging various program changes. CKF was most frequently cited as playing a significant role with regard to application and renewal processes (23 states). (Figure 4) States were less likely to report that CKF played a significant role

with regard to eligibility, cost-sharing requirements or benefits. While CKF frequently played a role when states made changes, states also sometimes cited CKF playing a significant role when a change was *not* made. In 26 states (72%), state officials reported that CKF had a significant role in encouraging or challenging changes to the Medicaid and SCHIP programs. In ten states (28%), state officials indicated that CKF did not have a significant role.

Figure 4
States Reporting Significant CKF Role by Type of Program Changes
(Some states have more than one type of change)



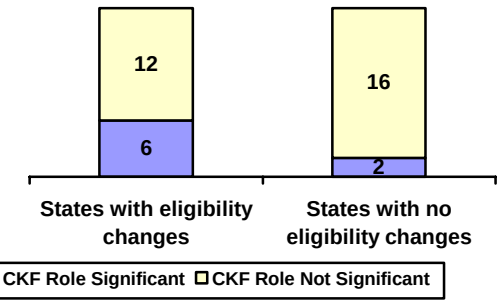
Eligibility Changes

Half of the states surveyed (18 of 36) reported eligibility changes. In one-third of these states (6 of 18), officials indicated that the CKF initiative played a significant role in encouraging or challenging those changes. (Figure 5) Of the 18 states that reported *no* significant changes in eligibility, two reported that the CKF initiative had played a significant role in that result. In particular, one state respondent stated:

> *"CKF efforts delayed the elimination of presumptive eligibility. CKF also successfully challenged a proposal to freeze SCHIP eligibility."*

Reported CKF eligibility activities were varied and included giving testimony to challenge program cuts, raising awareness of the impact of proposed changes, working to maintain programs that were in place, and challenging proposed eligibility cuts and enrollment freezes.

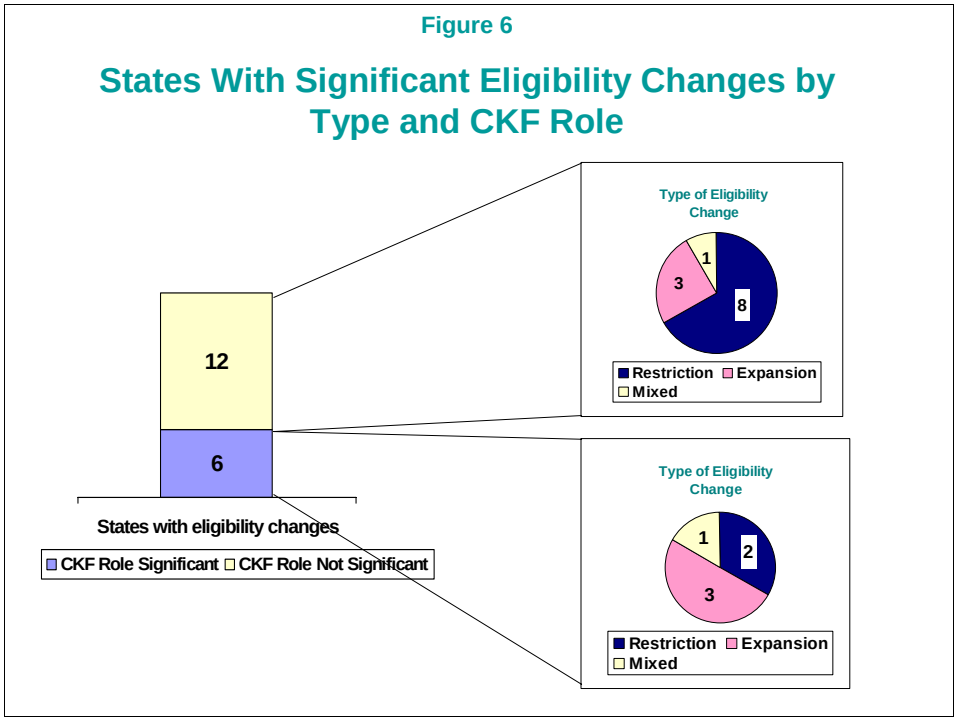
Figure 5
Significant Eligibility Changes and CKF Role



In the six states with changes in which CKF played a significant role, half (3) expanded eligibility, one-third (2) restricted eligibility and one state reported changes with mixed impact (both expanding and restricting eligibility). (Figure 6.) Of the 12 states reporting eligibility changes in which CKF *did not* play a

significant role, a higher proportion (8 of 12) restricted eligibility while three expanded eligibility and one state reported changes with mixed impact.

Figure 6



Of the 18 states with changes in eligibility, six expanded eligibility (including expanded coverage for parents), and two reported having changes that were mixed, both expanding and restricting eligibility. In the majority of the states with eligibility changes (10 of 18), eligibility was restricted to make fewer persons eligible for Medicaid or SCHIP. The types of eligibility cuts reported included:

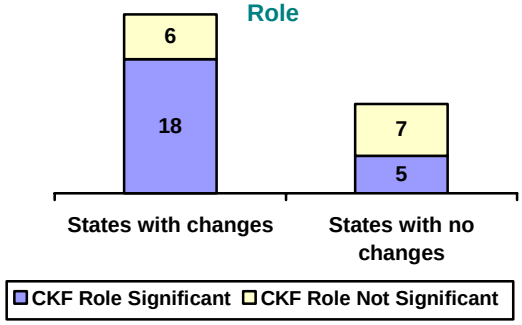
- parent eligibility reductions;
- elimination of three month retroactive coverage for some in Medicaid;
- reduced eligibility for SCHIP children;
- enrollment caps; and
- elimination of the medically needy program.

Application and Renewal Procedure Changes

CKF programs most often had an effect on application and renewal procedure changes, according to this survey of state officials. This is not surprising since administrative simplification is one of the three primary CKF program strategies. CKF had a significant role in 23 of 36 states: 18 of 24 states reporting

significant application or renewal procedure changes and five of 12 states reporting no changes. (Figure 7) In states where CKF had a significant role in application or renewal procedure changes, a large majority of states, 18 of 23 (78%), implemented significant changes. However, in states where CKF did not have a significant role in application or renewal procedure changes, fewer than half, six of 13 (46%), implemented significant changes.

Figure 7
Significant Changes in Application or Renewal Procedures and CKF Role



Reported procedure changes included:

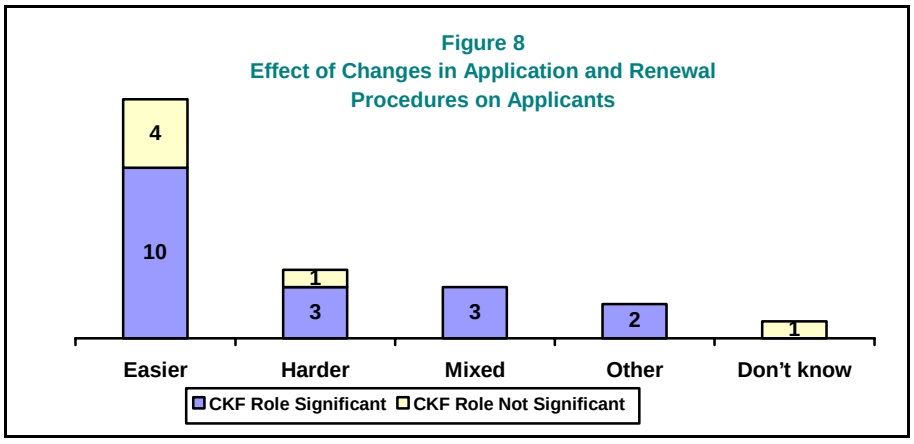
- creating a common application for Medicaid and SCHIP children;
- simplifying documentation requirements;
- creating a web-based eligibility and enrollment system;
- allowing self-declaration of income;
- establishing central processing of applications;
- streamlining renewal processes;
- adding a renewal grace period;
- eliminating presumptive eligibility;
- increasing income documentation requirements; and
- increasing the frequency of renewals.

"The State Grantee [members] are coalition builders extraordinaire and worked closely to make their views known, to explore other avenues before these changes were made. Unfortunately, budgetary need required these changes."

States with procedure changes were more likely to make application or renewal easier than harder. In the states with changes, over half (14 of 24) made application or renewal easier, four made it more difficult, and three reported changes that had a mixed impact. (Figure 8) The remaining three states reported other types of changes or did not identify whether the changes made application and renewal easier or harder. In states where CKF had a significant role, the majority of states (10 of 18) made application or renewal

easier and only three made it harder. In states where CKF did not have a significant role, two-thirds of the states (4 of 6) made the application or renewal procedure easier and only one state made it harder.

Figure 8
Effect of Changes in Application and Renewal Procedures on Applicants



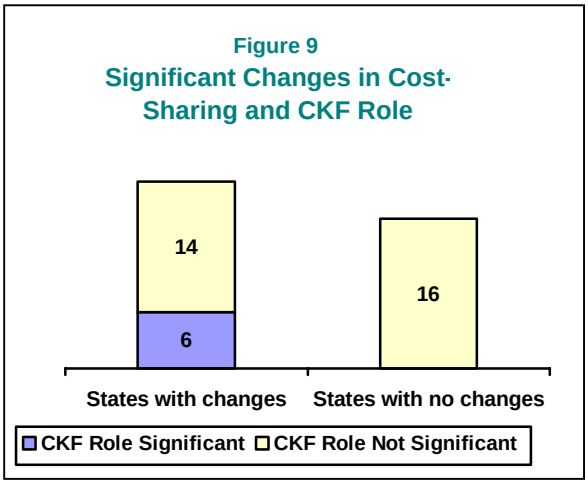
Reported CKF activities relating to application and renewal procedure changes included:

- working to implement changes to the process for sending out enrollee notices;
- helping to streamline the application and working for retention of self-declaration of income and preprinted renewal forms;
- giving testimony about a wait list and enrollment cap;
- helping in development of a web-based application;
- helping design a survey to assess why families leave coverage;
- working to delay elimination of presumptive eligibility;
- performing an enrollee reapplication study; and
- working to eliminate monthly reporting.

Cost-Sharing Changes

Twenty of the 36 surveyed states (56%) reported significant cost-sharing changes in the form of new or increased premiums or copayments. No state reported decreased beneficiary cost-sharing. CKF played a significant role in cost-sharing changes in few states. For the 20 states with changes, respondents indicated that CKF played a significant role in only six (30%), and for the 16 states without

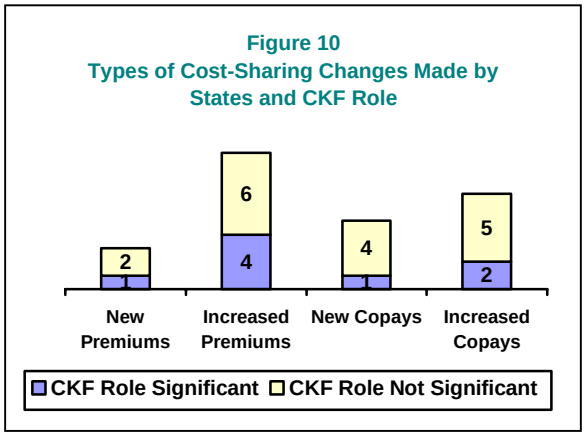
Figure 9
Significant Changes in Cost-Sharing and CKF Role



changes, no state reported CKF playing a significant role. (Figure 9)

In all, 17 states reported cost-sharing increases and eight reported new types of cost-sharing. Premium increases were somewhat more common than copayment increases. (Figure 10) In response to an open-ended question regarding "how" the CKF project had played a significant role in encouraging or challenging various types of program changes, only one CKF activity specifically related to cost-sharing was identified. In one state, the CKF project worked with the state to understand and address instances where children lose coverage for non-payment of premiums.

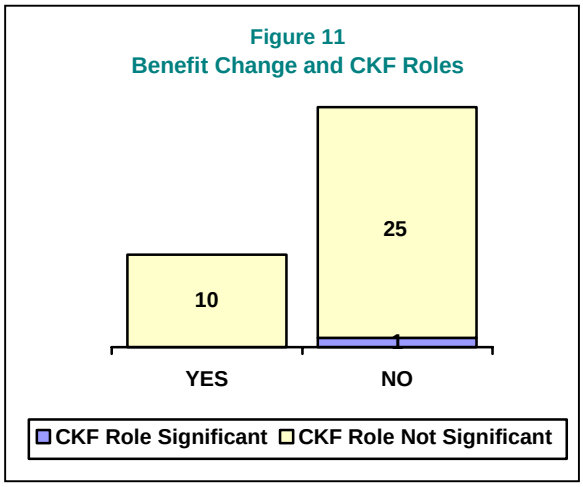
Figure 10
Types of Cost-Sharing Changes Made by States and CKF Role



Benefit Changes

With the exception of one state that made no benefit changes, all other states (35 of 36) reported that CKF *did not* play a significant role in decisions regarding benefit changes. (Figure 11) In all, ten of the 36 states (28%) reported benefit changes and in seven of those ten states, benefits were reduced, likely reflecting the severe fiscal pressures on states at the time of the survey. Two states reported changes with "mixed" impact and one state, North Carolina, reported that a successful Medicaid dental initiative was recently added to the SCHIP program for children. Benefit reductions included:

Figure 11
Benefit Change and CKF Roles



- reduced coverage for services by practitioners such as dentists, chiropractors, podiatrists, psychologists and others for Medicaid adults;
- cuts in physical, occupational and speech therapy;
- dental coverage caps for children; and
- limitations in orthodontia for children.

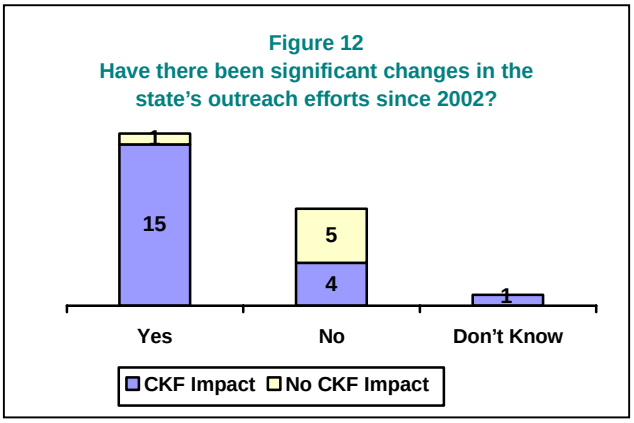
In the only state in which state officials reported CKF as having played a significant role in benefit changes, no benefit changes were made. In this case, CKF played a role in challenging a benefit reduction as one state official noted:

> *"At the end of FY03 there was a large state revenue shortfall that heavily affected state agencies. CKF did protect children and families from significant cuts in benefits. They did so by their presence at meetings, where they asked challenging, good questions. They help policy makers understand the full impact that changes will have, especially through use of their list serve."*

C. Outreach

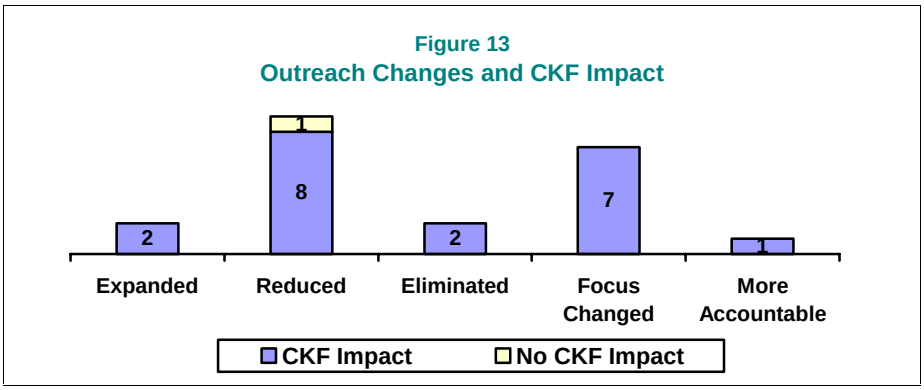
CKF played a significant role in outreach in most of the states surveyed. Of 26 states with state-sponsored SCHIP or Medicaid outreach, sixteen had significant changes between 2002 and November 2003.[4] In all but one of these sixteen states, CKF impacted state outreach strategies. (Figure 12) Among the ten states without significant outreach changes, CKF affected outreach strategies in four states. Several states also noted that it was difficult to isolate CKF's impact because the state and CKF worked so closely together.

Figure 12
Have there been significant changes in the state's outreach efforts since 2002?



In the 15 states where CKF altered outreach strategies, respondents reported 20 outreach changes. Reports of reductions in outreach and changes in focus were most common. Outreach expansions and eliminations were less common. In one state where CKF did not alter the state's outreach strategies, outreach was reduced. (Figure 13)

[4] The 10 states without state-sponsored outreach tended to be smaller. States reporting no state-sponsored outreach efforts were Delaware, Mississippi, Missouri, Nevada, New Hampshire, North Dakota, Ohio, Oregon, Tennessee, and Wyoming.



Several states reported CKF activities that publicize Medicaid and SCHIP programs and enrollment-related activities including:

- identifying and training organizations to help with outreach;
- influencing coordination between schools and the Medicaid and SCHIP programs;
- conducting outreach to school nurses, distributing information kits to doctors and financing local advertising;
- conducting all outreach activities in the state;
- purchasing outreach materials;
- helping to develop better outreach messages and extending outreach to help people navigate the managed care system;
- lending a national perspective to the work of the state agency; and
- effectively reaching local communities.

D. Overall CKF Impact on Policy and Procedures

Interviewers asked state officials whether CKF had impacted state Medicaid and/or SCHIP policy and procedures. For most of the states surveyed (28 of 36), respondents answered "yes." Respondents noted that CKF efforts most often resulted in enrollment growth, increased outreach, simplified application requirements and improved retention at renewal. The policies and procedures most frequently mentioned by state officials as being impacted by CKF were:

- simplified eligibility forms;
- improved application process;
- reduced verification requirements;
- expanded eligibility;
- outreach; and

- educating officials.

States often interacted with CKF as partners and state officials described these partnerships as positively impacting policy and procedures. For example, one state official reported that CKF provided "the funds and other resources necessary to maintain and protect those positive changes." Also, another official stated:

> *"Policies and procedures have been positively impacted, in general. The more people involved in brainstorming and decision-making, the better. CKF gives us a better perspective. They have been quite helpful in formulating a number of policies and procedures."*

Other states cited the following examples of CKF activities impacting policy and procedures:

- evaluating policy and procedures;
- increasing awareness of what other states are doing;
- making printed materials more accessible;
- publicly supporting policy changes;
- working with the state on a caseload study to determine why some individuals do not renew coverage;
- helping to implement an on-line application system;
- developing a training guide for outreach;
- performing telephone-based application assistance for the state; and
- working with the state to merge electronic eligibility systems.

E. Working Relationships

With a few exceptions, state officials reported strong, successful working relationships with CKF. Of 51 state officials that responded to a question about these relationships, 45 (88%) reported very positive relationships with CKF. In answering the question, "How well has CKF worked with you," officials used terms such as "excellent", "very well", "fantastically", "5 on a scale of 1 to 5", and "hand in hand." Only five respondents had unfavorable comments about their relationship with CKF. One official did not respond to this question. Also, a few officials had suggestions for how CKF might work more effectively with the state and the majority of officials surveyed did not believe their relationship with CKF could improve. Ten officials had the following suggestions:

- Three suggested that more grant funds from CKF would be helpful.
- Three suggested that CKF could work to better understand the state's situation.

- One thought CKF ought to be less adversarial.
- One thought communication could be improved.
- One thought CKF should lobby.
- One thought CFK should have more national considerations.

F. Impact of Program Changes by Eligibility Group

Survey respondents were asked to identify which of the following eligibility groups were impacted by changes in eligibility policies, application and renewal procedures, cost-sharing requirements and benefits:

- Medicaid children;
- Medicaid parents;
- Medicaid aged, blind and disabled;
- SCHIP children; and
- SCHIP adults.[5]

Changes in eligibility policies and application and renewal procedures were most common for Medicaid and SCHIP children. Changes in cost-sharing requirements and benefits were most common for SCHIP children (but not Medicaid children). A more detailed discussion of the survey responses concerning impacts by eligibility group is included in Appendix A to this report.

[5] Respondents could also select "Other" or "Don't know" for each of the types of program changes.

IV. CONCLUSIONS

The CKF program is well known to state Medicaid and SCHIP officials who reported recent interaction with CKF at the time of the survey. State officials were overwhelmingly positive regarding their relationship with CKF and many worked closely with CKF to operate their programs and to implement program changes. This was especially true with regard to outreach initiatives. In fact, several states reported relying on CKF to perform all outreach activities within the state. Although a few respondents suggested ways that CKF could better work with them, the vast majority did not have any recommendations for improvement because they worked together so well already.

In recent years, severe state fiscal conditions have caused Medicaid and SCHIP officials in almost all of the surveyed states to make program Medicaid and SCHIP program changes. Many of theses changes impacted children enrolled in Medicaid and/or SCHIP. Despite adverse budget conditions, the most common program changes reported were changes to application and renewal processes with the majority of these changes intended to make application and renewal processes "easier" rather than "harder." Almost two-thirds of the survey states (23 of 36) reported that CKF played a significant role in encouraging or challenging changes in this area. State officials also reported that the existence of CKF and its outreach initiatives altered outreach strategies in a majority of the states surveyed. With regard to eligibility, cost-sharing and benefits, reported changes were more likely to be negative (i.e. increases in cost-sharing or reductions in benefits), and more often than not, the CKF program did not play a significant role in these changes. Also, while CKF frequently played a role when states made changes, states also sometimes cited CKF playing a significant role when a change was *not* made.

V. IMPLICATIONS FOR FUTURE ANALYSIS

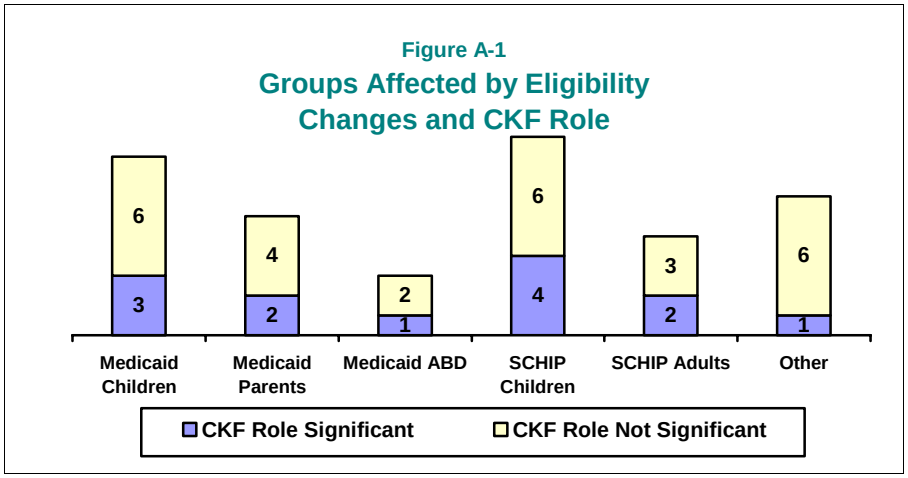
This survey was conducted in late 2003, at a time when, as a condition of a temporary increase in federal Medicaid funding, states could not reduce Medicaid eligibility standards.[6] Since that time, difficult fiscal situations have resulted in eligibility reductions and reversals of simplification of eligibility processes in several states. Other states have been able to maintain eligibility standards and simplified processes. Some states are even expanding eligibility and further simplifying enrollment and re-enrollment procedures. Future surveys will seek to assess the impact CKF may have had in maintaining or expanding eligibility standards or simplification of processes, or in mitigating negative changes in these areas.

This report indicates that many state officials believe that CKF had a significant impact on Medicaid and/or SCHIP policies and procedures. However because this telephone survey of state officials used opened-ended questions on the nature of the role of CKF, the information on the manner in which CKF acted to impact state policies and procedures is not as complete as it could be. Future evaluation components will seek to learn more about the CKF practices that were most effective in impacting state policy and procedures. In addition the evaluation will gather information on the extent to which these changes are still in effect.

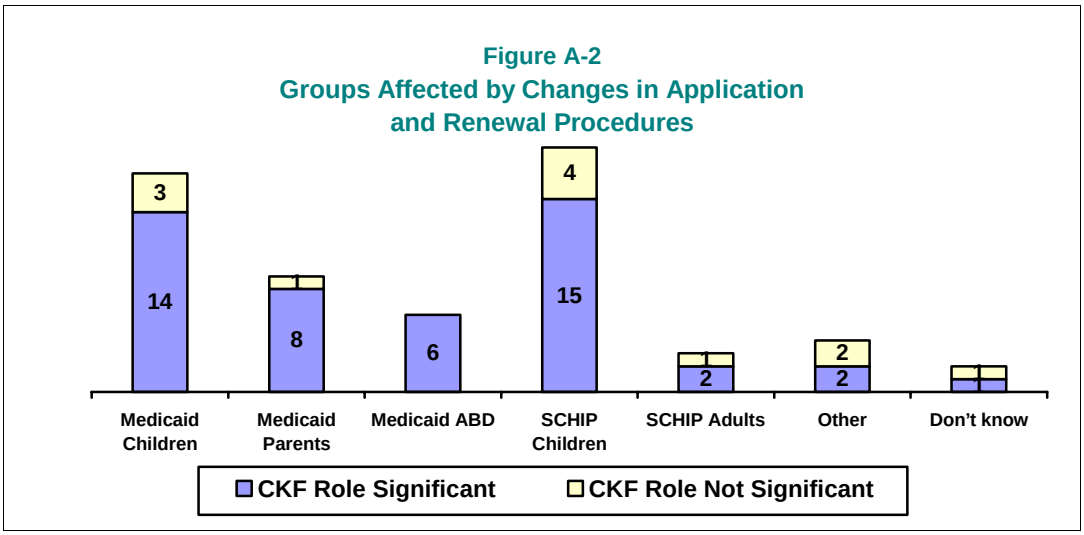
[6] The federal share of Medicaid benefit costs was increased by 2.95% from April 1, 2003 to June 30, 2004. A condition of this increase was that states could not reduce Medicaid eligibility requirements from those that existed on September 3, 2003.

Impact of Program Changes By Eligibility Group

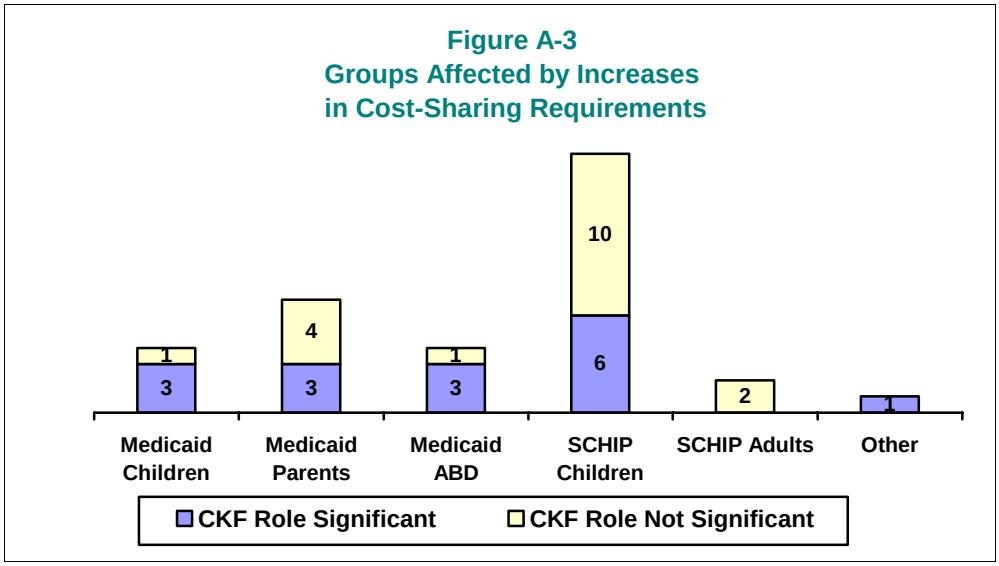
Eligibility. In the 18 states with eligibility changes, multiple eligibility groups were impacted in each state. State officials reported that changes to SCHIP for children and Medicaid for children were most common and that changes impacting Medicaid coverage for aged, blind and disabled adults were least common. In states where CKF had a significant role in encouraging or challenging eligibility changes, the changes were most likely to occur in SCHIP programs for children. In the states where CKF *did not* have a significant role in eligibility changes, the groups with the most change were spread between SCHIP and Medicaid for children and other eligibility groups. (Figure A-1)



Application and Renewal. In the 24 states with application and renewal procedure changes, state officials reported changes to 58 eligibility groups. Changes to SCHIP and Medicaid for children were most common and changes impacting SCHIP adults and Medicaid for aged, blind and disabled adults were less common. In states where CKF had a significant role, the changes were most likely for SCHIP and Medicaid for children. Numerous changes were also reported in these states impacting Medicaid for parents and Medicaid for the aged blind and disabled. Application or renewal changes in states with a significant CKF role were least likely in SCHIP programs for adults. (Figure A-2)

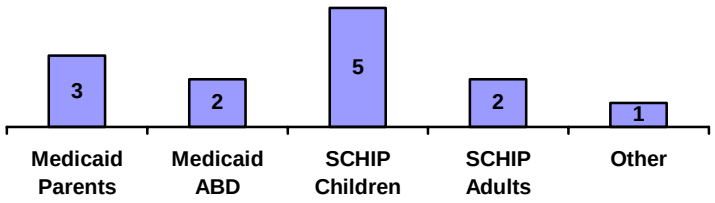


Cost-Sharing. A total of 34 groups in 20 states were impacted by cost-sharing changes including 16 eligibility groups in the six states where CKF played a significant role and 15 eligibility groups in the 18 states where CKF did not play a significant role. Cost-sharing changes were most likely to affect coverage for SCHIP children. Sixteen (80%) of the 20 states with cost-sharing changes made changes to cost-sharing for SCHIP children. Interestingly, four states reported cost-sharing changes for Medicaid children even though Medicaid regulations significantly limit the ability of states to institute cost-sharing for children. (Figure A-3)



Benefits. In the ten states with benefit changes, 13 groups were affected. State officials reported that changes were most likely to affect SCHIP programs for children and Medicaid coverage for parents. Medicaid benefits for children were not changed in any of the survey states. Most states with changes (7 of 10) reduced benefits and five of ten states changed benefits for SCHIP children. (Figure A-4)

Figure A-4
Groups Affected by Changes in Benefits



Interview Questions for CKF Telephone Interview with SCHIP/Medicaid Officials		
State name		
Medicaid or SCHIP official Official's name and title Official's phone number		Interviewer's name Date and time of call
1	Are you aware of the Covering Kids and Families initiative in your state?	1. Yes 2. No 3. Don't Know
2	Are you involved with CKF activities or do you interact with CKF in any way?	1. Yes 2. No 3. Don't Know
3	How do you participate in CKF? **(MARK ALL THAT APPLY.)**	1. Interact with CKF staff 2. Member of coalition 3. Member of Steering Committee 4. Participate in CKF workgroup 5. Other_____ 6. Don't Know
4	When was your most recent interaction with CKF?	1. Within the past week 2. Within the past month 3. Within the past three months 4. Within the past six months 5. More than six months ago 6. Don't know
5	What was the nature of your most recent interaction with CKF?	Text-Open
6	What is your role in the Medicaid and or SCHIP program in (name of state)?	1. Medicaid staff 2. SCHIP staff 3. Medicaid AND SCHIP staff 4. Other_____
7	From reports we have received from the Covering Kids and Families initiative in your state, it appears that there have been the following types changes in Medicaid [and/or] SCHIP policies in (name of state)? Is this correct? **(MARK ALL THAT APPLY.)**	1. Changes in eligibility 2. Changes in application procedures 3. Changes in cost-sharing requirements 4. Changes in benefits 5. Other restrictions in Medicaid/SCHIP programs 6. Cutbacks in outreach funds 7. Other _____ 8. Don't know
8	Were there significant changes in eligibility criteria? (For example, income eligibility standards or asset tests?)	1. Yes 2. No 3. Don't Know
9	If there were changes in eligibility criteria: Which program or programs were affected? **(MARK ALL THAT APPLY.)**	1. Children's Medicaid 2. Medicaid Parents 3. Medicaid ABD 4. SCHIP Children 5. SCHIP Adults 6. Other _____ 7. Don't know
10	If there were changes in eligibility criteria: Did these changes restrict or expand eligibility?	1. Restricted 2. Expanded 3. Mixed effect 4. Other _____ 5. Don't know
11	Please describe the most significant changes in eligibility criteria	Text-Open

12	Were there significant changes in application or renewal procedures, such as verification or interview requirements?	1. Yes 2. No 3. Don't Know
13	If there were changes in application/renewal procedures: Which program or programs were affected? **(MARK ALL THAT APPLY.)**	1. Children's Medicaid 2. Medicaid Parents 3. Medicaid ABD 4. SCHIP Children 5. SCHIP Adults 6. Other _____ 7. Don't know
14	If there were changes in application/renewal procedures: Did these changes make it easier or harder to apply or renew?	1. Easier 2. Harder 3. Mixed effect 4. Other_____ 5. Don't know
15	Please describe the most significant changes in the application/renewal process.	Text-Open
16	Were there significant changes in cost-sharing requirements (such as premiums and/or copayments)?	1. Yes 2. No 3. Don't Know
17	If there were changes in cost-sharing requirements: Which program or programs were affected? **(MARK ALL THAT APPLY.)**	1. Children's Medicaid 2. Medicaid Parents 3. Medicaid ABD 4. SCHIP Children 5. SCHIP Adults 6. Other_____ 7. Don't know
18	If there were changes in cost-sharing requirements: Were premiums or enrollment fees increased or decreased?	1. New Premiums/Fees 2. Increased Premiums/Fees 3. Decreased Premiums/Fees 4. Increased for some/decreased for others 5. Unchanged 6. Not Applicable 7. Other_____ 8. Don't know
19	If there were changes in cost-sharing requirements: Were copayments increased or decreased? **(MARK ALL THAT APPLY.)**	1. New Copayments 2. Increased Copayments 3. Decreased Copayments 4. Increased for some people/decreased for others 5. Increased for some services/decreased for others 6. Unchanged 7. Other _____ 8. Don't know
20	Please describe the most significant changes in cost-sharing requirements.	Text-Open
21	Were there significant changes in SCHIP or Medicaid benefits?	1. Yes 2. No 3. Don't Know
22	If there were changes in benefits: Which program or programs were affected? **(MARK ALL THAT APPLY.)**	1. Children's Medicaid 2. Medicaid Parents 3. Medicaid ABD 4. SCHIP Children 5. SCHIP Adults 6. Other _____ 7. Don't know
23	If there were changes in benefits: Were benefits expanded or reduced?	1 Expanded 2. Reduced 3. Mixed effect 4. Other _____ 5. Don't know

24	Please describe the most significant changes in SCHIP or Medicaid benefits.	Text-Open
25	Since (date of CKF grant) has there ever been a state-sponsored outreach effort related to SCHIP or Medicaid?	1. Yes 2. No 3. Don't Know
26	Have there been significant changes in the state's outreach efforts since 2002?	1. Yes 2. No 3. Don't Know
27	If there were changes in outreach: Has outreach been expanded, reduced, or eliminated? Has the focus or approach changed? (**MARK ALL THAT APPLY.)**	1. Expanded 2. Reduced 3. Eliminated 4. Focus/approach changed 5. Other _____ 6. Don't know
28	We have discussed many changes in the SCHIP Medicaid program in your state. Of these changes, which have affected the enrollment of children into either SCHIP or Medicaid the most? **(MARK UP TO TWO.)**	1. Greater restrictions in SCHIP/Medicaid programs 2. Changes in eligibility 3. Changes in application procedures 4. Changes in cost-sharing requirements 5. Changes in benefits 6. Cutbacks in outreach funds 7. Changes in the state's economy 8. Other _____ 9. Don't know
29	Has the CKF project played a significant role in either encouraging or challenging any of these changes? **(MARK ALL THAT APPLY.)**	1. Changes in eligibility 2. Changes in application or renewal procedures 3. Changes in cost-sharing requirements 4. Changes in benefits 5. Other _____ 6. Don't know 7. None of the above
29a	How so? (Please describe)	Text-Open
31	Has CKF had an impact on Medicaid and/or SCHIP policy and procedures in your state?	1. Yes 2. No 3. Don't Know
32	What Medicaid/SCHIP policies and procedures were impacted by CKF activities? **(MARK ALL THAT APPLY.)**	1. Simplified eligibility forms 2. Reduced verification requirements 3. Removed in-person interview requirement 4. Other_____ 5. Don't Know
32a	Please describe the impacts of these changes.	Text-Open
33	Has the existence of CKF and its outreach initiatives altered the state's outreach strategies?	1. Yes 2. No 3. Don't Know
34	What impact did CKF have on your outreach strategies?	Text-Open
35	How well has CKF worked with you?	Text-Open
36	How might CKF work more effectively with you?	Text-Open
37	That's all of the questions we have for you today. We really appreciate your time. Is there anything else that you would like to add about Medicaid and/or SCHIP in your state that we've missed?	Text-Open