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REPORT

The Impact of Maximizing Enrollment on Children's Medicaid and CHIP Coverage

March 28, 2014

Sean Orzol
Christopher Trenholm
Richard Chapman

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Sean Orzol
Christopher Trenholm
Richard Chapman

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Submitted to:
The Robert Wood Johnson Foundation
Route 1 and College Road East
P.O. Box 2316
Princeton, NJ 08543-2316

Submitted by:
Mathematica Policy Research
220 East Huron Street
Suite 300
Ann Arbor, MI 48104-2583
Telephone: (734) 794-1120
Facsimile: (734) 794-0241
Project Director: Chris Trenholm

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EXECUTIVE SUMMARY

This report presents findings from an impact evaluation of the Robert Wood Johnson Foundation's *Maximizing Enrollment* grant program on the enrollment of children in Medicaid and the Children's Health Insurance Program (CHIP). Implemented from early 2009 through early 2013, the program funded eight states seeking to maximize the coverage of uninsured children who were eligible for these two major public insurance programs. The eight states included: Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin.

Program Design and Implementation

Led by a dedicated program office at the National Academy of State Health Policy (NASHP), *Maximizing Enrollment* combined grant support with a variety of technical assistance efforts aimed at helping the eight states promote the adoption of enrollment and renewal simplifications and other procedural changes thought to increase children's Medicaid and CHIP coverage. Responding to passage of the Affordable Care Act (ACA), in 2010 NASHP and RWJF expanded the goals of the grant program in preparation for future coverage expansion for both adults and children. In turn, the focus of the grant effort expanded, with some states pursuing policies and procedures focused more broadly on revamping systems in anticipation of the eventual ACA expansion.

With the assistance of the grant program, the eight funded states successfully implemented a number of policy and procedural changes with the potential to increase children's coverage. These included several changes backed by research evidence, such as reducing documentation requirements and using available "third party" administrative data to simplify the application and/or renewal process. States also expanded their use of online technology in the application and renewal processes, with some potential to increase coverage through reduced burden on families. Finally, states pursued a number of less quantifiable but still potentially important changes to promote coverage gains, such as improved communication between agency staff and a more supportive culture among eligibility workers.

Evaluation Design

The evaluation of *Maximizing Enrollment* used two different approaches to analyze the impact of the grant on children's coverage during its first four years, 2009-2012. The first approach was a state-specific analysis that examined descriptively the link between the timing of specific policies adopted through *Maximizing Enrollment* and observed changes in enrollment and retention of children in public coverage. The second approach was a cross-state analysis that estimated the impact of the overall grant program on total enrollment of children in Medicaid and CHIP using a quasi-experimental design. The evaluation offers a comprehensive understanding of the extent to which the grant may have driven enrollment growth in Medicaid and CHIP. Importantly, however, it does not provide a means to assess other potential benefits from the grant program over time, such as improvements in program efficiency or technical capacity that may lower program costs or accelerate future enrollment growth under the ACA.

Evaluation Findings

Findings from the descriptive analysis show dramatic growth in both Medicaid and CHIP enrollment across the eight *Maximizing Enrollment* states—totaling an increase of more than 800,000 children (13 percent) over the first four years of grant, 2009-2012. This increase is evident across all eight of the funded states and, in three states (Alabama, Virginia, and Wisconsin), it exceeds 20 percent. However, the findings show little evidence linking this enrollment growth to specific policy or procedural changes supported by the grant. Indeed, in every state, significant enrollment growth can be seen in 2008, a year prior to the grant, when the U.S. economy began a severe downturn. This suggests that economic factors were likely a key driver of the enrollment growth seen over the grant period, as employer-based coverage declined and large numbers of additional children became eligible for public coverage.

Findings from the impact analysis are consistent with those from the descriptive analysis, offering no statistically significant evidence that *Maximizing Enrollment* contributed to the coverage gains seen over the program's first four years. Across numerous specifications, the estimated impacts of the grant program are positive but small (typically 1 to 3 percent) and not distinguishable from chance with a high degree of statistical confidence. These findings certainly allow for the possibility that *Maximizing Enrollment* produced modest effects on enrollment; however, they also suggest that factors affecting all states, such as declining economic conditions and federal incentives to promote coverage, may have contributed far more to the enrollment growth seen during the four-year period.

Discussion

RWJF and NASHP pursued *Maximizing Enrollment* during a period of unforeseen and unprecedented change in the nation's fiscal and public coverage landscape – an outcome that may have simply overwhelmed the contribution of a grant program designed to produce meaningful but incremental changes among a target group of states. Launched in the early stages of the Great Recession, the program operated in the midst of several major federal investments designed to support states financially and promote public insurance coverage. Key among these was the CHIP Reauthorization Act (CHIPRA), signed into law in early 2009, which introduced major new incentives for all states to pursue changes similar to those encouraged through the grant program. Whether *Maximizing Enrollment* would have achieved more measurable success in a relatively stable state and federal policy environment is unknown. However, available qualitative evidence suggests this could be the case. For example, the policy support and technical assistance NASHP provided throughout the grant appears to have been well received by states and retained an impressive degree of relevance as states' needs and opportunities shifted.

Developing a strategy that can successfully promote children's health care access regardless of the economic, fiscal or political environments is clearly a daunting task. Such a strategy may need to be multi-level, combining broad investments in advocacy or capacity building with more focused investments like *Maximizing Enrollment* that can produce incremental progress. These latter investments may be unable to turn a weak performing state on children's health care access into a strong performing one, and both coverage advocates and funding partners could benefit from setting goals and expectations accordingly. However, when incorporated into a broader strategy focused on building state-based leadership, investments like *Maximizing Enrollment* may increase the chances that children's health coverage can become a public policy priority for more and more states.

I. INTRODUCTION

In 2008, the Robert Wood Johnson Foundation announced a major new grant initiative, Maximizing Enrollment for Kids: Making Medicaid and SCHIP Work *(Maximizing Enrollment)* designed to support states seeking to maximize the coverage of uninsured children who were eligible for either a state's Children's Health Insurance Program (CHIP) or its Medicaid program. These eligible-but-uninsured children comprise roughly two-thirds of all uninsured children nationwide (Kenney et al. 2010), making them a critical target group in RWJF's continued efforts toward universal coverage of children. *Maximizing Enrollment* sought both to increase coverage in these funded states and to create models and build momentum for other states to follow suit. More than 28 states applied for the *Maximizing Enrollment* grant, which included $1 million in direct support to awardee states and a combination of technical assistance and collaborative-learning support led by the National Academy for State Health Policy (NASHP).

In early 2009, after a competitive grant application process, RWJF awarded *Maximizing Enrollment* grants to eight states—Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin—with funding extending for four years, from 2009 through 2012. All eight states had demonstrated a strong commitment to increasing children's enrollment in public coverage programs, even in the face of difficult economic times and changes in political leadership (Edwards et al. 2010a). Efforts in the first year focused on a needs assessment of each state and the development of a formal plan outlining the policies and procedures states would pursue to maximize coverage for children (Brown and Nathan 2010). With economic conditions worsening in many states, these plans often featured efforts to improve administrative efficiency, in part because that could help preserve available resources for increasing children's coverage. Subsequently, with the enactment of the Affordable Care Act (ACA) in 2010, the *Maximizing Enrollment* plans were broadened to encompass adults as well as children, and the grant program was rebranded to Maximizing Enrollment: Transforming State Health Coverage. In turn, the focus of the grant effort expanded, with some states pursuing policies and procedures focused more broadly on revamping systems in anticipation of the eventual ACA expansion. Reflecting this strategy shift, the grant effort was extended one year, through January 2014.

A. Evaluation of Maximizing Enrollment

In 2009, RWJF contracted with Mathematica to conduct a quantitative evaluation of the *Maximizing Enrollment* initiative. As originally conceived, the evaluation had two goals. First, drawing on administrative data from the grantee states, it would develop and monitor several measures of children's enrollment and retention in public coverage. These measures would be shared regularly with NASHP (and RWJF) as a means of monitoring progress toward maximizing coverage in the grantee states and directing NASHP's technical assistance. Second, it would estimate rigorously the impact of the grant initiative on children's Medicaid and CHIP enrollment, including the effect both of major policy or procedural changes arising from the grant and of the initiative overall.

Prior to this report, the evaluation focused mainly on the first goal of measuring and monitoring states' progress enrolling and retaining children in coverage; over the course of the grant, the activities tied to this goal became quite extensive. For example, the evaluation team

participated directly in many of the NASHP annual grantee site visits, briefing states on their progress maximizing coverage (based on the monitoring data) and discussing a range of questions about the measures used, the quality of states' data, and the opportunities for further analysis. As a follow-up to these meetings, the evaluation team conducted a number of ad hoc analyses for the grantee states, examining more specific aspects of their performance or assessing how they could improve their data or use them most successfully. The team also partnered with NASHP on a range of dissemination activities, focused on both specific findings and broader lessons learned from the formative evaluation. These activities included presentations at each of the annual grantee conferences, participation in selected NASHP learning collaborative calls and webinars, coauthorship of issue briefs on performance measures (Trenholm et al. 2012), and effective use of administrative disenrollment codes (Harrington et al. 2012). The activities concluded formally at the end of 2012, though the evaluation continued to support NASHP on a modest, ad hoc basis through the final year of its extended grant.

B. Purpose of this report

This report presents summary findings from the second component of the evaluation: the analysis of *Maximizing Enrollment*'s impact on children's enrollment in CHIP and Medicaid. This analysis focuses on the original period of the grant project, 2009-2012, and features two different methods for assessing *Maximizing Enrollment's* contribution to enrollment. The first is state-specific: drawing on performance measures constructed using Medicaid and CHIP enrollment data for each grantee state; we examined descriptively the link between specific policies adopted through *Maximizing Enrollment* and changes in enrollment and retention in public coverage. The second is a more formal impact assessment: using quarterly enrollment data for Medicaid and CHIP for all states over an eight-year period, we estimated the impact of the overall *Maximizing Enrollment* grant on total enrollment using a quasi-experimental (natural experiment) design.[1]

Notably, given its exclusive focus on children's enrollment, this study cannot assess the full range of activities that became the focus of Maximizing Enrollment and may have benefited outcomes beyond children's enrollment, For example, as the grant unfolded, much of its focus turned to systems or operational improvements that may have significantly benefited efficient operation of state eligibility programs but, by themselves, would unlikely produce measurable gains in children's enrollment. This is particularly true, for example, of the expanded use of technology in the application and renewal process, supported by the grant and documented by Weiss and Boudouin (2013).

[1] The original evaluation plan included a formal impact analysis of individual policy and procedures as well as a more general descriptive analysis; however, three factors ultimately discouraged this approach. First, the sheer number of changes tied to the grant, including some occurring simultaneously and others with no clear timing, made it difficult to isolate the impact of any one of them. Second, few of these changes likely had the potential for large impacts by themselves, which further undermined our ability to isolate their effects apart from other factors. Third, as detailed in Chapter III, our overall impact analysis found no statistical evidence that *Maximizing Enrollment* significantly increased overall enrollment. While this latter analysis was not well powered to detect impacts of modest size (say, 2 or 3 percent), it suggests that any effects from individual policies were small at best and not detectable with sufficient power to warrant the analysis.

In the next chapter, we present findings from the state-specific analysis, beginning with a description of various policy changes adopted under *Maximizing Enrollment;* we then present findings on enrollment and retention trends in each of the eight grantee states, showing possible linkages between individual policy changes and the growth in children's coverage. In Chapter III, we present findings on the cumulative effect of all these changes from a formal estimation of *Maximizing Enrollment's* impact on children's Medicaid and CHIP enrollment in the eight states. We conclude in Chapter IV by discussing lessons from our evaluation for continued efforts to maximize enrollment and retention of children eligible for public coverage.

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II. DESCRIPTIVE ANALYSIS

Over the course of the original grant period (2009 through 2012), the eight *Maximizing Enrollment* states pursued numerous policy and procedural changes with the support and guidance of NASHP and RWJF. These included many changes thought to increase the number of eligible children covered by CHIP and Medicaid, such as streamlined applications, reduced documentation requirements, and use of available "third party" administrative data to verify eligibility. It also included expanded use of technology in the application or renewal process, some of which (such as online applications) could again encourage the enrollment or retention of eligible children. Finally, it included steps that might likewise promote coverage of eligible children but are difficult to quantify, such as improved communication among CHIP and Medicaid agencies and positive culture change among program eligibility staff.

To assess how these individual policy or procedural changes might have benefited children's coverage, we present findings from a descriptive analysis of administrative enrollment data collected from each of the eight grantee states as part of our overall evaluation. These changes fall into six general categories, listed below.[2] (For details on the specific changes adopted by *Maximizing Enrollment* states within these categories, see Appendix Table A.1):

- *Simplified Applications Process:* Includes adoption of a streamlined or joint application for multiple programs; automated verifications; and reduced documentation requirements by relying more on electronic sources for eligibility verification.
- *Simplified Renewal Process:* Includes adoption of administrative renewals (ranging widely from use of pre-populated renewal forms to automatic renewal of children with eligibility criteria unlikely to change) and ex parte renewals, in which states use information from unemployment records or other trusted data sources to verify certain eligibility criteria.
- *Express Lane Eligibility (ELE):* Allows eligibility findings from an "Express Lane" agency, such as Supplemental Nutrition Assistance Program (SNAP) or Free and Reduced Lunch, to determine children's Medicaid or CHIP eligibility at either application or renewal. While arguably another form of simplified application/renewal process, it is considered separately because the 2009 CHIP Reauthorization (CHIPRA) encouraged its more widespread adoption by states.
- *Online Application:* Availability of an application for children's Medicaid or CHIP that can be completed entirely through use of an online website or tool and can be signed and submitted electronically for the state's eligibility review.
- *Online Renewal:* Availability of electronic submission of a renewal form (similar to online application) or, at minimum, supporting documentation needed to redetermine eligibility.

[2] Excluded from this list are less well-defined changes, such as improvements in coordination and cultural orientation of key agencies involved in children's coverage work, since their adoption and timing cannot be reliably identified. Also excluded are changes in technology or business procedures that, by themselves, would not be expected to produce a measurable change in program enrollment. In Chapter III, we capture the collective effect of *all* these policies when estimating the effect of the entire *Maximizing Enrollment* program.

- *Telephonic Application or Renewal:* Technology and procedures needed to accept either an initial application or a renewal, including telephonic signature capacity, over the phone for public health coverage.

The *Maximizing Enrollment* states pursued policy changes vigorously across these categories; seven (all but Illinois) adopted a change in at least one category, and six (all but Illinois and Wisconsin) adopted a change in two or more (Table II.1). Moreover, as detailed in Appendix Table A.1, states often pursued multiple changes within a given category. For example, Utah enacted multiple policies aimed at simplifying the application and renewal processes, including self-declaration of assets and adoption of an administrative renewal policy that effectively allowed ex parte renewal at the eligibility worker's discretion. Virginia likewise adopted multiple changes to its renewal processes, all aimed at simplifying them for families to retain coverage of their eligible children.

Table II.1. Maximizing enrollment progress indicators as of February, 2013

	AL	IL	LA	MA	NY	UT	VA	WI
Simplified application process	Y				Y	Y	Y	
Simplified renewal process	Y			Y		Y	Y	Y
Express lane eligibility (ELE)	Y		Y	Y	Y			
Online application			Y			Y		
Online renewal						Y	Y	
Telephonic application/renewals	Y				Y		Y	

Source: Grantee reporting tool, NASHP reports, and communication with NASHP and selected grantee state staff.

Notes: "Y" indicates that the state adopted at least one policy or procedural change within the category shown within the grant period. For a list of the specific changes made by states across these categories, see Appendix Table A.1.

Findings from our descriptive analysis, detailed below, reveal dramatic growth in both Medicaid and CHIP enrollment across the *Maximizing Enrollment* states—totaling an increase of more than 800,000 children for the eight states combined (Table II.2). However, evidence linking enrollment growth under *Maximizing Enrollment* to individual policy changes is scant, with only a couple of ELE-related policies showing links to measurable gains in coverage for children. Moreover, in each state, the enrollment growth evident under *Maximizing Enrollment* can be seen in 2008—the year prior to the start of the grant, when the economy in every state began a severe downturn. This suggests that economic factors may have contributed to much of the enrollment growth seen under *Maximizing Enrollment,* as ESI availability declined and large numbers of additional children became eligible for public coverage. In Chapter III, we explore this possibility as part a formal impact analysis of *Maximizing Enrollment's* impact on children's coverage in Medicaid and CHIP.

Table II.2. Trends in Children's Medicaid and CHIP Enrollment, January 2009 to December 2012

State	January 2009	January 2010	January 2011	January 2012	December 2012	Increase during *Maximizing Enrollment* period
Eight *Maximizing Enrollment* States						
Number	6,205,011	6,640,839	6,844,755	7,035,071	7,017,21	812,250
Percentage increase	-	7.0	3.1	2.8	-0.3	13.1
Individual *Maximizing Enrollment* States						
Alabama						
Number	423,328	461,450	499,545	537,687	527,644	104,316
Percentage increase	-	9.0	8.3	7.6	-1.9	24.6
Illinois						
Number	1,478,376	1,569,770	1,628,607	1,666,542	1,644,427	166,051
Percentage increase	-	6.2	3.7	2.3	-1.3	11.2
Louisiana						
Number	619,092	649,778	672,692	679,025	675,089	55,997
Percentage increase	-	5.0	3.5	0.9	-0.6	9.0
Massachusetts						
Number	554,268	581,072	606,421	617,305	630,931	76,663
Percentage increase	-	4.8	4.4	1.8	2.2	13.8
New York						
Number	2,041,813	2,153,241	2,153,885	2,214,416	2,214,726	172,913
Percentage increase	-	5.5	0.0	2.8	0.0	8.5
Utah						
Number	166,125	186,917	195,759	204,570	197,880	31,755
Percentage increase	-	12.5	4.7	4.5	-3.3	19.1
Virginia						
Number	530,981	592,782	620,260	638,701	651,259	120,278
Percentage increase	-	11.6	4.6	3.0	2.0	22.7
Wisconsin						
Number	391,028	445,829	467,586	476,825	475,305	84,277
Percentage increase	-	14.0	4.9	2.0	-0.3	21.6

Source: Mathematica analysis of state-provided administrative data.

Note: Percentage increase reflects the year-to-year change between columns, except for the last column, which reflects the change for the entire four-year period (January 2009 to December 2012).

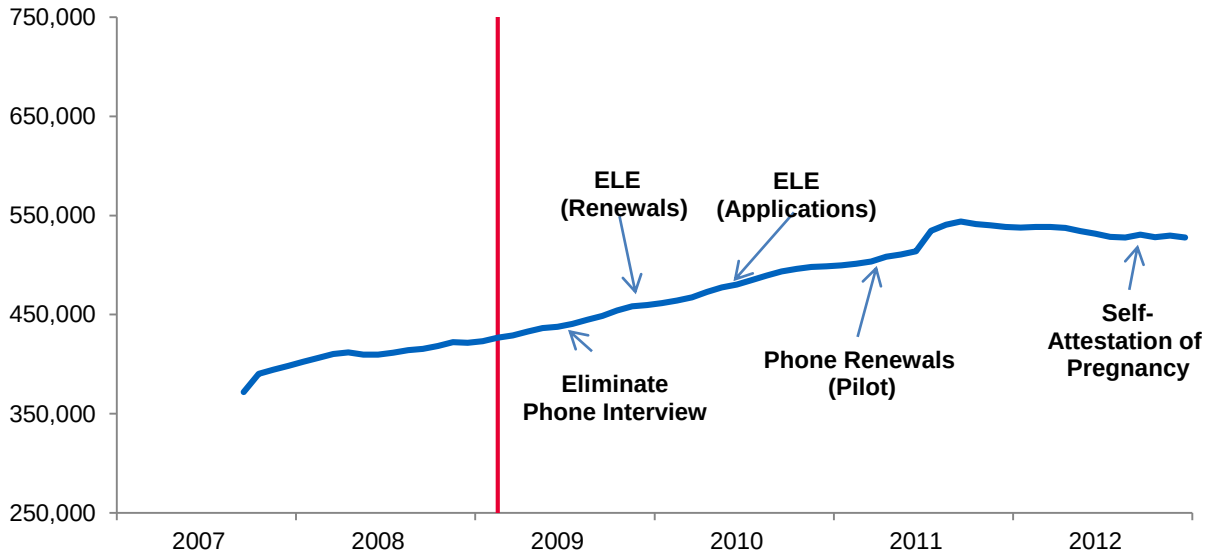
A. Findings by state

1. Alabama

During the *Maximizing Enrollment* grant period (2009 through 2012), Alabama's Medicaid and separate CHIP (AllKids) programs grew from roughly 420,000 children to 530,000, an increase of about 25 percent (Figure II.1). Despite this growth, we see no notable gains in

enrollment that coincide with the policies adopted with *Maximizing Enrollment* support. Rather, we observe a steady upward trend in enrollment that began prior to *Maximizing Enrollment* and continued through the economic downturn with little or no change associated with any of the policies adopted. The only notable change is in mid-2011, where we see an uptick in enrollment of about 20,000 children. As seen in Figure II.2, this uptick can be traced to a one-time spike in new enrollment in the state's AllKids program, which arose from a major eligibility expansion that allowed children in families with incomes between 200 and 300 percent of the federal poverty level (FPL) to enroll in coverage for the first time. The adoption of this policy was unrelated to *Maximizing Enrollment*.

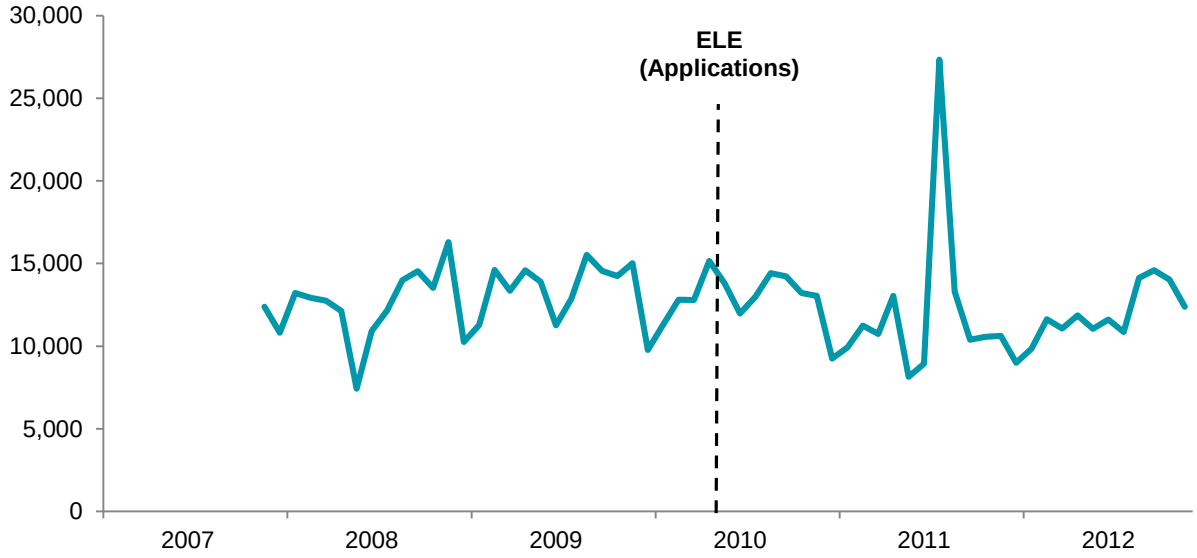
Figure II.1. Total monthly Medicaid and CHIP enrollment, Alabama, 2007–2012



Source: Mathematica analysis of state-provided administrative data.
Note: ELE = Express Lane Eligibility

Notably, Alabama had already begun to emerge as a leader on children's health insurance coverage prior to the grant, enacting by 2009 several notable process simplifications. For example, the state enacted a form of administrative renewal whereby pre-populated renewal forms were sent to families and required only that they confirm that the information is up to date. The state also adopted 12-month continuous eligibility regardless of changes in family income, took steps to administratively verify income at both enrollment and renewal, and eliminated the need for a face-to-face interview or an asset test. Furthermore, the state increased the usability of their online application and renewal system by adding the ability for families to submit them using an electronic signature.

Figure II.2. Monthly new Medicaid and CHIP enrollment, Alabama, 2007–2012



Source: Mathematica analysis of state-provided administrative data.
Note: ELE = Express Lane Eligibility

By comparison, the policies adopted during *Maximizing Enrollment* were arguably incremental, reflecting refinements to application and renewal processes that had already been substantially overhauled. Of these policies, the state's adoption of ELE garnered the most attention; the state became the first to implement ELE, adopting the process for renewals in October 2009, and for applications in April 2010. Through the policy, Alabama Medicaid began receiving data from SNAP and the Temporary Assistance for Needy Families (TANF) program to allow caseworkers to manually establish income eligibility once a family has completed a renewal or application form. This process eliminates the need for workers to conduct income determinations using Medicaid's income methods and reduces the time spent processing applications and renewals. However, it does not change the experience of most consumers: families must still complete the same renewal or application form, and most were already allowed to self-declare income under policies adopted in the past. Perhaps not surprisingly, therefore, we see no change in the enrollment trend associated with this policy (Figure II.2). As with the other policies, we see total enrollment in the state simply continue the same, steady rise it showed prior to ELE's adoption.

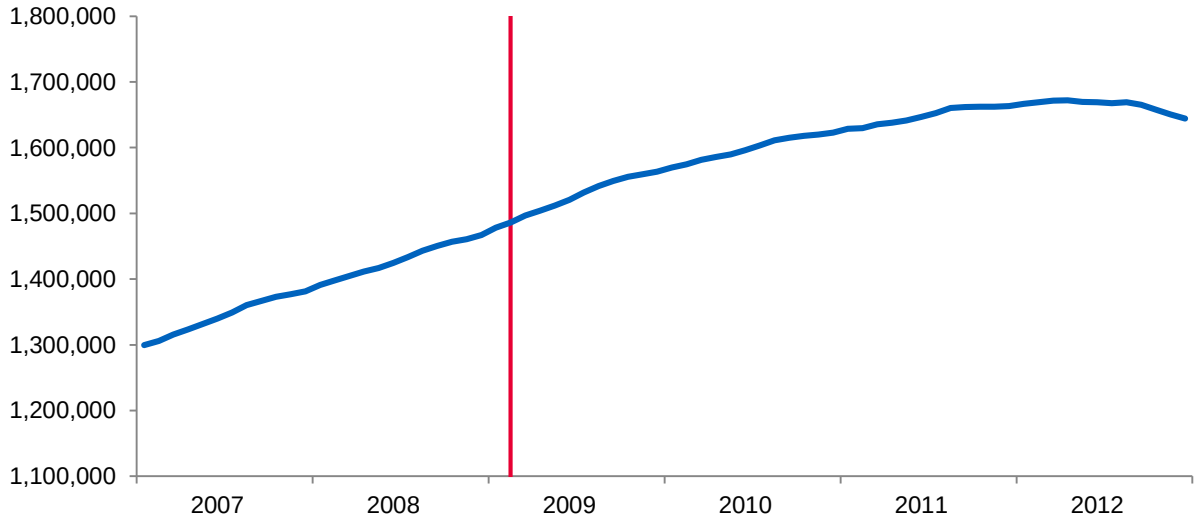
In February 2013, beyond our evaluation period, Alabama launched a completely automated ELE renewal process based on SNAP and TANF eligibility findings with the help of the *Maximizing Enrollment* grant. Unlike the manual ELE process, this automated renewal process requires neither staff involvement nor client action (such as submitting a renewal form or any documentation). A major federal evaluation of ELE, led by Mathematica, found that this type of automated process can benefit coverage retention and recommended that states interested in adopting ELE follow this approach (Hoag et al. 2013).

2. Illinois

If Alabama was emerging as a leader in children's public health coverage by the start of *Maximizing Enrollment,* Illinois was already there, becoming in 2006 the first state in the nation to offer healthcare coverage to all children. With its AllKids program, all children regardless of family income or immigration status are eligible for coverage through Medicaid, CHIP, or a state-sponsored program for higher-income families. Illinois had also taken numerous steps to simplify the Medicaid and separate CHIP application and renewal processes, including adopting a joint application for medical benefits, eliminating the need for asset tests and face-to-face interviews, establishing 12 months of continuous eligibility for children in both Medicaid and CHIP, and administratively renewing a child's coverage unless income has changed (Cohen-Ross and Marks 2009).

Perhaps not surprisingly given these many changes, total CHIP and Medicaid enrollment in Illinois has grown steadily since well before *Maximizing Enrollment* (Figure II.3). Over the five-year period from January 2007 through December 2012, total enrollment in the state surged from about 1.3 million children to just under 1.7 million—an increase of 27 percent. Although this growth includes an increase of roughly 166,000 following the start of *Maximizing Enrollment,* there is little from the descriptive analysis that ties it directly to policy changes influenced by the initiative. The overall enrollment trend shows the same steady growth after the grant as it did before, and as noted above, the state adopted no policies with *Maximizing Enrollment* support that would affect this trend. This is not to suggest that the grant made no contribution to the state's efforts to improve its AllKids program. Through the grant, for example, the state facilitated a major training project aimed at improving coordination and knowledge management among staff at the Department of Human Services, which has responsibility for SNAP, TANF, and other means-tested programs, and Healthcare and Family Services, which is responsible for Medicaid and CHIP. The state also focused efforts on evaluating technology and process improvements to address case backlog in CHIP and Medicaid. These types of changes would not, however, be expected to increase children's enrollment in a way we can identify.

Figure II.3. Total monthly Medicaid and CHIP enrollment, Illinois, 2007–2012

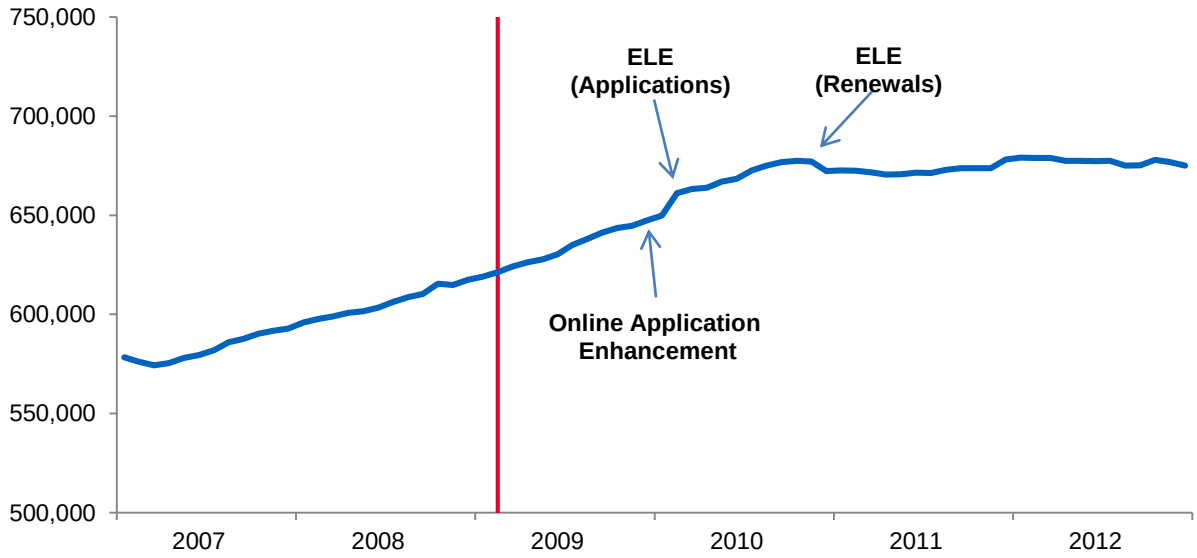


Source: Mathematica analysis of state-provided administrative data.

3. Louisiana

Louisiana is another grantee state that was hailed by coverage advocates as a model of policy simplification prior to *Maximizing Enrollment*, and it continued to show sizable gains in enrollment during the grant period (Figure II.4). Between January 2009 and December 2012, enrollment in Louisiana's CHIP and Medicaid programs increased by 9 percent, from about 620,000 to 675,000 children. All this growth took place in the first two years of the grant, during which the state adopted two major simplification policies tied to the grant. One of these, ELE, received considerable attention in policy circles, as the state became the first to use an automatic ELE process whereby eligibility findings from Express Lane partner agencies are used to automatically enroll or renew children in Medicaid or CHIP. In the overall enrollment trend, we do see a meaningful shift upward following the adoption of ELE for applications. By contrast, a similar ELE policy for renewals, adopted in November 2010, shows no descriptive link to enrollment growth. Indeed, from this point forward, enrollment in the state drifts slightly downward for the remainder of the grant period. Below, we elaborate on these policies and the evidence of potential effects from the descriptive trends.

Figure II.4. Total monthly Medicaid and CHIP enrollment, Louisiana, 2007–2012



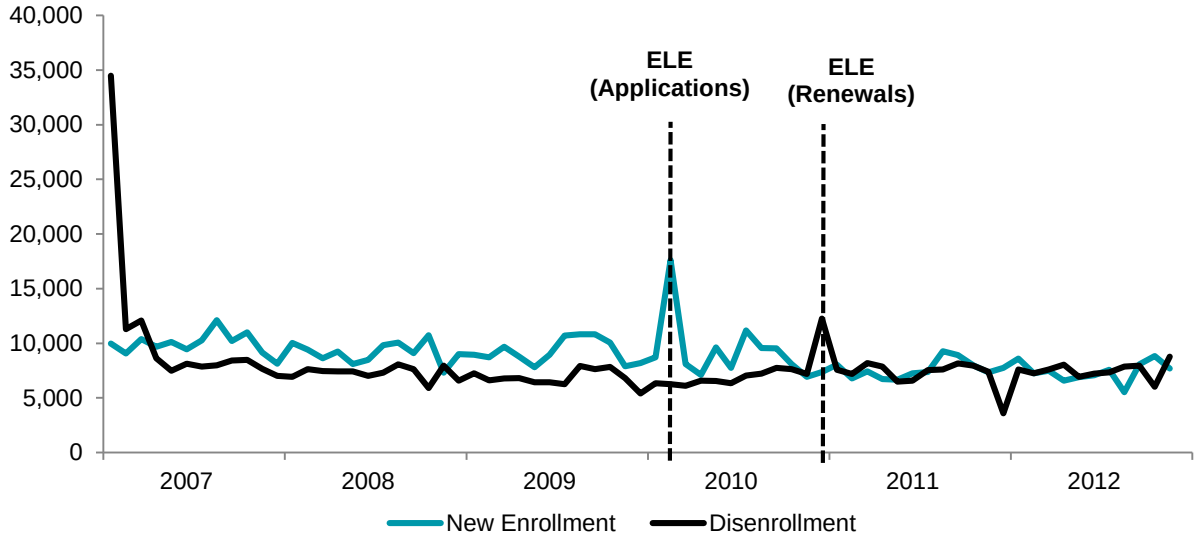
Source: Mathematica analysis of state-provided administrative data.
Note: ELE = Express Lane Eligibility

ELE (Applications). In 2010, Louisiana's Department of Health and Hospitals partnered with the Department of Children and Family Services to use SNAP eligibility determinations as a means to streamline enrollment and renewal in the Medicaid program. Louisiana was the first state to implement ELE as an "automated" process, whereby all the information needed for the eligibility or renewal determination is available from the partner agency, which removes the need for families to submit any information to the Medicaid agency.

The descriptive data suggest that using ELE to auto-enroll eligible children based on determination from the state SNAP agency extended coverage to a substantial number of

children. In Figure II.5, we observe large spikes in new enrollment during the first half of 2010, including the largest jump in the month ELE was implemented (February 2010). Findings from the National Evaluation of Express Lane Eligibility indicate that 17,000 children were newly enrolled in Medicaid via ELE between February 2010 and July 2010 (Hoag et al. 2013). This influx of new enrollees coincided with the increase seen in total enrollment in Figure II.4. The administrative data show that total enrollment of children in Medicaid and M-CHIP increased by roughly 27,000, from 649,778 in January 2010, the month prior to the first ELE enrollments, to 677,146 in November 2010, a 4 percent increase.

Figure II.5. Monthly new enrollment and disenrollment in Medicaid, Louisiana, 2007–2012



Source: Mathematica analysis of state-provided administrative data.

ELE (Renewals). Louisiana also authorized ELE for renewal in November 2010, using the same automatic matching process at redetermination to establish continued Medicaid eligibility based on SNAP receipt (Hoag et al. 2013). To test whether adoption of ELE coincided with an increase in the likelihood of retaining coverage, we examined the trend in the proportion of new enrollees remaining enrolled for 12 and 18 months, looking for an increase in the rate coinciding with adoption of the policy. In these rates we find no changes that coincide with the adoption of ELE for renewal; rates of 12-month continuous coverage remain steady at 90 percent, with 18-month rates similarly unaffected by the adoption of ELE (results available upon request).

Louisiana's enrollment leveled off toward the end of 2010, possibly as a result of ceiling effects, as the uninsured rate for children in the state fell to an estimated 3.5 percent (Barnes et al. 2011). Retention seems to have been a critical driver of this apparent success, as even before *Maximizing Enrollment,* the state was retaining far more children in coverage than other grantee states—a trend that continued throughout the grant. This success was likely fueled by the adoption of numerous simplifications prior to the grant— including administrative renewals, ex parte renewals, and telephone renewals—that together made the renewal process completely paperless for the vast majority of families (Kellenbeg et al. 2010). This pre-grant success may

explain in part why the automation of renewals via ELE does not coincide with major gains in enrollment, as the state's earlier progress could have "locked in" gains that might otherwise have arisen through ELE.

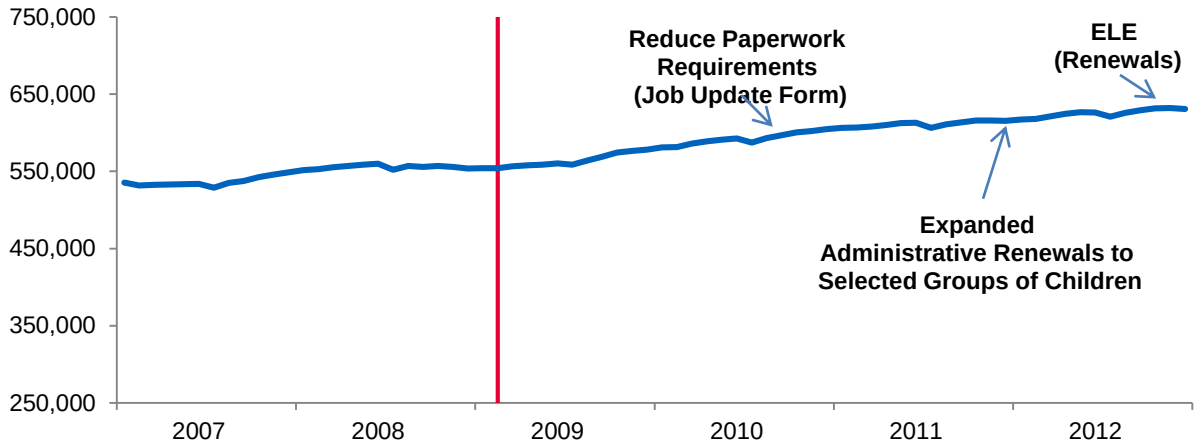
4. Massachusetts

Like Illinois, Massachusetts had also been a national leader in coverage expansion to children well before the grant, enacting its vanguard health reforms in 2006. These reforms directly affected children's coverage in several ways. First, the state became the first to pass a requirement that all adults have health insurance or face a tax penalty, unless coverage was deemed unaffordable. In addition, the state increased its income threshold for both children and adults in MassHealth—the single state program encompassing both Medicaid and CHIP—from 200 to 300 percent of FPL, creating a unified public coverage option for families. Finally, the state invested substantial resources to promote culture change within the MassHealth agency, encouraging eligibility and other agency staff to act as facilitators of coverage rather than as gatekeepers and to more broadly destigmatize the perception of public health insurance coverage within the state (Edwards et al. 2010b). These changes look to have achieved major success. According to data from the ACS, only 1.4 percent of children were without health insurance coverage in 2009, the lowest rate in the nation.[3] While these figures suggest that Massachusetts may have approached a coverage ceiling by the time of the *Maximizing Enrollment* grant, we nevertheless see continued enrollment growth during the grant period in MassHealth. From 2009 through 2012, enrollment in MassHealth grew from roughly 550,000 to 630,000 children, an increase of roughly 76,000, or 14 percent (Figure II.6).

Again as in Illinois, the enrollment growth in Massachusetts during *Maximizing Enrollment* is largely the continuation of a trend that began several years before the grant. Because participation in Medicaid and CHIP was already quite high before the grant began, the continued growth observed during the *Maximizing Enrollment* period appears due largely to the economic downturn and the corresponding decline in employment-based coverage that made significant numbers of children newly eligible for public coverage. Like many other states, the downturn in Massachussets was rapid and severe; between January 2008 and January 2010, the state unemployment rate approximately doubled, from 4.5 percent to 8.7 percent.

[3] American Community Survey 1-Year Estimates. 2008-2011.

Figure II.6. Total monthly Medicaid and CHIP enrollment, Massachusetts, 2007–2012



Source: Mathematica analysis of state-provided administrative data.
Note: ELE = Express Lane Eligibility

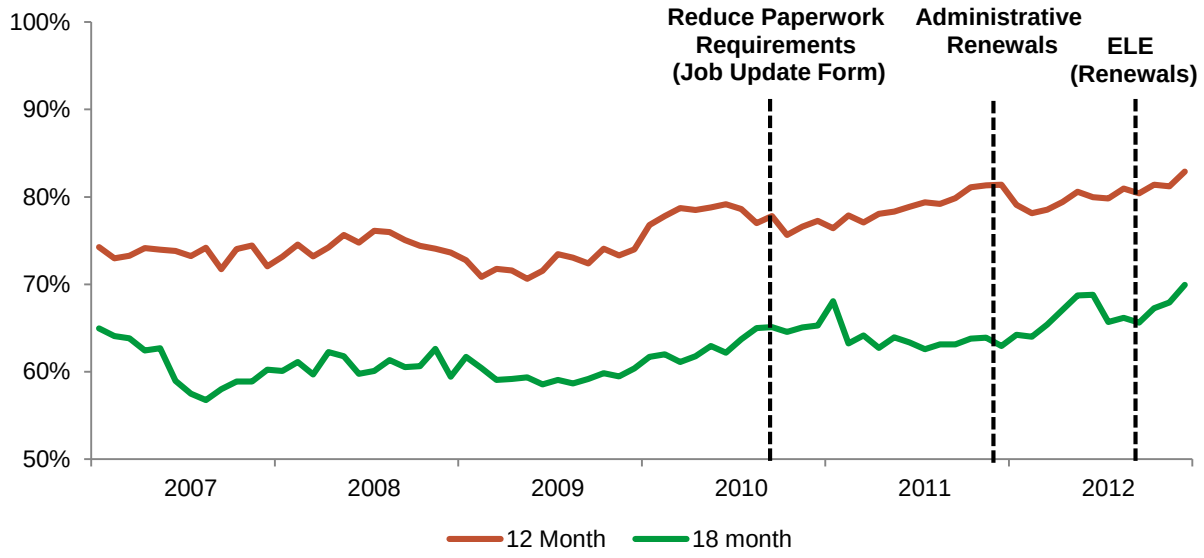
We see little in the enrollment trends that link specific policies adopted through *Maximizing Enrollment* to any of the coverage gains observed in Massachusetts. During the period of greatest enrollment growth, the state adopted two policies designed to remove procedural steps required of targeted enrollees. First, in response to concerns over widespread program "churn" (Edwards et al. 2010b), in September 2010 Massachusetts stopped using a Job Update Form that had been required of all individuals whose income appeared to have increased based on administrative sources (RWJF 2010). Second, in December 2011, the state adopted a form of administrative renewal that automatically renewed cases among eligibility groups with very low probability of eligibility changes, including those who are institutionalized, dually eligible for Medicaid and Medicare, or receiving SSI. Neither policy seems to have had an important outcome for children; as seen in Figure II.7, the retention of children in MassHealth gradually rose over the four-year period, with no evident shifts that coincided with the introduction of these policies. This is perhaps not surprising given the limited reach of these policies for children. Changes to the Job Update Form would have applied only to children whose parent(s) were working, a minority of the child Medicaid population. Likewise, while the administrative renewal policy was a major eligibility simplification, it ultimately reached only a few hundred (disabled) children in the state, causing any possible coverage gains from the policy to go undetected in our trend data.

ELE (Renewals). The final policy shown in Figure II.6, ELE for renewals, was enacted in the last months of our evaluation period and therefore could not be fully assessed. Based on its potential reach, however, it does appear to hold significant promise for reducing churn and adding to the numbers of children enrolled in coverage. As in Louisiana, this policy uses income eligibility findings from SNAP in lieu of requiring SNAP-enrolled families to provide this information at renewal.[4] Further, in contrast to the other policies adopted during the grant, it had

[4] To extend this process to entire families rather than just children, the state had to obtain a Section 1115 waiver from the Centers for Medicare & Medicaid Services (CMS) to include parents in the ELE renewal process.

the potential to reach a sizable number of eligible children: according to the National Evaluation of Express Lane Eligibility (Hoag et al. 2013), 48,000 children were renewed though the policy in just its first six months. Looking at Figure II.7, we do see modest evidence that the policy was benefiting coverage, as retention during the fourth quarter of 2012 was higher than in prior years. Further data will be needed to assess this policy more fully.

Figure II.7. Proportion of new Medicaid enrollees retained 12 and 18 months, Massachusetts, 2007–2012



Source: Mathematica analysis of state-provided administrative data.
Note: ELE = Express Lane Eligibility

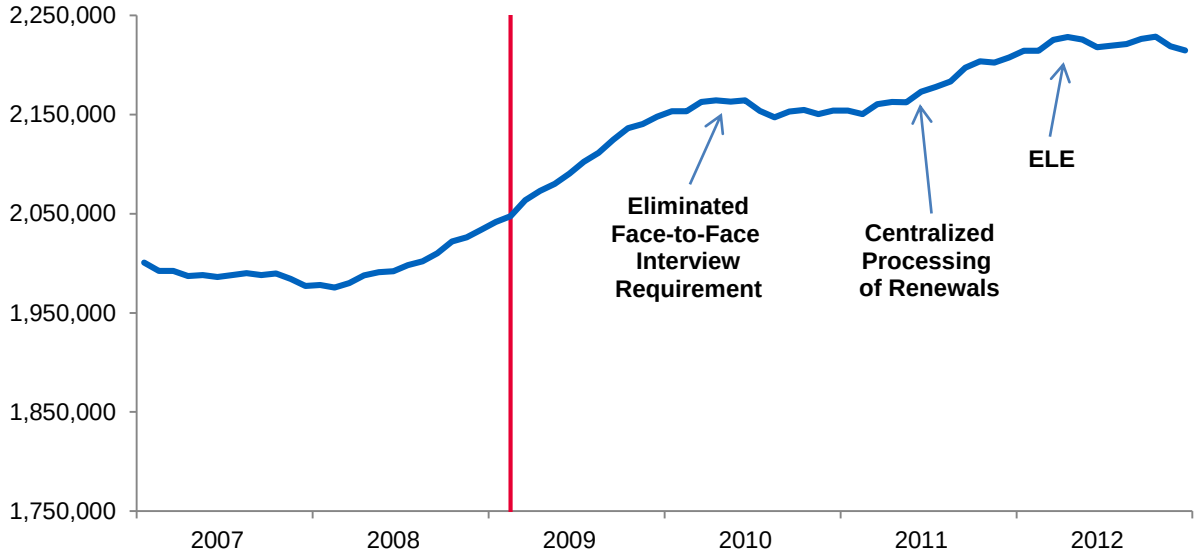
5. New York

Around the time that New York was chosen for the *Maximizing Enrollment* grant, it began introducing a series of simplifications and expansions aimed increasing enrollment of children in public coverage. In 2008, the state simplified its Medicaid application and renewal by allowing self-attestation of income and permitting Federally Qualified Health Centers to presumptively enroll children in Medicaid. Then, in 2009, New York substantially increased eligibility for CHPlus, the state's separate CHIP program, from 250 percent to 400 percent of FPL—the highest in the nation. Finally, in its 2009-2010 budget, the state outlined several further eligibility simplifications, including (1) aligning Medicaid eligibility levels of parents and children; (2) eliminating the face-to-face interview requirement for Medicaid; and (3) excluding children under the age of five from the waiting period.

Commensurate with these changes, enrollment in Medicaid and CHPlus grew rapidly between January 2008 and mid-2010 (Figure II.8). It leveled off over the next year, despite the elimination of face-to-face interviewing in 2010, the first of three major policies tied to the *Maximizing Enrollment* grant. Total enrollment then began a second upward surge toward the middle of 2011, coinciding with the adoption of centralized processing of Medicaid renewals, the second major policy supported by the grant. By the end of 2012, total enrollment in the New York stood at more than 2.2 million children, an increase of roughly 170,000 (8.5 percent) since

the start of the grant. Below, we examine the *Maximizing Enrollment*-supported policies shown in Figure II.8 in greater detail. Findings suggest they were not associated with increased enrollment, though further data are needed to assess that in full.

Figure II.8. Total monthly Medicaid and CHIP enrollment, New York, 2007–2012

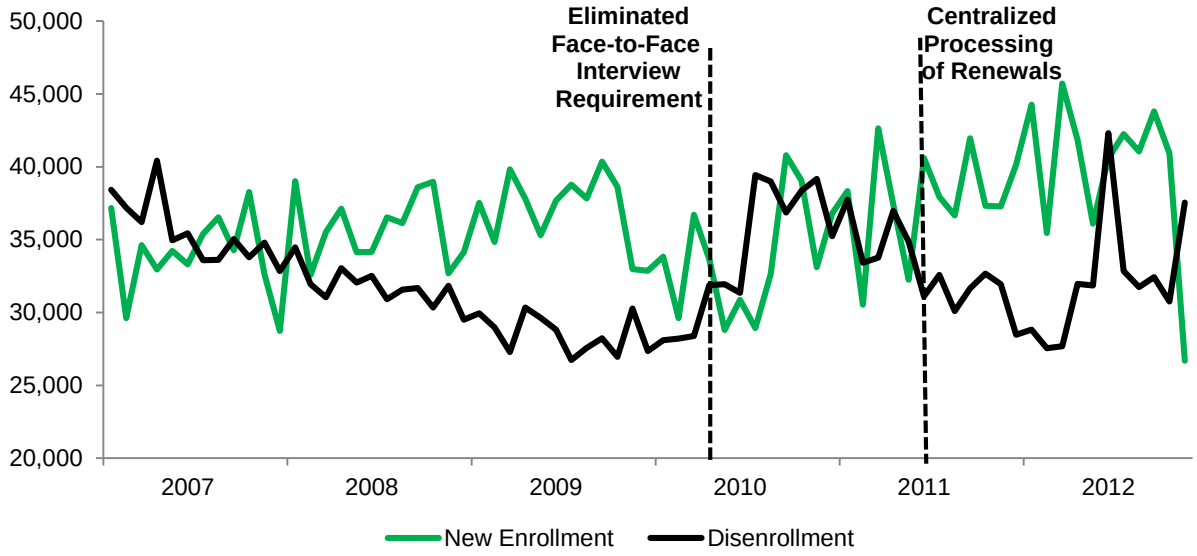


Source: Mathematica analysis of state-provided administrative data.
Note: ELE = Express Lane Eligibility

Face-to-face interview requirement. New York was one of the last states to require a face-to-face interview for Medicaid, eliminating it effective April 2010. Prior to the change, the face-to-face requirement could be satisfied through an interview with local department of social services (LDSS) staff or with a facilitated enroller (FE)—a certified, contracted entity with the ability to assist with completing and submitting an application. New York has long been a leader in using and supporting community-based application assistance to help enroll hard-to-reach populations (Hill and Hawkess 2002). These FEs have served a critical role in helping families with the application process, assisting with about two-thirds of CHIP applications and half of Medicaid applications prior to the change (Bitterman et al. 2010). Perhaps because the FEs are so valuable in helping families navigate the complicated application process, even today, with the face-to-face requirement lifted, many applicants continue to use FEs (Hill and Benatar 2012).

Descriptively, eliminating the face-to-face requirement did not lead to any evident growth in new enrollment (Figure II.9). New enrollments in Medicaid actually declined in the five months after the requirement was eliminated before increasing with the start of school in September 2010 (as they do every September). This finding underscores how much the context of a specific policy can matter to enrollment. While face-to-face interviewing has traditionally been seen principally as a barrier to enrollment, its implementation in New York appears to have been valued by a number of beneficiaries. In turn, by transitioning it from a requirement to an option, New York should be able to retain its value while opening the door for new application processes, such as online applications, that could yield enrollment gains in the future.

Figure II.9. Monthly new enrollment and disenrollment in Medicaid, New York, 2007–2012



Source: Mathematica analysis of state-provided administrative data.

Centralized Renewal Processing. Perhaps the most significant policy New York adopted with support from *Maximizing Enrollment* was the rollout of a centralized renewal-processing center, or "enrollment center." Because renewal practices were decentralized, it was difficult to ensure consistency in administrative processes and decision-making among counties outside New York City. It was hoped that by consolidating and standardizing the practices, the enrollment center would eliminate some of the procedural variation across the different LDSS agencies and make it easier for the state to implement certain process improvements that promote continued enrollment. Not only would a centralized renewal process allow the state to implement telephone renewals for Medicaid, it would streamline and simplify the process by allowing clients to ask questions and workers to clarify information in real time, thus minimizing the chance that the renewal form would be incomplete. Prior to adoption of the policy, the state estimated that 30,000 eligible beneficiaries were losing Medicaid coverage each month from failure to complete the renewal process (Hoag et al. 2013). The center began processing mail-in renewals for upstate counties on a phased-in basis starting in June 2011; in September 2011, the telephone renewal option began in four counties, and by early 2013, it had expanded to 32 counties (Silow-Carroll and Rodin 2013).

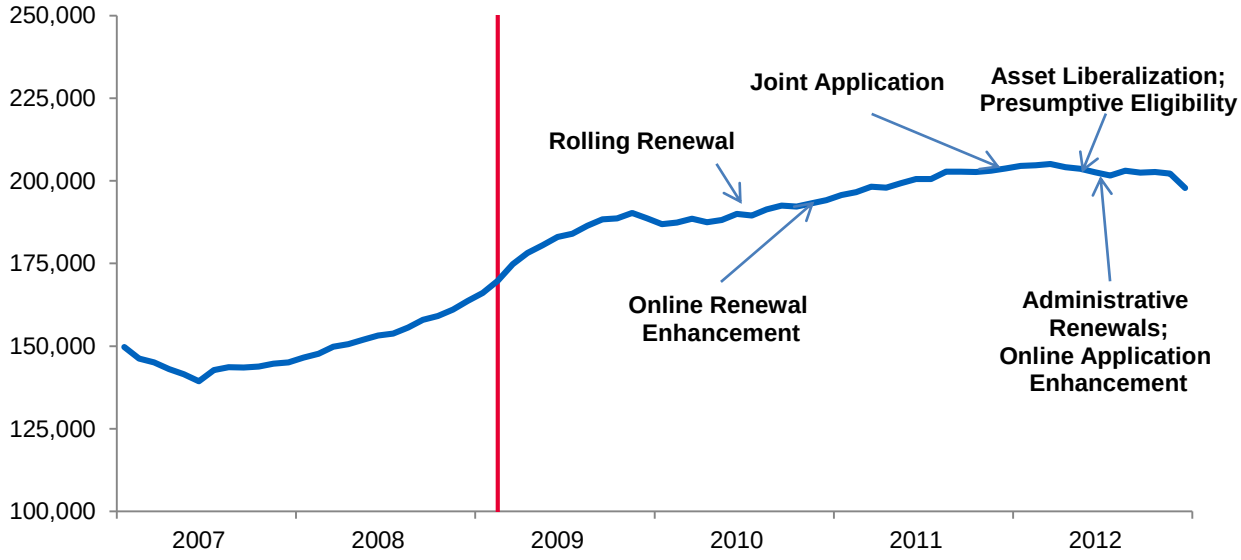
The disenrollment trend in Figure II.9 shows a steady decline in the months after the rollout of the enrollment center, which suggests that its introduction had successfully retained more eligible children in coverage. However, interviews with program staff suggest that the decline is due more likely to technical challenges that caused an initial backlog in the processing of renewals across many of the 28 up-state counties that had allowed the change to take place. This backlog caused beneficiaries to have their coverage extended for several months and culminated in a large disenrollment spike in June 2012 as the delayed renewals were finally processed. As a result of these implementation challenges, we are unable to assess descriptively whether or how this policy is associated with coverage of children in the state in the long term.

ELE (*Transfers*). New York adopted an ELE process in June 2012, in part to streamline the shift of a large number of children from CHIP to Medicaid following the increase in Medicaid income eligibility for children aged 6-19 from 100 percent to 133 percent of FPL. Prior to ELE, CHPlus enrollees who had income that qualified them for Medicaid were required to fill out a new application, which placed children at risk of losing coverage because of delays or failure to complete the new application process. Under ELE, this added application process is eliminated: once a CHPlus health plan determines that a child is eligible for Medicaid, the determination is sent to the state's Medicaid agency, and the child is temporarily reenrolled in CHIP for up to two months until the new Medicaid coverage becomes effective (Hensley-Quinn 2012). Although we do not have enough follow-up data to descriptively assess whether ELE reduced gaps in coverage for children making this transition, by eliminating the need to fill out a new, different application, this approach holds promise for improving retention rates among children eligible to transfer between programs.

6. Utah

During its first year in *Maximizing Enrollment*, Utah also experienced rapid growth in children's public coverage, continuing a trend that began at least a year prior to the grant (Figure II.10). Total enrollment in Utah's combined Medicaid and CHIP programs grew from about 166,000 to 187,000 children during 2009, an increase of more than 12 percent. Over the next three years, growth slowed considerably and actually reversed in 2012. This slowdown is attributable entirely to enrollment in the state's separate CHIP program, which saw a decline in overall enrollment since its peak in March 2010. Figure II.10 shows that Utah enacted all its *Maximizing Enrollment*-related policies later in the grant period, after enrollment growth had begun to slow, and we see no uptick in the enrollment trend associated with any of these policies.

Figure II.10. Total monthly Medicaid and CHIP enrollment, Utah, 2007–2012



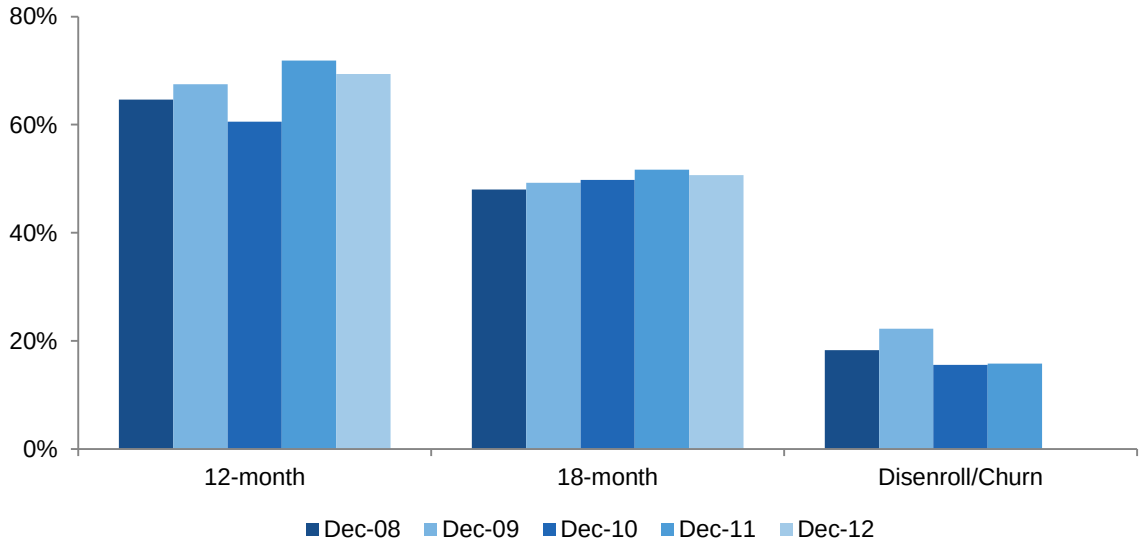
Source: Mathematica analysis of state-provided administrative data.

The absence of evident enrollment growth tied to the *Maximizing Enrollment* grant is perhaps surprising given how active Utah had been in its adoption of policies believed to

increase coverage. In total, Utah adopted seven such policies, including four that contributed directly to the state's receipt of a 2012 CHIRA performance award: liberalization of asset requirements, joint application for Medicaid and CHIP, administrative renewal, and presumptive eligibility. Moreover, in contrast to many *Maximizing Enrollment* states, Utah had among the highest uninsurance rates for children from families below 200 percent of FPL (17 percent) at the start of the grant period, leaving ample room for the grant to impact enrollment (State Health Access Data Assistance Center 2011).

Because many of Utah's policies focus on renewals, we explored trends in retention and churn to see whether gains were evident that might not have translated into obvious gains in total enrollment. As seen in Figure II.11, the trends for Medicaid do offer modest evidence of retention gains subsequent to the policy changes. On measures of 12-month retention and program churn, we see, from 2010 to 2011, improvement that is sustained through 2012. However, the retention gain seen at 12 months does not appear to be sustained through the first renewal process; at 18 months from enrollment, the retention rate in 2012 is 50 percent, which is essentially unchanged from 2009. Moreover, this retention rate remained easily the lowest of any of the *Maximizing Enrollment* states by the end of the initiative.

Figure II.11. Proportion of new Medicaid enrollees retained 12 and 18 months and the proportion of Medicaid disenrollees that churn back onto coverage (2008–2012)



Source: Mathematica analysis of state-provided administrative data.

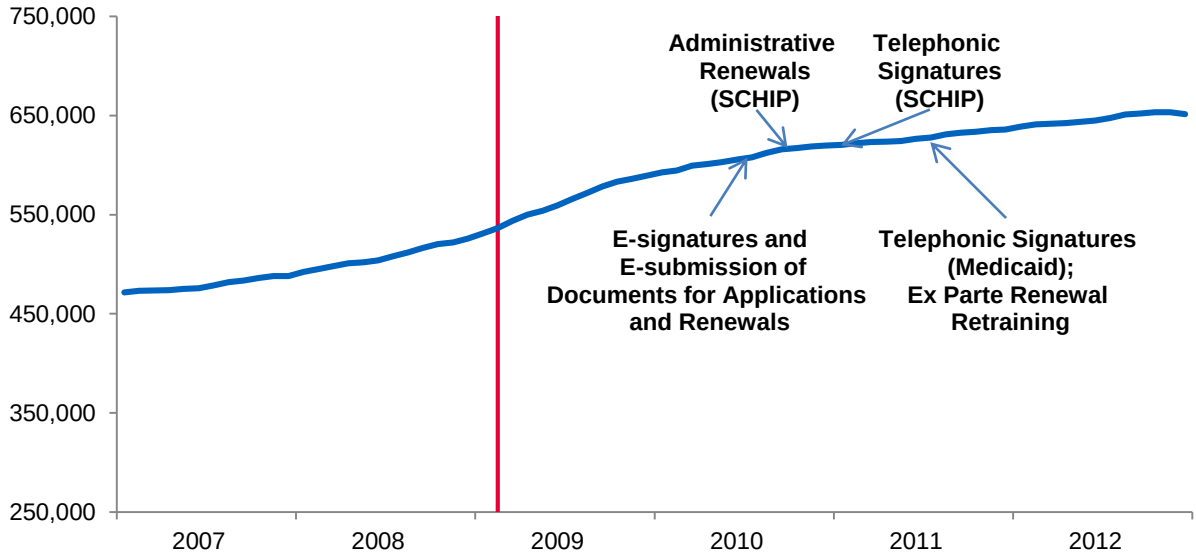
One factor that might have contributed to the weak gains associated with policy changes is that Utah, in contrast to the other *Maximizing Enrollment* states, has not adopted a policy of 12-month continuous eligibility, requiring Medicaid families to reverify income more frequently and placing them at risk of disenrollment more often (because of changes in income or failure to provide information). Further, Utah is the only grantee state whose eligibility system is not managed by the same department that oversees its public coverage programs and that pursued many of the policy simplifications through *Maximizing Enrollment*. This administrative separation took place just prior to the grant, in 2008, when Utah consolidated all public program

eligibility processing within its Department of Workforce Services (DWS), which also manages eligibility for numerous cash-related benefit programs, including TANF. This locating of eligibility processing within a broader public welfare agency could have blunted the effectiveness of the policies adopted through the grant, as caseworkers within DWS could have retained more of a traditional gatekeeper function in spite of the policy simplifications adopted by the state. This latter possibility is largely speculation, as the project was not able to undertake a qualitative study of the state's processes. Nevertheless, it illustrates how the success of policies to promote enrollment can be strongly influenced by the context in which they are adopted.

7. Virginia

Virginia is yet another *Maximizing Enrollment* grantee state that showed dramatic growth during the grant period but has few linkages tied to specific policy changes. Between January 2009 and December 2012, CHIP and Medicaid enrollment increased dramatically, from roughly 530,000 to 650,000, or about 23 percent (Figure II.12). During this period, Virginia concentrated policy efforts and resources on leveraging technology to make available new application and renewal options. In 2010 and 2011, with the help of the *Maximizing Enrollment* initiative, Virginia enhanced its online and telephone enrollment and renewal options to remove steps and barriers to enrollment and renewal. Further, in October 2010, Virginia adopted administrative renewal for its separate CHIP program, whereby the state's central processing unit (CPU) will send the FAMIS family a pre-printed renewal form using information, including gross income, contained in the eligibility system. Families are asked to review the form and, if there have been no changes in the family situation or income, attest to the correctness of the information and send the form back to the CPU for processing. If the returned form indicates no changes, eligibility staff at the CPU will then renew the case for another year without the need for verification.

Figure II.12. Total monthly Medicaid and CHIP enrollment, Virginia, 2007–2012

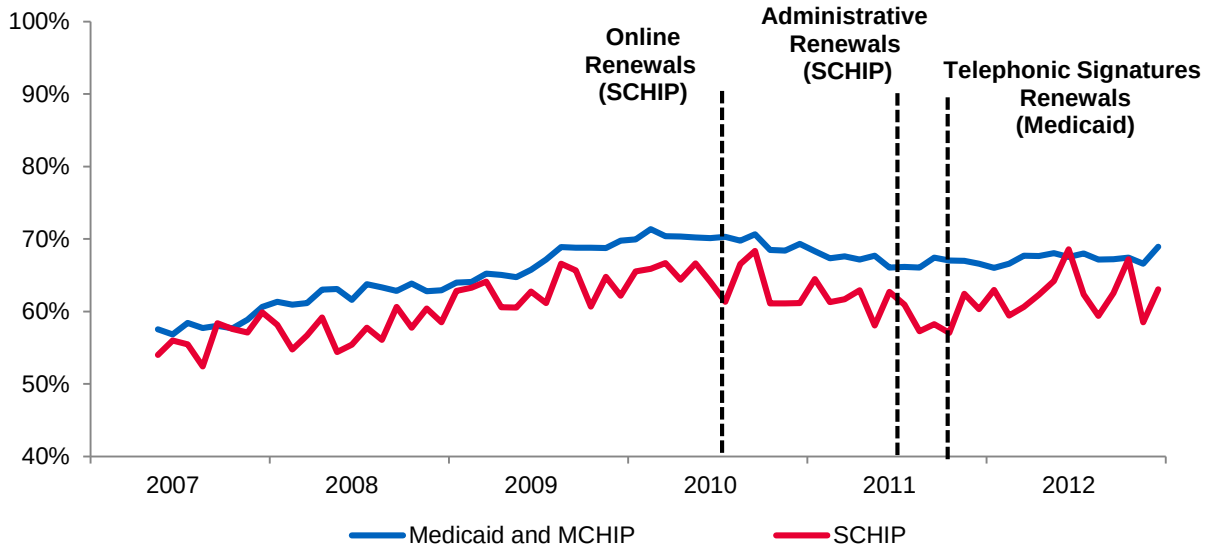


Source: Mathematica analysis of state-provided administrative data.

By reducing the burden on families that are enrolling or renewing their children's coverage, these simplifications have the potential to increase enrollment and retention rates in public coverage programs. However, there were no sizable enrollment shifts coinciding with the adoption of these policies. While enrollment increased during the period of the policy changes, the rise appears to be part of a broader trend that began before the start of *Maximizing Enrollment*, when the state's economy began to slow severely and push the unemployment rate from 3.3 to 7.4 percent between January 2008 and 2010. As with several other states, this suggests that economic factors contributed to much of the enrollment growth under *Maximizing Enrollment*, as ESI availability declined and additional children became eligible for public coverage.

Measures tied more closely to retention affirm a lack of a sizable effect from the policies adopted by Virginia under *Maximizing Enrollment.* For example, looking at the proportion of children retained in coverage for 18 months (through their first renewal), we see little to no change in retention rates during the period of the policy changes, 2010-2011 (Figure II.13). Throughout this period, about 60 percent of both new Medicaid and new SCHIP enrollees remain continuously enrolled for at least 18 months, a rate that actually declined slightly during 2011, the period when most of the new retention policies were put in place. Similarly, the adoption of these policies do not coincide with any obvious reduction in program disenrollment or churn, measures that should again be sensitive to retention-related polices (results available upon request).

Figure II.13. Proportion of new enrollees retained 18 months, by program type, Virginia, 2007–2012



Source: Mathematica analysis of state-provided administrative data.

These findings are not that surprising after considering the specifics of the polices that were enacted. While all the policy changes adopted by Virginia reflect meaningful ways to simplify the process for families to renew coverage, they are incremental steps whose effect may be modest in terms of overall enrollment numbers. For example, the recent enhancements to the

online and telephone systems—adopting telephonic signatures and allowing people to send an e-signature and e-submission of verification documents—removed steps that families previously needed to take when using both systems.[5] However, families are still required to initiate the process of applying for or renewing coverage for their children. While these measures almost assuredly increased customer satisfaction (they are the most frequent means through while families apply for coverage), they might not lead to the enrollment or renewal of a large number of people who would not otherwise have completed the process. Similarly, while the administrative renewal process eliminates the need to verify eligibility, families are still required to actively return a form, unlike the passive ex parte process used on the Medicaid side.

The Virginia ex parte experience is particularly useful in highlighting how implementing a valuable administrative simplification does not necessarily translate into meaningful changes in coverage. While local agencies were required to verify eligibility using existing data and passively renew those found eligible, the state found that in practice, the process was not used to the extent expected. In interviews with state staff, they reported that many local departments chose not to use the process for children, citing confusion over what populations were eligible for ex parte renewal. To "jump start" the process, the state, with the support of *Maximizing Enrollment,* retrained eligibility staff to help ensure it was used across the state. However, even with the retraining, it is still limited largely to the aged, blind and disabled populations, with a primary limitation of more widespread use being the electronic availability of income information for children of working families.

8. Wisconsin

Like at least three of the other seven grantee states (Illinois, Massachusetts, and New York), Wisconsin was already in the process of implementing major health care reforms when it was selected as a *Maximizing Enrollment* grantee. In 2008, the state dramatically expanded its BadgerCare Plus program, making all children under age 19 eligible for public coverage regardless of income and expanding eligibility for pregnant women up to 300 percent of FPL and for parents up to 200 percent. To coincide with the expansion, Wisconsin also undertook an aggressive marketing and outreach campaign in an effort to identify and enroll people targeted by the expansion (Commonwealth Fund 2009). As part of this effort, Wisconsin awarded "mini-grants" of up to $25,000 to selected community-based organizations to expand enrollment to hard-to-reach populations (Davis and Duchon 2010). As seen in Figure II.14, this expansion led to a sizable jump in children's coverage through the program: enrollment increased by 64,000 in the first month and by just under 100,000 (33 percent) in the first year.[6]

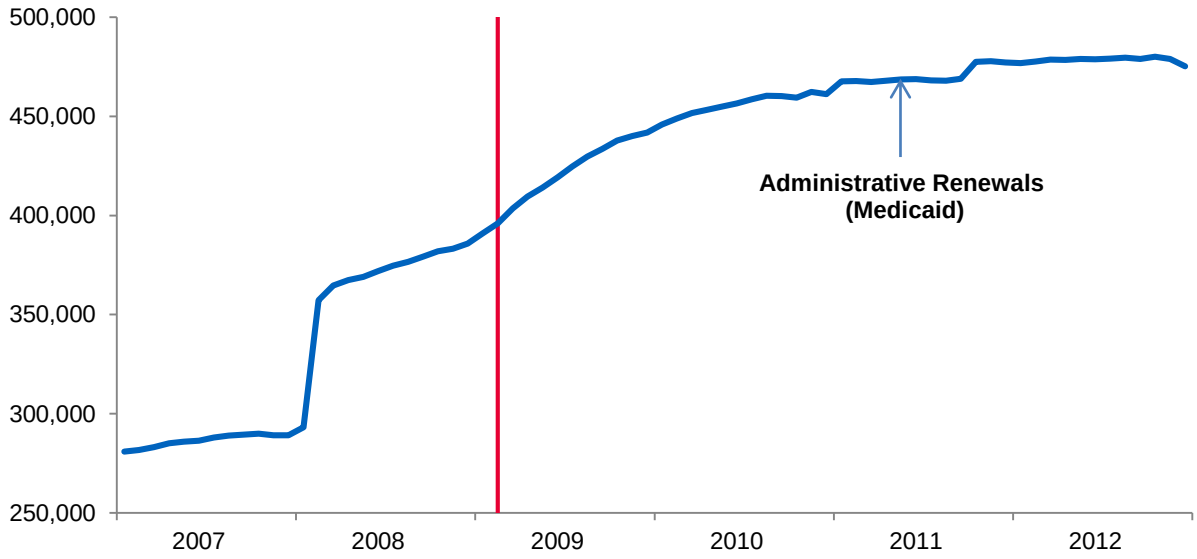
Following the *Maximizing Enrollment* grant, enrollment in Wisconsin's CHIP and Medicaid programs continued to grow, rising by 84,000 children (22 percent) between 2009 and 2012. Much of this growth took place in 2009, before the state had adopted any policy changes tied to

[5] Prior to these changes, applicants had to submit a hard-copy signature page via fax or mail when applying or renewing online or needed to finalize an application started by phone by signing a pre-printed form mailed out by the CPU (Davis and Duchon 2010).

[6] One interesting aspect of Wisconsin's expansion was the use of an auto-enrollment process whereby the state applied the new program eligibility criteria to existing data they already had in their eligibility system, such as information on siblings and parents of children already enrolled. Using this approach, the state was able to add 26,000 parents and 18,000 children to BadgerCare Plus on the first day of the expansion (DeLeire et al. 2012).

the grant; the growth could have been due the continued marketing and outreach efforts tied to the BadgerCare expansion. In fact, while the state leveraged the grant to make several administrative changes aimed at improving efficiency, it made only one change thought to potentially affect coverage: in May 2011, the state implemented administrative renewals for chosen enrollees with incomes below 75 percent of FPL, among other groups. This policy enabled children the state deemed all but certain to retain eligibility to have their renewal approved automatically, which saved case worker resources and ensured continued coverage for those approved. Soon afterward, we see a one-time shift upward in total enrollment, a possible link to coverage gains that we have investigated further by examining more-focused measures.

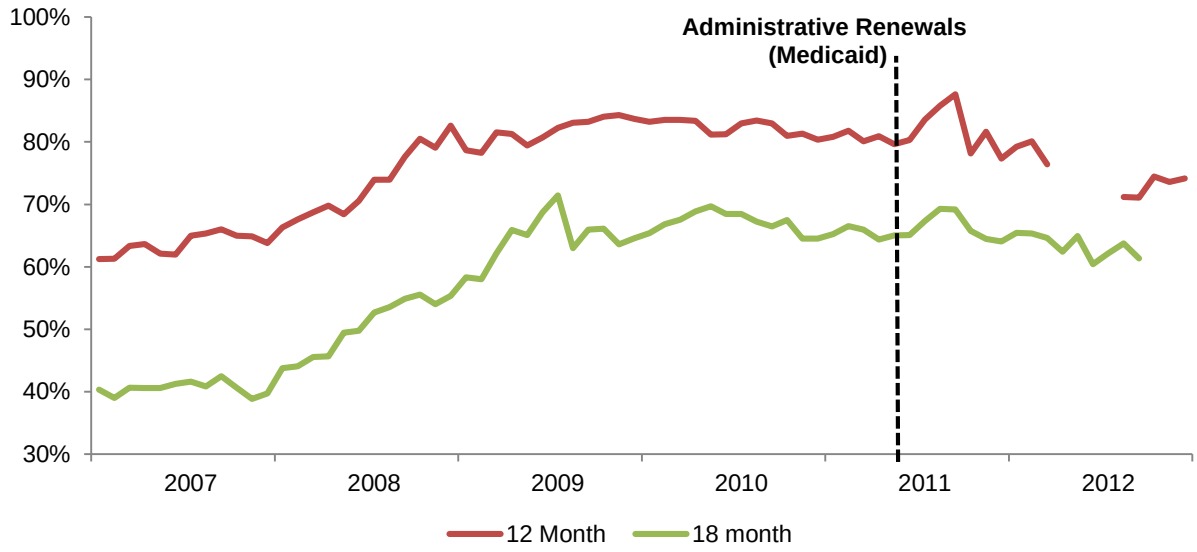
Figure II.14. Total monthly Medicaid and CHIP enrollment, Wisconsin, 2007–2012



Source: Mathematica analysis of state-provided administrative data.

Findings from our analysis, summarized in Figure II.15, tell a mixed story. In the months following the adoption of administrative renewals, we do observe an increase in the proportion remaining covered for 12 and 18 months. For example, the 12-month continuous-coverage rate increased by 7 percentage points between January 2011 and August 2011 (from 81 percent to 88 percent). We see a smaller but still notable bump in the 18-month rate as well. However, this increase does not appear to have been sustained: rates dropped back to pre-policy rates within six months after adoption and remained at these lower levels through the end of the period. The lack of a sustained increase suggests that this finding could be spurious or perhaps temporary, as the state could at any point expand or reduce the numbers of children subject to the policy.

Figure II.15. Proportion of new Medicaid enrollees retained 12 and 18 months, Wisconsin, 2007–2012



Source: Mathematica analysis of state-provided administrative data.

B. Conclusion

Looking descriptively across the eight *Maximizing Enrollment* states, we find little evidence associating individual policy changes during the initiative with measurable gains in enrollment. However, the gains during the initiative are striking—an increase of more than 800,000 children from 2009 through 2012—and are important to assess more rigorously. Because the timing of the enrollment growth in each state dates prior to *Maximizing Enrollment* and right around the start of the "Great Recession," we can be all but certain that economic factors have contributed significantly to the growth. However, it is not at all clear that this growth would have been either as large or as persistent in the *Maximizing Enrollment* states in the absence of the grant, particularly given the sheer volume of policy changes adopted by states to encourage enrollment and retention. Moreover, this volume does not even account for activities that cannot be explored descriptively but might further encourage enrollment growth, such as helping states foster cultural changes within their CHIP and Medicaid agencies and increase communication and coordination between them. In the next chapter, we take account of all the policy and procedural changes fueled by *Maximizing Enrollment*, along with other, less-identifiable changes, estimating rigorously the impact of the overall grant on total enrollment in the eight grantee states.

III. THE IMPACT OF MAXIMIZING ENROLLMENT ON CHILDREN'S COVERAGE

This chapter provides a rigorous assessment of *Maximizing Enrollment's* impact on enrollment of children into Medicaid and CHIP across the eight grantee states. This assessment is designed to be comprehensive: it captures the combined effects of all the specific policy and procedural changes explored descriptively in the prior chapter, as well as the effects of any further changes that cannot be easily measured or observed—such as improvements in staff culture, eligibility systems, or coordination across programs or agencies.

As detailed below, we estimate impacts following a balanced panel, difference-in-differences (DD) design that uses enrollment trends in a selected group of non-*Maximizing Enrollment* "comparison states" as the counterfactual against which to measure the impact of the grant. To ensure that these comparison states serve as a valid counterfactual, we apply statistical methods which ensure that the enrollment trends in the comparison and grantee states are well matched during several years prior to the start of the grant. In addition, using regression methods, we control, across states, for important confounders that might impact enrollment and vary substantially over time, including measures of economic conditions and numbers of children who are actually eligible for Medicaid or CHIP coverage.

Despite the many changes that took place over the course of the grant, we find no significant evidence that *Maximizing Enrollment* increased enrollment of children. Across numerous specifications, estimated impacts are positive but small (typically 1 to 3 percent) and not statistically significant. Although these findings certainly allow for the possibility that *Maximizing Enrollment* produced modest effects on enrollment that we cannot distinguish from chance, they strongly suggest that economic conditions and other factors contributed much more to the enrollment growth seen in the eight grantee states during the initiative.

A. Data and measures

The outcomes (enrollment) data for the analysis are from the web-based *Statistical Enrollment Data System* (SEDS) maintained by the Centers for Medicare & Medicaid Services (CMS), which contains Medicaid and CHIP enrollment data submitted quarterly by states for purposes of program monitoring and tracking. The submissions from states that comprise the SEDS include three forms:

1. ***Form CMS-21E*** collects data on children enrolled in separate child health programs.
2. ***Form CMS-64.21E*** collects data on children enrolled in Medicaid expansion CHIPs—that is, Title XXI-funded Medicaid coverage.
3. ***Form CMS-64EC*** collects data on children enrolled in the Medical Assistance Program—that is, Title XIX-funded Medicaid coverage or "traditional Medicaid."

To expedite the analysis, we obtained the SEDS data from colleagues at the Urban Institute, who had already compiled and cleaned the data for research purposes as part of the Congressionally Mandated Evaluation of Express Lane Eligibility that we conducted in partnership

with them.[7] (CMS gave Mathematica permission for this data transfer.) The specific outcome measures that we drew from the SEDS for this analysis were counts of children enrolled in either CHIP or Medicaid during a given quarter, from October 2006 through March 2013.

Notably, at the time of our analysis, data for Alabama were available only through the third quarter of 2011, which led us to exclude the state from our main impact findings and to explore its contribution to the overall *Maximizing Enrollment* effects as part of our robustness testing. Data from two potential comparison states, Montana and Maine, were also excluded from the analyses because of concerns about the reliability of their data.

To account for factors other than *Maximizing Enrollment* that might be substantially affecting enrollment over time across states, we drew on three state-level economic and demographic measures. From the Bureau of Labor Statistics' local area unemployment data, we include the state-month unemployment rate, and from the U.S. Census Bureau's Small Area Income and Poverty Estimates files, we include the state-year rate of children under age 18 in families with incomes below FPL.

In addition, to account for variation in states' Medicaid and CHIP income eligibility thresholds that also might substantially affect enrollment, we developed a measure of the proportion of children eligible for public insurance in each state over time. Our approach to this measure drew on methods used in several previous studies estimating the effect of insurance eligibility expansions on coverage (see, for example, Cutler and Gruber 1996). This approach included two steps. First, we drew a random sample of 10,000 children (under 19) from the March supplement of the Current Population Survey (2004-2012) and, using an individual's age, family income, and family structure, calculated the fraction of the national sample that would be eligible (for Medicaid or CHIP) in each state-year based on state Medicaid eligibility rules published by the Kaiser Family Foundation.[8] Next, we used state-year child population estimates (obtained from the U.S. Census Bureau's 2000-2012 state characteristics population estimates file) and estimates from the CPS simulation to compute the fraction of the state's child population eligible for public insurance in each time year.[9]

Finally, in selected robustness tests, we accounted for the influence that Medicaid and CHIP state policy changes might have had on coverage, including type of CHIP program, allowance of 12 months of continuous coverage, elimination of the asset test, elimination of the face-to-face

[7] Data cleaning involved mainly imputation, with CMS approval, of missing or errant observations. The imputation affected less than 5 percent of all observations in the data. See Hoag et al. (2012) for a full description of the imputation strategy applied by the Urban Institute for its analysis.

[8] This approach is preferable to using a state's actual eligible population, which might depend on conditions in the state that vary over time. To the extent that these conditions influence enrollment and are not captured in the state and quarter fixed effects (e.g., state-by-year trends such as recessions or changes in offers of ESI), they might bias the estimates of the impact of the *Maximizing Enrollment* grant. By using the same group (national sample) in each state simulation at each time point, we will generate, of the fraction eligible, an estimate that depends only on the state's eligibility thresholds (legislative environment) and is independent of changes in the demographic composition or economic condition of each state. Furthermore, it is a convenient way to summarize a state's income eligibility that not only varies across states, but within states by child age and by program time.

[9] Information for 2012 and 2013 was not available for child population or child poverty rates. We estimated state-specific values for 2012 and 2013 using linear extrapolation of 2009-2011 data by state.

interview requirement, presumptive eligibility, and adoption of ELE for applications and/or renewals. Information on the timing of the implementation of these policies was drawn from reports by the Kaiser Commission on Medicaid and the Uninsured and a scan of state Medicaid and CHIP plan amendments approved by CMS.

B. Methods

1. Selection of comparison states

To minimize the risk of bias in the impact estimates, we identified a set of comparison states displaying a similar enrollment trend during the years prior to the *Maximizing Enrollment* grant period. While this step cannot guarantee that the two groups of states would have continued to maintain similar trends in later years in absence of the grant, it does improve the validity of the DD design, which depends on the assumption that the differences between the grantee and comparison states would have remained constant in the absence of *Maximizing Enrollment.* The approach we used to limit the comparison sample followed methods recently applied by Urban Institute researchers for their evaluation of ELE impacts (Hoag et al. 2012). Specifically, we used enrollment trends from 2007 through 2009 (the pre-intervention period) and estimated Equation 1 below, including one non-*Maximizing Enrollment* state at a time and testing whether the average pre-period trend in the outcome variable differed between the *Maximizing Enrollment* states and the included non-*Maximizing Enrollment* state (β_3). If we detected a statistically significant difference in the pre-period trend, we excluded that state from the comparison set.

Equation 1. Model used to select comparison states

$$Log(Enroll)_{s,t} = \propto + \beta_1 MAX_{s,t} + \beta_2 TIMETREND_t + \beta_3 MAX_{s,t} * TIMETREND_t + \beta_4 X_{s,t} + \delta_s + \tau_t + \epsilon_{s,t}$$

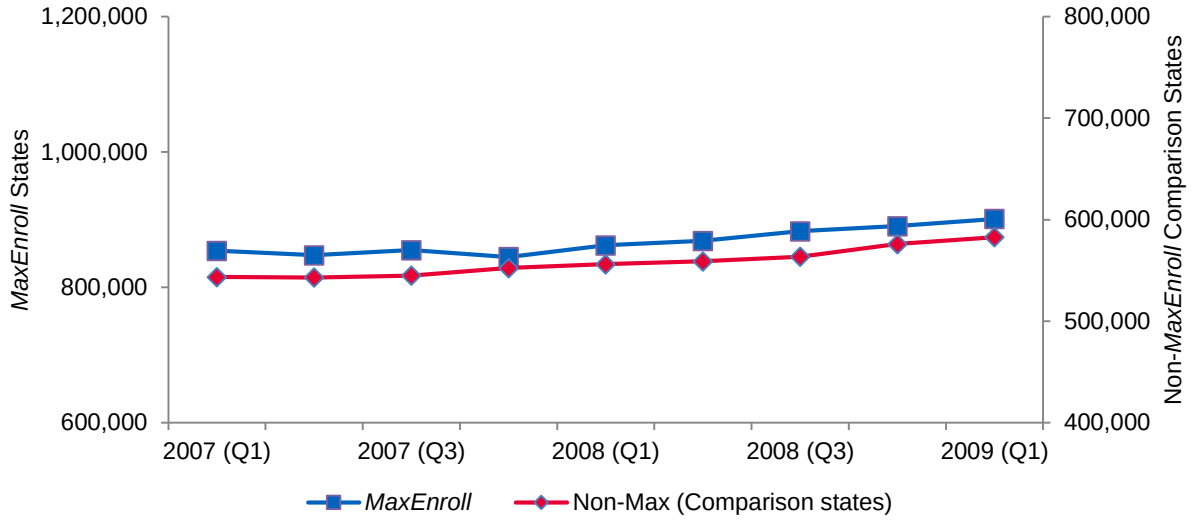
Where the model's variables include:

- $Log(Enroll)_{s,t}$, represents the log of the number of children ever enrolled in state *s* during quarter *t.*
- MAX_s is a binary variable that will take the value of one for states receiving a *Maximizing Enrollment* initiative and zero otherwise.
- $TIMETREND_t$ indexes the quarter, taking the value of the sequence 1, 2, 3 ... up to 9, the number of quarters in the pre-*Maximizing Enrollment* period.
- $X_{s,t}$ is a vector of state-time varying explanatory variables that may influence public coverage enrollment, such as the unemployment rate, described in the section above.
- δ_s is a set of state dummy variables to control for unmeasurable state-specific effects, fixed effects that vary by state but are constant over time.
- τ_t is a set of quarter-specific dummy variables to control for unmeasurable time-specific effects, fixed effects common to all states that vary over time.

Following this approach, we excluded from the comparison sample the following states: (1) for combined CHIP and Medicaid enrollment: Alaska, Colorado, Missouri, North Dakota, Texas, and Vermont; (2) for Medicaid-only enrollment: Colorado, the District of Columbia, and Missouri; and (3) for separate CHIP-only enrollment: California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, New Jersey, North Dakota, Oregon, South Dakota, Tennessee, Texas, Vermont, Washington, and West Virginia.

To illustrate the results of the selection process, Figure III.1 plots monthly enrollment in Medicaid and CHIP during the pre-*Maximizing Enrollment* period for the seven grantee states (left axis) and the 35 non-*Maximizing Enrollment* states (right axis) included in the comparison sample. While the two groups differ in terms of the average size of their Medicaid and CHIP populations, their pre-*Maximizing Enrollment* trends in total enrollment look nearly identical: for both groups of states, the trend is largely flat in 2007, with positive quarterly enrollment growth of about 1 percent starting in 2008.

Figure III.1. Trend in total enrollment (FY 2007 Q1 – FY 2009 Q1), *Maximizing Enrollment* and non-*Maximizing Enrollment* comparison states



Source: CMS Statistical Enrollment Data System as of August 2013.

2. Impacts model

Our model to estimate impacts, shown in Equation 2, follows a standard OLS specification similar to equation (1) above for the state selection process. The key difference is that this model includes an additional dummy variable, *Post*, that equals one for observations from the quarters following the start of the grant. This variable enters the model twice: as a simple indicator variable and as part of an interaction term with the binary variable for the grantee states (*MAX*). As with any standard DD model, the coefficient on this interaction term, β_3, provides the impact estimate. Specifically, given a log-transformed dependent variable, the coefficient measures the percentage change in total enrollment attributable to the *Maximizing Enrollment* initiative.[10]

[10] In tables 1 and 2, we report the converted log-linear coefficient.

Equation 2. Model for estimating impacts

$$Log(Enroll)_{s,t} = \propto + \beta_1 MAX_s + \beta_2 Post_t + \beta_3 MAX_s * Post_t + \gamma X_{s,t} + \delta_s + \tau_t + \varepsilon_{s,t}$$

Where the model's variables include:

- $Log(Enroll)_{s,t}$, represents the log of the number of children ever enrolled in state *s* during quarter *t.*
- MAX_s is a binary variable that will take the value of one for states receiving a Maximizing Enrollment initiative and zero otherwise.
- $Post_t$ indicates quarters that occur in the post-Maximizing Enrollment period.[11]
- $X_{s,t}$ is a vector of state-time varying explanatory variables.
- δ_s is a set of state dummy fixed effects.
- τ_t is a set of time fixed effects.
- $\epsilon_{s,t}$ is a random error term.

The dependent variable in the main specifications is the number of children ever enrolled in Medicaid or CHIP in a given state and quarter. In additional models, we estimate separate impacts for Medicaid (both traditional Medicaid and Medicaid-expansion) and separate CHIP enrollment. In the latter specifications, we include in the model only those grantee states that have a separate CHIP component throughout the analysis period (Illinois, Massachusetts, New York, Utah, and Virginia). We estimated all models with robust standard errors clustered at the state level to account for clustering and likely serial correlation in the residuals for each specification.

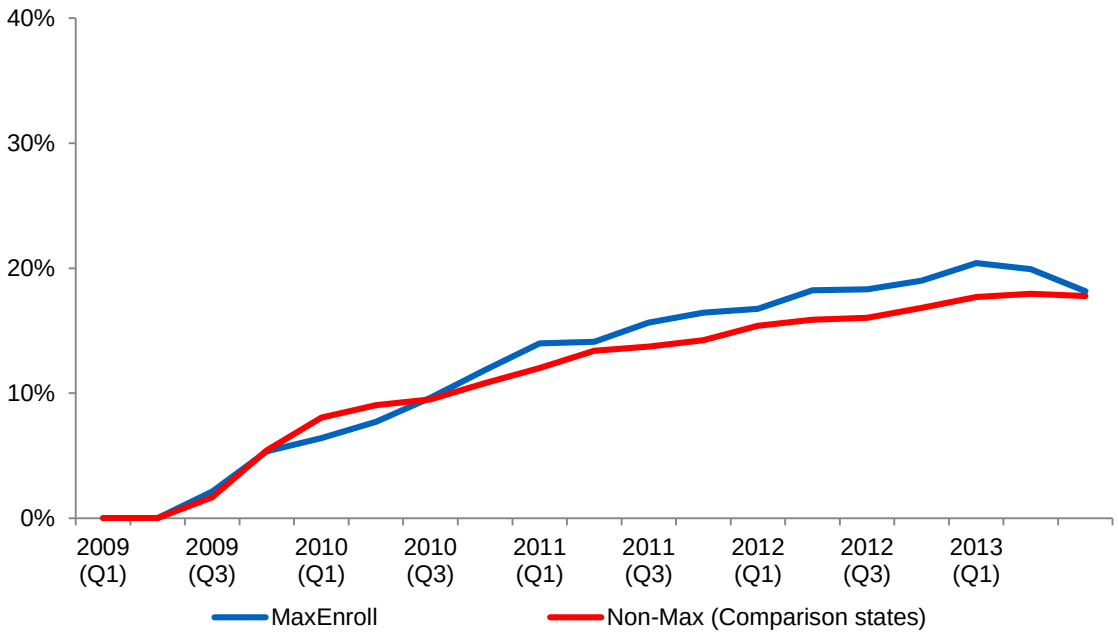
C. Descriptive findings

Before turning to the results of the multivariate regression, it is useful to examine the unadjusted differences in enrollment growth during the post-period between the *Maximizing Enrollment* states and our selected comparison group. To do so, we plot deviations in total enrollment from an initial quarter, here using the last full quarter prior to the *Maximizing Enrollment* initiative as the starting point (FY 2009 Q1), and visually examine how growth in the *Maximizing Enrollment* states differs from growth in the comparison states.

Findings, summarized in Figure III.2, show a similar trend for both the grantee and the comparison states in the first several quarters after *Maximizing Enrollment* began, followed by slightly faster growth in the grantee states in later quarters. While this trend is suggestive of potential gains arising from *Maximizing Enrollment*, the magnitude of the difference at any point in time is small—never more than 2 or 3 percentage points—and could arise from any number of factors. To examine these differences more rigorously, we need to turn to regression findings based on the DD impact design.

[11] To delineate the pre- and post-*Maximizing Enrollment* period, we use February 2009, the month in which the eight states were selected through an application process to receive the *Maximizing Enrollment* funding, as the starting point for the post-*Maximizing Enrollment* period, thus the second quarter of FFY 2009 is the first observation in the post-*Maximizing Enrollment* period. We also estimate models using the first full quarter after the award (Q3 of FFY 2009) as the start of the post-period. The results are not sensitive to this alternative specification.

Figure III.2. Percentage change in total enrollment, *Maximizing Enrollment* and non-*Maximizing Enrollment* comparison states (FY2009 Q1 – FY2013 Q2)



Source: CMS Statistical Enrollment Data System as of August 2013.

Note: Each data point is the percentage change in enrollment from FFY Q1 2009, the last quarter prior to the Maximizing Enrollment initiative.

D. Impact findings

1. Main analysis

Table III.1 presents the impact results for three alternative comparison group samples. Columns 1 and 2 report results from the preferred comparison sample, limiting states in the comparison group to those with pre-*Maximizing Enrollment* trends in total enrollment similar to those of the *Maximizing Enrollment* states. Columns 3-6 report results from two alternative samples: in columns 3 and 4 we include all 41 non-*Maximizing Enrollment* states in the comparison group, while in 5 and 6 we removed outlier states from the preferred comparison group sample.[12] We include results from these latter two samples to help ensure that any impacts we find are not sensitive to the results of our comparison group selection process.

[12] States are considered an outlier and excluded from the comparison group if the absolute value of studentized residuals for at least one state/quarter observation is greater than 3.

Table III.1. The effect of the *Maximizing Enrollment* initiative on public coverage for children, DD impact estimates

	Comparison group					
	Selected comparison states		All states		Selected comparison states, excluding outliers	
	(1)	(2)	(3)	(4)	(5)	(6)
Impact	0.86%	1.53%	0.90%	0.73%	0.75%	1.33%
p-value	0.85	0.70	0.84	0.84	0.87	0.73
State-level control variables	N	Y	N	Y	N	Y
Sample size	1,092	1,092	1,248	1,248	1,066	1,066

Source: CMS Statistical Enrollment Data System as of August 2013.

Note: All models include state and quarter fixed effects; control variables include state-quarter unemployment rate, state-year child poverty rate, and state-year estimates of eligible child population. Full results from the different models are in Appendix Table B.1.

Across all three samples, we find a positive effect of *Maximizing Enrollment* on total enrollment; however, its magnitude is small and not statistically significant from zero. In the fully controlled models, the percentage change in total enrollment attributable to *Maximizing Enrollment* is 1.5 percent using our selected comparison group, 0.7 percent in the model that includes all 41 states as the comparison group, and 1.3 percent when outlier states are excluded from the group of selected states. These findings together have central tendency of about 1 percent; however, the *p*-values are large, ranging from 0.70 to 0.84, thus offering no statistical confidence that the estimated impact is different from zero.

Findings from the models estimating program-specific enrollment effects are similar (results not shown). For models estimating Medicaid enrollment effects, estimated impacts across the different comparison samples are again positive and small, with a central tendency around 1 percent, and not statistically significant. For the separate CHIP models, estimated impacts are less stable across the different samples. Estimates range from large and negative to modest and positive, with few attaining significance. This inconsistency is likely due in part to wide variation in separate CHIP-only enrollment counts from quarter to quarter, which makes any interpretation from the models unreliable.

Point estimates on the control variables from the different models are in the expected direction. For example, with the preferred comparison sample in the main model, we find that a 1 percent increase in the size of the eligible child population raises total public enrollment by about 0.19 percent; and we find that a 1 percentage point increase in the child poverty rate raises total public enrollment by roughly 1.6 percent. Both these estimates are statistically significant at the $p<0.10$ level. Complete estimates for the control variables are in Appendix Table B.1.

2. Robustness analysis

Because of the many factors that might affect states' public coverage enrollment, we estimate several alternative specifications to examine the robustness of the results presented above and give a sense of the possible range of plausible impacts of the *Maximizing Enrollment* initiative. In the following section, we present estimates from models that vary the control variables and the time period examined; we also change how the comparison group is defined and estimate impacts in samples that systematically exclude *Maximizing Enrollment* states.

Inclusion of policy variables

In addition to controlling for state-level economic factors that might have affected public enrollment, we estimated models that control for the design of the state's public insurance programs or the adoption of specific policies designed to simplify enrollment or renewal. Many states implemented policies such as 12-month continuous coverage, presumptive eligibility, elimination of the face-to-face interview requirement, and ELE during the study period. Prior empirical work has demonstrated linkages between the adoption of some of these simplifications and the numbers of children enrolled and retained in coverage (Bansak and Raphael 2007).

We include enrollment and retention simplification policies only in robustness tests because their adoption is very likely correlated with the *Maximizing Enrollment* grant. If these policies are effective and more likely to be adopted in *Maximizing Enrollment* states, estimates of *Maximizing Enrollment's* impact from models that include these variables could be biased downward. On the other hand, if non-*Maximizing Enrollment* states are late adopters of these policies in comparison to *Maximizing Enrollment* states, and if these policies were effective in boosting enrollment, impact estimates from models that exclude these policies could be biased toward zero.[13]

Estimates of *Maximizing Enrollment's* impact from models that include the policy variables are consistently larger than the main model results by a slight margin (Table III.2).[14] While this might offer some suggestion of grant effects arising from changes less easily observed, such as culture change or improved program coordination, none of the estimated effects are statistically significant. For example, the estimated impact from the preferred specification increased from 1.5 percent in the main model to 2.3 percent when policy measures are included as added controls. However, the associated *p*-value, 0.60, offers no statistical confidence that the true effect is above zero.

[13] Evidence of this hypothesis is mixed. As shown in Appendix Table B.2, *Maximizing Enrollment* states were more likely than other states to have adopted presumptive eligibility and 12-month continuous coverage in Medicaid, but they were less likely to have eliminated asset testing and face-to-face interview requirements in Medicaid.

[14] The analysis focuses only on the Medicaid program because of multicollinearity problems that arise when including policy changes in both separate CHIP and Medicaid and the relative stability of the Medicaid impact estimates in the main model. Findings are similar whether we use the same comparison sample as the main models or reselect the comparison group based on models that include the policy measures.

Table III.2. The effect of the *Maximizing Enrollment* initiative on public coverage for children, models accounting for state-specific adoption of simplification policies

	Comparison group		
	Selected comparison states	All states	Selected comparison states, excluding outliers
Impact	2.3%	1.8%	2.8%
p-value	0.60	0.65	0.45
Sample size	1,092	1,248	1,040

Source: CMS Statistical Enrollment Data System as of August 2013.

Note: All models include state and quarter fixed effects, state-quarter unemployment rate, state-year child poverty rate, state-year estimates of eligible child population, and indicators for adoption of the following policies in a state's Medicaid program: 12-month continuous coverage, presumptive eligibility, elimination of the face-to-face interview requirement, and ELE. Full results from the different models are in Appendix Table B.3.

As we found with the estimated *Maximizing Enrollment* effect, none of the coefficients on the policy variables attain significance across the different sample (Appendix Table B.3). The magnitudes of these coefficients are also small, a finding that is inconsistent with some studies associating them with larger effects (Bansak and Raphael 2006). The largest coefficient is on the 12-month continuous coverage variable, which is associated with an enrollment increase of around 4 percent and approaches statistical significance (p=0.08) in one of the three samples.

Additional Specifications

To gain insight on the sensitivity of our estimated impacts across the individual grantee states, we re-estimated the models while excluding one *Maximizing Enrollment* state at a time to observe how the impact estimate changed. Results from these models, presented in Appendix Table B.4, show some modest changes in point estimates with removal of different states. Removing Illinois, Utah, and Virginia from the sample reduces the *Maximizing Enrollment* impact estimate, which suggests that the impact of *Maximizing Enrollment* may have been stronger in these states; removing Massachusetts, New York, and to a lesser extent, Louisiana increases the estimate. However, impact estimates across all the models remain statistically insignificant, offering no evidence that an otherwise significant overall effect has been "dragged down" by a weak performing or outlier grantee state.

Other sensitivity models included (1) re-estimating the main models using more conservative criteria for selecting the comparison states; (2) excluding small states, which are more prone to outliers in the within-state trend, from the comparison states[15]; (3) limiting the follow-up data through the third quarter of 2011 to allow inclusion of Alabama; and (4) redefining the post-period to 2011 and 2012, when *Maximizing Enrollment* was well under way and descriptive trends noted

[15] We exclude non-*Maximizing Enrollment* states that are substantially smaller than the *Maximizing Enrollment* states and thus might not serve as ideal comparisons. Using mean quarterly total enrollment in the pre-*Maximizing Enrollment* period, we exclude the 10 states that are 25 percent smaller than the smallest *Maximizing Enrollment* state, Utah (mean total enrollment of 159,265).

some deviation between the grantee and comparison states. Findings, presented in Appendix Table B.5, mirror closely those from the main models. Estimated impacts are consistently positive but small—from 1 to 2 percent—and none are statistically significant from zero.

E. Conclusion

Findings from the impact analysis reveal no statistically significant evidence that *Maximizing Enrollment* increased enrollment of children in Medicaid and CHIP during the grant period. Across numerous specifications, we find a consistently positive but small estimated effect that we cannot distinguish statistically from zero. This estimate could of course reflect a true effect of the grant that is small and that we simply do not have sufficient statistical power to detect; indeed, the consistency of the point estimates makes this conjecture more plausible. However, placed in context, such an effect would be even more modest than it might otherwise seem. For example, from 2009 to 2012, the administrative data show that enrollment in the grantee states rose by 812,250 children, an increase of 13 percent. Taking the central tendency impact estimate of 1 to 2 percent as a true impact, this would mean that *Maximizing Enrollment* contributed to only about one-tenth of the overall enrollment growth in the grantee states. In other words, even with optimistic assumptions about *Maximizing Enrollment's* effects, any contribution it made to enrollment growth in the grantee states was minor compared to other factors.

Two important limitations to the analysis should be noted when considering this conclusion. The first is the potential for estimation bias. Such bias can arise in any quasi-experimental design and is most likely to occur in a DD design from unobservable factors that change over time and differ between the treatment and comparison group. If these factors were correlated with the implementation of the *Maximizing Enrollment* initiative, the impact estimates might be biased. For example, if non-*Maximizing Enrollment* states experienced greater disruptions in employer-sponsored coverage due to the effects of the Great Recession than did grantee states, subsequently boosting enrollment in public coverage, our impact estimates could be biased downwards. While we attempted to exclude states that looked dissimilar from the *Maximizing Enrollment* states using pre-period data and controlled for state and time varying economic indicators, it remains possible that trends in outcomes between the two groups would have diverged in the post-*Maximizing Enrollment* period.

Second, had administrative data also been available for the comparison states, we would have estimated impacts not simply for total enrollment but on more refined measures like those we were able to explore in the descriptive analysis, such as new enrollment, retention, and churn. The advantage of these additional measures is that they are much more sensitive to changes that might arise through the grant and, as a result, would have offered considerably more interpretation to our overall impact findings. For example, assuming *Maximizing Enrollment* did have a modest impact on total enrollment, these more sensitive measures would likely have displayed larger impacts that we could have detected, lending more credence to this interpretation. Conversely, had these measures, like the total enrollment measure, shown no significant effects, it would have further affirmed a conclusion that the grant had no measurable effects.

IV. DISCUSSION

In evaluating the impact of *Maximizing Enrollment*, we had the opportunity to work collaboratively for four years with NASHP, RWJF, and the grantee states, and in that capacity gained a sound understanding of the grant strategy, its rollout across the states, and the challenges and opportunities experienced by stakeholders along the way. Drawing on this perspective and the findings from the analysis presented in this report, we offer reflections on the *Maximizing Enrollment* strategy and how its lessons might inform future RWJF investments in promoting health coverage.

A. *Maximizing Enrollment* as case study: adapting a strategy to rapidly changing events

At the time of *Maximizing Enrollment's* development, no one could have predicted how dramatically the policy setting for children's coverage would eventually change or how significantly it could affect enrollment in Medicaid and CHIP. At the time the strategy was being planned, opportunities for increasing coverage of eligible-but-uninsured children appeared to be state-centered and incremental. In 2008, the Bush administration twice vetoed CHIP reauthorization and continued to block efforts for state-based coverage expansion through CHIP, citing concerns about eroding private insurance. Most states were in sound financial shape at that time, but lacking support at the federal level, many appeared open to pursuing their own ways to increase enrollment in Medicaid and CHIP. Indeed, when framed effectively, efforts to increase coverage of eligible-but-uninsured children appeared to have broad political and public support in many states. Responding to this opportunity, *Maximizing Enrollment* launched in February 2009 with the aim of expanding and promoting best practices for maximizing coverage of children.

Within months of the initiative's rollout, however, the political and policy context for *Maximizing Enrollment* began to change dramatically. States started to experience major budget problems as the recession took hold. With revenues rapidly deteriorating, states faced growing pressure to limit their program expenditures, particularly for Medicaid, which remains the single-largest expenditure in many states. Similar pressures had emerged only a few years earlier, when a recession in the early 2000s led states to pull back on outreach for Medicaid and CHIP and even to introduce administrative hurdles that could slow growth of the two programs. That history raised immediate concerns among the major stakeholders that the core goal of *Maximizing Enrollment*—to secure state eligibility and enrollment simplifications—was at risk only months after the initiative had begun. Unlike with the earlier recession, this time federal policymakers took an active role in supporting states financially and helped retain the viability of *Maximizing Enrollment* in the process. In 2009 and 2010, the Obama administration signed a series of new spending measures aimed at states, including ones specifically designed to shore up continued enrollment in Medicaid and CHIP. Among these was the CHIP Reauthorization Act (CHIPRA), signed into law in early 2009, which introduced major new incentives for states to pursue policies aimed at maximizing children's public coverage.

Another major challenge emerged with passage of the ACA, which with its breadth and complexity demanded the immediate attention of state Medicaid and CHIP agencies and the technical and policy resources of their staffs. In turn, the ACA threatened to curtail these agencies' investment in more narrow or immediate policy aims, including increasing enrollment of children

through eligibility simplification. Only a year from *Maximizing Enrollment*'s launch its core goals were again under threat.

Responding to these changes, NASHP and RWJF made two important shifts to the *Maximizing Enrollment* strategy in its early years. First, acknowledging the dire fiscal situation in many states, they actively embraced administrative changes that could improve the efficiency of Medicaid and CHIP agency operations but would have no direct impact on children's enrollment. Second, they expanded *Maximizing Enrollment*'s focus in 2010 to include support for activities related to ACA implementation, rebranding the initiative from *Maximizing Enrollment for Kids* to *Maximizing Enrollment.* This change formally acknowledged that efforts to increase children's coverage had slipped to the "back burner" in at least some states and that a broader mission was necessary to maintain the grant's relevance. The result was a shift in the grant strategy toward a longer-term view on maximizing enrollment, shoring up progress that had been made and retaining a foundation for future progress.

One reason this strategy shift was even possible is that *Maximizing Enrollment* collaborated directly with Medicaid and CHIP directors, whose priorities and support would be critical to enacting changes that could maximize coverage. This focus was a deliberate pillar of the strategy and one that likely drew on lessons from RWJF's major predecessor grant initiative, *Covering Kids and Families* (CKF). Over the course of five years, CKF invested tens of millions in community-based organizations across the country to help reach eligible children and enroll them into public coverage. The initiative ran into serious challenges, however, when the economic downturn of the early 2000s drove a wedge between CKF's goals to enroll additional children into Medicaid and CHIP and the needs of state policymakers to control spending. This wedge stymied progress on the grant in its later years, and RWJF discontinued the initiative in 2007 despite its popularity among many state-based advocates. By designing *Maximizing Enrollment* to work in partnership with the Medicaid and CHIP agencies that held authority over policymaking, RWJF was better able to adapt the grant to rapidly changing circumstances.

The value of this adaptability is evident in the sheer volume of policy and procedural changes tied to the grant in its first four years. These included not only changes aimed at increasing coverage for kids, but also several dozen technical and administrative changes intended to improve agency operations. For example, *Maximizing Enrollment* supported numerous efforts focused on administrative efficiency, encouraging automation and other steps that could reduce labor hours, minimize processing errors, shorten wait times between application and enrollment, and encourage improved communication among administrative units and systems. And the grant offered a variety of technical assistance to support ACA implementation and to maximize coverage of people newly eligible for public or subsidized coverage. While our analysis found no evidence of impacts on enrollment outcomes for children, it is not able to shed much light on broader effects *Maximizing Enrollment* may have had on other state priorities, such as administrative savings, technology improvement, or coverage of more targeted populations within Medicaid or under the ACA.

B. Lessons for future coverage strategies

In reflecting on *Maximizing Enrollment* and how the grant unfolded, two questions emerge that seem central to drawing lessons from the evaluation for future RWJF investments focused on children's health coverage:

- Why did *Maximizing Enrollment* have little measureable effect on children's enrollment?
- What might succeed better for maximizing children's health coverage?

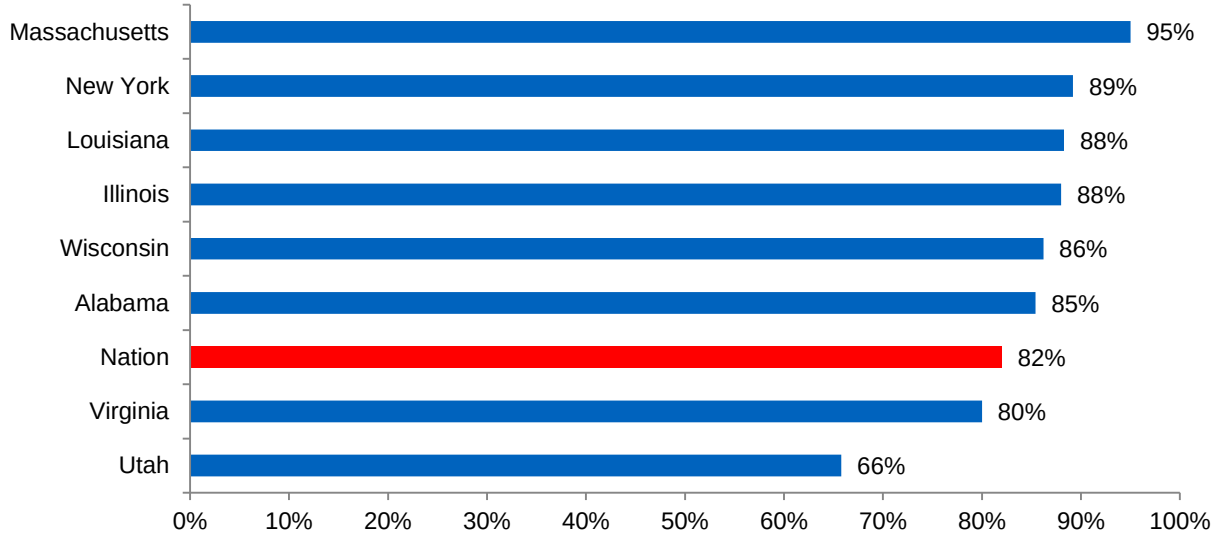
1. Why did *Maximizing Enrollment* have little measurable effect on children's enrollment?

One obvious reason might be misfortune. At various stages of the initiative, stakeholders expressed a sense that the strategy had encountered bad luck—namely, that the dramatic economic and policy shift during the past several years undermined the potential impact of *Maximizing Enrollment* on children's coverage outcomes. From an evaluation perspective, this can be framed in two ways. First, with the 1-2 punch of a bad economy and ACA turmoil, grantee states may have had less incentive and/or ability to adopt substantial policy or procedural changes tied to children's enrollment than they would have had otherwise. Second, with passage of CHIPRA and other federal stimulus funding, non-grantee states gained a new and substantial incentive to pursue changes similar to those sought after by *Maximizing Enrollment*. When combined, these shifting incentives may have substantially reduced the gap between grantee and non-grantee states, ultimately muting *Maximizing Enrollment's* potential effects. This story is broadly consistent with the changes we observed across the states; as noted in Chapter III, for example, many non-grantee states implemented policies similar to those of the grantee states, which suggests that many of the policy changes observed in *Maximizing Enrollment* states during the grant period might have eventually occurred otherwise.

Of course, this bad-luck explanation assumes that the strategy would have had a large impact on children's enrollment in the absence of external events, and we found little evidence to support that assumption. For example, in the trend data presented in Chapter II, we rarely see any evidence associating the policy changes adopted in the grantee states with large shifts in children's enrollment or retention, which casts doubt on how substantial the impact of changes could have been regardless of economic or other factors. In addition, in our discussions with grantee stakeholders, we gained little sense that the states adopted weaker or more incremental changes in light of external influences. Rather, they felt that *Maximizing Enrollment* helped them implement the most robust versions of the policies that were possible in their states, benefiting from both the state-to-state learning and the direct technical assistance made possible through the grant.

A second reason that *Maximizing Enrollment* could have fallen short of its goals is that the grantee states were approaching an enrollment ceiling by the time grant funding began, which minimized any potential effects it could have on coverage. This "ceiling effect" seems potentially credible for as many as six states that that were performing relatively well on nearly all indicators of children's coverage before the grant: Alabama, Illinois, Louisiana, Massachusetts, New York, and Wisconsin. For example, based on data from the ACS, all these states had participation rates in CHIP and Medicaid at or above 85 percent, and Massachusetts had a rate of 95 percent (Figure IV.1). Moreover, by the start of 2009, these states had already removed most of the policies commonly thought to be obvious barriers to coverage, such as asset testing (6 states) and face-to-face interviewing (5 states), and they had adopted many of the policies thought to promote enrollment and retention, including 12-month continuous coverage (4 states), presumptive eligibility (5 states), and joint applications (6 states). Four of the six states had also pursued major eligibility expansions for children in the years leading up to the grant, further illustrating the political and policy momentum that had already emerged in the *Maximizing Enrollment* states behind children's coverage before the grant.

Figure IV.1. Children's participation in Medicaid and CHIP, by state, 2008



Source: Kenney et al. 2012

Although an enrollment ceiling could certainly have reduced the potential for *Maximizing Enrollment* to achieve large gains across many grantee states, it cannot be the only reason why economic factors appear to have swamped any gains attributable to the initiative. First, only one state, Massachusetts, looked to be approaching a true ceiling in terms of children's enrollment, and all states continued to have opportunities to simplify their application or renewal processes in ways expected to increase enrollment. Indeed, the two states farthest from any enrollment ceiling, Utah and Virginia, adopted at least thirteen different policy changes aimed at increasing children's enrollment. Yet, like the other *Maximizing Enrollment* states, the enrollment gains seen in these states during the initiative appear linked to economic conditions far more than to policy changes.

A third and related reason for the findings in this report might be, simply put, unrealistic expectations—that, from the outset, the policy changes *Maximizing Enrollment* pursued were not capable of producing large impacts on children's coverage. This explanation is somewhat provocative, because the policies sought after by *Maximizing Enrollment* were among those identified by both advocates and the research literature as having large effects. Indeed, multiple impact studies from the past decade have found that a single policy change of the type promoted by *Maximizing Enrollment* can have large effects on Medicaid and/or CHIP enrollment, on the order of 5 percent or more (e.g., Kronebusch and Elbel 2004; Bansak and Raphael 2006; Sommers et al. 2012; Blavin et al. 2014). Our findings are not in line with this research: while we see clear evidence of enrollment gains across the *Maximizing Enrollment* states during the initiative, we see no evidence that they arose from policy effects on the order suggested by the research.

Aside from a possible ceiling effect among the states awarded *Maximizing Enrollment* grants, there are at least three reasons why the research literature might have overstated the potential for *Maximizing Enrollment* to affect enrollment. First, this research base is largely qualitative and descriptive, with few recent rigorous studies employing designs or statistical methods to account for potential confounders. Second, most studies applying more rigorous methods have focused on

policies adopted well before *Maximizing Enrollment*, when many states had only just begun to address key administrative barriers and a given policy simplification might be expected to have a relatively large marginal effect. Finally, lacking any option for experimental research designs, even the most rigorous of these studies remain subject to significant risk of bias. As with this evaluation, more rigorous studies have generally followed a "natural experiment" approach, whereby the change in a policy of interest is assumed to have arisen statistically at random—that is, apart from any unmeasured factors that might also affect enrollment. With this assumption, and after controlling for preexisting differences across states that might affect enrollment, the impact of a given policy can be reliably measured by comparing the states that implemented the change to those that did not. Unfortunately, this assumption can easily be violated; for example, should a policy of interest emerge as part of broader agenda promoting children's coverage that cannot be fully measured, the estimated effect of that policy is at risk of overstating the true impact (estimation bias).

Last year, for example, Oregon adopted ELE as part of a broad initiative to streamline the enrollment experience for families in Medicaid and CHIP. A recent case study from the Congressionally-mandated evaluation of ELE describes the extent of this initiative (Colby and Frost 2013):

> "At the same time [as ELE], Oregon pursued several streamlining initiatives to improve the enrollment experience for families, including providing 12 months of continuous eligibility for children (regardless of fluctuations in family income), reducing income verification requirements, aligning SNAP and public health insurance renewal dates, allowing a verbal signature during telephone application and renewal, and creating an online application. To reduce the number of pending applications, the agency also began encouraging eligibility staff to contact applicants by telephone to resolve outstanding questions more quickly than the process of issuing paper notices. The state also considered but did not implement presumptive eligibility policies, due to concerns about the financial liability of enrolling ineligible individuals. Eligibility processing staff, policy staff, and advocates identified the reduction in income verification requirements, the alignment of SNAP and Medicaid/CHIP renewal processes, and the campaign to reduce pend rates as the most effective concurrent policy changes."

Based on these findings, few in Oregon seem to have considered its version of ELE even to have been an important policy compared to the many other changes taking place at the same time. However, without adequate controls for all these changes—and their possible interaction in driving more systemic changes to staff culture or administrative effectiveness—any formal impact analysis of the ELE policy in this state would be at risk of upward bias.

Together, these limitations suggest how the research base could have contributed to unrealistic expectations for *Maximizing Enrollment*, particularly among a group of states (except Utah) that had already achieved a relatively high participation rate in Medicaid and CHIP before the initiative. Designed and implemented with considerable good judgment, *Maximizing Enrollment* might simply have been incapable of achieving truly sizable gains in children's coverage, at least not in the states that were targeted.

2. What might succeed better for maximizing coverage?

This discussion is not meant to suggest that the kind of policy simplifications *Maximizing Enrollment* pursued, CHIPRA encouraged, and coverage advocates have promoted are unnecessary for maximizing enrollment—only that they may not be sufficient. There are several reasons for this insufficiency, some of which have been suggested above and all of which were in

evidence during the initiative. First, by themselves, many changes may yield only modest gains in enrollment, well short of changing the relative performance of a state in maximizing coverage. Second, as we illustrated in Chapter II, policy changes can be implemented in ways that target or otherwise reach small populations, which reduces their potential impact from their outset. Third, the context in which these policies are adopted can further dampen their potential effects even beyond how they are targeted. As described in Chapter II, for example, the decision by Utah to conduct eligibility determinations in a separate workforce agency may have allowed competing policy priorities to weaken the effect of policies pursued by the state's health department to maximize coverage. Likewise, at the state level, changes in political leadership may affect the context in which program staff administer programs, shifting the focus toward goals that may run counter to maximizing coverage such as controlling program expenditures or ensuring integrity. This was arguably the case with several grantee states during the earlier CKF grant initiative, such as Kentucky and Missouri, and it may have been a factor for at least one state (Wisconsin) that participated in *Maximizing Enrollment.* Similar challenges can routinely confront states with county-based eligibility systems, such as Virginia or New York, where simplification policies adopted at the state level can become watered down at the county level as a result of lack of staff training, lack of oversight, or local preferences.

So, given all these possible constraints to implementing effective policies, what is sufficient to seeing that a state maximizes coverage for children? Guided by the examples of so many states in both *Maximizing Enrollment* and CKF, we submit that sufficiency stems from one state feature more than any other: leadership. That is, to make significant and lasting progress maximizing enrollment of children, a state's public and political leadership must unconditionally embrace this goal. It is not enough that a state adopt policies thought to encourage enrollment or retention of children in public coverage; what is needed is for a state to view covering children as a public policy priority. Regardless of economic conditions, federal incentives, or the availability of programs like *Maximizing Enrollment*, the state's leadership must prioritize the insuring of all children eligible for Medicaid, CHIP, and other forms of publically subsidized coverage.

Developing an overall strategy to promote sustained state leadership behind maximizing coverage is neither a simple nor short-term goal, and it is almost certainly multi-level, combining broad investments in advocacy or capacity building with more focused investments like *Maximizing Enrollment* that can produce incremental progress when the political and economic context is favorable and minimize backsliding when it is challenging. These more focused investments are unlikely to turn a weak performing state into a strong performing one, and both coverage advocates and funding partners would likely benefit from setting goals and expectations accordingly. However, when incorporated into a broader strategy focused on building state-based leadership, they may increase the chances that children's health coverage can become a policy priority for all states in the same way that public education or public health emerged as a policy priority for states in the past.

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APPENDIX A

TABLES

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APPENDIX A TABLES

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Table A.1. Enrollment and renewal policy or procedural simplifications adopted during *Maximizing Enrollment*, by state

State (program)	Date	Description	Target population
Alabama			
Medicaid	September 2012	*Streamlined application or enrollment process:* Self-attestation of pregnancy	Poverty level pregnant women
S-CHIP	March 2011	*Telephonic enrollment/renewals:* Began offering the option to renew coverage by phone to selected small groups (pilot program)	Pilot program; <1,000 children
Medicaid	April 2010	*Express* Lane Eligibility*:* Implemented manual Express Lane Eligibility for enrollment (SNAP/TANF)	Applicants also enrolled in SNAP and TANF
Medicaid	October 2009	*Express Lane Eligibility:* Implemented manual Express Lane Eligibility for renewal (SNAP/TANF)[2]	Medicaid beneficiaries also enrolled in SNAP and TANF
Medicaid	May 2009	*Streamlined application or enrollment process:* Eliminated verification step at application; stopped requiring a phone interview if all necessary documentation is provided with application	Medicaid applicants with complete documentation
Medicaid		*Simplified renewals:* Renewed "commitment" to administrative renewals; using information in its system to pre-populate renewal forms and requesting only updated information	Medicaid beneficiaries
Illinois			
None identified			
Louisiana			
Medicaid	November 2010	*Express Lane Eligibility:* Implemented automatic renewal using automatic Express Lane Eligibility for renewal (SNAP)	Medicaid beneficiaries also enrolled in SNAP
Medicaid	February 2010	*Express Lane Eligibility:* Implemented automatic Express Lane Eligibility for enrollment (SNAP)	Low-income children enrolled in SNAP
Medicaid /CHIP	November 2009	Online application enhancement: translate online application into Spanish; developed system enhancements	Spanish-language applicants
Massachusetts			
Medicaid /CHIP	September 2012	Implemented automatic Express Lane Eligibility for renewals (SNAP)	Low-income children and adults enrolled in SNAP
Medicaid /CHIP	December 2011	Administrative renewal for certain groups of enrollees whose circumstances were unlikely to change (i.e. members that have social security as their sole source of income and have Medicare)	Enrollees with social security as their only source of income and with Medicare coverage; Kaileigh Mulligan program members
Medicaid /CHIP	September 2010	Eliminated verification steps; MassHealth is no longer sending out Department of Revenue (DOR) Job update forms as a result of data match with DOR wage reporting and new hire files.	Working adults
New York			
Medicaid	May 2012	Implemented Express Lane Eligibility to process transfers from CHIP to Medicaid (prior to ELE the beneficiary had to fill out paper application)	Children transferring from SCHIP to Medicaid
Medicaid	June 2011	Established an enrollment center that centralized processing of renewals (mail and phone) for phased-in counties	County specific
Medicaid	April 2010	Eliminated the face-to-face interview requirement for applicants	Statewide

Table A.1 (*Continued*)

State (program)	Date	Description	Target population
Utah			
Medicaid	May 2012	Implemented simplified renewals for Medicaid (policy already in place for CHIP). Utah added administrative renewals (using a pre-populated form) for both children and parents in Medicaid in 2012 in two phases. If no changes have occurred during the 12-month certification period and the worker has no reason to believe the child may no longer qualify for CHIP (e.g., family income is not close to 200% of FPL), a pre-populated renewal form is sent to the family. The family only has to respond if anything has changed; otherwise, the system automatically extends eligibility for another 12 months	April 2012 for some groups (e.g., SSI, children in families <100% FPL); September 2012 for full population.
Medicaid /CHIP	May 2012	*Online application enhancement:* dynamic application; auto-populating information	Statewide
Medicaid /CHIP	April 2012	Eliminated verification steps; implemented asset liberalization to allow for self-declaration of assets	Families with assets under $2,000
Medicaid /CHIP	April 2012	Presumptive eligibility implemented for siblings in the home of children who are transitioning out of foster care	Siblings in the home of children transitioning out of foster care
Medicaid /CHIP	December 2011	Implemented a joint application and renewal form	Statewide
Medicaid /CHIP	August 2011	*Online renewals:* Upgraded consumer-facing portal (MyCase) allowing beneficiaries to renew coverage online using e-signature	Statewide
CHIP	April 2010	Rolling renewal; CHIP and UPP renewal periods may be updated when recertification is completed for another program (SNAP/TANF) and all information needed to update the renewal period has been provided	Children enrolled in SNAP/TANF
Virginia			
Medicaid	October 2011	Renewed "commitment" to ex parte renewals (i.e., retrained county eligibility staff to ensure it was being used across the state)	Medicaid beneficiaries
Medicaid	October 2011	*Telephonic enrollment/renewals:* Implemented telephonic renewals for Medicaid when renewal cannot be completed ex parte, allowing worker to contact the enrollee by telephone	Medicaid beneficiaries
S-CHIP	January 2011	*Telephonic enrollment/renewals:* Adopted telephonic signatures for new applications	S-CHIP applicants
S-CHIP	October 2010	Administrative Renewal process for CHIP; beginning October 1, 2010, the FAMIS Central Processing Unit moved to an administrative renewal procedure for all FAMIS redeterminations of eligibility. Families receive a pre-printed renewal form containing the information in the eligibility system. Families will be asked to review the form and, if there have been no changes in the family situation or income, attest to the correctness of the information and send the form back to the CPU for processing.	S-CHIP beneficiaries
S-CHIP	July 2010	*Online application enhancement:* implementation of e-signature and allow for electronic submission of verifications	S-CHIP applicants.
S-CHIP	July 2010	*Online renewals:* implemented online renewals and electronic submission of verifications	S-CHIP beneficiaries
Wisconsin			
Medicaid	May 2011	Implemented administrative renewals for BadgerCare Plus members with incomes below 75% of FPL	Children from families with income below 75% of FPL

Source: Grantee reporting tool, NASHP reports, and communication with NASHP and selected grantee state staff.

APPENDIX B

TABLES

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APPENDIX B TABLES

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Table B.1. Estimated impact of *Maximizing Enrollment* initiative on Medicaid and CHIP enrollment, 2007-2013 SEDS data

	Comparison states		All states		Comparison states excluding outliers[a]	
Variables	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**
Maximizing Enrollment initiative	0.0085 (0.043) *p*=0.845	0.0152 (0.039) *p*=0.696	0.0090 (0.043) *p*=0.835	0.0072 (0.039) *p*=0.853	0.0074 (0.043) *p*=0.865	0.0132 (0.039) *p*=0.734
Unemployment rate	-	0.0075 (0.007)	-	0.0057 (0.007)	-	0.0068 (0.007)
Under-18 poverty rate	-	0.0159** (0.008)	-	0.0135 (0.007)	-	0.0168** (0.008)
(Log) child eligible population	-	0.1882* (0.104)	-	0.2398 (0.910)	-	0.2039* (0.107)
Sample Size	1,092	1,092	1,248	1,248	1,066	1,066

Source: CMS Statistical Enrollment Data System as of August 2013.

Note: Dependent variable is total Medicaid and CHIP child enrollment. Robust standard errors clustered at the state level are in parentheses. All models include state and quarter fixed effects.

[a] Excluded the District of Columbia from the comparison group based on outlier analysis.

*/**/***Significantly different from zero at the .10/.05/.01 level.

Table B.2. Changes in Medicaid and CHIP policy from 2007 to 2013

Medicaid and CHIP Policy	2007 Q1		2009 Q1		2011 Q1		2013 Q1	
	Maximizing Enrollment (N=7)	Non-*Maximizing Enrollment* (N=41)	*Maximizing Enrollment* (N=7)	Non-*Maximizing Enrollment* (N=41)	*Maximizing Enrollment* (N=7)	Non-*Maximizing Enrollment* (N=41)	*Maximizing Enrollment* (N=7)	Non-*Maximizing Enrollment* (N=41)
No face-to-face interview (Medicaid)	5	38	6	39	7	39	7	39
12-month continuous coverage (Medicaid)	3	11	3	14	3	17	3	17
Presumptive eligibility (Medicaid)	2	8	5	9	4	11	4	11
Express Lane Eligibility	0	0	0	0	1	5	3	7
Separate CHIP program	5	29	7	30	7	29	7	28
No face-to-face interview (SCHIP)	4	27	7	29	7	28	7	27
12-month continuous coverage (SCHIP)	4	19	5	22	5	20	5	20
Presumptive eligibility (SCHIP)	3	4	4	5	3	6	3	7
No asset test (SCHIP)	5	26	6	26	6	27	7	26

Table B.3. Inclusion of Medicaid and CHIP policy indicators, 2007-2013 SEDS data

	Comparison states		All states		Comparison states, excluding outliers[a]	
Variables	**(1) Table A.1**	**(2)**	**(3) Table A.1**	**(4)**	**(5) Table A.1**	**(6)**
Maximizing Enrollment initiative	0.0152 (0.039) *p*=0.696	0.0223 (0.038) *p*=0.559	0.0072 (0.039) *p*=0.853	0.0179 (0.037) *p*=0.635	0.0132 (0.039) *p*=0.734	0.0279 (0.037) *p*=0.452
Unemployment rate	0.0075 (0.007)	0.0089 (0.007)	0.0057 (0.007)	0.0082 (0.007)	0.0068 (0.007)	0.0093 (0.007)
Under-18 poverty rate	0.0159 (0.008)	0.0148* (0.008)	0.0135 (0.007)	0.0124* (0.007)	0.0168 (0.008)	0.0189** (0.007)
(Log) child eligible population	0.1882 (0.104)	0.1605* (0.087)	0.2398 (0.910)	0.2205*** (0.079)	0.2039 (0.107)	0.1675* (0.089)
SCHIP	-	-0.0111 (0.021)	-	-0.0219 (0.019)	-	-0.0131 (0.021)
No face-to-face (MCD)	-	-0.0105 (0.046)	-	-0.0109 (0.047)	-	-0.0100 (0.044)
12-month continuous coverage (MCD)	-	0.0387 (0.028)	-	0.0468* (0.026)	-	0.0387 (0.027)
Presumptive eligibility (MCD)	-	0.0106 (0.039)	-	-0.0010 (0.033)	-	0.0120 (0.038)
Express Lane Eligibility	-	0.0165 (0.027)	-	0.0112 (0.026)	-	0.0197 (0.027)
State-level control variables	Y	Y	Y	Y	Y	Y
Medicaid and CHIP policy variables		Y		Y		Y
Sample size	1,092	1,092	1,248	1,248	1,066	1,040

Source: CMS Statistical Enrollment Data System as of August 2013.

Note: Dependent variable is total Medicaid and CHIP child enrollment. Robust standard errors clustered at the state level are in parentheses. All models include state and quarter fixed effects.

[a] Excluded the District of Columbia and Oklahoma from the comparison group in column (5,6) based on outlier analysis.

*/**/***Significantly different from zero at the .10/.05/.01 level.

Table B.4. Testing for state-specific impacts, 2007-2013 SEDS data

	Comparison states			All states			Comparison states, excluding outliers		
Impact of *Maximizing Enrollment*	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**	**(8)**	**(9)**
Main model findings (tables A.1 and A.3)									
All seven *Maximizing Enrollment* states	0.0085 (0.043) *p*=0.845	0.0152 (0.039) *p*=0.696	0.0223 (0.038) *p*=0.559	0.0090 (0.043) *p*=0.835	0.0072 0.039 *p*=0.853	0.0179 0.037 *p*=0.635	0.0074 0.043 *p*=0.865	0.0132 0.039 *p*=0.734	0.0279 0.037 *p*=0.452
Remove one Maximizing Enrollment state at a time									
Excluding Illinois	-0.0088 (0.046)	-0.0042 (0.040)	-0.0013 (0.038)	-0.0083 (0.046)	-0.0130 0.040	-0.0061 0.037	-0.0099 0.046	-0.0065 0.040	0.0047 0.037
Excluding Louisiana	0.0229 (0.047)	0.0253 (0.042)	0.0369 (0.041)	0.0234 (0.047)	0.0177 0.043	0.0321 0.040	0.0218 0.047	0.0232 0.042	0.0416 0.040
Excluding Massachusetts	0.0318 (0.042)	0.0324 (0.040)	0.0448 (0.036)	0.0323 (0.042)	0.0240 0.041	0.0399 0.036	0.0307 0.043	0.0301 0.040	0.0495 0.035
Excluding New York	0.0271 (0.045)	0.0352 (0.037)	0.0417 (0.036)	0.0275 (0.045)	0.0287 0.037	0.0373 0.035	0.0260 0.045	0.0333 0.037	0.0477 0.034
Excluding Utah	-0.0154 (0.042)	-0.0063 (0.039)	0.0020 (0.039)	-0.0149 (0.042)	-0.0146 0.039	-0.0015 0.038	-0.0164 0.042	-0.0082 0.039	0.0085 0.038
Excluding Virginia	0.0053 (0.050)	0.0068 (0.043)	0.0123 (0.044)	0.0058 (0.049)	-0.0013 0.044	0.0083 0.044	0.0042 0.050	0.0045 0.043	0.0169 0.042
Excluding Wisconsin	-0.0033 (0.048)	0.0128 (0.044)	0.0184 (0.044)	-0.0028 (0.048)	0.0062 (0.045)	0.0141 (0.044)	-0.0044 (0.048)	0.0116 (0.044)	0.0254 (0.043)
State-level control variables		Y	Y		Y	Y		Y	Y
Medicaid and CHIP policy variables			Y			Y			Y

Source: CMS Statistical Enrollment Data System as of August 2013.

Note: Dependent variable is total Medicaid and CHIP child enrollment. Robust standard errors clustered at the state level are in parentheses. All models include state and quarter fixed effects.

*/**/***Significantly different from zero at the .10/.05/.01 level.

Table B.5. Alternative samples, 2007-2013 SEDS data

	Comparison states			All states			Comparison states, excluding outliers		
Impact of *Maximizing Enrollment*	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Main model findings (Tables A.1 and A.3)	0.0085 (0.043)	0.0152 (0.039)	0.0223 (0.038)	0.0090 (0.043)	0.0072 *0.039)	0.0179 (0.037)	0.0074 (0.043)	0.0132 (0.039)	0.0279 (0.037)
Alternative specifications									
Excluding comparison states using 10% significance criteria	0.0076 (0.044)	0.0159 (0.039)	0.0239 (0.038)	NA	NA	NA	0.0064 (0.044)	0.0138 (0.039)	0.0224 (0.038)
Using Q2 FY 2011 as start of post-*Maximizing Enrollment* period	-0.0010 (0.033)	0.0031 (0.030)	0.0061 (0.029)	0.0005 (0.032)	0. 0002 (0.029)	0.0061 (0.028)	-0.0003 (0.033)	0.0035 (0.030)	0.0136 (0.028)
Excluding small states	0.0015 (0.044)	0.0110 (0.040)	0.0208 (0.039)	NA	NA	NA	0.0015 (0.044)	0.0110 (0.040)	0.0302 (0.037)
Using 2007-2011; including Alabama	0.0068 (0.037)	0.0123 (0.035)	0.0148 (0.033)	0.0088 (0.036)	0.0046 (0.034)	0.0089 (0.033)	0.0063 (0.037)	0.0114 (0.035)	0.0200 (0.033)
State-level control variables		Y	Y		Y	Y		Y	Y
Medicaid and CHIP policy variables			Y			Y			Y

Source: CMS Statistical Enrollment Data System as of August 2013.

Notes: Dependent variable is total Medicaid and CHIP child enrollment. Robust standard errors clustered at the state level are in parentheses. All models include state and quarter fixed effects.

*/**/***Significantly different from zero at the .10/.05/.01 level.

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