Issue Brief | February 2007

Judith Wooldridge, *senior vice president*, Mathematica Policy Research, Inc.

Lessons from *Covering Kids & Families*

A national program of the Robert Wood Johnson Foundation

Making Health Care a Reality for Low-Income Children and Families

After Congress established the State Children's Health Insurance Program (SCHIP) in 1997 in response to large numbers of uninsured children in low-income working families, states took this unique opportunity to expand children's coverage and introduce program innovations. To build on this opportunity, the Robert Wood Johnson Foundation (RWJF) funded a national initiative—*Covering Kids* (CK)—in 1999 to increase children's enrollment in SCHIP and Medicaid. In 2002, RWJF extended CK to families as well as children and renamed it *Covering Kids & Families* (CKF).

RWJF funded 46 state CKF grantees, which included community-based organizations, service agencies, government agencies, academic institutions and health care providers.[1] In turn these state grantees funded 152 local grantees—at least two in each state—using half of their grants (the average state grant was $828,215). Local grantees were intended to be local laboratories for innovation that could report to state grantees on barriers to enrollment and the most effective types of outreach. The 4-year grants began during 2002.

A wide-ranging independent evaluation of CKF funded by RWJF and conducted by Mathematica Policy Research, Health Management Associates and the Urban Institute is documenting the success of CKF in increasing SCHIP and Medicaid enrollment. This brief reviews evaluation findings about best practices in this area. For policy-makers considering SCHIP reauthorization, this brief provides information about the potential value of outreach and other types of program support. The study shows that CKF has helped simplify enrollment and coordinate SCHIP and Medicaid and that such changes are key to sustained enrollment.

Contents

MATHEMATICA Policy Research, Inc.

This issue brief was written by Mathematica Policy Research, Inc. Support for this publication was provided by the Robert Wood Johnson Foundation in Princeton, New Jersey.

CKF required its grantees to use three strategies to increase enrollment of eligible uninsured children and families in SCHIP and Medicaid:

- *Outreach* to encourage enrollment.
- *Simplification* of SCHIP and Medicaid policies and procedures to make it easier for families to enroll their children and keep them in the programs.
- *Coordination* between SCHIP and Medicaid to ensure that families transition easily between programs if they apply for the wrong program or their eligibility changes.[2]

CKF also encouraged community commitment by requiring every grantee to be embedded in a community coalition, and it encouraged *collaboration* between grantees and state officials.

The evaluation has assessed the role of the three CKF strategies and of coalitions and collaboration in increasing enrollment.

COALITIONS HELP IMPLEMENT OUTREACH, SIMPLIFICATION AND COORDINATION

CKF grantees' coalitions were diverse and dynamic organizations of varied size. Members, principally drawn from community-based organizations, health plans and providers, and government usually provided time and expertise rather than financial support. Although some coalition members had a limited understanding of their coalition's goals and priorities, coalition leadership was fully aware of priorities: 41 percent reported outreach as their coalition's highest priority, 20 percent reported coordination of coverage, and 8 percent reported simplification.

Coalitions had the greatest success implementing the CKF strategies if they included, among their members, SCHIP and Medicaid officials with the authority to make program changes. Other keys to success were having strong leaders who set the agenda and maintained the focus on goals and good communication among members.

OUTREACH AFFECTS NEW SCHIP AND MEDICAID ENROLLMENT

Outreach Was a Key CKF Activity

As one of three key CKF strategies and a high coalition priority, outreach absorbed a large share of resources. Seventy-seven percent of local grantees and 59 percent of state grantees cited outreach as one of their top three resource-using activities.

Grantees employed diverse approaches to outreach and sustained them throughout the grant period. State grantees used media outreach more often than local grantees did. Local grantees used intensive in-person approaches more often than state grantees did. Both types of grantees believed that effective outreach must be:

- conducted by a trusted community organization;
- targeted to special populations;
- accessible and convenient to clients;
- coordinated with other organizations offering outreach; and
- coordinated with state government efforts.

It is not known which of these outreach characteristics is most important in increasing enrollment. We did find, however, that sustained outreach is necessary for enrolling children in SCHIP and Medicaid.

Sustained Outreach Was Crucial for Sustaining New Enrollment

Evidence of the *need for sustained outreach* to maintain new enrollment comes from our study of California. During the severe economic downturn that occurred between 2001 and 2003, public program eligibility was expanded and simplified–which would normally have spurred significant program growth. However, new Medi-Cal and Healthy Families (SCHIP) enrollment grew little. This stagnation appears largely to have resulted from reduced state funding for outreach and application assistance. In 2002, while the economy was worsening, California stopped paying for outreach and application assistance in schools and community-based organizations and cut back statewide media announcements; in 2003, it eliminated its Certified Application Assistant program. These cuts seem to have blunted enrollment growth. This suggests that, when funded, sustained outreach was important in expanding coverage.

Meanwhile, local outreach programs, both CKF and others, may have limited the dampening effect of the state cuts on enrollment growth. For example, Sonoma County identified new funding sources after losing state outreach funds and increased the skills of the certified application assistants, achieving higher-than-expected new enrollment throughout the period.

Comparable effects of local outreach on new enrollment were found in our study of a school-based program in Virginia. This program was funded by a local Foundation with ties to the state CKF grantee (see box below).

The Fairfax County project—the Partnership for Healthier Kids (PHK)—is a local outreach initiative sponsored by INOVA Health System that emphasizes reaching families with the help of local schools. PHK involves the local schools in identifying uninsured children, getting parental consent to refer them for coverage, and following up with them when they do not apply. The superintendent of Fairfax County Schools made this outreach possible by championing use of the schools to enroll children in public health insurance coverage. The original program began in October 1998 with 10 schools, but grew quickly.

During 2004, five PHK outreach workers worked with 201 area schools and received 2,100 consent forms. These forms led to 1,400 Medicaid and SCHIP applications. This total—about 350 children per quarter during 2004—reflects a sizable fraction of the children enrolling in Medicaid and SCHIP in Fairfax County.

SIMPLIFYING AND COORDINATING SCHIP AND MEDICAID AFFECTS ENROLLMENT

Simplification and Coordination Were Key CKF Activities

Attempts to simplify policies and procedures and coordinate SCHIP and Medicaid were intended to make it easier for eligible families to enroll their children in public coverage and keep them covered at renewal. All the state grantees (but few local ones) tried to simplify enrollment and coordinate coverage. State grantees believed these activities often led to policy changes that made enrollment in SCHIP and Medicaid easier—a view supported by state policy-makers.

The simplification activities grantees most often identified as promising were those related to applications and enrollment (see Table 1). Other activities grantees identified as promising related to the renewal process and effective use of coalition meetings. Examples of these activities include the following:

- Pressing for a shorter and simpler joint application form. *For example, Michigan's CKF grantee helped the state develop and implement a shortened and combined SCHIP and Medicaid application.*
- Simplifying the renewal processes and the renewal notice. *To make renewals easier, for example, Washington and Nebraska state CKF grantees helped their states implement pre-populated renewal forms.*
- Involving state policy-makers directly through their participation in coalition meetings. *For example, the California CKF grantee said the coalition meetings were invaluable: state leaders came to the table to listen, giving CKF staffers a way to inform and influence policy.*

TABLE 1

Grantees' Most Promising Simplification Activities

Most Promising Activities	Number Reporting
Simplifying applications, application processes or application requirements	40
Simplifying renewal processes or requirements	13
Exchanging ideas through coalition and other meetings	11
Data analysis	8
Training sessions	6
Other activities	11
Total number of activities reported	89
Percent of grantees reporting that the activity led to SCHIP or Medicaid simplification	76%

SOURCE: Survey of 46 State Grantees 2005

The coordination activities grantees most often identified as promising related to identifying and eliminating barriers to coordination of policies or procedures (see Table 2). Making infrastructure improvements and identifying and eliminating barriers to SCHIP and Medicaid program administration also ranked high. Examples of these activities include the following:

- Aligning SCHIP and Medicaid requirements so that one form could be used for both programs. *Pennsylvania made procedural and policy changes to align Medicaid and the Children's Health Insurance Program (CHIP) renewal processes. For example, before this change, Pennsylvania CHIP required 60 days of income proof, while Pennsylvania Medicaid required 90 days of income proof.*
- Helping states develop electronic applications for public coverage and tools that determine automatically the programs for which people are eligible. *For example, Wisconsin's CKF grantee helped the state develop, test and implement an online enrollment self-assessment tool that can enroll and re-enroll individuals in Medicaid, SCHIP and other public programs such as food stamps.*
- Identifying gaps in communication between SCHIP and Medicaid organizations. *For example, the Florida CKF grantee created flowcharts for the state SCHIP and Medicaid organizations to show the gaps between the agencies and where coordination needed improvement (four state agencies are involved, one for eligibility, one for benefits, one for Medicaid, one for SCHIP).*

TABLE 2

Grantees' Most Promising Coordination Activities

Most Promising Activities	Number Reporting
Identify and eliminate barriers to coordinating policies or procedures	30
Create electronic tools to assess eligibility for multiple public programs	8
Identify and eliminate barriers to coordinating SCHIP and Medicaid administration	6
Other activities	13
Total number of activities reported	57
Percent of grantees reporting that the activity improved coordination between SCHIP and Medicaid	93%

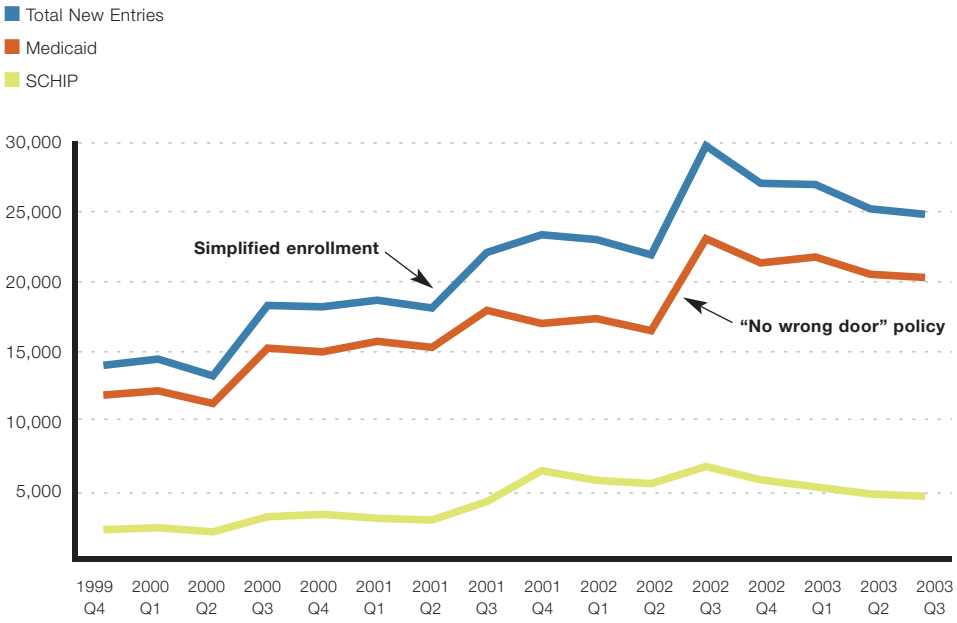
SOURCE: Survey of 46 State Grantees 2005

Importance of Simplification and Coordination

Evidence of the benefits of *simplification* and *coordination* for raising enrollment comes from our studies of Virginia and Arkansas. In Virginia, several policy changes simplified enrollment in SCHIP and Medicaid and improved coordination between the two programs. These changes were immediately followed by large gains in enrollment (see Figure 1).

FIGURE 1

New Entries to Public Health Coverage*
Virginia: October 1999–September 2003



*New entries are children enrolling in Medicaid or SCHIP for the first time in the past 12 months

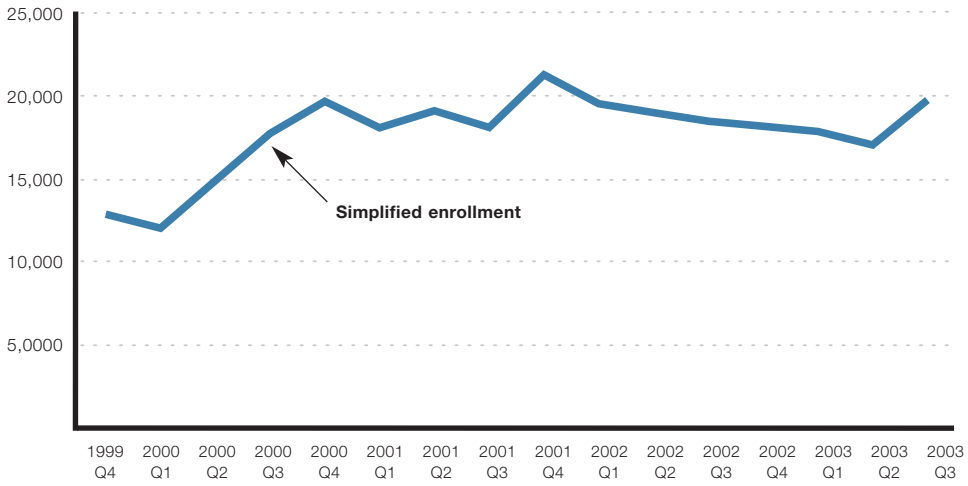
SOURCE: Medicaid Statistical Information System.

The largest gain in Virginia's SCHIP enrollment took place in 2001, after the state simplified enrollment by allowing families interested in SCHIP to apply at locations other than the local Department of Social Services. Similarly, the largest gain in new Medicaid enrollment took place in late 2002 after the state adopted a "No Wrong Door" policy that allowed families eligible for Medicaid the same flexibility when applying for coverage. This policy not only resulted in simplification for Medicaid-eligible families but also encouraged greater coordination between the two programs.

In Arkansas, two public health insurance programs were integrated under a common name—"ARKids First"—in 2000. This branding helped destigmatize Medicaid coverage and improve marketing coordination. In further simplification steps, the state developed a common application form and introduced self-declaration of income and assets. After these changes, the state sustained high levels of new enrollment in both SCHIP and Medicaid (see Figure 2).

FIGURE 2

New Entries in Public Health Coverage*
Arkansas: October 1999–September 2003



*New entries are children enrolling in Medicaid or SCHIP for the first time in the past 12 months

SOURCE: Medicaid Statistical Information System

STATE OFFICIALS REPORT CKF CONTRIBUTED TO IMPROVED STATE POLICIES AND PROCEDURES

As of mid-2003, most states indicated that they had recent and positive interactions with CKF. Thirty of 52 SCHIP and Medicaid officials from 36 CKF states had interacted with a CKF grantee in the past week. CKF grantees helped implement change and also challenged changes that did not match the mission of simplification and coordination.

By 2005, most state grantees worked *with* state officials. CKF was able to coordinate with the state and get the right stakeholders together in coalition meetings and elsewhere. As a result of this collaboration, state officials knew

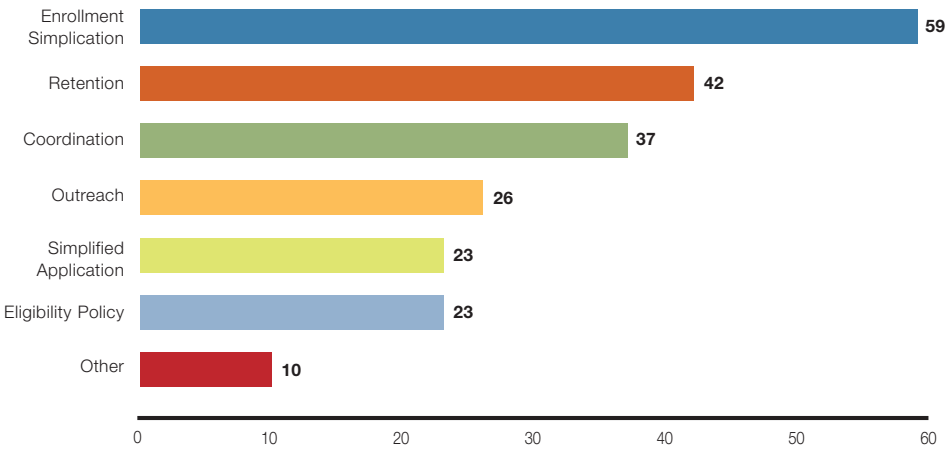
what CKF was trying to achieve, were able to report on CKF success in reaching their goals, and often drew on the evidence grantees provided to make the case to legislators for policy and procedural changes.

Sixty-one out of 65 state officials said CKF had affected state policy. Figure 3 shows the top three policy or procedural areas that CKF influenced–from the perspective of state officials–and how they ranked them.

FIGURE 3

State Officials' Views: The Top Three Areas that CKF Influenced

(Percentage of State Officials, N = 65)



SOURCE: Survey of 65 State Officials in 46 States, 2005.

Like grantees, state officials were most likely to rank simplification of the application and enrollment process in the top three areas of CKF influence. They mentioned retention (an aspect of both simplification and coordination) as the second most influential activity and coordination as the third most influential activity. Only 26 percent thought that CKF had influenced state outreach policy. In 2005, state officials reported that they thought about two-thirds of these policy and procedural changes would be sustained–especially enrollment simplifications.

Perhaps most important, state officials believed that nearly half of these changes would not have happened at all without CKF and that other changes would not have been implemented so quickly without CKF.

State CKF grantees were, by and large, highly respected, worked collaboratively with the state, and were able to provide objective information from the frontlines that states were not always aware of. (Local grantees provided information about the difficulties families had enrolling their children or renewing coverage.) CKF grantees became critical actors in changing (and sustaining) state policies because they provided a sustained external voice, followed clear goals and known strategies, and contributed objective information.

STATES BENEFITED FROM CKF-SPONSORED LEARNING COLLABORATIVES

In 2004, the CKF technical assistance contractor introduced learning collaboratives—an approach to procedural change. During 2004 and 2005 the contractor ran two year-long collaboratives involving 22 states that followed the quality of care improvement model developed by the Institute for Healthcare Improvement (2003). The focus was on improving enrollment and retention procedures. This model of collaboration drew state leadership, frontline eligibility staff, and CKF grantees into a team working on the shared goal of efficient enrollment and retention of children in public coverage. Members had the opportunity to learn from other state teams and from the technical assistance faculty who provided help with objective reviews of the enrollment process, health literacy and federal eligibility requirements. The collaboratives, which participating states and grantees viewed positively, yielded numerous procedural improvements, some of which were reported to save states a lot of money. For example:

- Oregon reduced the number of application steps from 72 to 16, cutting the average number of days from application to enrollment from 22 to 3 (and saving over $28,000 a month in overtime).
- Iowa automated referrals from SCHIP to Medicaid, decreasing the referral time from 15 to 2 minutes and increasing the number of referrals from 350 to over 800 per month.
- Arkansas introduced statewide phone renewal and phone follow-up for incomplete renewals, which they reported reduced the closure rate at renewal from 25 percent to 6 percent.

Successful collaboration depended on including in the team state officials committed to improving the program and able to act on the findings.

ENROLLMENT CAN FALTER EVEN WHEN CKF STRATEGIES ARE FOLLOWED

Our study found broad evidence of increased enrollment from following CKF's core strategies, but policy-makers should note an important lesson—that enrollment can still falter—as the experience from New Jersey illustrates. In 1999, the state introduced the most generous SCHIP income eligibility levels in the nation—children's eligibility was raised to 350 percent of the federal poverty level—and simplified and coordinated the enrollment process for public coverage. For example, a joint application form was introduced and the requirement for face-to-face interviews with Medicaid applicants was abolished. Furthermore, in 2000, the state expanded coverage to uninsured adults with incomes up to 200 percent of the poverty level. Throughout this period, the state and CK/CKF worked collaboratively on outreach, simplification and coordination.

Although all the conditions necessary for sustaining new enrollment existed in New Jersey, its SCHIP program lost momentum in 2000—because a new vendor for SCHIP applications was overwhelmed by the volume of applications from uninsured adults. (The new adult coverage proved more popular than the state had anticipated, and the vendor could not process all the applications for child and adult coverage.) The state had to scale back outreach while defending itself against criticism that it was failing to insure eligible families. Owing to this lack of infrastructure, new SCHIP enrollment among children remained depressed for a full year, with no subsequent rebound.

LOOKING AHEAD

SCHIP created new opportunities to provide public insurance coverage for children and was also a catalyst for changes in the Medicaid program. CKF was able to push these changes even further in the direction that SCHIP's founders intended. Policy-makers are considering whether to reauthorize SCHIP, examining evidence on its effectiveness and the elements that contribute to success.

Our study shows that enrollment increases were most likely when the full set of CKF strategies was implemented: an effective coalition, successful efforts to simplify enrollment and coordinate coverage, sustained intensive outreach, and innovative projects emanating from local programs. Also required were:

- strong leadership and championship of children's coverage in state government;
- state willingness to collaborate with CKF grantees on the frontline; with close ties to families; and
- adequate infrastructure.

Weakness in any of these areas limits programs' ability to enroll children efficiently. Combining them can lead to highly effective programs for insuring children.

The evaluation also provides one further lesson for SCHIP reauthorization: the best results occur when states are not facing budget pressure (and thus not inclined to cut outreach or make enrollment more difficult).

These findings make a case for requiring states to support outreach. They also suggest the importance of supporting coordinated enrollment systems and encouraging states to simplify enrollment and renewal processes–not just to make it easier for eligible children to apply, but also because it may be more efficient to do so.

Endnotes

1. In addition to the 46 state grants, RWJF funded small liaison grants with the remaining states.
2. Grantees also coordinated with programs such as food stamps as well as coordinating with both private and public coverage.

Reference

Institute for Healthcare Improvement. *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* Innovation Series 2003. 2003. Institute for Healthcare Improvement, Cambridge MA.

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

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

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

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

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

Morgan G, Ellis E and Gifford K. "Areas of CKF Influence on Medicaid and SCHIP Programs." Lansing, M.I.: Health Management Associates, December 27, 2005. *www.rwjf.org/files/research/CKFpermanencereport.doc*

Lavin B, Wooldridge J, Ellis E and Stevens B. "An Analysis of CKF Coalitions." Princeton, N.J.: Mathematica Policy Research, Inc., July 23, 2004. *www.rwjf.org/files/research/ Coalitions%20Synthesis.pdf*

Howell E and Courtot B. "Reaching Out to Enroll Children in Public Health Insurance: The CKF Grantees and Their Experience." Washington, D.C.: The Urban Institute, December 21, 2005. *www.rwjf.org/files/research/CKF_Reaching_Out_to_Enroll_Children.pdf*

All CKF evaluation reports are available at: *www.rwjf.org/portfolios/features/featuredetail.jsp?featureID=1031&type=3&iaid=132*

Robert Wood Johnson Foundation

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