JUNE 2010

Covering Kids & Families® Evaluation

A Continuing Program for Increasing Insurance Coverage Among Low-Income Families

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About the *Covering Kids & Families*® Evaluation

Since August 2002 Mathematica Policy Research and its partners, The Urban Institute and Health Management Associates (HMA), have been conducting an evaluation to determine the impact of the Robert Wood Johnson Foundation's investment in the *Covering Kids & Families* (CKF) program, as well as to study factors that may have contributed to, or impaired, its efforts.

The evaluation focuses on these key issues:

- **Documenting and assessing the strategies and actions of CKF grantees and their coalitions aimed at increasing enrollment of children and families and the barriers to their implementation.**
- **Assessing the effectiveness of CKF grantees and their coalitions in conducting outreach; simplifying the application and renewal process; and coordinating efforts by existing health insurance programs to expand coverage measuring progress on CKF's central goal—expanding enrollment and retention of all eligible individuals into Medicaid and the Children's Health Insurance Program (CHIP).**
- **Assessing the sustainability of CKF after RWJF funding ends.**

Findings from the evaluation can be found at *www.rwjf.org/coverage/product.jsp?id=20929*.

Context and Rationale

Until 2010, the United States was less willing to provide universal health insurance than to provide such coverage to children, as shown by passage of the Children's Health Insurance Program (CHIP)* for low-income children, which was recently renewed and expanded. Moreover, some states have expanded their CHIPs to cover the parents of low-income children. Nevertheless, despite 10 years of CHIP coverage, there are still children eligible for CHIP who have not been enrolled, or who were once enrolled but no longer are and have become uninsured. This paper describes the uses of coalition-based approaches to change the CHIP and Medicaid programs to increase the number of insured children. It explores the effects of the Robert Wood Johnson Foundation's *Covering Kids & Families* (CKF) program on policy and procedures and assesses the effects of policy change on health insurance coverage of children and parents.

The Challenge and RWJF's Strategy

Shortly after CHIP legislation was passed, the Robert Wood Johnson Foundation (RWJF) began an ambitious, decade-long effort to increase the health insurance coverage of low-income children nationwide. In 1999 RWJF implemented *Covering Kids: A National Health Initiative for Low-Income, Uninsured Children* (CKI), which supported state and local organizations aiming to increase enrollment of children in Medicaid and CHIP. *Covering Kids & Families*—which reached out to parents as well as children—succeeded CKI in 2002. From 2002 to 2006 RWJF distributed $44 million in CKF grants to organizations in 46 states to work on increasing the numbers of children enrolled in CHIP and Medicaid.[1]

CKI had demonstrated the value of following three approaches to increasing children's coverage: increasing awareness and enrollment among eligible families through outreach, recommending simpler CHIP and Medicaid policies and procedures to states to make it easier for families to enroll their children and keep them covered, and improving coordination between CHIP and Medicaid to ensure the transfer of families between programs if they apply for the wrong program or their eligibility changes.

Recognizing that CKF grantees would be more successful in implementing the three approaches if they worked closely with the state and other groups interested in children's coverage, RWJF selected grantees with coverage experience and required them to set up and work with coalitions of stakeholders including state Medicaid and CHIP staff. RWJF required the 46 state grantees to spend at least half their grants on local community sites. These local sites were to provide outreach and pilot innovations; they were to report back on the most effective types of outreach and the chief barriers to enrollment, information that state policy-makers might not otherwise receive.

*This program was formerly known as State Children's Health Insurance Program (SCHIP).

The Foundation also wanted the outreach, simplified procedures and coordination approaches to continue after the funding ended (Robert Wood Johnson Foundation, 2001).[2] To promote this goal, RWJF required grantees to match 50 percent of their grant amount by the third year of the four-year funding period.

To help the grantees increase coverage, RWJF funded technical assistance through a national program office (NPO)—The Southern Institute for Children and Families—which had a long history of working with state and local organizations to improve the coverage of low-income families. The NPO helped grantees implement the three approaches and aim for long-term sustainability. RWJF worked closely with the NPO to respond to changing needs resulting from a changing environment. When state budget cutbacks that affected enrollment made outreach a less useful grantee activity, simplifying enrollment and retention processes became more relevant and the NPO worked with selected grantees and their state and local partners in a process improvement collaborative to help them simplify these processes.

After CKF ended in 2006, many of the organizations that had been state grantees continued some of the three program approaches. Moreover, at their request, RWJF funded a formal network of continuing CKF projects to help them continue sharing information and ideas with their peers. The network members share newsletters and hold telephone conferences and annual meetings to discuss their continued activities (Community Health Councils, 2008).

The Foundation wanted to know the most effective ways of enrolling children and families in public coverage. The Foundation also wanted to know how it could improve the CKF program and design new programs, if needed, when CKF ended. To meet these goals, RWJF contracted with Mathematica Policy Research and its partners, The Urban Institute and Health Management Associates, to evaluate CKF. The evaluation included a formative component, to help the Foundation and the NPO improve the program, and a summative component, to assess the effects of CKF on policy and procedures and the effects of policy and procedures on coverage.

Methods

The CKF evaluation was based on a logic model that recognized the three CKF approaches, likely environmental influences on the program, and the questions RWJF wanted answered. These questions were:

- Who were the grantees and how were they structured?
- What did CKF grantees do to address the three program strategies?
- In what environment did the program operate and how did the environment affect achievement of program goals?
- What happened to coverage policy in the state?
- Are coalitions an effective model for encouraging change?
- Did CKF change knowledge about or attitudes to Medicaid and CHIP?
- What factors governed changes in enrollment and retention? And what role did CKF have?
- Do access barriers reduce enrollment?
- What did local grantees do to address barriers to access among children and families enrolled in Medicaid and CHIP?
- Has CKF continued beyond the Foundation-funded program? What factors are responsible for survival?

The broad scope of these questions combined with the program's design required an innovative evaluation design. We provided the Foundation with early formative feedback by participating in monthly information-sharing partner meetings with RWJF, the NPO, and a media support contractor, and by preparing descriptive analyses reported in highlight memos which we shared with these partners.

The summative evaluation would ideally have estimated the effects of the CKF program through a formal impact analysis employing a control or comparison group. Because the CKF program was implemented nationwide more or less simultaneously, we could not use control or comparison groups to assess program effects on coverage. Instead, the evaluation adopted a mixed-method approach that blended quantitative and qualitative methods to assess the effects of the grantees' activities. We were particularly interested in the potential links of enrollment and retention trends to major policy changes, especially those associated with the CKF grantees' activities.

The central element in our approach to addressing the challenges of attributing causality was a rigorous synthesis of information across a variety of sources using case studies of 10 CKF states. We combined exploratory data analysis of new enrollment (and retention) trends from 1999 through 2005 with information from state grantee project directors, CHIP and Medicaid directors, coalition members and former CKF employees. The trend data were constructed from individual-level eligibility records provided by the state. Follow-up interviews with state and CKF grant staff provided a way to identify likely causes of major shifts in enrollment trends. This approach allowed us to assess the potential influence that policy changes had on new enrollments and retention. In addition, we explored data across sites to assess the strength of the patterns in what appeared to be promising policies and procedures for increased enrollment and higher retention rates. This approach was supplemented with descriptive analyses of program activity from the perspectives of grantees, state officials and coalition members.[3]

When local pilot sites found that even families with coverage sometimes had problems getting the care they needed, they pressed RWJF to fund activities to improve access to care. Some of the earlier CKI program grantees believed, moreover, that poor access led to reduced enrollment. The CKF evaluation assessed whether families' experiences with access, good or bad, influenced their decisions either to enroll their children in Medicaid or CHIP or to renew their coverage. We also evaluated access improvements achieved through a new program introduced by RWJF—the Covering Kids and Families Access Initiative (CKF-AI)—which provided $4 million to 18 local pilot sites to work on access improvements.

Most of the evaluation's data sources were program-based. The evaluation team designed an online grantee database to meet the needs of all the partners while minimizing grantee burden. The evaluation team fielded Web and telephone surveys of CKF program directors, coalition members, state Medicaid and CHIP officials and CKF employees, many of which were repeated. In-person meetings with grantees and state staff took place during 10 site visits early in the evaluation, 10 visits to case study states[4]; and two meetings in which grantees and the evaluation team held an intensive structured discussion of outreach, enrollment and retention. The access analysis drew on data from focus groups and interviews with parents (in 2005 and 2008, respectively). We also visited five of the 18 local access initiative grantees to collect data for our evaluation of the CKF Access Initiative. Finally, the Centers for Medicare & Medicaid Services provided Medicaid and CHIP enrollment data from the Medicaid Statistical Information System.

Results

The findings were that broad-based cooperation on policy and procedural change—among advocacy groups, providers, state Medicaid and CHIP officials and other stakeholders—can be achieved and that such cooperation can be fundamental to increasing insurance coverage among children. Furthermore, many of these changes endured well beyond the CKF grant period, and some (such as eliminating face-to face interviewing requirements) have become the national norm. Moreover, the evaluation found ample support for the notion that policy and procedure engineering can significantly increase enrollment. Among the key process influences on enrollment we found were elimination of face-to-face interviews and state use of centralized enrollment processing.

CKF Grantees Built Diverse, Experienced and Broad-Based Coalitions That Advocated for Coverage

Grantees were diverse and experienced in children's coverage. Many types of organizations, including advocacy, health and social services, government and academic organizations, received CKF grants (see Table 1). Advocacy organizations focused on children and children's health (such as Arkansas Advocates for Children and Families, DC Action for Children and Ohio's Children's Defense Fund) predominated. Furthermore, most grantees had worked on children's coverage: two-thirds of them had been CKI grantees and three-quarters of them had staff with Medicaid or CHIP experience. Similarly two-thirds of the local pilot sites had some staff with Medicaid or CHIP experience (Paxton, Wooldridge and Stockdale, 2005).

TABLE 1

Types of Organizations Receiving CKF Grants

Types of Organizations	State	Local	Total
Advocacy	**23**	**23**	**46**
Children's Health	13	10	23
Health	8	6	14
Other	2	7	9
Health Care/Social Services Resources	**9**	**22**	**31**
Health Care/Social Services Resources	1	5	6
Health Care Center Consortium	5	11	16
Other	3	6	9
Health Care Provider	**2**	**23**	**25**
Health Care Center/Clinic	1	16	17
Hospital	0	6	6
Health Care System	1	1	2
Community Service	**0**	**17**	**17**
Government	**7**	**10**	**17**
State	7	0	7
County and City	0	10	10
Health Outreach/Education	**0**	**11**	**11**
CKF Coalition Only	0	7	7
CKF Pilot Site Only	0	4	4
Academic	**4**	**5**	**9**
University	4	3	7
School District	0	2	2
Health Insurance Provider	**1**	**2**	**3**
Total	**46**	**113**	**159**

Source: CKF telephone interviews, 2003, and grantee Web sites

The CKF coalitions represented broad constituencies. When CKF began, one-third of state grantee coalition members were from community service (including advocacy) organizations, one-fifth were from government and another one-fifth from health plans and providers (Ellis and Tang, 2003). At the end of the CKF program, project directors and coalition leaders reported fairly stable coalition membership: over three-quarters of them said coalition member turnover was less than 25 percent over the four years (Hoag and Wooldridge, 2007b). Most coalition members contributed time, technical expertise, in-kind support and political influence rather than direct financial support.

Coalitions Are an Effective Model for Policy Change

The CKF coalitions were intended to build relationships between CKF program staff and state officials and thus increase the likelihood that CKF could influence coverage policy and practice. The coalitions appear to have built relationships and encouraged change, although state grantee and local site coalitions used different pathways to achieve this change.

State grantee coalitions were an effective forum for influencing government policies and procedures. State coalitions included state officials as well as state-level advocacy and provider groups who were already connected with policy-makers. State officials reported that they valued the coalitions because they offered communication networks and forums for policy dialogue–both of which are program legacies (Hoag and Wooldridge, 2007b).

The coalition-building strategy resulted in CKF grantees and coalition members becoming "trusted partners" of state staff. State officials commented that CKF often helped them. Some said that CKF became a trusted partner in simplification and outreach–to the point that some of these officials regretted the end of CKF funding. The CKF coalitions provided a foundation on which states could build and enhance their community partnerships on policy and outreach, and continue to simplify and coordinate their Medicaid and CHIP programs. CKF's coalitions also supported expanded coverage and mitigated contractions in coverage resulting from economic and political reversals. CKF gave help on legislation, policy changes and program improvements. For example, one state official said, "Our state has tried to improve its programs for children, and CKF has been there every step of the way. They've helped with legislation, stakeholder support and have been a major player in reform efforts." The four-year life of the CKF coalitions from 2002 to 2006 (and for many, a prior life as a CKI coalition) allowed a long-term relationship to develop. Coalitions provided accurate information and worked with the state on changes to outreach and simplification that were of interest to both, which resulted in a steady influence from a trusted team.

Naturally, not all states were as positive about CKF and a few state officials spoke of tensions between their agency and CKF and of coalitions that were not well-lead early on in the grant period. As trust developed, these types of problems were resolved, and by the 2007 survey of Medicaid and CHIP officials in 46 states, there were no negative reports about grantees or coalitions. For example, the Oregon CKF grantee spoke of a change in their relationship that resulted from the opportunity to cooperate with the state on process improvements—the grantee felt that they had changed from being only an advocate to a partner. Because the relationships developed through the CKF period were strong, many of the coalitions continue (Duchon and Ellis, 2009 and Hoag and Stevens, 2008).

Local site coalitions helped develop trust on the part of low-income families, and communicated valuable information about the difficulties of those families to state officials. Local site coalitions brought together partners in the community who knew and worked with vulnerable low-income families who trusted them. These partnerships enhanced local sites' ability to reach out and enroll families and identify the barriers to coverage and renewal that these families experienced. Local grantees' detailed program knowledge played a role in redesigning procedures. Local knowledge was transmitted to state officials about which processes worked and which did not and where simpler processes and policy changes were needed. For example, local sites described the effects on enrollment of adding documentation requirements (it often leads to more face-to-face interviews, even if they are not technically required, and reduces enrollment among eligible families). The local coalitions also provided accurate information to their community partners on who was eligible for CHIP and Medicaid and how to get enrolled–which enhanced the trust among coalition members.

Outreach Was Resource-Intensive and a High Priority for CKF Grantees

Outreach was the first priority of many state grantees and most local grantee sites throughout the program's four years. Indeed, about half of state grantees and two-thirds of local grantees reported that just two or three major outreach activities consumed most of their resources.

Outreach activities were varied. Grantees did school-based outreach, marketing and media outreach, provider-based outreach, one-on-one-application assistance and other community-based outreach. Sixty percent of state and local grantees reported that school-based outreach was a successful approach to reaching families with children (often in coordination with the Foundation-sponsored Back-to-School Campaign). Although all grantees used the media to reach families, their expenditures on media outreach were low (consistent with their limited grant funding), tended to peak in the spring around RWJF's Cover the Uninsured Week and in the fall around the Back-to-School Campaign, and decreased over time. Local pilot sites favored person-to-person outreach (such as

helping families fill out applications) because they considered it particularly effective at getting families enrolled. State grantees used more earned media activities (such as feature articles in the press) than local pilot sites and used funds and technical assistance provided by a CKF-funded media contractor.

Community partnerships (both state and local) appear critical to sustaining quality outreach. Partnerships included shared outreach and training of partner staff by CKF staff. Partnering with community-based organizations that had more resources and would outlast the grant had the potential for continued outreach after the grant period ended. For example, in Florida, CKF partnered with the sheriffs' fire and rescue squads statewide on outreach (Southern Institute on Children and Families, 2007). Though often attempted, partnering with businesses on outreach (especially those employing low-wage workers) was less successful, partly because these were new relationships and successful partnerships take time to build.

Many CKF grantees influenced state outreach policy and practice. In a 2007 survey after CKF funding ended, state officials recognized 26 instances of CKF grantee influence on outreach policy and practice (Duchon and Ellis, 2009). Because of their knowledge of CHIP and Medicaid policies and their close ties with state officials, grantees in some states trained state and local health and human services agency staff to help families apply for CHIP or Medicaid. In New Jersey, for example, training local staff became a shared responsibility of the CKF grantee and state agency staff, each training local staff in different counties (Trenholm, Lavin, and Wooldridge, 2006). Furthermore, as of summer 2008, six states continued to fund outreach conducted by CKF grantee organizations. For example, in May 2007 Connecticut committed outreach funds for CKF activities for two years (Duchon and Ellis, 2009).

School-based outreach appears to be the most promising outreach tactic. In Kentucky, the CKF grantee demonstrated the importance of coalitions in mobilizing resources and securing support for children's coverage from several major grassroots organizations. In particular, the support of the school-based Family Resource Youth Services Centers (FRYSCs) (entities created to promote the well-being of school-aged children in the state) appears to have been critical to new enrollment. Staff at the FRYSCs identified uninsured children in local schools and helped families apply for CHIP and Medicaid. In the face of state policy changes that might otherwise have curtailed program growth, the FRYSCs and other local groups contributed to sustained growth in the numbers of children enrolled in public coverage in Kentucky. In Virginia, the Fairfax County Partnership for Healthier Kids, though not a CKF project, had similar goals. It emphasized reaching families with the help of other organizations, especially local schools. It reached out to schools for their help in identifying uninsured children, referring them to coverage, and following up on them when they did not apply. This project was championed by the superintendent of Fairfax County schools who believed in using the school setting to enroll children.

State budget woes created both opportunities and challenges for CKF outreach. Just as CKF began, the national economy slowed and some states began to cut back on CHIP-funded outreach. For example, California stopped paying application assistors and Kentucky, Oregon and Washington ended their statewide outreach programs. In a handful of states, the continuing outreach by CKF was considered crucial by state staff for maintaining outreach in light of the state cutbacks. For example, in Connecticut the CKF grantee became the primary source of information about the HUSKY program throughout the state. However, in other states, the cutbacks reflected a broader effort to slow enrollment growth in Medicaid and CHIP, in some cases reducing the level of cooperation on outreach (and other program strategies) between the state and CKF grantees (Courtot et al., 2008).

Some grantees turned to improving retention when state cooperation on outreach waned. Retention was not an initial priority of most CKF grantees. However, as state support for outreach waned during economic downturns, grantees recognized they could increase enrollment by ensuring that fewer eligible children lost coverage due to such avoidable reasons as administrative barriers. For example, in Colorado, when the 2003 legislative session led to a CHIP enrollment cap, termination of Medicaid and CHIP outreach and termination of Medicaid coverage to legal immigrants, CKF targeted outreach to those already enrolled, and tried to reduce barriers to re-enrollment. Most states supported these efforts despite their budgetary concerns. Three factors led to state support for retention practices. First, retention rates tended to be lower than state officials expected; second, improving retention was a way of maintaining increased coverage; and third, states were interested in the potential administrative savings from reducing the number of eligible children who leave Medicaid and CHIP only to re-enroll after a short time (so-called churning).

CKF-supported help in improving renewal processes influenced state retention policies. In response to the increased interest in retention, the NPO ran two year-long process improvement collaboratives that focused on simplifying application and renewal procedures. The NPO invited some of the most effective grantees. State and local government staff who took part in these collaboratives said that they helped them find and eradicate inefficient processes.

CKF Influenced Adoption of Numerous Program Simplification and Coordination Measures, Many of Which Remain in Effect

Although administrative simplification and program coordination are two distinct concepts, attempts to influence them overlap. For example, a simplification in Medicaid application procedures that aligns it with CHIP application procedures may make it easier for families to be considered for both programs when they apply for coverage. During the CKF program the grantees increased their focus on simplification and

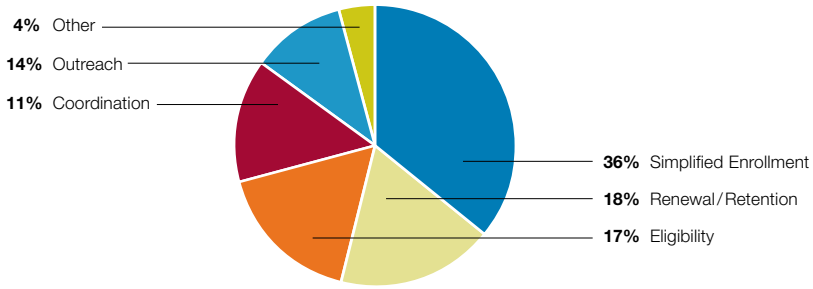
coordination. Indeed, state officials reported that CKF grantees influenced at least 183 separate policy changes during the period from 2002 through 2006—most focused on simplifying enrollment and renewal. Moreover, officials reported that most of these policies remained in effect two years beyond the grant period and were expected to continue another two years.

States rated simplified enrollment as the most common area of policy or process change that CKF influenced. Of the policy and procedural changes state CHIP and Medicaid officials reported that CKF had influenced, simplified enrollment procedures were the most common (36%); see Figure 1 (Duchon and Ellis, 2009). Simplified enrollment included changes that made the enrollment process easier, such as limiting documentation, removing a face-to-face interview requirement, implementing presumptive eligibility, shortening or simplifying application forms or training enrollment workers to assist applicants, as described by the grantees (see Table 2).

FIGURE 1

Types of Policy or Procedural Changes CKF Influenced, as Reported by Medicaid and CHIP Officials

N = 183 policy or procedural changes



Simplified Enrollment included changes that make the enrollment process easier, such as limiting documentation, removing a face-to-face interview requirement, implementing presumptive eligibility, shortening or simplifying application forms, or training enrollment workers to better assist applicants.

Renewal/Retention included policy or procedural changes that are intended to make the renewal or re-enrollment process easier and retain enrollment of those eligible for coverage (e.g., pre-printed or individualized renewal application).

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

Outreach included policy or procedural changes designed to make uninsured families more aware of their potential eligibility for coverage in Medicaid and/or CHIP, and increase the opportunities for families to enroll in Medicaid, CHIP or other public health programs for which they may be eligible (e.g., advertising campaign, enrollment facilitators in a hospital emergency room).

Coordination included policy and procedural changes that help to create a seamless enrollment process across public programs such as Medicaid, CHIP or any state or locally funded programs, regardless of the particular program for which an individual or family members may be eligible. Examples include joint Medicaid and CHIP applications, integration of information systems between Medicaid and CHIP, and training eligibility workers to screen individuals for multiple health insurance programs.

Other included efforts mentioned outside the scope of the five areas described above. Examples include staff training, restoring benefits or preventing benefit cuts, review of proposed regulatory changes, and raising awareness of Medicaid/CHIP programs among legislators.

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

TABLE 2

Grantees' Most Promising Simplification Activities

Most Promising Simplification Activities	Number of Grantees Reporting Activity
Simplifying application, 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 simplification activities reported	89
Percentage of grantees reporting that the activity led to CHIP or Medicaid simplifications	76%

Source: CKF Survey of 46 State Grantees, 2005

CKF grantees rated simplifying application forms and requirements, eliminating barriers to coordination between CHIP and Medicaid and improving the administrative infrastructure as promising practices for improving enrollment. Simplifying application forms, processes and documentation requirements were the activities CKF grantees worked on most often and considered most promising for increasing enrollment (Wooldridge, 2007). For example, Michigan's CKF grantee helped the state develop and implement a shortened and combined CHIP and Medicaid application. Grantees also identified improving renewal processes as a promising activity. For example, to make renewals easier, Washington and Nebraska CKF grantees helped their states implement pre-populated renewal forms. A third promising simplification activity was using state coalition meetings to engage state policy-makers. 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.

A common barrier to coordination is different CHIP and Medicaid application and renewal requirements. Different requirements imply different forms, making coordinating enrollment or renewal in Medicaid and CHIP more difficult (see Table 3) (Wooldridge, 2007). Identifying and eliminating barriers to coordination of policies or

procedures is a promising way to increase enrollment. Pennsylvania, for example, changed procedures and policy to align Medicaid and the Children's Health Insurance Program (CHIP) renewal processes. (Before this change, Pennsylvania CHIP required 60 days of income proof, while Pennsylvania Medicaid required 90 days of income proof.)

Grantees also helped states identify gaps in communication between CHIP and Medicaid agencies. For example, the Florida CKF grantee created flowcharts for the four state CHIP and Medicaid organizations to show the gaps between the agencies where coordination could improve.

Improving the infrastructure of CHIP and Medicaid program administration also ranked high as a promising activity for increasing enrollment. For example, some grantees helped states develop electronic applications for public coverage and tools that determine automatically the programs for which people are eligible. 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, CHIP and other public programs such as food stamps.

TABLE 3

Grantees' Most Promising Coordination Activities

Coordination Activities	Number of Grantees Reporting Activity
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 CHIP and Medicaid administration	6
Other activities	13
Total number of promising coordination activities reported	57
Percentage of grantees reporting that the activity led to improved coordination of CHIP and Medicaid	93%

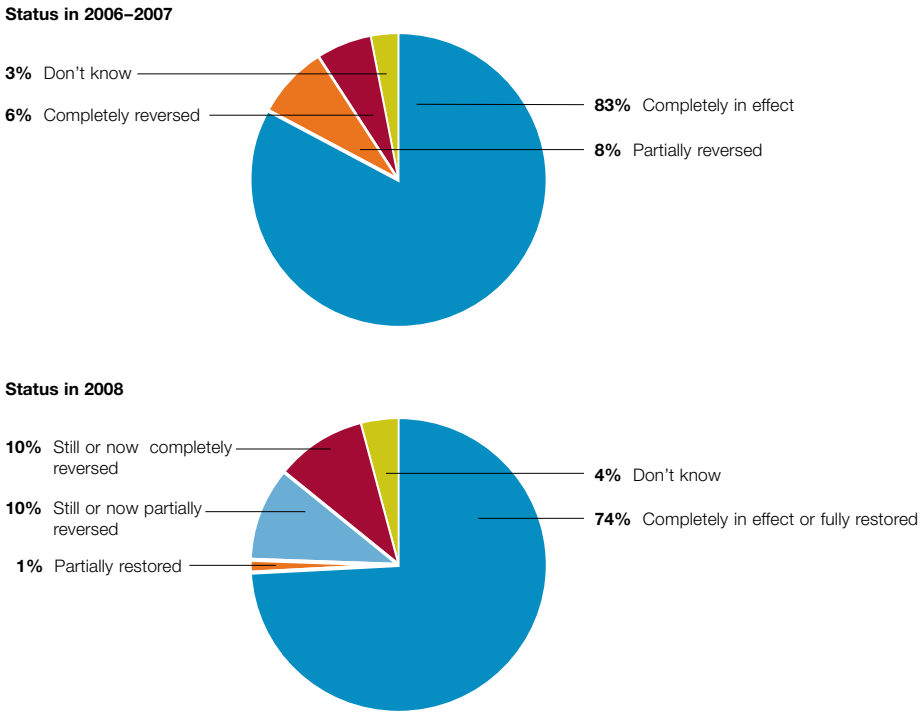
Source: CKF Survey of 46 State Grantees, 2005

Three-quarters of the changes CKF grantees influenced were still in effect two years after CKF funding ended. Among the changes CKF influenced between 2002 and 2006, three-quarters were still in effect in 2008—two years after the CKF grant funding ended. Taking into account changes that had been partially reversed earlier, but restored by 2008, 131 (74%) of the 183 policies and procedures CKF had influenced were still fully in effect. One year earlier, 83 percent of the changes had still been fully in effect, suggesting a reduction in CKF influence over time (see Figure 2) (Duchon and Ellis, 2009).

FIGURE 2

Status of Policy and Procedural Changes CKF Influenced, as Reported by Medicaid and CHIP Officials

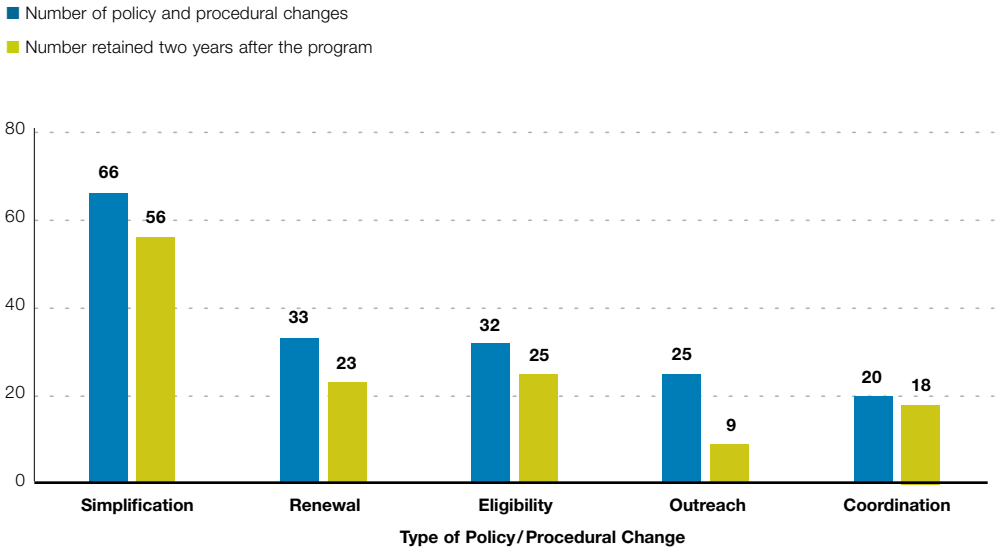
N=183 Policy or Procedural Changes



Source: 2006–2007 CKF Survey of State Officials and 2008 CKF Survey of State Officials

FIGURE 3

Retention of Policy and Procedural Changes Two Years After the Program Ended



Source: 2008 CKF Survey of State Officials

Simplified enrollment changes were especially durable. Enrollment simplifications were not only the most common type of change influenced by CKF, but 85 percent of them were retained two years after CKF ended. State officials commented on their continued pursuit of simplification: "We continue to improve the streamlining process and build on the efforts of CKF." Coordination changes were also durable, but there were fewer of them (see Figure 3) (Duchon and Ellis, 2009).

Many changes to renewal procedures to improve retention stayed in effect. Though not sustained at the same rate as enrollment simplifications, 70 percent of renewal simplifications were still in effect in 2008 (down from 88% a year earlier) (see Figure 3). Most of the changes that states reversed between 2007 and 2008 were pilot programs that did not succeed (or were not fully implemented). In states where renewal simplifications had been retained, officials described how they were building on CKF's efforts. This included activities such as pre-populating renewal application forms, adding a second reminder letter, and implementing a Web-based "express renewal initiative."

In contrast, many of the outreach policies and procedures influenced by CKF were discontinued or repealed. Grantees attempted to sustain outreach activities beyond the life of the grant by embedding them in other community organizations and by influencing states' outreach policies. However, by mid-2008, only nine of the 25 state

outreach efforts that CKF influenced were still in effect (Figure 3). States had smaller budgets and fewer staff for outreach than during the CKF grant period and could no longer maintain it. Only a few states said they intended to maintain the outreach that CKF had influenced.

The CKF program changed the way some state and local officials thought about procedures. The inclusion of two process improvement collaboratives in the CKF program gave state and county staff and CKF staff in 21 states an opportunity to cooperate closely on improving enrollment and renewal processes. The collaboratives were a forum for making small-scale changes and testing their effects and, when successful, extending them statewide. Some states achieved sustained statewide process changes. More states identified local process changes that they hope to extend statewide. For the long run, the collaboratives changed the way some states conducted business; for example, Iowa and Oregon brought the tools of the process improvement collaborative into everyday use (Hoag and Wooldridge, 2007a). The collaborative also improved relationships and reinforced trust between state and county staff and CKF grantee staff as they cooperated on solving problems that both thought important (and, in some states, improved procedures saved money).

Enrollment Growth in Many States Can Be Linked to Policies and Procedures Advocated by CKF Grantees

Enrollment is most likely to increase when a number of state and program factors coincide (Trenholm and Zutshi, 2009).[5] Important state factors are simplified enrollment and better coordinated coverage; sustained and intensive outreach; strong leadership and championship of children's coverage in the state; state willingness to collaborate with advocacy groups having close ties to families; and adequate infrastructure and positive economic conditions. Program factors are a CKF coalition with active membership by state officials, reliable information provided by local pilot sites and successful efforts to influence simplified enrollment and coordinated coverage. Loss of any one of these factors can limit enrollment growth (Wooldridge, Trenholm and Gerolamo, 2009).

Eliminating face-to-face interviews appears to reduce enrollment barriers. Requiring face-to-face interviews as part of the application process is viewed by many as making it unnecessarily difficult for working families to enroll their children in public coverage, both because of the potential stigma associated with applying for coverage at a local welfare office and because of the time required to do so. To overcome these problems, several states abandoned face-to-face applications and allowed mail-in (e.g., Missouri) or online (e.g., Illinois) applications as part of a process of simplifying enrollment. However, some states, such as Kentucky, reversed these changes when the state budget was tight and policy changed to restrict new enrollment.

Rebranding and de-stigmatizing Medicaid programs appears to increase enrollment. Arkansas tried to reduce the stigma of Medicaid in order to increase enrollment. Arkansas' Medicaid and CHIP programs were brought under a common umbrella program named ARKids (A and B) to avoid using the word "Medicaid" with its connotations of welfare offices and to ensure that any child would be considered for both programs. Arkansas also developed a joint application for its Medicaid and CHIP programs. Arkansas' rebranding of Medicaid to reduce the stigma associated with it, together with the introduction of the joint application form and the centralizing of enrollment processing, resulted in sharp increases in Medicaid enrollment (and smaller increases in the separate CHIP) (Walls et al., 2006).

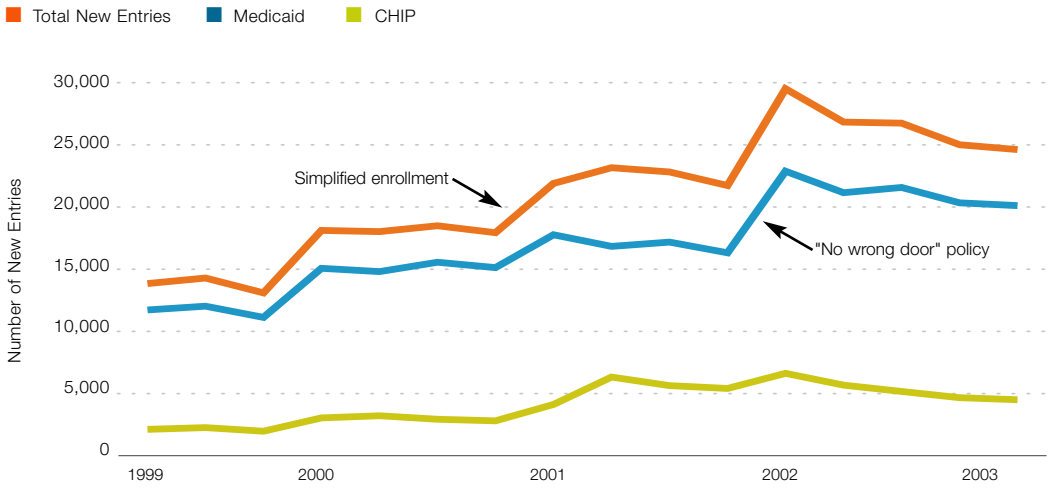
Effective centralized processing appears to boost enrollment. Centralized eligibility procedures can improve the quality and efficiency of the application and renewal processes, which may be uneven across county offices. During the period of the grant, three case study states (Illinois, Michigan and Virginia) adopted such procedures, processing some or all forms through a state-based system. This program feature was strongly associated with increased enrollment in Virginia.

Strong state champions can offer protection during economic downturns and are an important catalyst for enrollment growth. Governors in several states, including Arkansas, Illinois and Virginia championed children's coverage, including simplifications and expansions of coverage. In Arkansas, the governor was a strong supporter of children's coverage and of coverage expansions, so that despite critical budget problems in 2002 and 2003, the state pursued significant steps to de-stigmatize coverage and experienced strong growth in new enrollment. In Virginia, the governor's steady support for children's coverage led the state to simplify the application process and improve CHIP and Medicaid coordination, suspend premium payments and introduce a "no wrong door" policy, which allowed children's applications to be submitted at either local Department of Social Services offices or the state's central processing unit. These policies were all designed to increase children's coverage and took place in spite of a weak economic environment. Figure 4 shows the new enrollment trends in Virginia between 1999 and 2003 and shows upticks in enrollment when enrollment was simplified and again when the "no wrong door" policy was introduced (Howell et al., 2006).

By contrast, in Missouri, which had expanded coverage broadly, a new governor and changes in the legislature in 2004 led to the introduction of cost sharing and enforcement of annual eligibility checks in 2005 (Cook, Schott and Trenholm, 2007).

FIGURE 4

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



Source: Medicaid Statistical Information System
Note: New entries are children enrolling in Medicaid or CHIP for the first time in the past 12 months.

Ineffective processing can capsize enrollment growth. In New Jersey, CHIP enrollment dropped dramatically over a one-year period when the vendor was unable to process the large number of applications that resulted from an aggressive media campaign to enroll low-income parents, and there was a sharp drop in applications of all types submitted and processed (Trenholm, Lavin and Wooldridge, 2006).

Economic downturns present a major threat to enrollment. Difficult economic times can elevate the importance of Medicaid and CHIP for retaining coverage of children, as employers shed jobs and families lose access to employer-based coverage. Nevertheless, faced with declining budgets, states often cut back on services and take steps to discourage enrollment. During the CKF program, the economic problems of late 2001 through 2002 led to cutbacks in outreach (e.g., California and Colorado) as well as to freezes in enrollment (e.g., Colorado and North Carolina). They also led to reduced eligibility periods (e.g., in Washington, which reduced the period of continuous eligibility from 12 months to six months) (Hoag and Uzoigwe, 2008). In many states, these policy changes and spending reductions affected enrollment. Cuts in outreach (e.g., California), reversals of simplification procedures (e.g., Kentucky), and enrollment caps (e.g., North Carolina) were all linked to slowed enrollment.

A brief study of enrollment caps in seven separate CHIPs during the period 2001 to 2003 showed that the caps were introduced because of difficult economic conditions in the states, had an immediate chilling effect on overall enrollment, and saved the states money (although enrollment rebounded after the caps were removed). State officials preferred enrollment caps to reversing simplified enrollment or reducing benefits (Hill, Courtot and Sullivan, 2007).

Access to Care Did Not Influence Enrollment

Despite the beliefs of some CKI grantees, access did not appear to influence the likelihood that families would enroll their children.

Low-income parents value health insurance coverage and have reasonable access to care for their children. Confirming many previous studies, parents in focus groups who had enrolled their children in public coverage were positive about their access to primary care but parents of uninsured children were less positive about their access to primary care. Moreover, for both groups, access to dentists and specialists was more problematic and Spanish-speaking families had the most access barriers, due to language difficulties and perceived discrimination. Parents of both insured and uninsured children placed a high value on health insurance coverage, so even when they had problems accessing care, very few said that this discouraged them from enrolling their children in Medicaid or CHIP, or from renewing their children's public coverage (Hill et al., 2006).

The relationship between access and enrollment was explored further during interviews with parents of children eligible for Medicaid or CHIP in four states. These interviews confirmed the findings of the focus groups. Most parents wanted and appreciated the medical and financial security that Medicaid and CHIP offer. Access to primary care—and even dental and specialty care—was good for children enrolled in CHIP and Medicaid, but Spanish-speaking families continued to have problems accessing care (and enrolling in CHIP and Medicaid).

Persistent parents overcame enrollment barriers because they valued access. Parents were also asked about barriers to enrollment. Some parents, especially those whose children have health problems, found it simple to keep their children covered. Persistence in the face of administrative obstacles seemed to explain why some parents succeeded in enrolling their children and others did not. Even though all the parents interviewed lived in states that had eliminated face-to-face interviews and had joint applications (if a separate CHIP)—parents still faced barriers such as having to make a face-to-face appointment or drop in and wait after a mailed-in application was lost or a case worker did not return phone calls. In the two states with separate CHIP programs,

some parents reported that their children lost Medicaid coverage and became uninsured rather than being transferred to CHIP when they reached an age at which income level affected eligibility. Most parents of uninsured children in these two states were not aware of CHIP. These stories, drawn from a few cases, illustrate that simplification is not complete when policies and procedures change formally; it is complete when an effective statewide process has been implemented (Duchon, Ormond and Pelletier, 2009).

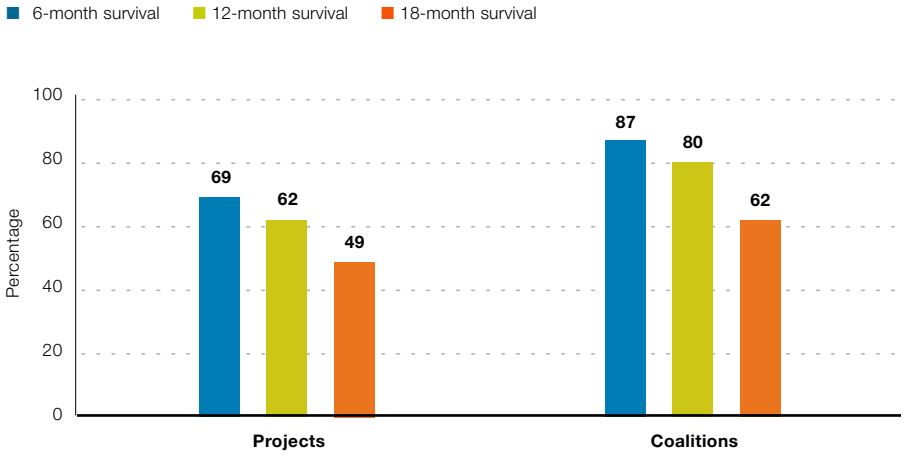
Local community groups can improve access. The approaches of the 18 local CKF sites with Access Initiative grants to improving access included preparing clear educational materials for families, providers and pharmacies to help children receive prescribed medications; preparing materials and doing cultural competency training for providers of prenatal care to pregnant immigrants; developing a community health worker program that offered culturally appropriate services to recent immigrant families to help them select health plans and communicate with their providers; developing an interpreter network that provided translation to families with limited English proficiency to help them receive high-quality primary care; and introducing an emergency department coordination program to reduce rates of inappropriate use of emergency department care and to help families get a primary medical care provider. The most successful grantees were those most experienced in community-based advocacy; those that assessed needs thoroughly (which sometimes yielded different needs than grantees expected); and those whose approaches to improving access were focused narrowly (Hill, Courtot and Palmer, 2008).

CKF Continued in Many States Two Years After Funding Ended

Funders always hope that programs will continue after they stop supporting them directly. In the case of the CKF program, RWJF designed the program to encourage its continuance after the funding stopped—including requiring each grantee to build a coalition that included state staff and to match their grant funds and start using the match halfway through their grant periods. This design appears to have paid off; in many states, CKF activities continued after funding ended. Although survival dropped over time, 18 months after grant funding ended, the survival rate was just over half of CKF grantees and just under two-thirds of their coalitions (see Figure 5) (Hoag and Stevens, 2008).

FIGURE 5

Survival Rates After Grant Funding Ended



Source: Survey of CKF Project Directors and Coalition Leaders, 2007, and follow-up calls, 2008

Note: For 6- and 12-month survival, the percentages are out of 45 projects and coalitions, because all projects finished at least 12 months prior to our May 2008 calls. The 18-month survival percentages are out of 37 projects and coalitions, because only 37 projects and coalitions had completed their grants at least 18 months prior to the May 2008 calls.

The pathways to CKF's sustainability included locating substitute funding, developing coalition member support and incorporating CKF activities into the operations of other organizations. The insistence of the Foundation on cost sharing may have contributed to the program's survival after funding ended. Half of the grant projects that survived six months had found new funding, including support from coalition members, and in 10 states, from the state Medicaid and CHIP agencies (this dropped to six states by mid-2008). Without the development of strong relationships and mutual respect between states and CKF projects, such support would have been unthinkable. Although half of the projects that survived 18 months remained organized as they had been during the grant funding, the other half had been absorbed by host agencies, transferred to other agencies, or split up so that CKF activities had been adopted by several agencies. One formed a new nonprofit organization.

Many coalitions survived intact, though others modified their mission in order to survive. Two-thirds of the coalitions that survived six months continued in the same way that they had during the grant funding. But by mid-2008, only half of survivors continued in the same way and the rest had modified their missions or merged with other coalitions.

CKF's legacy is to have increased community capacity to address problems of the uninsured. CKF has left a legacy of people who know a lot about advocating for insurance coverage for children and families and making enrollment easier. During CKF, many grantee staff (including local sites) developed new advocacy and coalition-building skills and became more knowledgeable about Medicaid and CHIP. Although many CKF staff moved on to other organizations after CKF funding ended, most continue to work on coverage improvements either through their employment or by participating in a topically related coalition. This increased capacity around insurance coverage issues continues to be available in the states. Table 4 shows the percentage of former CKF employees who still focus on coverage advocacy outside of their paid positions (Stevens and Hoag, 2009).

TABLE 4

Post-CKF Activities of Former Employees Focused on Insurance Coverage

(N = 50)

Type of Activity	Percentage of Former Employees
Volunteer work	35
Reading policy papers, attending meetings	50
Participation in coalitions	66
Work-related contact with former colleagues	72

Source: MPR telephone interviews with former CKF employees, August to September 2007
Only former employees who were currently employed were asked these questions.

Discussion

The introduction of SCHIP (later called CHIP) to cover uninsured low-income children created an opportunity for advocates of increased health insurance coverage to increase the number of publicly insured children and families. RWJF aimed to achieve such an increase through a community development approach implemented nationwide. Their vision was achieved in large part. State and local grantees built coalitions that brought stakeholders together to reach out to families and encouraged them to enroll their eligible children. State grantees included state CHIP and Medicaid officials in their coalitions and worked with them to simplify enrollment and coordinate CHIP and Medicaid coverage so that families would find it easier to enroll their children, and children would be transferred smoothly between programs if their eligibility changed. The local pilot sites shared information about barriers to coverage with their coalition members—including state and local officials. State officials documented numerous instances of the CKF programs having a sustained effect on CHIP and Medicaid program processes and policies. In many states there were improvements in relationships between state officials and other CKF coalition members as they cooperated on problem solving. Furthermore, grantees raised funds to sustain their efforts to increase coverage after grant funding ended, and many grantees across the country were able to continue their support for coverage.

States faced major economic challenges during the period that had important spillover into the activities of the grantees. The economic slowdown that began in 2001 and continued through 2002 resulted in some states spending less on CHIP and Medicaid, particularly spending less on outreach but also freezing CHIP enrollment and introducing other program limitations to save money. Some states had pronounced changes in policy direction as a result of new administrations. In some states new champions for coverage for low-income children came into office, in others new administrations opposed the broad coverage offered by their CHIP and the resulting retrenchments caused previously generous programs to become less so. Such changes challenged CKF grantees, requiring them to refocus their resources on new areas of need. For example, in Colorado, the grantee had initially focused most of its efforts on outreach, but in 2003 the state froze CHIP enrollment and terminated Medicaid and CHIP outreach. The Colorado grantee and coalition quickly changed their focus to retention of current enrollees, along with monitoring the effects of the policy changes. Conversely, when the state budget and legislative environment were more conducive to public insurance expansion in Colorado, as in the 2005 legislative session when eligibility was expanded and the Medicaid and CHIP outreach budget was restored, CKF activities shifted to advocacy for increased income eligibility levels and outreach to those newly eligible (Uzoigwe and Hoag, 2008).

Enrollment gains were most evident when several common factors were present: sustained (particularly school-based) outreach, strong champions for children's coverage and strong economic conditions. Centralized eligibility processes also improved enrollment rates relative to localized processes. When economic conditions were bad, the presence of some of these conditions (such as a strong champion for children's coverage) appeared to limit reductions in enrollment. In sum, CKF programs that worked closely with their states on outreach and simplified processes appear to have had a role in enrollment increases. A number of state officials went out of their way to single out the role of CKF programs in enhancing simplification and mitigating program cutbacks, suggesting that CKF was in fact an important player in maintaining and increasing children's coverage–in at least some states.

Since the CKF program funding ended, CHIP and Medicaid programs have continued to evolve. In fact, by 2008, all but three states had abandoned the requirement for face-to-face interviews (Ross and Horn, 2008)–one of the changes CKF promoted vigorously. CKF analyses, however, showed that many families continue to have face-to-face interviews before they get their children enrolled after mail-in and other approaches fail. The CKF program and its evaluation have illustrated challenges families face enrolling their children, approaches for improving enrollment and retention processes and eligibility processing (including the possibility of culture change at the level of eligibility front-line workers), and the value of advocacy groups cooperating with state and local officials to promote information gathering and problem solving.

At the start of 2010, economic conditions have deteriorated and the future of comprehensive insurance coverage is uncertain. The CKF program suggests several lessons for advocates of increased coverage–regardless of whether comprehensive coverage is passed. Simple approaches to enrollment–not just in principle, but also in fact–help working families enroll their children. Using centralized eligibility processes to avoid local variation in the way eligibility is assessed appears to be a promising approach for increasing enrollment. Outreach that reaches the target population–such as school-based outreach for children–appears to be a promising way to maximize enrollment. CKF-style coalitions that communicate with those charged with implementing insurance coverage are an effective way of ensuring that barriers to enrollment are identified quickly.

RWJF has built on the CKF findings to design a new program–*Maximizing Enrollment for Kids*–which will quantify the effects of policies and procedures that show promise for increasing enrollment, such as those described in this report.

Endnotes

1. Sixteen of the 46 grantees also received "family" grants to target parents' coverage. Another five states received limited "liaison" grants that funded them to attend grantee meetings and meet with their peers in other states.

2. The call for proposals stated that CKF was to build "lasting capacity in states and communities to continue progress toward the initiative's objectives even after the funding period."

3. All the findings are available at the RWJF Web site, *www.rwjf.org/pr/product.jsp?id=20929*.

4. The 10 case study states are: Arkansas, California, Illinois, Kentucky, Michigan, Missouri, New Jersey, North Carolina, Oregon and Virginia. They were selected for wide geographic representation and for the availability of good Medicaid Statistical Information System data on Medicaid and CHIP for the period from 1999 to 2005.

5. This paper summarizes some of the important conclusions from stakeholder interviews. A later, more formal analysis of the eligibility data offered further validation of several of the policies identified as important from these interviews. Notable among them are the elimination of face-to-face interviewing, the centralization of eligibility procedures, and the adoption of self-declaration of income for both program application and renewal (Trenholm and Zutshi, 2009).

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