COVERING KIDS AND FAMILIES EVALUATION

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

Final Report

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I. INTRODUCTION

Covering Kids and Families (CKF) is a national initiative, funded by the Robert Wood Johnson Foundation (RWJF), that works through state and local coalitions to increase enrollment in public health insurance for low-income children and adults who are otherwise uninsured. The program's strategies are to (1) conduct outreach to children and families without coverage, (2) simplify enrollment and renewal processes, and (3) coordinate existing health care coverage programs. Mathematica Policy Research, Inc. and its subcontractors, the Urban Institute and Health Management Associates, are evaluating the CKF program.

This case study explains the trends in new Medicaid and SCHIP enrollment in Virginia from 1999 through 2003. In particular, we are interested in examining the potential links between new enrollment trends and major outreach strategies or policy changes that took place in Virginia at the state and local level, especially those associated with the CKF grant. Ideally, we would examine such links through a more formal impacts analysis that estimates the effect of individual policy changes or outreach efforts on the number of children enrolling in Medicaid or SCHIP. This type of analysis is not possible, however, because many of the outreach efforts and policy changes occurred at the same time. In addition, no state or other geographic area is a defensible comparison group for a more rigorous analysis. The case study approach, which combines exploratory data analysis with in-depth key informant interviews, allows us to assess the potential influence that major outreach efforts or policy changes have had on new enrollments.

The main source for the study is child-level enrollment data from the Medicaid Statistical Information System, which we obtained from the Centers for Medicare & Medicaid Services. Using these data, we developed a measure indicating the number of new entries in Medicaid or SCHIP during each month of this period. Our definition of a new entry is any child who is newly enrolling in one of these programs and who has not been enrolled in either of them in the

past 12 months. (Thus, it excludes any child who is transferring between these programs or reentering one of them after a short time.) We focus on this measure, rather than on a count of all new enrollees or of overall enrollees, because we expect new entries to be more sensitive to major outreach efforts or policy changes associated with new enrollment.[1]

With these data, the evaluation team assembled a timeline showing the number of new entries in Medicaid and SCHIP for Virginia from October 1999 through September 2003. This period covers nearly the entire period of RWJF's original Covering Kids (CK) grant to the state (awarded in mid-1999) and the first 15 months of the subsequent CKF grant (awarded in July 2002). We also assembled a similar timeline for each local project and for each county the projects served.

In April 2005, we discussed these data in detailed interviews conducted with the state CKF grantee, state officials, selected local projects, and other key stakeholders. During these interviews, we asked informants to identify the key changes taking place in state and local policies and outreach practices and whether and how these might account for the trends seen in new entries. Other sources provided additional insights. These sources included an earlier site visit to Virginia conducted in May 2003, the CKF Online Reporting System, program documents, and demographic and economic data from the Bureau of Census and from the Bureau of Labor Statistics.

[1] In addition, within the Medicaid program, we focus on new-entry children whose program eligibility is based on income (either in the poverty expansion eligibility group or one of the eligible groups related to Temporary Assistance for Needy Families). Outreach efforts and enrollment simplification policies are more likely to affect these children than those enrolled for other reasons, such as disability or foster care status.

II. STATE POLICY CONTEXT

From 1998 through 2003, Virginia made many changes in its public health insurance programs for children (Table 1). Effective October 1998, Virginia's first SCHIP program—the Children's Medical Security Insurance Plan (CMSIP)—was implemented as a separate Medicaid "look-alike" program that covered children up to 185 percent of the federal poverty level (FPL). CMSIP was developed and implemented under the administration of Governor James Gilmore, who, according to those we interviewed, had little enthusiasm for implementing what he viewed as another "welfare program." CMSIP provided a full Medicaid benefit package at no cost to families and used a common application with Medicaid, which local offices of the Virginia Department of Social Services (DSS) processed. Unlike Medicaid, however, the program (1) required a 12-month waiting period for the previously insured (with no exceptions), (2) required parents to cooperate with child support enforcement authorities as a condition of eligibility, and (3) was not an entitlement for children meeting the eligibility standards.

Several problems—lackluster enrollment, the failure of Virginia to use its full SCHIP allocation, and reported difficulty with the CMSIP application process—led advocacy groups to pressure the legislature and the governor to reduce enrollment barriers in CMSIP and encourage more uninsured children to enroll. The Gilmore Administration, with the support of the legislature, responded by replacing CMSIP with a new program—Family Access to Medical Insurance Security (FAMIS). Implemented in August 2001, FAMIS is a stand-alone SCHIP program modeled on the state employee plan and designed to resemble private insurance. This major revision to SCHIP incorporated many program changes that could affect children's enrollment, including (1) a shorter waiting period of six months, (2) eliminating the child support enforcement requirement, and (3) accepting FAMIS applications at a Central Processing Unit (CPU) rather than at DSS offices.

TABLE 1

KEY RECENT EVENTS IN CHILD HEALTH COVERAGE IN VIRGINIA
(1998–2003)

January 1998	Governor James Gilmore takes office.
June 1998	Virginia obtains approval to operate its SCHIP program—the Children's Medical Security Insurance Plan (CMSIP)—as a separate "Medicaid look-alike." Features include: -- Income eligibility to 185% of the federal poverty level (FPL) -- 12-month waiting period -- Joint application with Medicaid -- Eligibility determined by Virginia Department of Social Services (DSS)
October 1998	CMSIP implemented.
July 1999–June 2002	Robert Wood Johnson Foundation's (RWJF's) Covering Kids Initiative. Virginia DSS is lead agency for the state coalition. Three local pilot projects are located in Richmond, Norfolk, and Nelson and Elmhurst Counties.
October 1999–present	Sign Up Now program provides enrollment training and technical assistance.
November 1999–present	Project Connect grants are located in selected counties around the state, initially funded by Virginia Health Care Foundation (VHCF) and later by state.
August 2001	CMSIP program changed to Family Access to Medical Insurance Security (FAMIS), modeled on the state employee plan. Features include: -- CMSIP children grandfathered into FAMIS -- Eligibility expanded to 200% FPL with no disregards -- Waiting period reduced to 6 months -- Certain benefits limited -- Small premium instituted, although not enforced -- Eligibility determination shifted to Central Processing Unit (CPU) -- Child support enforcement requirement suspended -- State-funded outreach campaign initiated
January 2002	Governor Mark Warner takes office.
April 2002	Premium collection suspended.
July 2002–June 2006	RWJF's Covering Kids and Families (CKF) Initiative. VHCF is lead agency for the state coalition. Two local pilot projects are located in Charlottesville and Hampton Roads.
September 2002	SCHIP Medicaid expansion created for income eligibility to 133% FPL. Single Medicaid and SCHIP (FAMIS) application established. "No Wrong Door" policy allows application processing at DSS or CPU.
July 2003	Radford University CKF local project begins.
September 2003	Medicaid for children renamed "FAMIS Plus." Waiting period reduced to 4 months. 12-month continuous coverage for FAMIS.

Although FAMIS was regarded as an improvement over CMSIP among those we interviewed, the creation of separate Medicaid and SCHIP programs led to new enrollment challenges for some eligible families. A report that Virginia's Joint Legislative Audit and Review Commission (JLARC) issued in December 2001 documented difficulties that this system caused. Key among them were having a separate application for FAMIS and mixed program eligibility for some families.[2] The JLARC recommended that a single Medicaid eligibility level be established for children of all ages at 133 percent of the federal poverty level (FPL) to eliminate the confusion for families that otherwise would have children enrolled in both Medicaid and FAMIS.

In January 2002, Governor Mark Warner took office after a campaign that pledged to increase enrollment of uninsured children eligible for Medicaid or FAMIS. Governor Warner had a long-standing interest in children's access to health care. In 1992, he was instrumental in founding the Virginia Health Care Foundation (VHCF), which became the state CKF grantee in July 2002. The foundation had advocated for reform of CMSIP and, later, for reducing barriers to enrollment in the FAMIS and Medicaid programs. Governor Warner brought many people into his administration who had supported these efforts, among whom were the Secretary of Health and Human Resources, and the directors of Medicaid and FAMIS.

The Warner Administration immediately pursued Medicaid and FAMIS program modifications designed to simplify the application process and improve coordination between the two programs. In April 2002, the collection of FAMIS premiums was suspended. Further modifications, made in September 2002, included:

[2] For families with incomes between 100 and 133 percent of poverty, children under age 6 were eligible for Medicaid, while children age 6 and older were eligible for FAMIS.

- Adopting a SCHIP Medicaid expansion, with uniform income eligibility standard for all children up to 133 percent of the FPL
- Restoring a common application form for children's Medicaid and FAMIS, reducing application verification requirements, and adding an affordability exception to the FAMIS waiting period
- Adopting a "No Wrong Door" approach, which allowed children's Medicaid and FAMIS applications to be submitted either to a local DSS office or to the CPU

In September 2003, to improve enrollment, further changes (although not as sweeping as those made in 2002) were made to the Medicaid and FAMIS programs. The FAMIS waiting period was reduced to four months, and Medicaid coverage for medically indigent children was renamed "FAMIS Plus" to help outreach and marketing efforts. In addition, 12-month continuous coverage was established for FAMIS (but not for Medicaid).

III. HISTORY OF THE COVERING KIDS (CK)/CKF PROGRAM IN VIRGINIA

In late 1998, the VHCF and other advocacy groups began work on an application to RWJF for funding under the CK program. Initially, the Gilmore Administration was nominally supportive.[3] Shortly before the application deadline, however, it decided to apply directly as the grantee (requesting, and receiving, an application extension). The Virginia DSS became the state grantee. The three local projects the CK grant funded were a faith-based coalition (Hampton Roads), a rural health outreach project (Nelson and Amhurst Counties), and a project in Richmond City based at a community health center. According to those we interviewed, the three local projects made only modest progress in outreach, simplification, and coordination. Indeed, two of the three local projects ended before the CK grant expired.

In 1999, after being excluded from the CKF application process, the VHCF established two enrollment projects: (1) "Sign Up Now," a program that provides training and technical

[3]Like the later CKF grant, the CK grant required that the state government endorse any application for funding.

assistance at the local level on how to enroll children in SCHIP; and (2) "Project Connect," a program that originally provided 18-month grants to 12 local organizations to fund the hiring and training of outreach workers.[4] These outreach projects were intended to make enrollment easier and to document enrollment barriers to aid future advocacy efforts.

In early 2002, just as Governor Warner was taking office and with his strong support, the VHCF applied as the lead agency for the CKF grant. RWJF awarded the foundation a $900,000 four-year CKF grant that began in July 2002, when Virginia was in the midst of the major overhaul of its public health insurance programs for children. Half of the grant was allocated for state-level activities and half for three local projects, of which the following two are included in this case study:[5]

- United Way-Thomas Jefferson Area Insurance for Children Project, providing school-based, employer, and provider outreach in Albemarle, Fluvanna, Greene, Louisa, and Orange counties and the city of Charlottesville
- Consortium for Infant and Child Health (CINCH), providing school, child care, and faith-based outreach in seven cities in the Hampton Roads area (Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Suffolk, and Virginia Beach).

In addition to CKF funding, Project Connect funds have supported the Charlottesville and Hampton Roads projects since 1999 and 2003, respectively. The projects also receive some limited local funding for outreach and enrollment activities similar to those funded by CKF.

The CKF state and local programs in Virginia have enjoyed strong, consistent leadership at the coalition and staff levels. Until a recent change in directorship, the state grant was led by the

[4] Currently, Sign Up Now is funded by CKF grant funds (to the state grantee), along with private contributions and state SCHIP outreach funds. Project Connect grantees are funded by state SCHIP outreach funds.

[5] The Radford CKF project did not begin operating as a CKF local project until July 2003 because it had existing funding for activities similar to those that would later be funded under CKF. Consequently, due to timing, post-CKF enrollment data for Radford are not available.

same director and had kept much of its original staff. The local projects have also maintained consistent leadership throughout the grant, although there has been some limited turnover in operational staff.

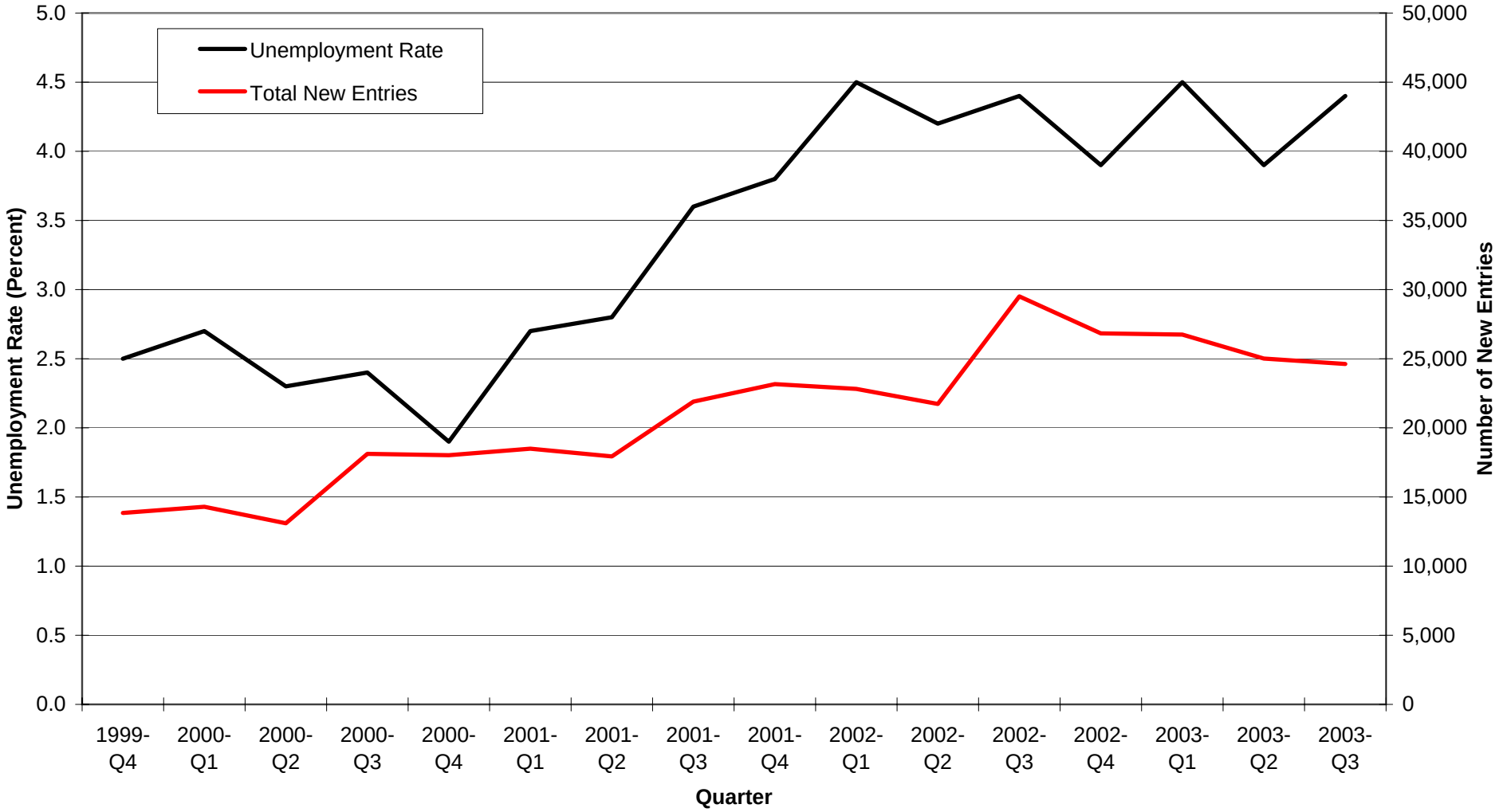
IV. STATE-LEVEL FINDINGS

Economic Trends. The economy has a major influence on public health insurance enrollment. Typically, as the economy worsens, more families depend on public coverage for their children. Virginia's unemployment rate, which had been below two percent, began rising in early 2001, a trend that continued until early 2002, when it leveled off at more than four percent (Figure 1). This rise in the unemployment rate coincided with a growth in the number of new entries to public health insurance programs (Medicaid and SCHIP)—also shown in the figure. However, the largest increases in the two did not always coincide. In particular, the biggest growth in public programs was confined to the third quarters of 2000, 2001 and 2002. Therefore, although the growth in enrollment in Medicaid and SCHIP is highly correlated with the economic trends, there are also other explanations for the growth, which appear to be linked to policy changes and outreach.

Links Between Enrollment and Major Policy Changes. The major overhaul of the SCHIP program in Virginia (summarized in Table 1) is closely associated with the sustained rise in enrollment in fall 2001. With FAMIS replacing CMSIP in August 2001, the state addressed two major enrollment barriers by halving the 12-month waiting period and eliminating child support requirements. In addition, in response to FAMIS implementation, outreach (both state- and foundation-funded) intensified, raising awareness across the state of the remodeled SCHIP program. Finally, the use of a CPU instead of the DSS for FAMIS applications destigmatized the FAMIS application process.

Figure 1

Unemployment Rate and Total New Entries to Public Health Coverage
Virginia: October 1999 - September 2003



Source: Bureau of Labor Statistics and Medicaid Statistical Information System data.
Note: New entries are children enrolling in Medicaid or SCHIP for the first time in the past 12 months.

Trends by program type strongly suggest that these changes are responsible for some of the increase in new entries in 2001 (Figure 2). In the second half of 2001, the number of new entries in SCHIP (yellow line) climbed dramatically—from 2,500 children per quarter to more than 5,000—and remained at this level for the next two years. During this time, the Medicaid program (blue line) also had a substantial increase in the number of new entries.

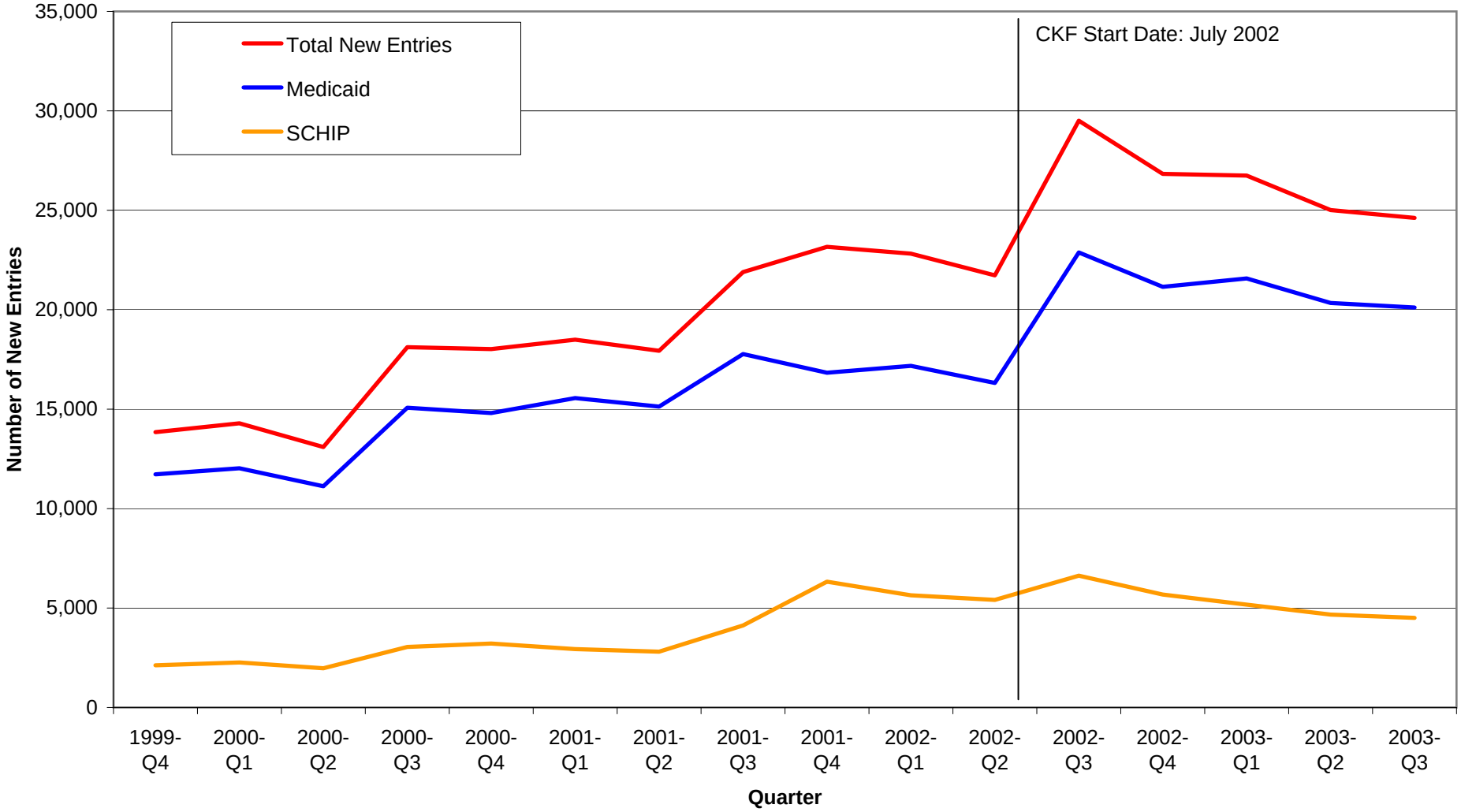
Policy changes also appear to have been the driving factor behind the large enrollment gains in fall 2002. In contrast to 2001, the increase is most closely linked to Medicaid enrollment gains (Figure 2). During this third quarter, the number of new entries in Medicaid rose from about 16,000 to about 23,000. Although this number dropped slightly in later quarters, it remained above 20,000 for the rest of the observation period (through third quarter 2003). SCHIP also displayed an increase in new entries in the third quarter of 2002, but it was relatively small and not sustained, as it was for Medicaid.

Although this increase in Medicaid enrollment coincides closely with the awarding of the CKF grant in July 2002, it seems unlikely that the grant could have had a large impact in such a short time. (For example, the staff for the CKF state program were not hired until fall 2002.) Instead, it appears related to policy changes around this time, most notably the adoption of the No Wrong Door policy, which took place in September 2002.[6] With this policy, families could complete a joint application for FAMIS and Medicaid, and submit it either to the local DSS or to the CPU (which previously had processed only FAMIS applications). Many families with children eligible for Medicaid may have previously been unwilling to apply for coverage at the DSS or had difficulty with the process. In addition, with the adoption of the No Wrong Door

[6] The large increase in new enrollments in the third quarter of 2002 may overstate the impact of the policy change. At this time, the state finished cleaning out a backlog in its CPU, which led to delays in processing many applications. The processing of these backlogged applications explains a portion of the rise in third-quarter enrollment.

Figure 2

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



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

policy, the Medicaid program was for the first time linked to FAMIS, a program that did not have the stigma often associated with Medicaid.

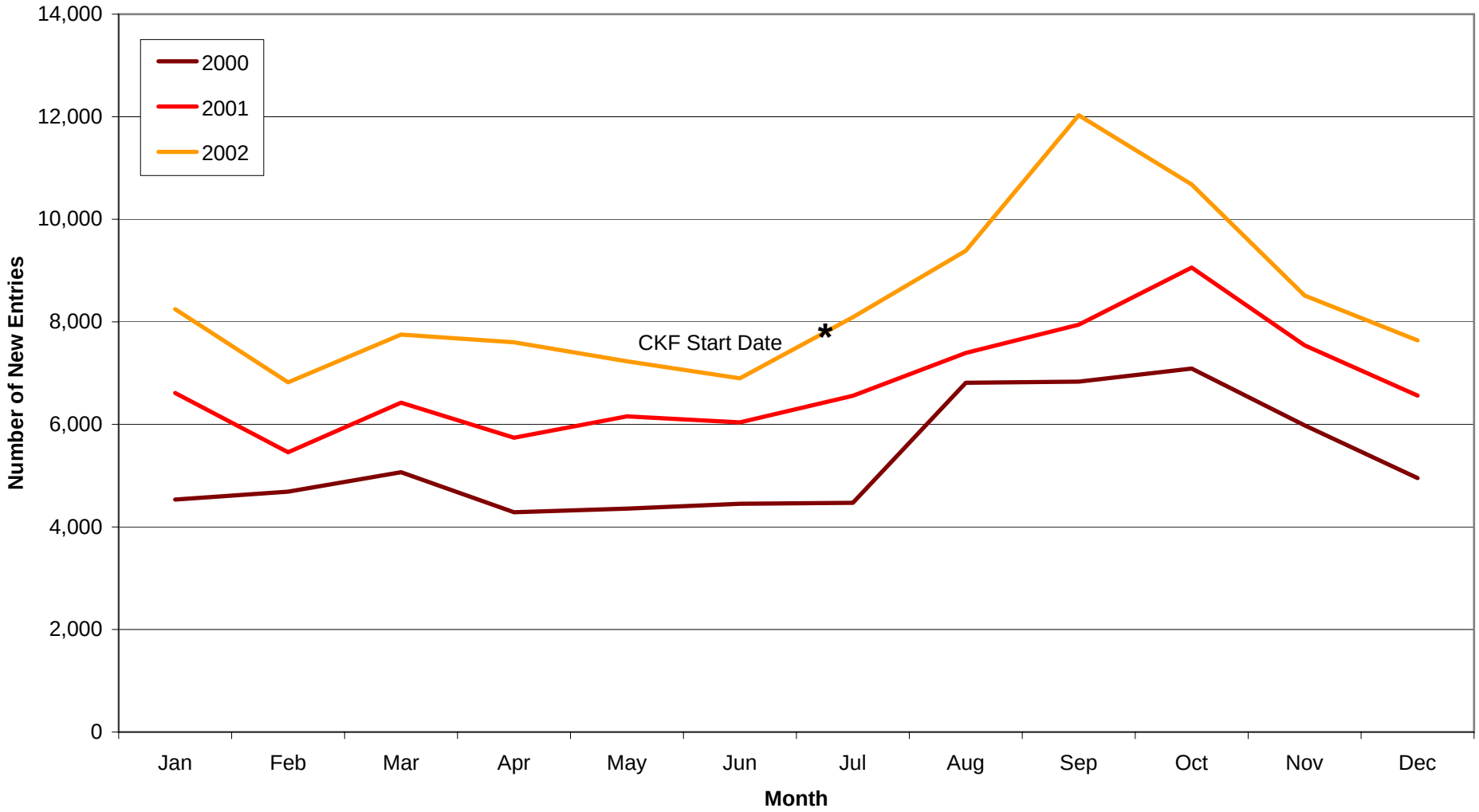
Links Between Enrollment and Back-to-School. Some of the major policy changes described above (those in 2001 and 2002) coincide closely to the Back-to-School outreach efforts that began in Virginia in fall 2000 and that have been important at the state and local level each fall since then. Many of the Back-to-School outreach efforts across the state were funded by RWJF, through CK and CKF grants, and had technical assistance from GMMB, the RWJF-funded media consultants for Back-to-School. Because the timing of the implementation of large policy changes in 2001 and 2002 coincides so closely with the timing of Back-to-School, it is not possible to disentangle the effects of each. Nevertheless, trends in new entries on a monthly basis in 2000, 2001, and 2002 show a strong seasonal trend that corresponds very closely to the Back-to-School period (Figure 3). Thus, while we cannot establish an unambiguous link between RWJF-funded Back-to-School outreach activities and enrollment gains in Virginia, our data are entirely consistent with this link.

V. LOCAL-AREA FINDINGS

The Virginia case study focuses on two of the three Virginia CKF local projects: (1) the United Way-sponsored program that serves five counties and the city of Charlottesville, and (2) the CINCH program in the Hampton Roads region sponsored by a preexisting local child health coalition. We also studied a third project—the Partnership for Healthier Kids (PHK). This project is in a local area with relatively high enrollment growth, but it did not receive CKF funding. It is a local outreach initiative sponsored by INOVA Health System that has served Fairfax County in northern Virginia since 1998. Its goals are similar to those of the local CKF projects, although it has more resources (as described below).

Figure 3

New Entries to Public Health Coverage, by Month
Virginia: 2000 - 2002



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

Links Between Enrollment and Local Projects. In each of the three local areas, the trend in new Medicaid and SCHIP enrollment displays the same upward slope seen at the state level (Figure 4). In addition, the largest gains in enrollment coincide with the periods outlined above for the entire state. For example, each of the local areas showed a major gain in enrollment during fall 2002, shortly after the Warner Administration implemented its No Wrong Door policy. This suggests that state policy changes had a strong impact on each of the local areas the three programs served.

To explore the possibility that local outreach activities related to the two CKF projects and the third (non-CKF) project may have an effect on the number of children enrolling in public coverage, we compared the enrollment trends in each of the three local areas with the trends we would have expected based on those in other parts of the state.[7] To the extent that the actual enrollment in these areas exceeded our expectations, it suggests that local outreach activities were relatively more successful than outreach activities elsewhere in the state.

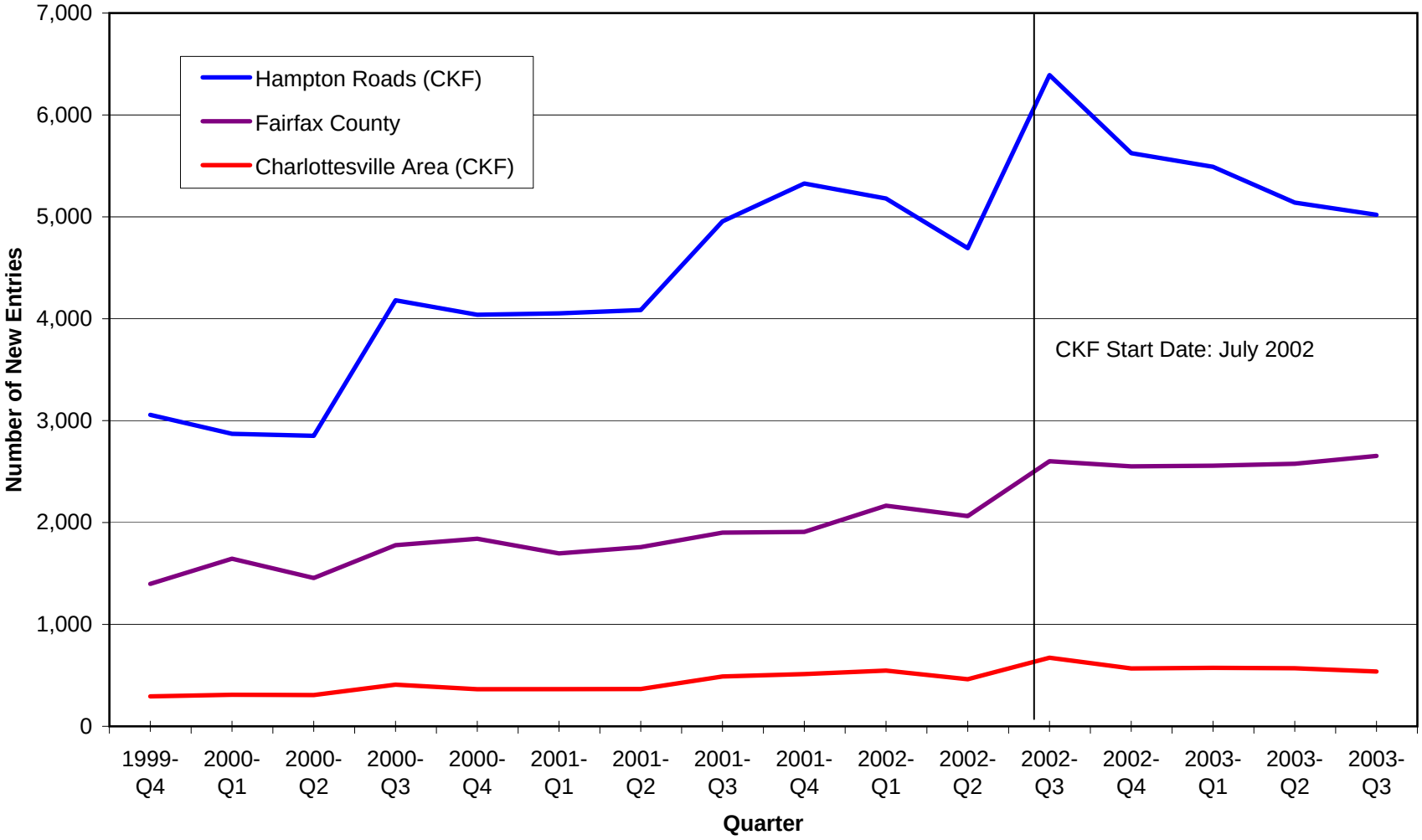
Findings for the two local areas the CKF grantees served—Charlottesville and Hampton Roads—show little difference between actual enrollment and expected enrollment (Figure 5; upper two panels). Both before and after the CKF grant award, the two trend lines in the two areas are very similar. This does not necessarily mean that CKF programs were ineffective at increasing enrollment in Medicaid and SCHIP, but rather that the CKF local projects were about as effective at enrolling children as were outreach efforts in other parts of the state.

In contrast, the Fairfax County area program (the non-CKF program that we studied) has an enrollment trend generally above the level expected (Figure 5; lower panel). This difference is

[7] Expected enrollment is based on a forecasting model that predicts, for each county and city in the state, the number of children enrolling in Medicaid or SCHIP in each quarter. Inputs to the model include (1) the number of children below 200 percent of the FPL, (2) the population that has just moved into the county from out of state, and (3) the local unemployment rate.

Figure 4

Total New Entries to Public Health Coverage
Local Projects: October 1999 - September 2003

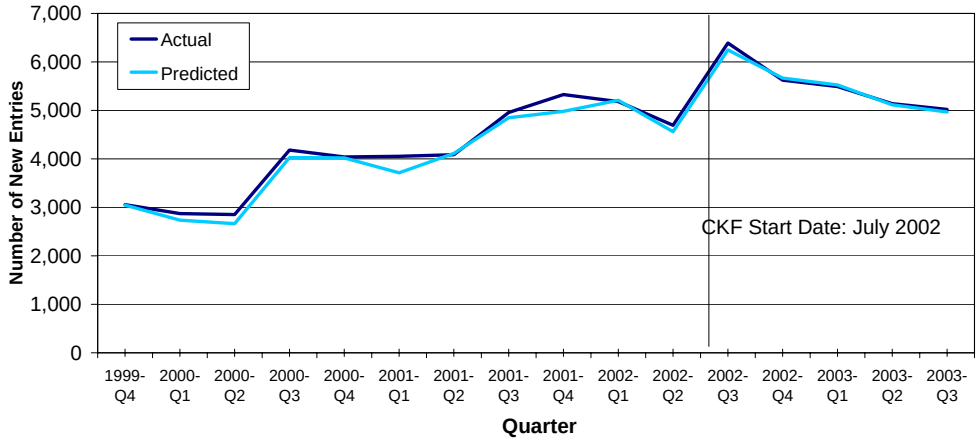


Source: Medicaid Statistical Information System.
Note: New entries are children enrolling in Medicaid or SCHIP for the first time in the past 12 months.

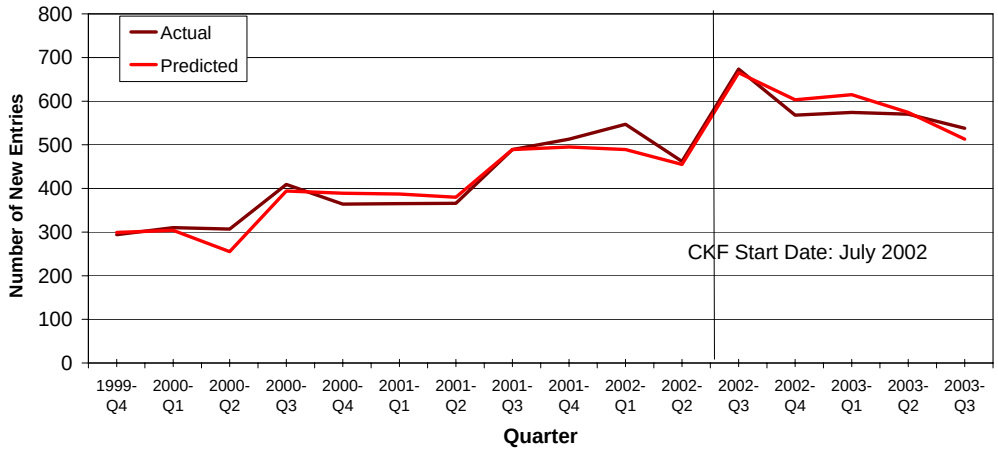
Figure 5

New Entries to Public Health Coverage
Local Areas: Actual versus Predicted
October 1999 - September 2003

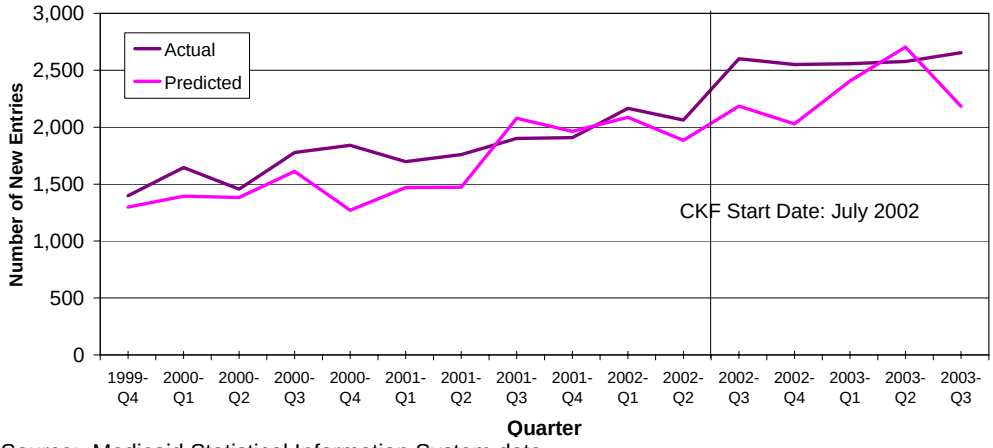
Hampton Roads Consortium for Infant and Child Health



Charlottesville Area United Way



Fairfax County



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

particularly large toward the end of 2000 and the end of 2002. For example, in the last quarter of 2002, the number of new entries to Medicaid or FAMIS totaled just over 2,500, compared to an expected count of only 2,000, a difference of 500 children, or 25 percent.

Differences Among Local Projects. In light of these findings, we sought to understand how the three local projects differed and whether the differences could explain the results in Figure 5. Interviews with the local programs suggest that there are at least two key differences—one associated with the outreach approach taken, the second with the level of resources applied to outreach efforts.

The Charlottesville project, with funding beginning in 1999 (from Project Connect), has maintained a consistent school-based outreach approach, with some variation in the type and intensity of other outreach activities, such as employer and provider outreach. The Charlottesville school-based outreach approach is to develop a partnership with each school district to distribute flyers for students to take home to parents. These flyers provide information on Medicaid and FAMIS and encourage families with uninsured children to contact the grantee for more information and help in applying. The local program considers this approach effective, and it has been continued, although, because the project serves a wide geographic area, there are not enough resources to intensively work with all the schools. Employer outreach, on the other hand, has been deemphasized because it did not yield many referrals. Staff believe this is because of the stigma that employees felt when asked to sign up for public insurance at the workplace.

The Hampton Roads project (CINCH) began in mid-2002. In its first year, the project focused on partnering with area churches to identify and train volunteers interested in providing outreach and application assistance to families with uninsured children. The project later abandoned this approach because of heavy volunteer turnover, which made the partnerships

difficult to sustain. CINCH then focused on school outreach but had mixed results because of lack of support from school superintendents concerned about privacy and the misdirection of school resources. Consequently, this type of outreach has developed slowly and was not being used substantially during the period of this case study.

On the surface, the Fairfax County project (PHK) is similar to the two local CKF-funded projects. Like those projects, it emphasizes reaching families with the help of other organizations, especially local schools. The main feature that distinguishes the PHK project from the two CKF projects is the intensity of its school-based outreach, which actively involves the local schools in identifying uninsured children, referring them for coverage, and following up with them when they do not apply. (Exhibit 1 provides more detail on the specific steps the Fairfax County project follows in school outreach.) This outreach was made possible because of early support from the superintendent of Fairfax County Schools who, according to the PHK staff, "was a champion" for using the school setting as a means to enroll children into public health insurance coverage. The original program began in October 1998 with 10 schools, but it grew quickly and currently involves 201 schools.

Resources appear to be an important factor in the relative intensity of PHK's school-based outreach. School personnel do much of the initial outreach to parents on a voluntary basis; this level of school staff support is not available to the Charlottesville and Hampton Roads projects. In addition, since its start in 1998, the project has maintained roughly five full-time-equivalent (FTE) outreach staff to serve a single county. In comparison, the two CKF grantee programs have more modest resources. In Charlottesville, the project has used between 1.5 and 3 FTE outreach staff (depending on the time period) for a service area covering five counties and one

EXHIBIT 1

FAIRFAX COUNTY SCHOOL-BASED OUTREACH MODEL

The school-based outreach model of the Partnership for Healthier Kids (PHK) in Fairfax County, Virginia, is a potential model for other communities that want to develop a school-based approach.

At the heart of this strategy is the review of emergency contact forms, which parents complete when their children start school in the county. One question on the form is the name of the child's health insurance plan. A member of the school staff, called the in-school coordinator, reviews the emergency contact forms and sends a follow-up letter (from the principal, on school stationery) when no health insurance is reported. The letter asks parents for the child's insurance information, informs them of the application assistance PHK provides, and asks their consent to be contacted by the program. The returned consent forms are forwarded to the program, where the child's information is entered into a tracking database. The program then contacts the family by telephone. During this contact, the outreach workers screen for eligibility and provide application assistance. Later, they follow up with families to make sure the application has been submitted. This followup occurs every two weeks for up to six months. PHK gives the school a list of all the children identified for outreach and the status of their applications so that the in-school coordinator can contact families who have not completed the application process.

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 or SCHIP in the county.

The critical factors in the success of this approach to school-based outreach are:

- Strong, consistent leadership from the superintendent of the school system
- A large amount of effort by school personnel, above and beyond the efforts of the outreach staff
- Intensive followup with families by outreach staff in partnership with school staff, helped by an automated tracking system

city. In Hampton Roads, the program has five FTE outreach workers, but they are allocated across a large region that includes seven cities and a large, mobile population.

Finally, the PHK project is embedded in a large health care system, which provides additional in-kind support. This affiliation has allowed the PHK project to develop specialized tools, most notably an effective tracking database. Such support is a likely reason why the project could expand to many area schools (including schools in neighboring Loudoun County and Alexandria City).

Contribution of Local Projects to State Policy. In Virginia, the local projects—both those funded by the CKF grant and those with other funding, such as in Fairfax County and the Project Connect areas—play a significant role in identifying enrollment barriers and developing potential ways to overcome them. This role was perhaps most critical in the first three years of the state's SCHIP program (1999–2001), before the CKF program. During this period, a coalition led by the VHCF, the eventual CKF state grantee, worked with local programs to document cases where families either failed to complete applications or were denied approval, as well as the reasons for these events. The coalition used this information to press the governor and the legislature to make significant policy changes that reduced enrollment barriers.

This process has continued during the CKF program period. The CKF coalition is broad and includes representatives from many parts of the state, not just from local areas that receive CKF funds. Although the local projects continue to play a valuable role in the CKF efforts to affect state policy change, the major policy changes that affect children's enrollment predated the CKF funding.

VI. CONCLUSIONS

Findings from this case study indicate many important links between enrollment of children into public health insurance and changes in policies and outreach activities at the state and local

levels. While quite a few of these changes preceded the CKF grant, and are consequently not directly associated with CKF funding, they nevertheless provide strong validation of the CKF model for affecting change. Specifically, when well implemented, the CKF model includes the following key components:

- An effective coalition of diverse stakeholders—particularly, key state and local public agencies and advocacy groups—who work well together to overcome barriers to enrolling children in public insurance
- Successful efforts to implement simplification and coordination strategies that make it easy for families to enroll their children and that link Medicaid and SCHIP
- Intensive outreach to inform families of the programs available and help them enroll
- Dedicated staff in a state-level, strong organizational entity that works closely with state officials on simplification/coordination activities and coordinates statewide outreach
- Local programs that develop innovative projects that go further than the activities of the state grantee

All these components of the CKF model were developed successfully in Virginia, although they were in place well before the funding of the CKF grant.

An Effective Coalition. Before the Gilmore Administration created the first SCHIP program (CMSIP) in 1999, child health advocates in the state, including VHCF, had already formed a coalition that was effectively lobbying the legislature and pressuring the governor to reduce enrollment barriers. After CMSIP was created, the coalition began testing outreach approaches and receiving critical feedback on the difficulty families were having applying for coverage. When Governor Warner took office in 2002, the coalition made recommendations to the new administration, and many were quickly implemented.

Simplification and Coordination. Many Virginia policy changes have simplified the enrollment process for both Medicaid and SCHIP and have led to increased coordination between the two programs (Table 1). The enrollment trends presented earlier show that these

changes have increased the number of new enrollees coming into the programs. Except for the declining economy, these changes are the factors most closely associated with increased enrollment in Virginia during the period studied. For example, the largest gain in SCHIP new enrollment followed the creation of the FAMIS program and the establishment of the CPU, which simplified the SCHIP enrollment processes. Likewise, the largest gain in new enrollment in Medicaid followed the establishment of the No Wrong Door policy and the close coordination of the Medicaid and SCHIP application process.

Effective Outreach at the State and Local Levels. Since 2000, Virginia has had a coordinated program of statewide outreach ("Sign Up Now") and designated local projects (funded in a variety of ways) that have advertised the Medicaid and SCHIP programs and helped parents enroll their children. These programs, coordinated by the statewide coalition, have emphasized different outreach approaches, especially school-based outreach. The school outreach program in Fairfax County seems to have been particularly effective. Virginia emphasizes Back-to-School efforts across the state, which appear to be related to increases in enrollment in the Back-to-School fall quarter.

Strong Leadership. The state and local programs we studied all have had strong, continuous leadership. The program staff work well together and with the individuals in state government responsible for children's health insurance enrollment.

Role of CKF Funding. By the time the CKF grant was awarded in mid-2002, most of the major policy changes to improve coordination between Medicaid and SCHIP and to simplify the application process had been made. As a result, the primary role of CKF funding at the state level has been to sustain enrollment activities and to pursue less substantial improvements to the programs, such as reducing delays in processing applications.

Given that our data for this case study cover only a fraction (15 months) of the CKF grant period, we cannot fully assess the impact of more recent CKF-funded efforts. For example, the state CKF grantee has become interested in refining policies and practices affecting retention of children in Medicaid and SCHIP. In addition, since 2003, both of the local CKF projects in this case study have refined their enrollment and outreach strategies. To learn whether and how these subsequent CKF activities (after fall 2003) may have benefited children's coverage, we need more data, for a later period. Nevertheless, while this case study provides strong evidence that the CKF model is associated with increasing the number of new Medicaid and SCHIP enrollees, it does not appear, due to the unique historical circumstances in Virginia, that CKF program funding was directly associated with most of the key changes leading to those enrollment gains.

In closing, this report is the first in a series of case studies of CKF-funded programs. Information from subsequent case studies will help us understand whether findings from the Virginia case study can be generalized to other parts of the country.