COVERING KIDS AND FAMILIES EVALUATION

Case Study of Arkansas: Exploring Medicaid and SCHIP Enrollment Trends and Their Links To Policy and Practice

Final Report

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CONTENTS

TABLES

Table **Page**

FIGURES

I. INTRODUCTION

Covering Kids and Families (CKF) is a national initiative, funded by the Robert Wood Johnson Foundation (RWJF), which works through state and local coalitions to increase enrollment in public health insurance of uninsured, low-income children and adults. The program's strategies are (1) to conduct outreach to children and families without coverage, (2) to simplify enrollment and renewal processes, and (3) to 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 discusses the trends in new Medicaid and State Children's Health Insurance Program (SCHIP) enrollment of children in Arkansas from 1999 through 2003. In particular, we examine the potential links between new enrollment trends and major outreach strategies or policy changes that took place in Arkansas, especially those associated with the CKF grant. Ideally, we would examine such links through a formal impact 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 rigorous analysis. The case study approach, which combines exploratory data analysis with in-depth interviews with key informants, 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 (MSIS), which we obtained from the Centers for Medicare & Medicaid Services (CMS). Using these data, we developed a measure indicating the number of new entries in Medicaid or SCHIP during each month of the study period (1999 through 2003). Our definition of a *new entry* is any child who enrolls in one of these programs and has not been

enrolled in either of them in the past 12 months. (Thus it excludes anyone transferring between these programs or re-entering one of them after a short time.) We focus on this measure, rather than on the number of all new enrollees or the total number of 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 Arkansas from October 1999 through September 2003. This period covers nearly the entire span of RWJF's original Covering Kids (CK) grant to the state (awarded in January 1999) and the first 21 months of the subsequent CKF grant (awarded in January 2002).

In June 2005, we discussed these data in detailed interviews with the state CKF grantee and state officials. During these interviews, we asked informants to identify the key changes taking place in state and local enrollment policies and outreach practices and whether and how these might account for the trends seen in new entries. We gained additional insights from other sources, including the CKF Online Reporting System, program documents, and demographic and economic data from the Bureau of Census and from the Bureau of Labor Statistics.

II. STATE POLICY CONTEXT

Political support for children's health insurance coverage in Arkansas predates both the federal SCHIP program and the CK initiative. Lieutenant Governor Mike Huckabee assumed the office of Governor in July 1996 when Governor Guy Tucker resigned. Governor Huckabee

[1] In addition, within the Medicaid program, we focus on new entries 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.

embraced the notion of expanding coverage for children early in his tenure, and subsequent policy changes are considered part of his legacy.

Effective September 1997, Arkansas implemented ARKids First, a Section 1115 Medicaid demonstration that extended health care coverage to uninsured children up to 200 percent of the federal poverty level (FPL) (Table 1). ARKids First provided a benefits package modeled on the Arkansas State Employees and State Teachers insurance program, and it required cost sharing through nominal copays for such services as prescription drugs, office and well-child visits, and durable medical equipment. Enrollment for the expansion group, unlike for Medicaid, was simplified and streamlined with a mail-in form and enrollment assistance at various sites, such as hospitals and schools. With implementation of ARKids First, Arkansas initiated an extensive public service campaign through broadcast and print media to reduce the stigma associated with Medicaid. By characterizing Medicaid and ARKids First as health insurance rather than a welfare program, the state hoped to entice parents to enroll their children.

In October 1998, Arkansas adopted a modest SCHIP-funded Medicaid expansion program. This program extended full Medicaid coverage to a small cohort of teenage children who were at or below 100 percent of FPL and not included in federal mandatory populations.[2,3] Unlike the state's Section 1115 demonstration, the SCHIP Medicaid expansion did not require cost sharing.

In August 2000, the state adopted a series of policies designed to increase coordination between its public health insurance programs and further destigmatize Medicaid for children. The state combined its traditional Medicaid program and SCHIP Medicaid expansion program

[2] The state tried to convert a portion of its Section 1115 Medicaid demonstration to SCHIP funding but could not reach agreement with CMS, a result of concern over the state's treatment of EPSDT services in the expansion population and, later, its practice of allowing families eligible for Medicaid to choose participation in the Section 1115 demonstration, which has more restrictive benefits as well as cost-sharing requirements.

[3] The Medicaid expansion was fully phased out in September 2002, when the last eligible children aged out of the program.

TABLE 1

KEY EVENTS IN ARKANSAS' CHILD HEALTH INSURANCE HISTORY
(1996–2002)

July 1996	Governor Michael Huckabee assumes office upon resignation of Governor Guy Tucker.
1997 legislative session	Legislation establishes ARKids First for uninsured children.
Summer 1997	Federal Balanced Budget Act of 1997 creates SCHIP.
September 1997	Statewide implementation of ARKids First, a Section 1115 demonstration. Features include: • Expanded coverage to uninsured up to 200 percent of FPL • DHHS public service campaign destigmatized Medicaid for kids • Mail-in application process implemented for ARKids First
October 1998	Phase I SCHIP Medicaid is expanded to children born between 9/30/82 and 10/1/83 in families at or below 100 percent of FPL.
January 1999– December 2001	Robert Wood Johnson Foundation's Covering Kids Initiative. Arkansas Advocates for Children and Families (AACF) is the lead agency for the state coalition. Two local programs are established: • Healthy Connections (5 counties on Arkansas' western border) • Our Kids Count Coalition (7-county area of northeast Arkansas)
August 2000	ARKids First becomes umbrella program for ARKids A (comprising traditional Medicaid for children and SCHIP Phase I Medicaid expansion) and ARKids B (Section 1115 demonstration). Features include: • Joint application for both programs • Mail-in application allowed for ARKids A • Self-declaration of income and assets
August 2001	Removal of asset test requirement for ARKids A (ARKids B had no asset test). Information brochure and application are combined into application kit.
January 2002– December 2005	Robert Wood Johnson Foundation's Covering Kids and Families Initiative. AACF is again the lead agency for the state coalition. Three local program sites are added to the existing two: • Northwest Arkansas ARKids (initially comprising 3 counties) • Our Children First Coalition (8-county southwest area) • Community Health Network (3-county area around West Memphis on the mid-eastern border)
April–June 2002	AACF initiates outreach campaign with school administrators and school nurses, also develops outreach strategy with hospitals to enroll children.
October–December 2002	AACF rolls out hospital outreach strategy. Enlistment of school nurses for outreach is delayed by system issues and budget shortfall.

Source: Interviews with Arkansas officials and Covering Kids and Families state grantee.

DHHS = Department of Health and Human Services.
FPL = federal poverty level.
SCHIP = State Children's Health Insurance Program.

under the single name ARKids A and named its Section 1115 demonstration ARKids B. ARKids First became the umbrella name for all three programs, removing any link to the term *Medicaid.* In addition, the state implemented several changes to simplify enrollment. To reduce verification and paperwork requirements, it instituted, for ARKids A and ARKids B, a joint application that could be mailed in for processing and allowed self-declaration of income. The state also gave applicants a choice of either benefit package.[4]

A year later, in August 2001, the state took modest steps to simplify enrollment further: it refined the application materials and combined them with an information brochure explaining ARKids A and B eligibility and coverage, and packaged them for distribution as an "application kit." The state also removed the asset test requirement for ARKids A, placing it on equal footing with ARKids B, which never required an asset test.

In 2002 and 2003, the state faced critical funding issues, not only from the economic downturn experienced by the rest of the nation but also from a November 2002 state supreme court ruling that upheld a lower court finding that the state's school funding system was inequitable and inadequate (*Lakeview School District, No. 25 v. Huckabee* May 25, 2001). In two special sessions beginning in May 2003 and ending in 2004, the state enacted one of the largest tax increases in its history. Throughout the budget discussions, Medicaid and ARKids First were deemed a priority (after education) and thus escaped major budget cuts.

[4] When the state combined its applications, parents could check a box to apply for "ARKids A," "ARKids B," or "either program." The state contends that many Arkansas families "resist government handouts" and wish to contribute toward their children's health care. CMS objected to this practice but eventually conceded and allowed this unusual aspect of Arkansas' program with some caveats. All applications are screened to determine Medicaid eligibility. If a family is eligible for Medicaid and has applied for ARKids B, a case worker contacts the family to verify its choice. The state must provide sufficient information on the advantages and disadvantages of enrolling in ARKids B, with its more limited benefits and copays, versus the traditional Medicaid program so that applicants can make an informed choice. Further, the state must allow eligible ARKids B enrollees to switch to ARKids A if their circumstances change or they decide it is to their advantage.

III. HISTORY OF THE CK/CKF PROGRAM IN ARKANSAS

The work of Arkansas Advocates for Children and Families (AACF) on issues of access to health care by children and families predates the CK and CKF grants by several years. AACF began as a research, policy, and advocacy organization in the early 1990s with a grant from Little Rock's Children's Hospital. AACF's research and advocacy work, which focused on child and adult health issues, made them a natural partner with the state administration when, in late 1996, Governor Huckabee proposed legislation establishing ARKids First. AACF provided the data and policy analysis that supported his initiative.

With the successful enactment of the ARKids First legislation in 1997, AACF made an intentional transition from research to the provision of direct outreach and enrollment assistance. It received a small grant from Daughters of Charity to do statewide outreach. When, in the fall of 1997, the state was ready to launch the ARKids First program, AACF worked closely with Arkansas' Department of Health and Human Services (DHHS) to promote the program. While DHHS focused its promotional campaign through global media, AACF used a hands-on approach to work with local communities. Limited funding supported only one part-time outreach staff member, which was inadequate for covering the entire state, so AACF recognized early on the need to build a network of experts to assist with its outreach efforts.

During this time, AACF formed a coalition of health care professional associations, DHHS representatives, providers, and local advocates to promote and assist with implementation of ARKids First. Thus, when RWJF released its request for proposals for CK, AACF was well positioned to establish its coalition partners and submit a successful proposal. When AACF became the state CK Grantee in January 1999, it was able to hire full-time staff and a second statewide coordinator. The CK grant funded two local programs: (1) the *Kids Count Coalition,* serving Jonesboro and its surrounding counties in northeastern Arkansas, and (2) *Healthy Connections,* located in Mena and serving the mid-western border counties.

Arkansas applied for a CKF grant in late 2001, again proposing AACF as the lead agency. In January 2002, AACF received a $950,000 four-year CKF grant. Half the grant was allocated for state-level activities and half for five local programs, two of which are included in this case study:[5]

1. ***Northwestern Arkansas ARKids,*** which serves a four-county area in the northwest corner of the state. The program is housed in Poplar House Clinic, which has provided direct health care in Benton County since 1992. Its mission is to provide free care to low-income, uninsured families, and its outreach and enrollment assistance activities date back to 1994, when it served as an off-site enrollment center for WIC and other federal support programs. When it became a CKF grantee in 2002, funding allowed the clinic to expand its outreach activities and to add two counties to its service area.
2. ***Community Health Network,*** which serves three mid-east border counties near Memphis. The program is housed by the Crittenden Memorial Hospital/Impact Center. In 1999, the hospital assembled a group of education, health, medical, and state and local political representatives to discuss options to reduce poverty and homelessness and to improve health care in the hospital's tri-county service area. This group formed the Community Health Network coalition.

The state grantee, AACF, adopted a strategy to "institutionalize" outreach through established channels of access to parents. AACF staff commented on a conceptual "continuum for outreach." Attention is focused initially on one-on-one assistance to help a parent fill out an application, then shifts to finding organizations, such as schools and hospitals, to assist with enrollment.

Throughout the RWJF CK and CKF funding periods, health programs for children benefited from remarkable continuity of leadership. At the state level, there has been one governor since 1996 and little turnover in top administrative positions. AACF has also had stable leadership.

[5] The two programs were chosen because they focused on a small geographic region of the state and had not received funding under the earlier CK grant, which provided an opportunity to observe trends before and after the start of the RWJF support. The other three local programs funded under CKF were Kids Count Coalition and Healthy Connections, both of which had received CK funding, and a third new program, Our Children First Coalition, which operates in the state's southwestern border counties.

The CKF Program Director has been on staff at AACF since 1994, and the former Executive Director recently retired from AACF after over 20 years of service.

The relationship between state officials and CKF state and local grantees has been close and mutually supportive, and a good deal of trust has developed. AACF leadership enjoyed and still enjoys direct access to the governor and state policymakers, and state officials we interviewed noted the close working relationship. AACF was closely involved in the policy developments in 2000 and 2001 to improve access to health insurance. They worked closely with the administration both to develop and promote ARKids First and then to monitor its implementation. A state official noted reliance on the state and local grantee organizations for support and feedback. Even in instances of disagreement over policy, such as use of an asset test, the state acknowledged the value of AACF contributions and insight.

IV. STATE-LEVEL FINDINGS

Economic Trends. Economic changes typically affect trends in public health care programs, with enrollment usually increasing as unemployment rises. However, policymakers in Arkansas noted that this relationship might not be very visible in the state, because its poverty rate is so high and persistent that modest changes in unemployment have little or no bearing on the number of children eligible for public health insurance. In 2003, Arkansas ranked 49th among all states and Washington, DC, in median household income and, among families with children in the state, 26 percent had income below the FPL—the fourth-highest rate in the nation.[6] For minority families, the picture is even more dismal, with 43 percent of African

[6] Median income in Arkansas is $33,948 versus the national average of $44,473 (3-year average 2003–2005, Kaiser Family Foundation, State Health Facts at www.statehealthfacts.org).

American and 37 percent of Hispanic families having income below the FPL (fifth and third highest nationwide, respectively).

Findings confirm the perspective of state policymakers, as there is little pattern evident between the state's unemployment rate and the number of new entries in public health coverage during the study period (Figure 1).[7] Indeed, the most striking increase in new entries occurred during the third quarter of 2000, from 15,000 to nearly 20,000, when the unemployment rate was falling. In addition, as the unemployment rate increased steadily from 3.5 percent in late 2000 to about 6 percent in late 2003, the number of new entries held stable at about 18,000 per quarter.

Links Between Enrollment and Major Policy Changes. As seen in Figure 2, the sustained increase in new entries that began in the third quarter of 2000 can be traced largely to the state's ARKids A program (that comprises traditional Medicaid for children and the SCHIP Medicaid expansion group). Before this period, the number of new entries to ARKids A was at or below 10,000; afterward, it rose to about 15,000 per quarter and remained close to this level for the rest of the study period. A similar trend is not evident in the state's ARKids B (Section 1115 demonstration) program, though there is a brief rise in new entries.

This increase in new entries in the ARKids A program coincides closely with the major round of policy changes, which focused on improving coordination in public coverage and reducing perceived stigma among eligible people (see Table 1 above). These changes, which occurred during the third quarter of 2000, tended to focus more on the families eligible for ARKids A than ARKids B, which is consistent with the larger and more sustained gains seen in the ARKids A program in the third quarter of 2000. For example, the state sought to reduce the

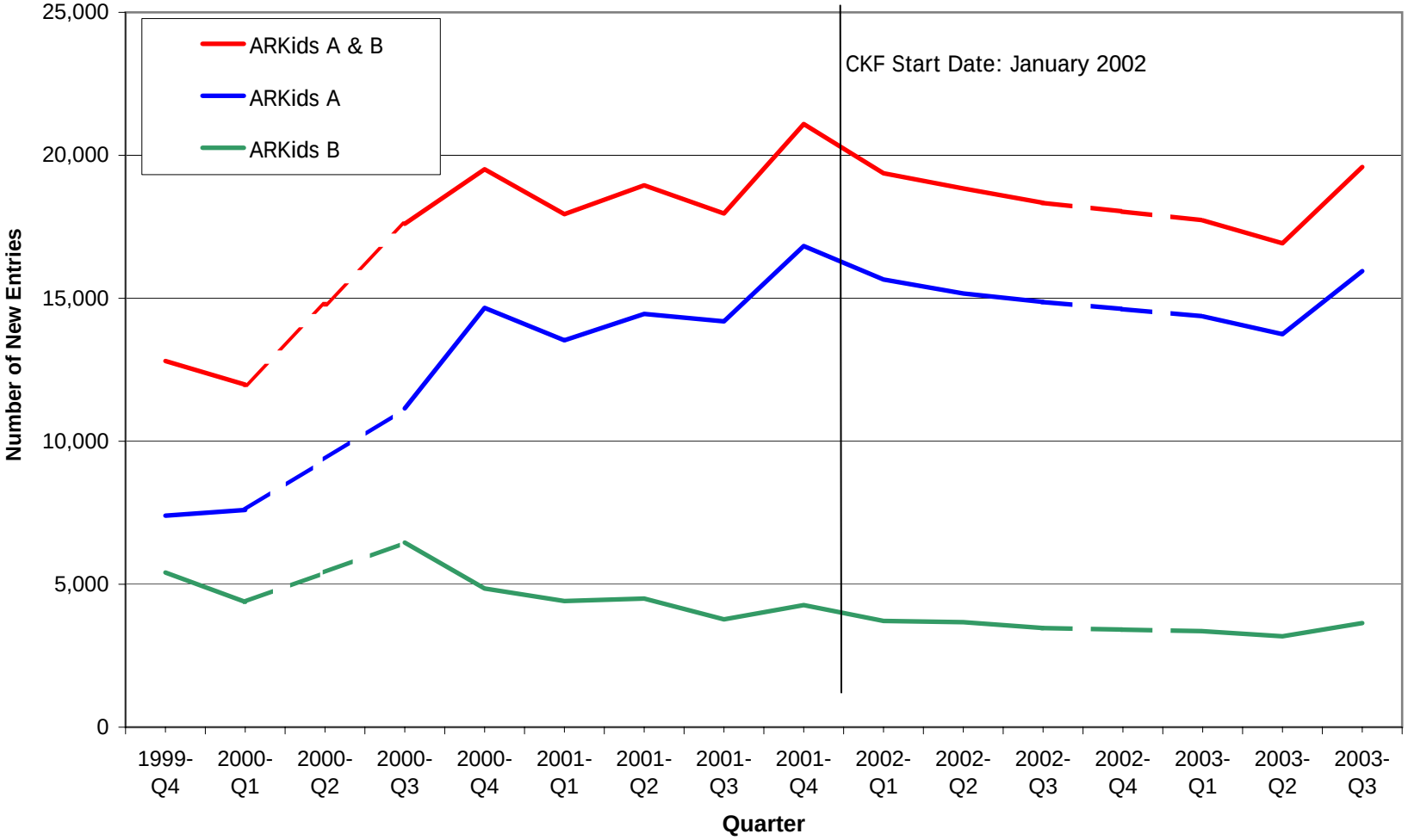
[7] In Figure 1 and all subsequent figures, we have excluded data for two quarters: second quarter 2000 and fourth quarter 2002. Both quarters show very sharp changes in the number of new entries and, based on information from the MSIS Anomalies File, we suspect that data error may be the cause. (In the first of these quarters, the MSIS data show a very sharp decrease in the number of new entries, while in the second, they show a very sharp increase.)

Figure 1
Quarterly New Entries in Public Health Coverage and Unemployment Rate
Arkansas, October 1999–September 2003

Source: Medicaid Statistical Information System and Bureau of Labor Statistics

Note: ARKids A is the name given to Medicaid for children and the SCHIP Medicaid expansion. ARKids B is the name given to the Section 1115 demonstration. New entries include all children who enroll in Medicaid or SCHIP for the first time in the past 12 months.

Figure 2
Quarterly New Entries in Public Health Coverage, by Coverage Type, Arkansas, October 1999–September 2003



Source: Medicaid Statistical Information System

Note: ARKids A is the name given to Medicaid for children and the SCHIP Medicaid expansion. ARKids B is the name given to the Section 1115 demonstration. New entries include all children who enroll in Medicaid or SCHIP for the first time in the past 12 months.

perceived stigma associated with traditional Medicaid by coupling it with the SCHIP Medicaid expansion under the combined name, ARKids A. In addition, the state instituted a mail-in application for its ARKids A program, removing the burden and potential stigma of applying for coverage face to face at local social service offices.

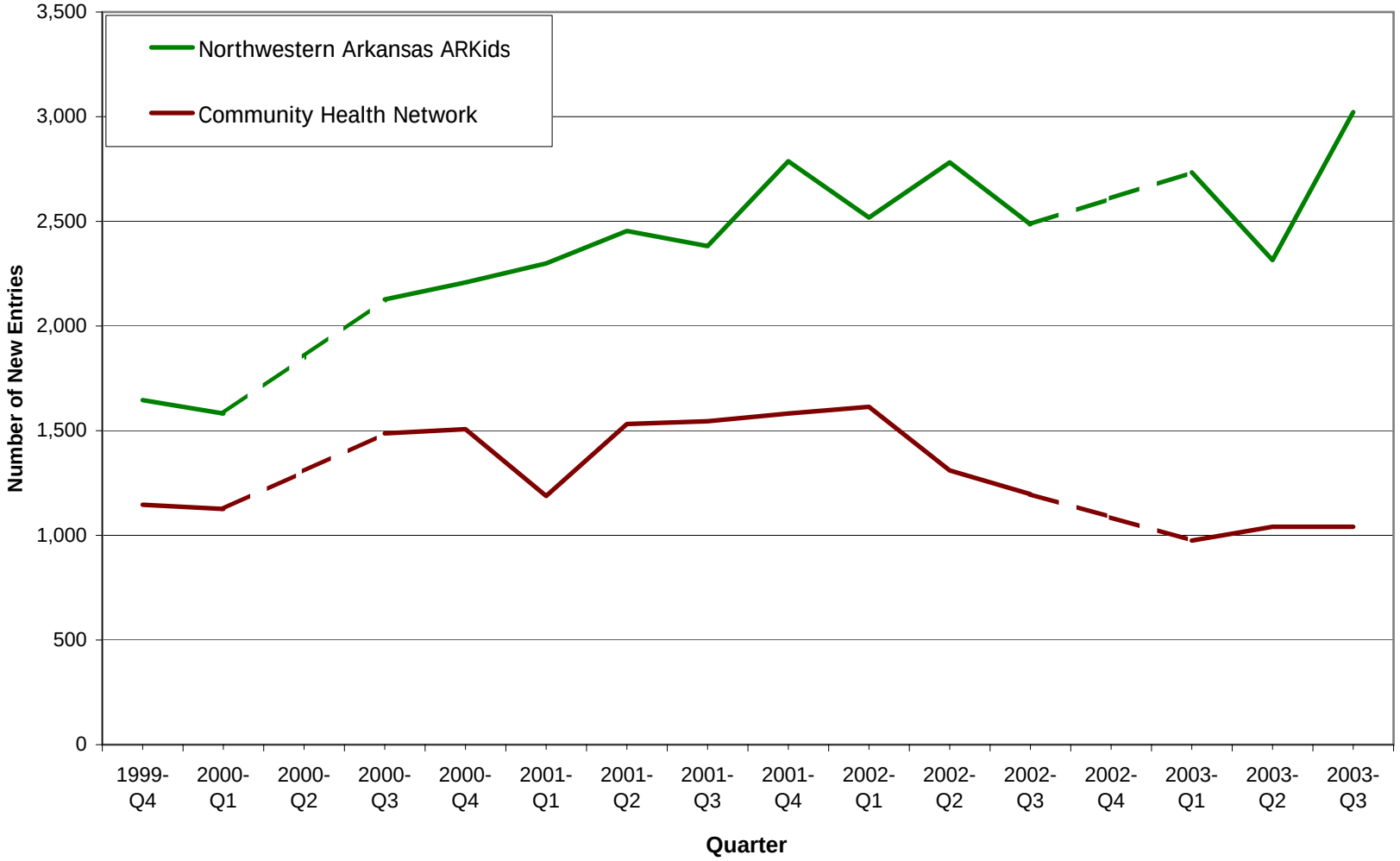
Unlike the policy changes in 2000, the elimination of asset testing (and other smaller changes) for ARKids A applicants in August 2001 does not coincide with any notable change in the numbers of new entries. While there was a rise in the number of new entries to ARKids A in the third and fourth quarters of 2001, the increase is much smaller than in 2000 and was not sustained. This suggests that the sweeping policy changes in 2000, which focused on simplification and on reducing stigma, were far more valuable to enrolling new children into public coverage.

V. LOCAL-AREA FINDINGS

Our analysis of local-area trends focuses on two of the five Arkansas CKF local programs: (1) the Northwest Arkansas ARKids program, housed at Poplar House Clinic in Rogers, which serves four counties; and (2) the Community Health Network in West Memphis, which serves three counties on the eastern border near Memphis. We selected these two programs because neither had received funding from the earlier CK grant, so we had an opportunity to look at trends in enrollment before and after the start of CKF funding in early 2002.

Links Between Enrollment and Local Programs. The trend in total new entries in the two local program areas generally follows the pattern seen within the entire state (Figure 3). The largest gains at the local level coincide with the major state policy initiatives enacted in August 2000. A smaller increase in new entries occurred in the third and fourth quarters of 2001, which is consistent with the state-level test.

Figure 3
Quarterly New Entries in Public Health Coverage,
Local CKF Project Areas, 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.

To explore the possibility that local outreach activities related to the two CKF programs might have affected the number of children enrolling in public coverage, we compared the enrollment trends in each local area with the trends we would have expected based on those in other parts of the state.[8] To the extent that the actual enrollment in these areas exceeded expectations, it suggests that local outreach activities were relatively more successful than outreach activities elsewhere in the state.[9]

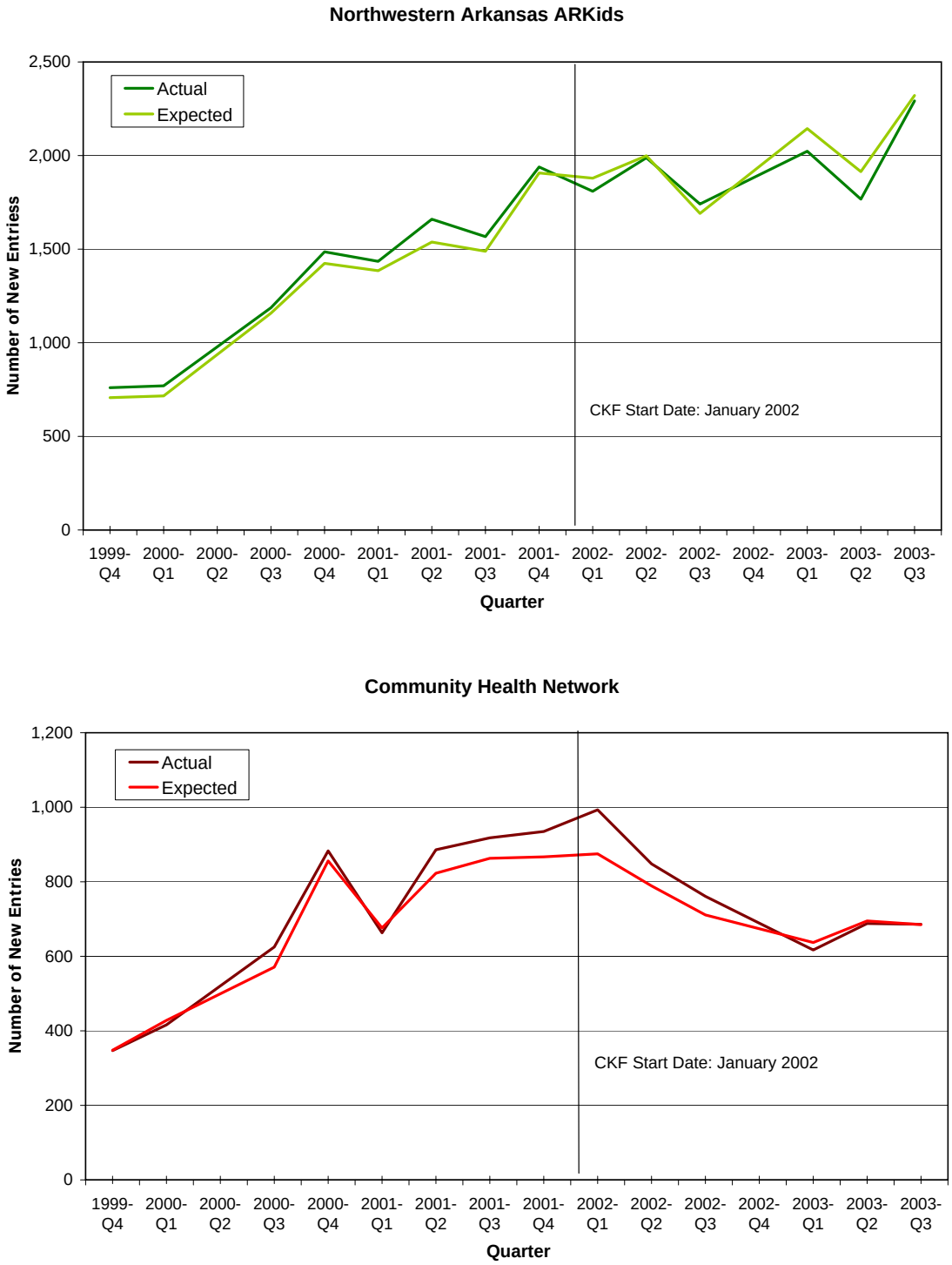
In the area served by Northwest Arkansas ARKids, the trend in new entries over the study period is about what was expected based on the area's demographic characteristics and economic conditions (Figure 4, upper panel). With the exception of a small difference between actual and expected new entries in 2001, the two trend lines are nearly identical both before and after CKF funding. This does not mean to suggest that Northwest Arkansas ARKids was ineffective at increasing public health insurance enrollment, but rather that the program appears as effective as efforts in other parts of the state to enroll eligible children.

In the area Community Health Network serves, the trend in new entries is often higher than expected, though the gap opens up well before the start of CKF (Figure 4, lower panel). From the second period of 2001 through the fourth quarter of 2002, the actual number of entries consistently exceeds the number expected. The largest difference is in the first quarter of 2002,

[8] Expected enrollment is based on a forecasting model that predicts, for each county in the state, the number of children enrolling in Medicaid or SCHIP in each quarter. Inputs to the model include the demographic characteristics of children and families in the county, most notably the number of children below 200 percent of FPL. All these variables are obtained from Census data; some but not all are time varying (depending on whether Census updated them after 2000). The model also includes the local unemployment rate, obtained from Department of Labor statistics.

[9] Caution must be used in interpreting differences in the trend between expected and actual new entries, because the expected trend is estimated imprecisely, which leads even fairly large differences in a given quarter to be statistically insignificant. Our main focus, therefore, is on whether the differences persist over long periods.

Figure 4
Quarterly New Entries to Public Health Coverage, Local CKF Project Areas: Actual versus Expected, October 1999 - September 2003



Source: Medicaid Statistical Information System

Note: New entries include all children who enroll in Medicaid or SCHIP for the first time in the past 12 months. The trend in expected number of new entries is estimated from a regression model (see text for additional details).

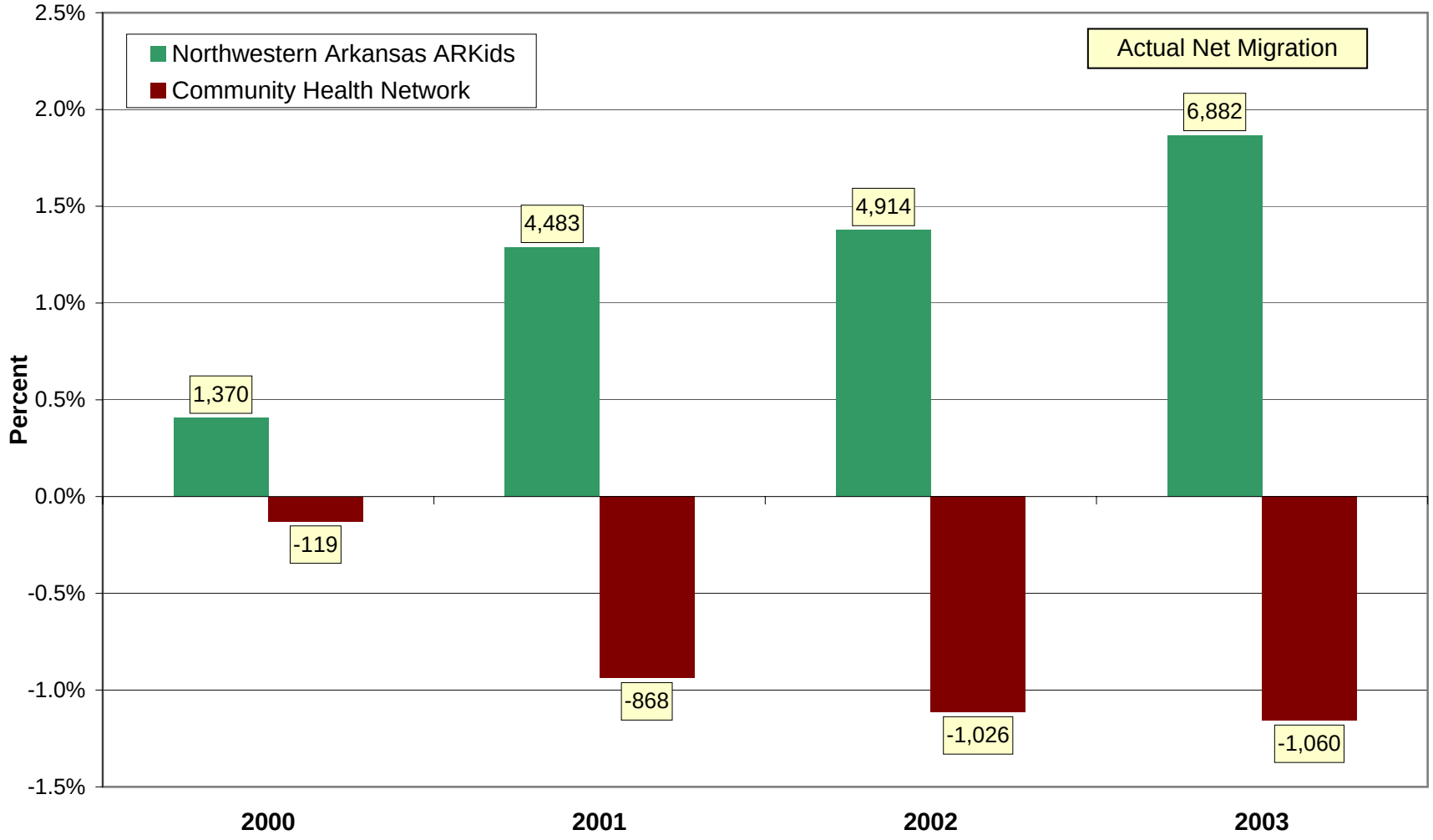
when the area had 1,000 new entries compared with an expected count of 875, a difference of 14 percent.

Differences Among Local Programs. Comparing the two programs, probably the most notable difference is not in their activities but rather in their service areas. In contrast to other parts of Arkansas, the area served by the Northwest Arkansas ARKids experienced a major economic expansion during the study period. For many years, this section of Arkansas has been easily the wealthiest area of the state and has the distinction of having "more millionaires per square mile than anywhere in the world."[10] Corporate home to a mega-business triumvirate—Wal-Mart (retail), JB Hunt (transportation), and Tyson Foods (meat processing)—the area is known as the Golden Triangle. In January 2000, Wal-Mart informed its vendors that they would be required to locate a decision-making office within 20 miles of the Wal-Mart corporate offices by October 2004 as a condition of doing business. This mandate contributed to an influx of new businesses and high- and mid-income residents, which in turn increased the demand for labor and service sector jobs, attracting low-income families to the area.

In contrast, the area served by Community Health Network continued to experience economic stagnation during the study period and remained one of the poorest regions in the state. One Community Health Network staff member noted that the area still has no major manufacturers or corporations and that job growth is nonexistent. As seen in Figure 5, the two very different economic experiences of these areas are evident in the migration of children and families living in the counties served by the two local programs. While the area served by Northwest Arkansas ARKids experienced large gains in population, the economic stagnation in the area served by Community Health Network has led to net population declines.

[10] Northwest Arkansas ARKids CKF Program Director, personal interview.

Figure 5
Annual Net Domestic Migration as a Percent of Total Population
Local CKF Project Areas, 2000–2003



Source: US Census Bureau Estimates

Aside from this key difference in the areas that they serve, findings from the case study interviews suggest that the two programs are largely similar, differing little in the focus or scope of their activities. This similarity weakens any conclusion that Community Health Network has had relative success enrolling children into coverage, despite the somewhat favorable trend seen above in Figure 4.

Following the guidance of the state grantee, Northwest Arkansas ARKids directed its outreach toward organizations or individuals with existing relationships with families. Early on, the coalition approached school nurses and school counselors to assist with enrolling children. Staff also worked with hospital nursing staff on discharge planning for new mothers and infants. In another initiative, the grantee partnered with a sympathetic juvenile court judge who agreed to mandate, when uninsured children came before the judge, that eligible families enroll their children into the health care program. Northwest Arkansas ARKids staff then trained court staff to assist families with enrollment. Program staff also worked with staff of alternative schools, boys and girls clubs, and the Head Start program. Other partnerships have been formed with the Northwest Arkansas chapter of the National Association of Social Workers and with the League of United Latin American Citizens, a nonprofit organization serving as a voice for the Hispanic community.

Among all Northwest Arkansas ARKids' activities, perhaps the most innovative has been its participation in a local physician outreach initiative, which provided a $20 voucher to any area physician whose office assists a first-time patient with completing an ARKids First application. This voucher system (1) guaranteed the physician a $20 payment for the child's first visit, (2) assured the physician that the patient is actively pursuing insurance coverage, and (3) resulted in the assignment of the child to the physician for ongoing primary care case management.

Like the Northwest Arkansas ARKids program and the state CKF coalition, Community Health Network has focused on partnering with entities that have existing relationships with parents and children. In 2000, Community Health Network recruited school nurses and school coaches to provide outreach and application assistance. Staff noted particular success with an annual school-sponsored event providing physicals for students participating in school athletics, which allows Community Health Network to reach 400 to 500 children and their parents. Crittenden Memorial Hospital offers both a birthing clinic and a parenting program, which uses prevention and intervention strategies to enhance both parent and child development. Community Health Network uses these venues to educate new and expectant mothers about public health insurance options. Moreover, the coalition has trained hospital staff to assist families to complete the ARKids First application.

A unique Community Health Network activity was a cable television campaign designed to encourage enrollment in ARKids First beginning in the summer of 2002.[11] Community Health Network does not have enrollment data to confirm the effectiveness of the campaign, but it has received numerous telephone inquiries, which they believe suggests that the campaign was effective. The media campaign cannot explain the favorable findings seen in Figure 4 above, however, since it started more than a year after the gap between actual and expected enrollment appears.

[11] Because of their geographic location in the state, neither of the local programs is in a media catchment area that benefits from public service announcements or other mass media campaigns originating in Little Rock. Their border areas receive news from other cities, and sometimes from other states. Unlike Community Health Network, Northwest Arkansas ARKids was unable to capitalize on public service announcements or even a local media campaign, a result of business and community pressure to downplay any perception of economic need in the area.

VI. CONCLUSIONS

Policy changes in Arkansas represent a successful effort to destigmatize public health insurance and thereby attract more eligible children. In August 2000, Arkansas integrated its entire public health insurance program under the name ARKids First, severing any obvious link to the term Medicaid. It also implemented a joint application for ARKids First's three programs and allowed self-declaration of income and assets, which further distanced this newly named program from its predecessors. In turn, these changes are associated with a marked and sustained increase in new entries to public health insurance coverage, with the largest increases occurring in the eligibility groups we would expect: Medicaid and SCHIP Medicaid expansion.

While these important policy changes predate CKF funding, the CK state grantee, AACF, was actively involved in promoting these. By all accounts, AACF worked collaboratively with the state not only to develop and structure ARKids First, but to promote and monitor the program once it was enacted. And later, as the CKF grantee, ACCF continued to monitor the implementation of ARKids First and provide constructive feedback.

Critical to the feedback AACF has provided have been the local CK/CKF programs, whose on-the-ground experiences have served as a basis for many of the recommendations made to the state. This feedback has in turn contributed to some key modifications in the outreach and enrollment activities taking place across Arkansas. For example, state and local outreach dollars have focused increasingly on partnering with organizations that have existing relationships with parents and children, such as schools, boys and girls clubs, and birthing clinics, and institutionalizing outreach activities within these organizations. While the enrollment data offer no clear evidence on the success of these efforts (pro or con), everyone we interviewed for the case study supported these changes, believing the increased focus on outreach partners and on sustainability would increase the number of children with coverage.