

REPORT

FINAL REPORT

Moving the Needle on Health Insurance Coverage: Evaluation of the Cities Expanding Health Access for Children and Families Project

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CONTENTS

EXECUTIVE SUMMARY v

I. INTRODUCTION AND EVALUATION AIMS 1

 A. Selected CEHACF cities’ characteristics and strategies 2

 B. Evaluation of CEHACF 4

 C. Organization of this report 5

II. KEY FINDINGS 6

 A. Are cities effective conduits for increasing coverage take-up? 6

 B. What factors contributed to success, and what factors challenged outreach and enrollment campaigns? 8

 1. Identifying and developing relationships with partners 8

 2. Planning for data collection to measure success 11

 3. Balancing best practices in outreach and enrollment with innovation 12

 4. Implementing the multistage grant strategy 13

 C. Will participating cities sustain the work begun under the CEHACF grants, and if so how? 14

III. DISCUSSION 17

REFERENCES 19

TABLES

I.1 Summary of CEHACF implementation grantees, target populations, enrollment goals, grant amounts, and planned end dates 3

II.1 Sustained CEHACF activities, by city 14

FIGURES

I.1 CEHACF three-phase competitive approach and timeline 2

II.1 Total applications, enrollments, and renewals (children and adults), August 2014–July 2016 7

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EXECUTIVE SUMMARY

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 held great promise for expanding insurance coverage to millions of uninsured Americans. When the ACA was enacted, about 6.2 million children were uninsured; of those, nearly 70 percent were eligible for coverage through Medicaid or the Children’s Health Insurance Program (CHIP), but were not enrolled (Kenney et al. 2012). Viewing the ACA as an opportunity to find and enroll these children into coverage, in December 2012, the Atlantic Philanthropies granted \$3.25 million to the National League of Cities’ (NLC) to launch a three-year project to engage cities on children’s coverage issues.

The Cities Expanding Health Access for Children and Families (CEHACF) project was designed to capitalize on both cities’ responsibility for protecting the health and well-being of their residents and municipal leaders’ platform for engaging residents. The project’s overarching goal was to empower municipal leaders in competitively selected cities to partner with key stakeholders to find uninsured children—and, potentially, their adult parents who were newly eligible for coverage through ACA rules—and enroll them in Medicaid or CHIP. Beginning in January 2013, CEHACF engaged selected cities on children’s coverage issues through a three-stage, competitive grant-making process. NLC staff helped municipal leaders and their partners from participating cities to (1) learn more about the development and implementation of health insurance outreach and enrollment strategies, (2) develop business plans to implement outreach campaigns, and (3) implement those business plans.

In 2014, Atlantic commissioned Mathematica Policy Research to evaluate the CEHACF project. Since that time, evaluators have produced a [literature review](#) on competitive grant-making strategies, a paper describing [lessons](#) for funders using similar competitive grant-making strategies, and a [video](#) highlighting participating cities’ experiences. This executive summary presents highlights from the final evaluation report, which summarizes evaluation findings about whether municipal governments can become effective agents for increasing coverage take-up, what factors contribute to success, what challenges were encountered, and whether the work is likely to be sustainable after the project ends. It is based primarily on interviews conducted in 2015 and 2016 with staff from participating cities and NLC, review of program documents, and analysis of monthly data collected between August 2014 and July 2016 from the eight cities that were selected to implement outreach and enrollment campaigns through the project.

Key findings

- **Cities can effectively conduct outreach and enrollment work: nearly 20,000 adults and children have enrolled in Medicaid or CHIP as a direct result of campaigns in four of the participating CEHACF cities.** As of July 2016, 12,730 adults and 7,099 children have enrolled in Medicaid or CHIP as a direct result of campaign efforts in four of the cities (the four other cities were unable to track enrollment data); presumably this is a lower bound, since the other cities also supported applications (even though they could not track resulting enrollments). These four cities able to track enrollments also supported renewal efforts: together, these campaigns assisted 5,232 adults and children with renewal of their Medicaid or CHIP coverage. Although the cities focused primarily on enrolling children—only two of the eight cities set adult enrollment goals—adult enrollments were nearly double child

enrollments. This appears to be the result of a combination of factors. First, there are so many more uninsured adults than uninsured children; as of 2014, there were nearly six uninsured adults for every one uninsured child. That makes uninsured adults much easier to find, compared to uninsured children. Second, ACA rules that permit expansion of Medicaid clearly helped drive adult enrollment, since the cities with the largest adult enrollments are all located in states that expanded Medicaid. Third, many cities conducted campaign outreach at locations that serve low-income adults and children, such as community centers and clinics, rather than focusing only on child-centric locations, such as schools or day care centers. Thus, many CEHACF campaigns benefited from the “welcome mat effect,” which is when parents seeking to enroll their child in coverage find out that they, too, are eligible.

- **Developing partnerships with community organizations that were likely to serve uninsured children and families during the grant period was challenging; the most successful cities leveraged partnerships that predated their CEHACF campaigns.** Most of the participating cities used the first months of their campaigns to build relationships with local partners. As a result, it took them much longer to ramp up application and enrollment assistance, resulting in fewer campaign-supported applications and enrollments than expected as of July 2016. The two cities that were most successful in terms of total applications and enrollments designed their campaigns around longstanding partnerships with local schools, a community health center, and a local county safety net agency, gaining buy-in from these groups before they won their CEHACF grants. This enabled these two cities to start providing assistance immediately when the grant began.
- **With partnerships, context is key: partnerships that are essential to one city’s campaign may not be easily replicated in another city.** Partnerships critical to outreach and enrollment campaigns in one city did not always work well in another city. For example, although schools are a natural place to find children—all of the cities’ initial business plans identified partnerships with schools as key to their campaigns, and the city with the most enrollment success based their campaign primarily around a school partnership—most participating cities were unable to develop relationships that enabled them to embed high-touch enrollment strategies and assistance in schools during the grant period. This meant they had to identify alternative partners that could help their campaigns. Through a trial and error process, many of the cities found that other government programs and municipal agencies could be important conduits for reaching uninsured families. For example, one participating city had its greatest campaign success when the local water agency included information about the campaign as an insert with the monthly water bill.
- **The cities that had the most success tracking enrollments attributable to their campaigns thought about data from the outset: they had detailed data plans and data-sharing agreements in place before their campaigns began.** Detailed data collection and reporting plans for partners, as well as access to Medicaid and CHIP enrollment data, were essential components of successful campaigns: cities needed to be able to track an application, determine if the application resulted in an enrollment, or if not, provide additional enrollment assistance to the family (such as obtaining additional income documentation or helping a family file an appeal). The CEHACF cities that tracked application and enrollment data successfully had thorough data collection plans in place before their campaigns began. This enabled them to assess campaign successes and failures, and to identify patterns to help them modify their campaigns, if needed. Several of the

CEHACF campaigns were hampered by data problems throughout their grants. For example, some cities could not get partners to report data back to the campaign, while others could not get agreements with their state Medicaid agencies to enable them to track enrollment outcomes.

- **Cities worked to balance best practices in outreach and enrollment against the desire to develop innovative campaigns. In the end, the cities that built their campaigns on evidence-based practices and adapted them to their local circumstances were more likely to find and enroll the uninsured.** The CEHACF application for the implementation grants encouraged cities to propose innovative outreach and enrollment approaches. However, this frequently resulted in the use of outreach approaches that were not effective in enrolling individuals into coverage. For example, although one-on-one enrollment assistance is associated with increased enrollment rates, the emphasis on—and proportion of the total grant budgeted for—such assistance varied among cities. Cities with the most enrollment success budgeted much more than their counterpart cities to support direct enrollment assistance. Cities that planned to incorporate more enrollment assistance through partner donations of “in-kind” staff time found it was difficult to supervise, and nearly impossible to monitor, such work.
- **Participating cities are developing strategies to sustain this work, including institutionalizing campaigns within existing city efforts and seeking additional funding sources.** NLC required that all campaign business plans include plans for sustainability following the end of CEHACF funding. Incorporating sustainability discussions from the outset ensured that campaign strategies and activities were planned and implemented with an eye toward continuing beyond the grant period. As a result, campaign staff reported that they either will continue their work under the city department or agency in which they began, or will transition the work to a key campaign partner willing to support staff involved in day-to-day operations of the campaign. As of July 2016, seven of eight CEHACF cities reported that they have already, or are currently integrating campaign efforts within city operations, while three cities have obtained additional funding to support continuation of their campaigns.

Discussion

Over the past two years, our evaluation has found that cities can move the needle on health insurance coverage. The cities participating in this project found they were well positioned to navigate complex federal and state Medicaid and CHIP policies in developing and implementing outreach and enrollment campaigns in areas with concentrations of eligible but not enrolled children and adults. At the same time, while progress in health benefits outreach and enrollment work at the city level is promising, several challenges persisted throughout the grant. For example, neither NLC nor the cities fully anticipated the level of trust and numerous “touches” the campaigns would need to develop with families before these families would share sensitive income and health status information. In some cities, campaign staff noted that they assumed at the start that people in need of health insurance would show up for assistance once they learned help was available. In fact, in order to reach the target population, campaign staff learned they had to establish or leverage partnerships with entities that already provide services to this population, which helped to provide legitimacy to the outreach campaigns.

Cities interested in pursuing similar work should consider the following lessons before initiating their own outreach campaigns:

- **Network with local organizations and city agencies to help determine which types of partners are most conducive to outreach and enrollment work to the target population, and to foster buy-in for the campaign.** Among the CEHACF cities, those with partnerships established before campaign implementation had more successful campaigns. If not already in place, cities should begin cultivating partnerships with groups likely to have access to the target population before beginning outreach and enrollment activities, and if possible, provide incentives for partners to participate
- **Develop comprehensive data collection plans to monitor and assess progress, and execute data-sharing agreements.** Cities that were most successful in collecting application and enrollment data established data collection processes and agreements with outreach and enrollment partners. They also had agreements in place with their state Medicaid agencies to enable them to track campaign-assisted Medicaid or CHIP enrollments. It is important for cities to collect this data, since without it they cannot assess what aspects of their campaign are or are not working well, nor examine data patterns that might show where activities could be modified.
- **Use evidence-based outreach and enrollment strategies.** Although innovation is important—and might be required to identify and develop successful partnerships in a particular city—one-on-one direct enrollment assistance was the most successful strategy for enrolling children and their parents in the CEHACF cities. If possible, cities should incorporate a ‘warm hand-off’ approach, which promotes a seamless referral between identification as eligible and enrollment assistance. Many seemingly innovative strategies, such as referrals from 2-1-1, 3-1-1, or robo-calls, did not yield the same response as boots-on-the-ground, direct enrollment assistance. Such referral strategies put the burden on the uninsured, requiring them to reach out for assistance, rather than targeting members of the potential eligible population where they already accessed programs and services.

I. INTRODUCTION AND EVALUATION AIMS

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 held great promise for expanding insurance coverage to millions of uninsured Americans. While it provided new coverage opportunities for low-income adults who previously had no access to coverage through employers or public options, ACA provisions also benefited children. For example, public coverage for children with family incomes less than 138 percent of the federal poverty level (FPL) would shift from separate Children’s Health Insurance Program (CHIP) programs to Medicaid (which provides slightly enhanced benefits compared to CHIP); some families with incomes up to 400 percent of the FPL would benefit from tax credits in the newly created marketplaces; and new coverage options for parents would likely increase children’s coverage rates through the “welcome mat” effect, whereby parents newly enrolling themselves in coverage would simultaneously enroll their eligible children (Kenney et al. 2016; Hoag et al. 2015). When the ACA passed in 2010, about 6.2 million children were uninsured; of those, nearly 70 percent were already eligible for coverage through Medicaid or CHIP but were not enrolled (Kenney et al. 2012).

Viewing the ACA as an opportunity to identify and enroll eligible uninsured children into Medicaid or CHIP coverage, the Atlantic Philanthropies granted \$3.25 million to the National League of Cities’ (NLC) Institute for Youth, Education, and Families (YEF) to launch a three-year project to engage cities on children’s coverage issues.¹ Begun in January 2013, the Cities Expanding Health Access for Children and Families (CEHACF) project helped municipal leaders and their local partners to:

1. Learn more about the development and implementation of effective health insurance outreach and enrollment strategies through Leadership Academy conferences (Phase I)
2. Develop business plans to implement outreach campaigns (Phase II), and
3. Implement those outreach campaigns (Phases III and IV) (Figure I.1).²

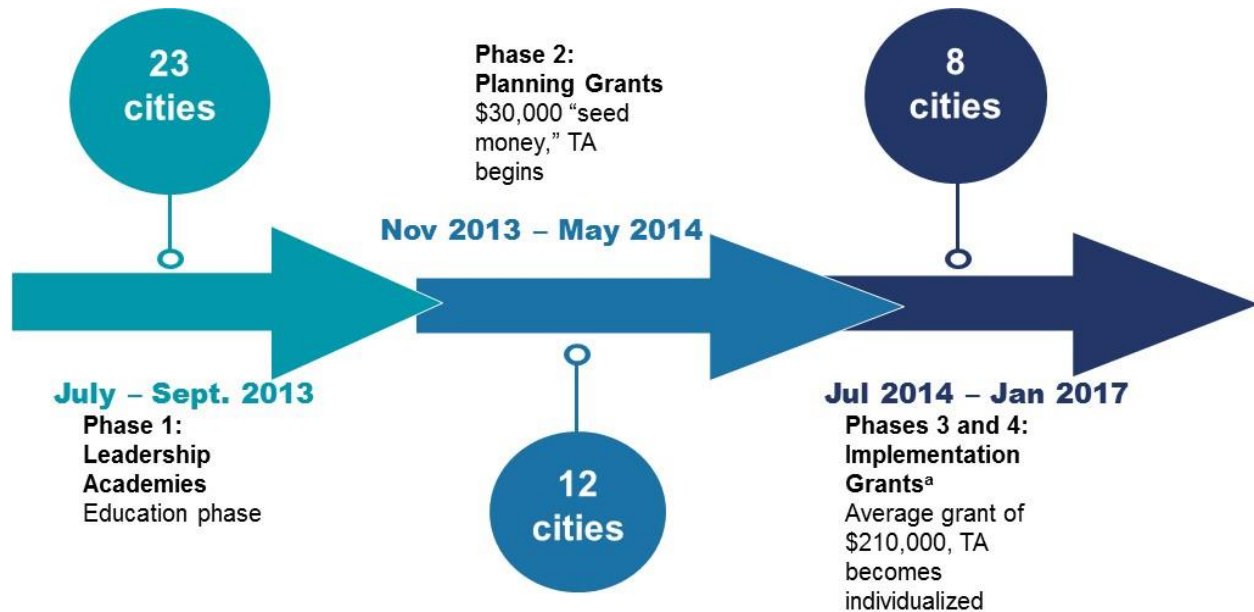
CEHACF was designed to capitalize on cities’ responsibility for protecting the health and well-being of their residents, and municipal leaders’ platform for engaging residents. The project’s overarching goal is to empower municipal leaders in competitively selected cities to partner with key stakeholders to find uninsured children—and, potentially, their adult parents—who are newly eligible for coverage, and enroll them in Medicaid or CHIP. In addition, project leaders expected that participating cities would develop ways to sustain this new outreach and

¹ The Atlantic Philanthropies also provided support for children’s coverage through the development of the KidsWell campaign, a \$29 million investment in state and national advocates to advance a coordinated agenda to accelerate progress in covering children in the short term, while building an infrastructure to maintain gains in coverage in the long term (see [Hoag et al. \[2015\]](#) and [Peebles et al. \[2016\]](#) for more information on KidsWell). The KidsWell grant also supported the Children’s Defense Fund and the School Superintendents Association to help support health insurance enrollment in school settings (see <http://www.insureallchildren.org/> for more information). Atlantic Philanthropies further supported ACA implementation by joining with seven other national foundations to create the ACA Implementation Fund, which provided strategic support to state-based health advocates.

² The original design called for three phases, but because some cities and NLC had funds remaining when Phase III ended in December 2015, the project permitted cities to spend down remaining funds into 2016, and also added a competitive fourth phase that awarded additional NLC funds (averaging \$29,000) to four Phase III cities.

enrollment work after the grants ended, by identifying new sources of financial support for the work or by institutionalizing the work at city and partner agencies. NLC used a competitive process to select eight cities to implement their proposed campaigns in partnership with public schools, community organizations, health agencies, advocates, and other stakeholders to find uninsured children and families and enroll them in Medicaid and CHIP.

Figure I.1. CEHACF three-phase competitive approach and timeline



Source: Mathematica analysis of project documents.

Notes: TA = Technical assistance.

^aThe last grants end in January 2017, but the end dates are staggered from April 2016 through January 2017.

A. Selected CEHACF cities' characteristics and strategies

The eight cities awarded implementation grants differ in geographic location, community demographics, enrollment goals, and states' decisions to expand Medicaid under the ACA. In addition, projected enrollment goals for eligible but not enrolled (EBNE) children and their parents or guardians under the grant varied from several hundred (Garden City, Michigan) to 30,000 (Dallas, Texas). However, most cities proposed to adopt similar strategies to meet their respective enrollment goals, using city teams focused on enhancing their outreach to EBNE children and families via partnerships with public school districts, city agencies, community-based organizations, hospitals and health centers, and faith-based communities, among others. Table I.1 summarizes the NLC sites' target populations, enrollment goals, and grant amounts and end dates (all of the grants began in July 2014).

Table I.1. Summary of CEHACF implementation grantees, target populations, enrollment goals, grant amounts, and planned end dates

City and campaign name	Lead city agency	Target population	Enrollment goals	Implementation grant amount	End date
Dallas, Texas Healthy Children in a Healthy Environment	Housing/Community Services Department	60,000 EBNE children in 17 targeted zip codes in Dallas	Enroll or reenroll 30,000 children, which would reduce EBNE children in target zip codes by 50 percent	\$40,000 ^b	4/30/2016
Garden City, Michigan ^a Healthy Kids—Happy Families	Community Resources Department	10 percent of EBNE Garden City children and families who use the emergency room for nonemergency purposes (630 children and parents/guardians)	Enroll 325 EBNE children up to age 19 living in Garden City or attending Garden City public schools	\$180,000	6/30/2016
Hattiesburg, Mississippi E ³ (Educate, Enroll, Empower) Health Initiative	Mayor's office	5,900 EBNE adults and children living in Hattiesburg zip code 39401	Enroll 2,950 adults and children, which would reduce EBNE children and adults in target zip code by 50 percent, and increase Medicaid and CHIP retention rates by 25 percent	\$250,000	8/15/2016
Jacksonville, Florida Cover Jacksonville	Jacksonville Children's Commission	16,000 EBNE children with family incomes less than \$40,000 in target zip codes identified through income analysis and zip codes where the largest proportion of children receive free and reduced-price lunch, and at target businesses in which up to 30 percent of employees earn less than \$40,000 per year	Enroll 3,200 children in Duval County, which would reduce EBNE children in target zip codes by 20 percent	\$260,000	5/20/2016
New Bedford, Massachusetts ^a Healthy Access Kids New Bedford	Health Department	2,930 EBNE children in New Bedford public schools and their families with incomes up to 300 percent of the FPL; those with limited language proficiency; those new to New Bedford (whether documented or not)	Enroll 1,495 children, which would reduce EBNE children in schools with income less than 300 percent of the FPL by 50 percent, and target 70 percent of students/families currently enrolled in Medicaid for retention to maintain coverage	\$217,900 ^c	12/31/2016
Pittsburgh, Pennsylvania ^a Healthy Together	Mayor's office	2,000 EBNE children, specifically those ages 10 to 17; families needing to renew insurance; immigrants and families new to the region; and residents of the South Hilltop, Perry North, and East End neighborhoods	Enroll 800 children and 750 parents or guardians; renew coverage for 250 children and 200 parents or guardians	\$230,000 ^c	12/31/2016
Providence, Rhode Island ^a	Healthy Communities office	1,800 EBNE children	Enroll 1,000 children, which would reduce EBNE children by 55 percent, targeting parents with EBNE school-age children, EBNE high school-age children, and immigrant families with children	\$228,900 ^c	12/31/2016
Savannah, Georgia The Mayor's Campaign for Healthy Children & Families	Mayor's office	4,559 EBNE children in Chatham County; the target population also includes Hispanic and non-Hispanic families enrolled in Medicaid who need reenrollment assistance	Enroll 2,279 in Chatham County, which would reduce EBNE children in the county by 50 percent	\$270,000 ^c	1/31/2017

Source: Abstracted from cities' National League of Cities competitive grant applications, and new information from NLC about Phases III and IV funding. Data on end dates current as of August 2016.

Note: CEHACF = Cities Expanding Health Access for Children and Families; CHIP = Children's Health Insurance Program; EBNE = eligible but not enrolled; FPL = federal poverty level; NLC = National League of Cities.

^aThese cities are in states that have expanded Medicaid to uninsured adults up to 138 percent of the FPL, as permitted by the ACA.

^bNLC awarded Dallas a "mini-grant" to try to support a lower intensity outreach and enrollment campaign, compared to the other cities. NLC did not have enough funds to award a full grant to Dallas, but wanted to invest in Dallas in hopes the city would collaborate with Atlantic's KidsWell grantees in Texas on outreach and enrollment issues.

^cThe implementation grant amounts for New Bedford, Pittsburgh, Providence, and Savannah include Phase IV funding that they received (\$27,000 in New Bedford, \$30,000 in Pittsburgh, \$38,900 in Providence, and \$20,000 in Savannah).

Although the original grant period concluded in December 2015, all eight cities continued their campaigns in some form past this date. Some cities had some unspent funds, and NLC had funds remaining to grant additional funds to selected cities. Beginning January 1, 2016, six cities received no-cost extensions: Dallas, Garden City, Hattiesburg, Jacksonville, New Bedford, and Savannah. They were able to spend remaining implementation grant funds through 2016, with varying end dates (shown in Table I.1). NLC referred to these no-cost extensions as “Phase III” of the project. With unspent grant funds, NLC also created “Phase IV” of the grant, which is providing four of the CEHACF cities with additional funding to build upon and expand their outreach and enrollment campaigns. Six of the eight implementation cities submitted proposals for additional funding (all cities except Dallas and Hattiesburg applied); the four cities awarded Phase IV grants were New Bedford, Pittsburgh, Providence, and Savannah. This phase officially launched in February 2016. Although NLC’s technical assistance program and grant extension with Atlantic Philanthropies conclude in September 2016, the grants for New Bedford, Pittsburgh, and Providence will end in December 2016. Savannah’s grant will end in January 2017.

B. Evaluation of CEHACF

In July 2014, the Atlantic Philanthropies commissioned Mathematica Policy Research to evaluate outcomes of the CEHACF project. Key research questions for the evaluation include:

1. Are cities effective conduits for increasing coverage take-up?
2. What factors contributed to success in outreach and enrollment to eligible but not enrolled children and families? What factors hindered or challenged campaign efforts?
3. Will participating cities sustain the work begun under the CEHACF grants, and if so how?

Methods. To answer these questions, Mathematica undertook a series of activities to monitor implementation of the outreach campaigns in each of the cities. These included:

1. Review of CEHACF project documentation, including proposals submitted by cities to participate in each phase of the project, internal NLC planning tools and documents on the city selection process, webinar slides documenting advice cities were given about launching outreach campaigns, and the cities’ outreach campaign business plans, among other sources.
2. Development and distribution to cities of an electronic data collection tool to track grantees’ outreach and enrollment activities on a monthly basis. Mathematica launched this tool in August 2014, and held when a webinar to train city staff to use it. Cities began submitting the data monthly to Mathematica beginning in September 2014. Data elements required included (1) monthly application and enrollment data, broken down by children and adults;³ and (2) the results of outreach and enrollment assistance activities, such as the number of applications distributed and completed at an event, and whether a city official took part in the event. The tool also collected data on results, challenges, and factors promoting and

³ An application can include more than one person, such as multiple members of the same family. Enrollments represent individuals, rather than households or families.

inhibiting campaign success each month. Due to problems collecting data from partners, only six of the eight cities—Garden City, Hattiesburg, Jacksonville, New Bedford, Pittsburgh, and Savannah—were able to report application data.⁴ Four of the eight cities—Garden City, New Bedford, Pittsburgh, and Savannah—were also able to report enrollment outcomes that resulted from their outreach and application assistance efforts; the other cities were unable to negotiate contracts with their state Medicaid and CHIP agencies to provide any enrollment data. Seven quarterly reports—spanning November 2014 through May 2016—were submitted to Atlantic Philanthropies to provide updates on applications, enrollments, successes, and challenges associated with their campaigns.

3. Observation of some peer-to-peer learning activities offered to cities by NLC throughout the project, such as webinars and group teleconferences.
4. Interviews throughout the project with staff from participating cities who were administering the campaigns, as well as with NLC staff, to inquire about progress, successes, challenges, and sustainability issues. Interviews were conducted four times: (1) in July 2014, at the kickoff of the implementation grants (8 city respondents); (2) in December 2014 and January 2015, after six months of campaign implementation (2 respondents from Atlantic Philanthropies, 4 respondents from NLC, and 29 respondents from the cities participating in all three phases of the program); (3) in October 2015, at an in-person gathering of city officials (2 respondents from NLC and 14 respondents from the cities), and (4) in July 2016, as the grants were concluding (2 respondents from NLC and 10 respondents from the cities).

Following standard qualitative methods (Bradley 2007; Miles 2013), all 71 interviews conducted between July 2014 through July 2016 were recorded and professionally transcribed, then transcripts were reviewed by research staff for accuracy and quality. The research team identified the main research themes of interest, and analyzed the results to inform the findings.

C. Organization of this report

This is the final project report and it is designed to answer the three key research questions of interest identified above. It builds on [earlier research](#) that examined the competitive grant strategy and early effects on cities, as well as on the seven internal quarterly reports that summarized monthly outcomes by city. Chapter II presents key findings for each of the study research questions, including implementation successes and challenges experienced by the implementation cities. Chapter III discusses the implications of our findings for other cities interested in undertaking outreach and enrollment work.

⁴ Dallas has faced multiple barriers reporting application data and enrollment activities. We have excluded the city from the analysis because it has been unable to collect and report campaign data. Providence was unable to report application and enrollment data, although it reported monthly on campaign successes and challenges.

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II. KEY FINDINGS

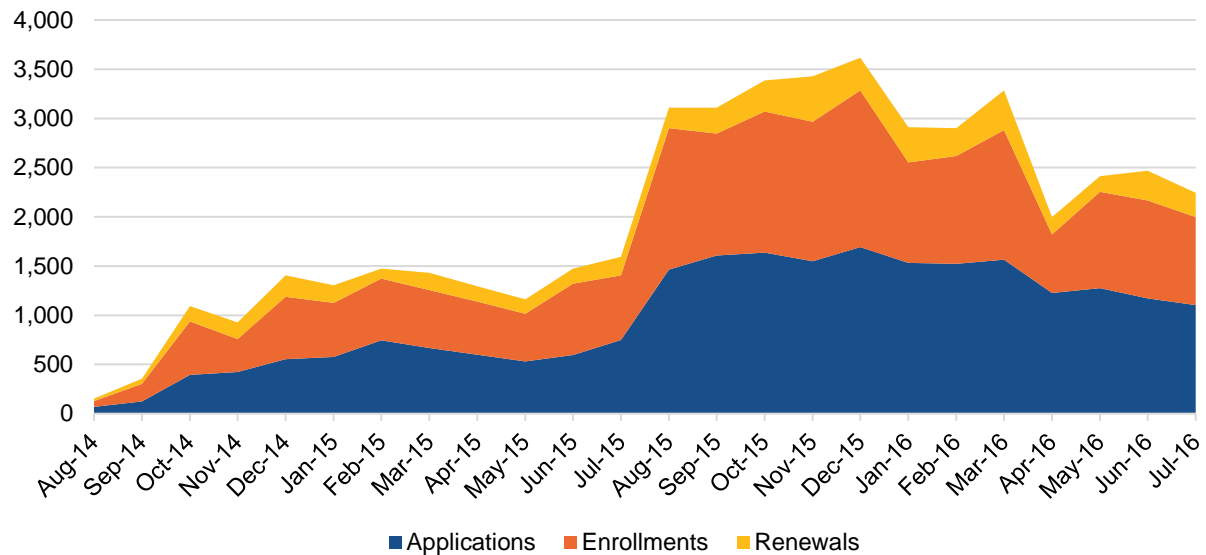
This chapter presents key findings on each of the major research questions. First, it presents aggregate application and enrollment outcomes from August 2014 through July 2016. Second, it discusses implementation successes and challenges cities experienced in conducting outreach and enrollment to EBNE children and families. Finally, it summarizes grantees' plans to sustain their campaigns.

A. Are cities effective conduits for increasing coverage take-up?

Cities can effectively conduct outreach and enrollment work: nearly 20,000 adults and children have enrolled in Medicaid or CHIP as a result of CEHACF cities' campaigns. In the aggregate, the six cities that have been able to track applications resulting from their work (Garden City, Hattiesburg, Jacksonville, New Bedford, Pittsburgh, and Savannah) supported 23,372 applications. During the same time frame, the four cities that can attribute enrollments to their campaign applications (Garden City, New Bedford, Pittsburgh, and Savannah) helped 19,829 children and adults enroll into coverage, and 5,232 children and adults renew their coverage between August 2014 through July 2016 (Figure II.1).⁵

⁵ An application can include more than one individual, such as multiple members of the same family. Enrollments represent individuals, rather than households or families.

Table II.1 (continued)

Figure II.1. Total applications, enrollments, and renewals (children and adults), August 2014–July 2016

Source: Mathematica analysis of city-reported data, August 2014–July 2016.

Note: Applications include those applications submitted for Medicaid and/or CHIP initial enrollment or renewal.

Despite success with applications and enrollments, campaigns encountered implementation challenges, with a slow start-up reported by staff from most participating cities as outreach strategies were tested and refined. After two months, enrollments began to increase, with spikes in applications and enrollments occurring at the end of the first campaign year. These spikes were related to new outreach and enrollment activities targeting youth summer programs and back-to-school activities. In the first year, cities generally experienced reduced enrollments during winter holidays and poor weather (particularly in the Northeast), although applications remained relatively steady from August 2015 onward.

Although the cities focused primarily on enrolling children—only two of the cities even set adult enrollment goals—adult enrollments were nearly double child enrollments (12,730 adults compared to 7,099 children). This appears to be the result of a combination of factors. First, there are so many more uninsured adults than uninsured children; as of 2014, there were nearly six uninsured adults for every one uninsured child. That makes uninsured adults much easier to find, compared to uninsured children. Second, ACA rules that permit expansion of Medicaid clearly helped drive adult enrollment, since the cities with the largest adult enrollments are all located in states that expanded Medicaid. Third, many cities conducted campaign outreach at locations that serve low-income adults and children, such as community centers and clinics, rather than focusing only on child-centric locations, such as schools or day care centers. Thus, many CEHACF campaigns benefited from the “welcome mat effect,” which is when parents seeking to enroll their child in coverage find out that they, too, are eligible. As staff in New Bedford noted, “In order to enroll a child, you have to reach the adult, so you’re going to focus more on the adults than the children. The kids can bring home a message in their backpack from school, but you’re still reaching out to the adult.”

Table II.1 (continued)

B. What factors contributed to success, and what factors challenged outreach and enrollment campaigns?

Cities participating in this project found they were well positioned to navigate complex federal and state Medicaid and CHIP policies in developing and implementing outreach and enrollment campaigns in areas with concentrations of EBNE children and adults. However, they encountered challenges along the way, some of which they successfully overcame. This section reviews successes and challenges in four areas: (1) identifying and developing relationships with partners, (2) planning and implementing data collection plans to measure campaign success, (3) balancing the use of best practices in outreach and enrollment against the desire to innovate locally, and (4) implementing the multistage funding strategy.

1. Identifying and developing relationships with partners

Campaign leaders understood the value of partnering with community groups that served the same target population, but developing those partnerships during implementation was challenging; the most successful cities relied on partnerships that predated CEHACF. The two cities that leveraged

existing relationships had the most campaign success. For example, New Bedford's community-based partnerships were well-established before the campaign launched, making it much easier to move right into application assistance and enrollment activities. The New Bedford campaign was housed in the city's public health department, which is the city's primary provider of services to uninsured people. This department already had ties with the city's community health center and school-based nurses. This enabled New Bedford to couple health service delivery—such as a pediatric dental program administered in the schools—with health care enrollment initiated through CEHACF. When children and families arrive for services and are identified as uninsured, they are immediately given a warm hand-off to enrollers, after which providers can bill for services. These identification, referral, and enrollment practices are now institutionalized among city and partner staff.

"The Health Department, the community health center's chief of pediatrics, and the school nurse were the core partnership, and we're boots on the ground. It's easier than if you are a 501(c)3 trying to work in a municipality; you don't have the connections and the infrastructure just there. You have to make the connections, and hope those people work with you . . . When someone said can you make policy, we make policy and implement it, that's what we do. We don't have to rely on someone else to make our policy for us, we just do it. So this is different, our leadership team is uniquely qualified to just start running."

-New Bedford grantee

Savannah's campaign leveraged existing relationships between the Chatham County Safety Net Planning Council and school district administrators as an entry point to developing relationships with school principals. The campaign's program manager then focused on

On accessing schools: "You pretty much have to have the buy-in from the very top. The same way that we had the mayor on our side. So that opened a door to all kinds of staff people knowing that they could spend staff time on work that, frankly, was not in their game plan. So that, I think, is a good parallel. If you don't have those relationships at the very top, it would be harder to work your way in the door otherwise. It's the people on the ground where those relationships are really key and make the difference."

-Savannah grantee

developing relationships with social workers, parent facilitators, and school nurses within each school. Savannah noted that those individual school-level relationships became "really powerful engines for enrollment," but agreed that without buy-in from high-level school administrators, this route into local schools would have been difficult. After this approach succeeded, the Savannah team began grassroots outreach to high-level juvenile justice program administrators. This helped them develop a relationship

Table II.1 (continued)

between the campaign and juvenile probation officers, which resulted in an opportunity to enroll eligible juveniles into Medicaid. Juvenile justice staff viewed the partnership as a win-win, since youth in the juvenile court system needed insurance coverage in order to access court-ordered behavioral health services. The campaign now has a health enrollment referral process embedded in the juvenile court system. Although the campaign has not seen many referrals from this source compared to referrals from the school system, those who have enrolled are high-needs, underserved youth.

With partnerships, context is key: partnerships that are essential to one city's campaign may not be easily replicated in another city. As discussed above, New Bedford and Savannah leveraged existing relationships with their school systems to facilitate their campaigns. Although schools are a natural place to find children—all of the cities' initial business plans identified partnerships with schools as key to their campaigns—the other cities did not have relationships in place that enabled them to embed high-touch enrollment strategies and assistance in schools during the grant period. For example, Garden City's initial strategy of providing school-based outreach and enrollment at parent-teacher conferences did not lead to the anticipated “flood” of people interested in information nor an expected increase in enrollment appointments: “We thought [by being at the schools] we were going to get a lot of feedback or a lot of people calling from the school. It's been interesting to see how that's not necessarily the best place to reach parents. The water bill [insert]—of all things—was how to reach parents; they have to pay their water bill to care for their kids. It's been interesting to see the little nooks and crannies of the community, and how they react to different things.” Hattiesburg also expected the schools to be their primary source of accessing children and families for outreach. Although Hattiesburg experienced some success with outreach activities at school registration events, the response to monthly school enrollment events elicited a low response. Finally, Pittsburgh has struggled to establish a school-based referral pipeline for enrollment assistance. The school district is just now—two years after campaign launch—including an insurance status question on its online enrollment forms that will automatically ask parents or guardians if they would like assistance and will connect them to the campaign; it is too early to assess whether this will lead to meaningful enrollments in the 2016-2017 school year.

Other examples of partnerships that were less successful than anticipated in some cities included those with libraries (Providence) and churches (New Bedford and Hattiesburg), and agreements with partners to hire enrollment assistants (Jacksonville and Savannah). In Providence, libraries were not high-traffic areas that attracted clients seeking to apply for or renew coverage. Churches were less successful partnerships for Hattiesburg and New Bedford for two separate reasons: (1) in Hattiesburg, the majority of families attending church did not fit the eligibility demographics for Medicaid or CHIP; and (2) in New Bedford, churches were already inundated with requests to act as intermediaries to community resources. In contrast, Savannah had a successful partnership with a church-based organization that the city already coordinated with on other community work. Although Hattiesburg found success using Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) centers as enrollment locations, New Bedford's efforts to partner with its local Head Start has been challenging. Head Start had historically been charged with helping families enroll in health insurance in New Bedford, and the implementation of the CEHACF campaign prompted some territorial issues between the groups that have yet to be resolved. For Jacksonville and Savannah, enrollment assistance through partnerships did not materialize. In Jacksonville, the campaign subcontracted

Table II.1 (continued)

with an agency to conduct enrollment activities, but the agency took months to hire staff and the campaign ultimately pulled the funding because the agency did not produce results. Similarly, an agreement with a hospital in Savannah to hire an enrollment assistor at a local hospital took significantly longer than anticipated due to internal human resources processes.

Some participating cities successfully harnessed other government agencies or municipal programs to embed outreach and enrollment strategies. Some campaigns emphasized integrating outreach and enrollment within existing city or government programs or services to reach the target population where they live and work. For example, both Hattiesburg and Providence focused on reaching potentially eligible children and families through government services such as WIC centers and the Low-Income Home Energy Assistance Program (LIHEAP), whereas Pittsburgh used 2-1-1, which helps residents navigate community resources, services, and referrals, and a neighborhood employment center.

Because the Hattiesburg campaign staff were new to this work, they first determined the services EBNE families were likely to use: “Our process was, how do I find where our people are going? So if you are eligible for Medicaid and CHIP, what are you doing on a daily basis, where do you go, who do you see, and how can [the campaign] be a part of that process?” Hattiesburg noted that the relationship with WIC centers and the health department were the most successful partnerships and enrollment sites, particularly because eligibility to participate in programs like WIC typically met Mississippi’s eligibility requirements for Medicaid and CHIP. In Mississippi, WIC participants can only pick up their food at specific WIC centers, so campaign administrators knew they had a chance to interact with this population in person weekly. Thus, offering enrollment sites in those locations enabled Hattiesburg to best reach the EBNE population in the city.

“Our affiliation with WICs and the health department automatically gave us rapport, legitimized our efforts [to enroll EBNEs], and made it a lot easier for clients and consumers to trust us and engage us in conversations about their health status or health insurance status . . . WIC has a long history in the community. As far as finding the right place and the right partnership, that was key. But then to make it successful, we had to be an expected part of that agency culture. We have become known in those WIC centers, so our clients know that we’re going to be in the same place at the same time every week, so if they have questions they can come back to us. They don’t have to hunt for us, they can find us as part of their regular routine.”

-Hattiesburg grantee

On embedding outreach and enrollment strategies to reach families: “Taking a seasonal approach and working with captive audiences has maximized our resources. When I talk about taking a seasonal approach, it’s understanding how the community moves throughout the year and where we can find them during specific times of the year. We know that during the winter, it’s very hard to get people out in the middle of the snowstorm, but if there is a turkey basket being given away for Thanksgiving, or if it’s a toy drive for Christmas, you will have families that will be coming to different locations to secure those for their family; those are opportunities to work with those partners in the community to reach out to individuals.”

-Providence grantee

Like Hattiesburg, Providence was also cognizant about targeting its efforts in places where community members regularly go. In particular, Providence focused on outreach and enrollment through the city’s housing authority and LIHEAP. A campaign staffer and the coordinator of one of the public housing sites personally introduced themselves to occupants of over 330 public housing units. Providence staff noted that, as a trusted person within the community, the housing coordinator helped the campaign staff introduce themselves and conduct outreach, enrollment, and renewals. Providence also conducted enrollments and renewals with residents waiting to apply for and receive heating assistance through LIHEAP, as well as at holiday toy drives and summer meal distributions.

Table II.1 (continued)

Pittsburgh’s campaign credited its relationship with the mayor’s office for opening the door to training 2-1-1 operators to engage callers about health insurance when residents contact the service for referrals to address issues such as shelter, clothing, and other immediate needs. The campaign implemented a warm transfer process, referring callers interested in eligibility and enrollment to enrollment assisters and directly transferring their calls, which has been more effective than providing callers with another number to call. Pittsburgh additionally set up on-site enrollment assistance at a neighborhood employment center with heavy foot traffic, which enabled residents to learn about eligibility, schedule appointments, and apply for coverage.

“We make sure that we are engaging people where they are at in the community, because that’s always been our biggest point—to reach them rather than having people have to find and reach us.”

Pittsburgh grantee

2. Planning for data collection to measure success

The cities that had the most success tracking enrollments attributable to their campaigns thought about data from the outset: they had detailed data plans and data-sharing agreements in place before their campaigns began. Detailed data collection and reporting plans for partners, as well as access to Medicaid and CHIP enrollment data, were essential components of successful campaigns: cities needed to be able to track an application, determine if the application resulted in an enrollment, or if not, provide additional enrollment assistance to the family (such as obtaining additional income documentation or helping a family file an appeal). Cities that tracked application and enrollment data successfully had thorough data collection plans in place before their campaigns began, enabling them to assess campaign success. They also had established data collection processes and agreements with outreach and enrollment partners, and entered into agreements with their state Medicaid agencies to track campaign-assisted Medicaid or CHIP enrollments.

However, even for some cities with established data-sharing agreements with state Medicaid agencies (as in Hattiesburg and Providence), accessing data on enrollments attributable to campaigns proved to be a persistent barrier to data tracking and reporting.⁶ In particular, despite Hattiesburg’s established relationship with the state Medicaid office, its relationship with the regional office that was responsible for processing Medicaid and CHIP applications in the Hattiesburg area was strained. While Hattiesburg and Providence were able to access total enrollments in their respective zip codes, these enrollments were not necessarily attributable to their campaigns, nor did they appear to be accurate, given the numbers of people the cities reportedly have helped with applications. Although they were the grant administrator and were providing technical assistance to the cities, NLC was new to Medicaid and CHIP outreach and enrollment work, which limited its ability to help cities overcome these data barriers.

⁶Negative interactions with state staff hindered the execution of a signed memorandum of understanding between the Jacksonville campaign and the state’s Medicaid agency, which made it impossible to obtain state determination data. In addition, the campaign’s enrollment partners were unable or unwilling to track application assistance they provided and report it to the campaign

Table II.1 (continued)

3. Balancing best practices in outreach and enrollment with innovation

Cities that built their campaigns on evidence-based practices and adapted them to their local circumstances were more likely to find and enroll the uninsured. The CEHACF application for the implementation grants encouraged cities to propose innovative outreach and enrollment approaches. However, upon award, this frequently resulted in the use of outreach approaches that were not effective in enrolling individuals into coverage. For example, although

On one-on-one enrollment assistance: “We found that mobile enrollment assistors, helping people, holding their hand, doing this enrollment assistance is critical to kids and families getting on Medicaid. I know that was the core of our strategy.”

-Savannah grantee

one-on-one enrollment assistance is associated with increased enrollment rates, the emphasis on—and proportion of the total grant budgeted for—such assistance varied among cities. Cities with the most enrollment success budgeted much more than their counterpart cities to support direct enrollment assistance. For example, New Bedford—the most successful of the CEHACF cities in terms of total enrollments—invested more than half of its grant in direct

assistance. In five of the other eight cities that received implementation grants, the amount budgeted for direct enrollment assistance ranged from less than 5 percent to 18 percent. Cities that planned to incorporate more enrollment assistance through partner donations of “in-kind” staff time found it was difficult to supervise, and nearly impossible to monitor, such work.

Cities’ experiences with direct enrollment assistance also varied. For example, Pittsburgh had a Navigator grant and experience with enrollment before the NLC implementation grant, whereas Hattiesburg was starting from scratch. Jacksonville struggled the most throughout the campaign as its enrollment was initially supposed to be conducted by partners. In hindsight, Jacksonville noted that using paid enrollers directly supervised by the campaign would have been more efficient: “There [are] a lot of places where you can fill out and submit an application. In Florida, the process is so cumbersome that unless you have someone there to follow up with you [and help navigate forms or missing information]—if you don’t have someone there following up with you and walking you through it, people won’t follow through.” Using enrollers donated by partners also led to data reporting problems for Jacksonville: the partners would not report data on assisted applications to the campaign because they were not paid to do so.

On direct enrollment assistance: “Our role, originally, when we wrote this proposal was supposed to be coordination. If I had the chance to do it over again, this truly would have been a city campaign. The Jacksonville Children’s Commission would have run it. We would have hired all the staff. Outreach and enrollment were fragmented [in our campaign]: You can submit applications all day long, but if you submit 100 applications without the [one-on-one] navigation process, maybe five or ten percent of them will actually make it to completion, which doesn’t really help anybody.”

-Jacksonville grantee

Table II.1 (continued)

4. Implementing the multistage grant strategy

NLC was well known and well regarded by city governments. Their management of the grant gave the project immediate credibility and helped the cities connect with each other. Cities also appreciated NLC's approach in structuring the phases of the grant to enable cities to learn about, research, and plan their approaches. Overall, both NLC and implementation cities valued the leadership academies and planning phases, which were needed since most cities were new to health benefits outreach work. For example, Garden City credited

the leadership academy for portraying health insurance assistance as “doable,” and recruiting partners to the table—even those who initially did not support integrating Medicaid and CHIP outreach and enrollment assistance within a city department. In addition, although some cities noted that the planning process was intense, that intensity contributed to a well-developed implementation plan. Staff from Hattiesburg, Jacksonville, Savannah, and Providence also reported that the planning phase was an opportunity to assess community needs and resources, fully understand the problem of EBNE children and families in their communities, and develop outreach and enrollment strategies.

-NLC staff

However, staff from NLC and some cities cited drawbacks of this grant strategy, including missed opportunities with cities that did not receive implementation grants, inherent tension among participating cities about sharing ideas and strategies in a competitive award environment, and NLC's limited experience with health benefits outreach. Although the nature of the multistage grant funding strategy meant not all who developed business plans would secure the next stage of funding, NLC staff noted that they wished they had planned for follow up with cities involved in the earlier stages of the grant (for example, they might have linked them to other funders potentially willing to fund their campaigns, or offered ongoing technical assistance to cities willing to undertake campaigns without grant funding through CEHACF). NLC also discussed some grantees' concerns about others “stealing” ideas, especially during Phase II when cities were developing their campaign plans but were still competing for the implementation awards. NLC attempted to allay these concerns by emphasizing that it would assess cities' plans independently, based on the merits of the planned strategies. Cities reported that initially, NLC was unable to provide the support and technical assistance grantees needed specifically on Medicaid and CHIP outreach and enrollment strategies and policies. However, as implementation ramped up, so did NLC's health benefits outreach knowledge.

Although cities lauded NLC's ongoing technical assistance and facilitation of peer-to-peer learning among cities, some TA strategies were better received than others. Both NLC and cities found the multiple cross-site meetings the most helpful opportunity to meet and share ideas, experiences, and challenges in person, followed by the individual technical assistance monthly calls. These monthly calls were an opportunity for cities to report on progress and setbacks, and for NLC to provide feedback and advice. In addition, if NLC heard similar challenges among two or more cities, it could easily connect them to work through potential solutions. Webinars were considered the least useful form of technical assistance, particularly if

Table II.1 (continued)

they focused on information or featured experts that were not applicable to all cities. Overall, cities involved from the leadership academy through the implementation phase were able to build strong relationships with one another and with NLC, and they expect those relationships to continue after the grant funding ends.

C. Will participating cities sustain the work begun under the CEHACF grants, and if so how?

Seven of eight CEHACF cities will sustain their campaigns by integrating them into city or partner operations.⁷ NLC required that all campaign business plans include plans for sustainability following the end of CEHACF funding. Incorporating sustainability discussions from the outset ensured that campaign strategies and activities were planned and implemented with an eye toward continuing beyond the grant period. As a result, campaigns either will continue their work under the city department or agency in which they began (Garden City, Jacksonville, New Bedford, Providence, and Savannah), or have transitioned the work to a key campaign partner (Hattiesburg and Pittsburgh) with campaign implementation staff still involved in day-to-day operations (Table II.1).

Table II.1. Sustained CEHACF activities, by city

City and campaign name	Campaign location	Sustained activities	Funding
Garden City, Michigan Healthy Kids—Happy Families	Garden City Community Resource Department	<ul style="list-style-type: none"> Continued outreach at school-based summer lunch program, back-to-school events, and outreach and enrollment information via city water bill insert mailings 	<ul style="list-style-type: none"> 2015 Navigator grant (through January 31, 2017): Navigators located in local libraries, city halls, and community centers county-wide Secured city funding for continued direct enrollment assistance via the City Community Resource Department
Hattiesburg, Mississippi E ³ (Educate, Enroll, Empower) Health Initiative	Past: City of Hattiesburg's Mayor's Office Present: University of Southern Mississippi	<ul style="list-style-type: none"> Campaign housed within the University of Southern Mississippi's School of Social Work Continued direct enrollment assistance at WIC centers and city health department 	<ul style="list-style-type: none"> 2015 Navigator grant (through January 31, 2017): Replicating campaign model in 24 counties Connecting Kids to Coverage CHIPRA grant: Replicating campaign model in 8 counties
Jacksonville, Florida Cover Jacksonville	Jacksonville Children's Commission	<ul style="list-style-type: none"> Developed Cover Jacksonville web-based toolkit that shares planning and implementation strategies Continued identification and referral of uninsured children to enrollment assistance through summer camp registrations; all contracts and requests for proposals require that intake forms ask insurance status 	<ul style="list-style-type: none"> Currently seeking additional funding sources
New Bedford, Massachusetts Healthy Access Kids New Bedford	New Bedford Health Department	<ul style="list-style-type: none"> Coupling health insurance enrollment with provider care in schools and the community 	<ul style="list-style-type: none"> Currently seeking additional funding sources

⁷ Dallas was excluded from this analysis: it did not submit monthly data reports and did not respond to requests for the final round of interviews.

Table II.1 (continued)

City and campaign name	Campaign location	Sustained activities	Funding
Pittsburgh, Pennsylvania Healthy Together	Past: City of Pittsburgh's Mayor's Office Present: Consumer Health Coalition	<ul style="list-style-type: none"> Continued partnership with Enroll America linking identified EBNEs to direct enrollment assistance Secured commitments of new and existing partners Integrating campaign within the city's existing Live Well Pittsburgh initiative (promotes wellness citywide) Implemented online referral form (on getenrolledPGH.com website) to generate requests for enrollment assistance from city agencies and community-based organizations 	<ul style="list-style-type: none"> Currently seeking additional funding sources
Providence, Rhode Island	City of Providence Healthy Communities Office	<ul style="list-style-type: none"> Campaign partners (United Way, housing authority, LIHEAP) are training staff to provide direct enrollment assistance and assume work of the campaign 	<ul style="list-style-type: none"> Currently seeking additional funding sources
Savannah, Georgia The Mayor's Campaign for Healthy Children & Families	Step Up Savannah and Chatham County Safety Net Planning Council	<ul style="list-style-type: none"> Continued outreach and direct enrollment assistance via the Chatham County school system, juvenile court, and libraries 	<ul style="list-style-type: none"> Healthcare Georgia Foundation grant Connecting Kids to Coverage CHIPRA grant: Expanding campaign to 5 counties

Source: Analysis of monthly data reports, final reports to NLC, and July 2016 interviews.

Note: CEHACF = Cities Expanding Health Access for Children and Families; EBNE = eligible but not enrolled. Dallas has faced multiple barriers reporting application data and enrollment activities. We have excluded the city from the analysis because it has been unable to collect and report campaign data

Although cities have noted they intend to sustain outreach and enrollment strategies and activities, the extent to which they are currently doing so varies, depending on the strength of their community partnerships and available funding. For example, New Bedford and Pittsburgh are seeking additional funding opportunities to support campaign activities, but they believe that integrating their campaigns into the work of the city and their partners will be key to sustaining their campaigns. Providence is seeking additional funding sources but anticipates that its partners, United Way, the housing authority, and LIHEAP—which are each training their own staff to provide direct enrollment assistance and become certified enrollers—will take on the bulk of enrollment assistance. It is unclear to what extent city staff will be able to maintain enrollment and renewal efforts in Providence.

Garden City, Hattiesburg, and Savannah obtained additional funding to support the work of their campaigns. This new funding support has enabled these cities to continue campaign activities and spread their respective campaign models beyond city limits. Garden City and Hattiesburg received 2015 Navigator grants⁸ and have replicated successful campaign strategies in additional counties. In June 2016, Hattiesburg and Savannah were notified that they were among 38 state, school district, and local community organization recipients of the Connecting Kids to Coverage CHIPRA grants to enroll children in Medicaid and CHIP. Similar to the Navigator grant, Hattiesburg will use the same program model and strategies in eight

⁸Awarded by CMS, Navigator grants fund in-person assistance to help consumers with health insurance coverage questions and enrollment in states with Federally Facilitated Marketplaces and State Partnership Marketplaces. Navigators are knowledgeable about the range of health care plans available on healthcare.gov, as well as Medicaid and CHIP.

counties. The core of Savannah's strategy for the new grant is expanding the campaign it built through its CEHACF campaign to five contiguous counties.

III. DISCUSSION

Over the past two years, our evaluation has found that cities can move the needle on health insurance coverage. The cities participating in this project found they were well positioned to navigate complex federal and state Medicaid and CHIP policies in developing and implementing outreach and enrollment campaigns in areas with concentrations of eligible but not enrolled children and adults. Highlights of successes of the CEHACF project include:

- Cities have supported more than 23,000 applications; nearly 20,000 children and adults have enrolled in Medicaid or CHIP as a result of cities' campaigns, and over 5,000 have renewed coverage.
- Cities developed key partnerships with community groups that served the target population, and embedded outreach and enrollment strategies within many existing city or government programs or services to reach uninsured but eligible children and families where they live, work, and play.
- Cities have largely institutionalized their campaigns within city operations or partner programs so that campaigns will continue after the CEHACF grants end. Some have also obtained additional resources—ranging from city funding to federal grants—to continue and spread campaign efforts to reach uninsured children and adults.

At the same time, while progress in health benefits outreach and enrollment work at the city level is promising, several challenges persisted throughout the grant. For example, neither NLC nor the cities fully anticipated the level of trust and numerous “touches” the campaigns would need to develop with families before these families would share sensitive income and health status information. In some cities, campaign staff noted that they assumed at the start that people in need of health insurance would show up for assistance once they learned help was available. In fact, in order to reach the target population, campaign staff learned they had to establish or leverage partnerships with entities that already provide services to this population, which helped to provide legitimacy to the outreach campaigns.

Cities interested in pursuing similar work should consider the following lessons before initiating their own outreach campaigns:

- **Network with local organizations and city agencies to help determine which types of partners are most conducive to outreach and enrollment work to the target population, and to foster buy-in for the campaign.** Among the CEHACF cities, those with partnerships established before campaign implementation had more successful campaigns. If not already in place, cities should begin cultivating partnerships with groups likely to have access to the target population before beginning outreach and enrollment activities, and if possible, provide incentives for partners to participate
- **Develop comprehensive data collection plans to monitor and assess progress, and execute data-sharing agreements.** Cities that were most successful in collecting application and enrollment data established data collection processes and agreements with outreach and enrollment partners. They also had agreements in place with their state Medicaid agencies to enable them to track campaign-assisted Medicaid or CHIP

enrollments. It is important for cities to collect this data, since without it they cannot assess what aspects of their campaign are or are not working well, nor examine data patterns that might show where activities could be modified.

- **Use evidence-based outreach and enrollment strategies.** Although innovation is important—and might be required to identify and develop successful partnerships in a particular city—one-on-one direct enrollment assistance was the most successful strategy for enrolling children and their parents in the CEHACF cities. If possible, cities should incorporate a ‘warm hand-off’ approach, which promotes a seamless referral between identification as eligible and enrollment assistance. Many seemingly innovative strategies, such as referrals from 2-1-1, 3-1-1, or robo-calls, did not yield the same response as boots-on-the-ground, direct enrollment assistance. Such referral strategies put the burden on the uninsured, requiring them to reach out for assistance, rather than targeting members of the potential eligible population where they already accessed programs and services.

REFERENCES

- Bradley, Elizabeth H., Leslie A. Curry, and Kelly J. Devers. “Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory.” *Health Services Research*, vol. 42, no. 4, August 2007, pp. 1758–1772.
- Chung, Phillip, Tia A. Cavender, and Debbi S. Main. “Trusted Hands: The Role of Community-Based Organizations in Enrolling Children in Public Health Insurance Programs.” The Colorado Trust. February 2010. Available at http://www.coloradotrust.org/attachments/0001/0489/TrustedHands_021010_FINAL.pdf. Accessed February 23, 2015.
- Enroll America. “In-Person Assistance Maximizes Enrollment Success.” March 2014. Available at <https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf>. Accessed February 23, 2015.
- Flores, Glenn, Alan Meyers, Harriet Fernandez, and Ana Milena Diaz. “A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children.” *Pediatrics*, vol. 116, no. 6, December 1, 2005.
- Hoag, S., D. Lipson, and V. Peebles. “On the Road to Universal Children’s Health Coverage: An Interim Report on the KidsWell Campaign. Princeton, NJ: Mathematica Policy Research, 2015. Available at <https://www.mathematica-mpr.com/our-publications-and-findings/publications/on-the-road-to-universal-childrens-health-coverage-an-interim-report-on-the-kidswell-campaign>.
- Kenney, G., J. Haley, C. Pan, V. Lynch, and M. Buettgens. “Children’s Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation under the ACA.” Washington DC: The Urban Institute, 2016. Available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf429061.
- Kenney, G.M., V. Lynch, M. Huntress, J. Haley, and N. Anderson. “Medicaid/CHIP Participation Among Children and Parents.” Washington, DC: Urban Institute, December 2012. Available at <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412719-Medicaid-CHIP-Participation-Among-Children-and-Parents.PDF>.
- Miles, Matthew B., A. Michael Huberman, and Johnny Saldaña. *Qualitative Data Analysis: A Methods Source Book*, 3rd ed. Thousand Oaks, CA: Sage Publications, 2013.
- Miller, Christina. “KATCH-ing the Uninsured: Lessons from Kansas’ Out-stationed Eligibility Workers.” January 23, 2012. Available at <https://statehealthaccess.wordpress.com/2012/01/23/katch-ing-the-uninsured-lessons-from-kansas-out-stationed-eligibility-workers/>. Accessed February 23, 2015.
- Orfield, Cara, Debra Lipson, and Sheila Hoag. “Competitive Grant-Making: Lessons for Funders to Help Local Governments Increase Health Coverage.” Report submitted to The Atlantic Philanthropies. Princeton, NJ: Mathematica Policy Research, May 20, 2015.
- Peebles, Victoria, Sheila Hoag, Michaella Morzuch, Linda Barterian, and Debra Lipson. “Supporting Advocacy to Achieve Universal Children’s Health Coverage: Final Report on the KidsWell Campaign.” Report submitted to The Atlantic Philanthropies. Princeton, NJ: Mathematica Policy Research, 2016.

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