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Covering Kids & Families Evaluation

*Case Study of Illinois: Exploring Links
Between Policy, Practice and the Trends in
New Medicaid/SCHIP Enrollments*

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About the Covering Kids & Families Evaluation

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

The evaluation focuses on these key issues:

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

Findings from the evaluations can be found at www.rwjf.org/special/ckfeval.

Background

The *Covering Kids & Families*® (CKF) initiative of the Robert Wood Johnson Foundation (RWJF) has two goals: to reduce the number of children and adults eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) who remain uninsured, and to build the knowledge, experience and capacity necessary to sustain the enrollment and retention of children and adults in those programs after the CKF program ends. RWJF issued four-year CKF grants to 46 states, beginning in 2002. CKF expanded on its predecessor, the RWJF *Covering Kids Initiative* (CKI), which operated from 1999 to 2002.

CKF works through state and local coalitions to maximize enrollment in public health insurance programs for uninsured, low-income children and adults. CKF grantees employed three strategies to increase enrollment and retention of eligible uninsured children and families:

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

This is one of 10 case studies that examine the link between enrollment trends and policy and practice at the state and local levels. The case studies look particularly at the role of outreach, simplification and coordination in changing levels of new enrollment over time. The case studies are the work of Mathematica Policy Research, Inc., and its subcontractors, the Urban Institute and Health Management Associates, the team entrusted with evaluating the CKF program.

Introduction

This case study examines enrollment trends in Illinois for children in Medicaid and SCHIP from 1999 through mid-2005. It also examines the activities of the CKF project and its interaction with state policy from January 2002 through June 2006, when the Illinois CKF grant ended. In particular, the study examines the potential relationship between new enrollment during these periods and the specific activities and efforts associated with Illinois' 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. However, because many of the outreach efforts and policy changes occurred at or near the same time, such analysis is not possible. In addition, no state or other geographic area is a defensible comparison group for a rigorous analysis. The use of a case study approach, which combines exploratory data analysis with in-depth interviews, allows us to ascertain where and how CKF's influence was most likely a factor.

The primary source of data used in the study was quarterly enrollment data from the Medicaid Statistical Information System (MSIS), obtained from the Centers for Medicare & Medicaid Services (CMS). Using these data, we developed a measure indicating the number of new entries per quarter into Medicaid or SCHIP from October 1999 through June 2005. A new entry was defined as any enrollment, into either program, of a child (excluding new babies) who had not been enrolled in either program within the past 12 months. This definition supports the CKF objective of expanding program enrollments and also focuses on the population of children whose enrollment would have most likely been influenced by policy changes and major outreach efforts.

In the late winter and early spring of 2007, we conducted detailed interviews with CKF state and local grantee staff, state Medicaid and SCHIP officials in Illinois and a former state official who led the Illinois Bureau of KidCare from 1997–2003. We asked interviewees to comment on the evolution of Medicaid/SCHIP coverage in the state, related policy changes, CKF activities, and other factors that might have affected Medicaid and SCHIP enrollments. Additional insight was garnered from other sources, including pertinent state and project Web sites, CKF online reports, and other program documents. To identify common themes and qualitative explanations for data trends, we compared and analyzed interview responses, program information, and new enrollment data.

State Policy Context

During the study period, Illinois demonstrated continuous and growing support and commitment to the expansion of health coverage through its Medicaid and SCHIP programs despite severe state budget challenges. At the time of the passage of SCHIP at the federal level in 1997, the Illinois Medicaid program covered pregnant women, infants and almost all children at the federally required minimum levels.¹ In contrast, just eight years later in November 2005, Illinois enacted landmark legislation authorizing the All Kids program to provide health insurance coverage for every child in the state from birth through age 18, regardless of income.

Changes in Program Eligibility

In 1998 Illinois implemented SCHIP through the creation of Illinois KidCare—a combined Medicaid and SCHIP program providing coverage for pregnant women and children through five different coverage configurations. Phase I (implemented in January 1998) standardized Medicaid income eligibility for all children through age 18 at 133 percent of the Federal Poverty Level (FPL). This category of coverage was called KidCare Assist. At the same time, Illinois increased the income standard for pregnant women and infants up to age one to 200 percent of the FPL. This category of coverage was called KidCare Moms & Babies. Phase II of SCHIP implementation occurred in August 1998 when Illinois increased coverage for all children through age 18 to 185 percent of the FPL by creating three new KidCare coverage categories:

- KidCare Share, providing Medicaid-equivalent benefits with copayment requirements to children through age 18 in families with incomes from 134 percent to 150 percent of the FPL;
- KidCare Premium, providing Medicaid-equivalent benefits with premium and copayment requirements to children through age 18 in families with incomes from 151 percent to 185 percent of the FPL; and
- KidCare Rebate, an entirely state-funded benefit reimbursing families for all or part of the cost of private or employer-sponsored health insurance coverage up to a maximum of \$75 per child per month for children through age 18 in families with incomes from 134 percent to 185 percent of the FPL.

Table 1 describes the KidCare and FamilyCare program components as they existed in 1998 and tracks program enhancements and expansions through June 2006, when the CKF grant ended. At the time of KidCare implementation, the FamilyCare Assist program provided Medicaid coverage for parents and caretakers in families with incomes up to 38 percent of the FPL. In October 2002 the State obtained federal Section 1115 waiver authority to enhance KidCare and expand FamilyCare Assist to a higher income level. The full expansion authorized by the waiver was only partially implemented in 2002 (increasing the FamilyCare Assist income limit from 38 percent to 49 percent), but provided a ready avenue for future expansion. KidCare enhancements included the addition of a premium assistance option to the KidCare Share and KidCare Premium programs and the refinancing of KidCare Rebate (formerly state-funded) with a combination of Medicaid and SCHIP funds.

When Governor Rod Blagojevich took office in January 2003, the State was facing many fiscal challenges due to the national economic downturn that began in 2001 and resulted in state budget deficits. Despite budget shortfalls and the need to cut other state spending, the State continued to build on its previous health care expansions by expanding KidCare coverage from 185 percent to 200 percent of the FPL and FamilyCare Assist coverage from 49 percent to 90 percent of the FPL effective July 2003. In 2004 Illinois expanded FamilyCare Assist coverage from 90 percent to 133 percent of the FPL. Finally, in January 2006, the State implemented All Kids and added the FamilyCare Share, FamilyCare Premium and FamilyCare Rebate coverage options with a new upper income limit of 185 percent of the FPL.

During the time period when these eligibility expansions occurred, Illinois experienced SCHIP and Medicaid enrollment increases that were among the most significant in the nation:

- In Calendar Year 2003, Illinois was one of only six states to increase SCHIP eligibility levels and one of only five states to see SCHIP enrollment increases greater than 19 percent.²
- During Fiscal Year 2004, Illinois experienced the third highest state Medicaid enrollment growth rate in the nation (9.5%).³
- In Calendar Year 2004, Illinois ranked second in the nation (behind only California) in both the absolute increase in SCHIP enrollment (31,000) and the percentage increase in SCHIP enrollment (33%).⁴
- During Fiscal Year 2005, Illinois experienced the fourth highest state Medicaid enrollment growth rate in the nation (7.2%).⁵

TABLE 1

Summary of Illinois Medicaid and SCHIP Program Changes for Families and Children (1998–2006)

1998: KidCare Program Established

KidCare Assist (Base Medicaid and M-SCHIP* expansion) Medicaid expanded for children through 18 years in families with incomes up to 133% FPL (Jan)	KidCare Share (Separate SCHIP) Medicaid-equivalent benefits for children through 18 years in families with incomes between 134% and 150% FPL; some copays (Aug)	KidCare Premium (Separate SCHIP) Medicaid-equivalent benefits for children through 18 years in families with incomes between 151% and 185% FPL; premium and copays (Aug)	KidCare Rebate (State-funded) Established rebate for insurance costs up to \$75 per child per month for children through 18 years in families with incomes between 134% and 185% FPL (Aug)	KidCare Moms & Babies (M-SCHIP) Medicaid for pregnant women and infants up to 1 year expanded to 200% FPL (Jan)	FamilyCare Assist Covers Medicaid parents/caretakers in families with incomes up to 38% FPL; Some co-pays (pre-existing)
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2002: KidCare Enhanced; FamilyCare Expanded

	KidCare Share Premium assistance option added (Oct)	KidCare Premium Premium assistance option added (Oct)	KidCare Rebate Refinanced with Medicaid/SCHIP funds with option of supplemental coverage through KidCare Share or Premium (Oct)		FamilyCare Assist Expanded to 49% FPL (Oct)
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2003: KidCare and FamilyCare Expanded

		KidCare Premium Expanded to 200% FPL (July)		KidCare Moms & Babies Added coverage for unborn children (July)	FamilyCare Assist Expanded to 90% FPL (July)
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2004: KidCare Rebate and FamilyCare Expanded

			KidCare Rebate Expanded to 200% FPL (Jan)		FamilyCare Assist Expanded to 133% FPL (Sept)
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2005: All Kids Enacted; All Kids Pre-Enrollment Begins

2006: All Kids and FamilyCare Share, Premium and Rebate Implemented

All Kids Assist Replaces KidCare Assist; no changes	All Kids Share Replaces KidCare Share; no changes	All Kids Premium Level 1 Replaces KidCare Premium; no changes	All Kids Rebate Replaces KidCare Rebate; no changes	Moms & Babies Replaces KidCare Moms & Babies; no changes	FamilyCare Assist No changes
		All Kids Premium Levels 2–8 Coverage added for children through 18 years in families with the following income levels (State funded) (July) #2: 201–300% FPL } Premiums w/cap; copays w/ max #3: 301–400% FPL #4: 401–500% FPL #5: 501–600% FPL } Premiums w cap; copays w/ max #6: 601–700% FPL #7: 701–800% FPL #8: over 800% FPL } Premiums w/cap; copays w/ max			FamilyCare Share Added coverage for parents/caretakers with incomes between 134% and 150% FPL; additional copays (Jan)
					FamilyCare Premium Added coverage for parents/caretakers with incomes between 151% and 185% FPL; premiums and additional copays (Jan)
					FamilyCare Rebate Coverage added for parents/caretakers with incomes between 134% and 185% FPL (Jan)

* "M-SCHIP" refers to the Medicaid expansion portion of SCHIP.

Sources: SCHIP Approved State Plan Information (Illinois); Centers for Medicare and Medicaid Services; www.cms.hhs.gov

Illinois KidCare Parent Coverage 1115 HIFA Waiver; CMS; www.cms.hhs.gov

KidCare Application Agent Manual (September 2004) and KCAA/AKAA Alerts; www.allkids.com

TABLE 2

Selected Outreach, Simplification and Coordination Activities (1998–2006)

1998	<ul style="list-style-type: none"> • Asset test for all family cases eliminated. • Joint application for all KidCare programs adopted
1999	<p>Q1</p> <ul style="list-style-type: none"> • CKI grant began <p>Q2</p> <ul style="list-style-type: none"> • Governor Ryan launches an expanded public outreach campaign • KidCare Application Agents (KCAAs) engaged among agencies across Illinois to identify potentially eligible families and assist them with completing applications; increasing in number from 500 in 1999 to 1,330 in 2001 • \$50 Technical Assistance Payments (TAPs) to KCAAs for each complete and approved KidCare application instituted • Joint application for all KidCare programs simplified and reduced in length • Central processing unit created for KidCare applications
2000	<p>Q1</p> <ul style="list-style-type: none"> • 12-month continuous eligibility for children authorized
2002	<p>Q1</p> <ul style="list-style-type: none"> • 12-month continuous eligibility for children authorized County/Chicago Area Coalition continues • Significant statewide CKF media/PR campaign mounted <p>Q2</p> <ul style="list-style-type: none"> • 3-month waiting period for KidCare Share and KidCare Premium families losing private insurance eliminated • Significant level of statewide CKF outreach presentations/trainings/events sponsored <p>Q3</p> <ul style="list-style-type: none"> • CKF Back-to-School Campaign conducted • National CKF Public Service Announcements (PSAs) pitched to local media outlets throughout state with special RWJF funding • CKF Faith-Based Toolkit developed <p>Q4</p> <ul style="list-style-type: none"> • Significant level of CKF outreach presentations/trainings/events sponsored in 217 CKF Coalition area • CKF KidCare enrollment model piloted in health care settings through special grant

TABLE 2 (continued)

2003

- Q1**
 - Governor Blagojevich took office; high turnover in statewide CKF Coalition occurred due to change in Administration
 - FamilyCare applications simplified by reducing to a 1-page form when adding adult(s) to existing KidCare cases
 - Significant level of statewide CKF outreach efforts sponsored
- Q2**
 - Joint application for KidCare and FamilyCare instituted
- Q3**
 - CKF Back-to-School Campaign conducted
 - Significant statewide CKF media/PR campaign mounted
 - Significant level of CKF outreach presentations/trainings/events sponsored in 217 CKF Coalition area
- Q4**
 - Illinois participated in RWJF-sponsored “Supporting Families Process Improvement Collaborative” initiative
 - State experienced a backlog in processing KidCare applications averaging a 90 day turnaround

2004

- Q1**
 - State requirement for KidCare earned income verification reduced to a single pay stub
 - Self-declaration of day care expenses allowed
 - State CKF Grantee received additional RWJF grant to conduct CKF outreach for FamilyCare enrollments
 - State experiences a 6-month lag time in processing State Technical Assistance Payments (TAPs) payments
- Q2**
 - Presumptive eligibility implemented for children
- Q3**
 - CKF Back-to-School Campaign conducted
 - Significant level of statewide CKF outreach presentations/trainings/events sponsored
- Q4**
 - State Technical Assistance Payments (TAPs) for KCAAs submitting online applications through RealBenefits authorized

TABLE 2 (continued)

2005

- Q3** • Began state acceptance of electronic submission of KidCare and FamilyCare applications, directly from clients or from AKAAAs (“All Kids Application Agents”, formerly “KidCare Application Agents”)
- CKF Back-to-School Campaign conducted
- Q4** • 217 CKF Coalition grant ended
- All Kids enacted
- State began process of folding KidCare into All Kids program and pre-registration for All Kids

2006

- Q1** • Passive redetermination allowed for All Kids Assist, Share and Premium, Level 1
- Q2** • CKF statewide grant ended

Sources:

CKI Illinois report of grant results, www.rwjf.org; CKF On-line Report, <http://minerva.urban.org/ckf/reporting>; Illinois SCHIP Plan Amendments and 1115 HIFA Waiver, www.cms.hhs.gov; and KidCare Application Agent Manual and KCAA/AKAA Alerts, www.allkids.com; Governor Ryan Press Releases, www.il.gov. Report to the General Assembly, Public Act 93-0536, http://www.allkidscovered.com/assets/041504pa93_0536.pdf.

Other Major Enrollment Policy Changes

Table 2 provides a description of the policies and procedures related to KidCare and FamilyCare in effect before 2002, when CKF began, and tracks significant policy changes and major CKF activities and events that occurred from 2002 to June 2006, when the CKF grant ended. From 1999 through 2001, the State simplified the KidCare enrollment process in a number of ways including developing a single, shortened application for all program components and reducing eligibility verification requirements. Also, 12-month continuous eligibility for children was authorized. These measures, as well as others, reduced procedural barriers to enrollment, making coverage more accessible to qualified families. During the CKF grant period, additional simplifications were adopted including eliminating the three-month waiting period for KidCare Share and KidCare Premium (2002), instituting a joint application for KidCare and FamilyCare (2003), reducing the income verification requirement to a single pay stub (2004), instituting presumptive eligibility for children (2005), implementing Web-based KidCare and FamilyCare applications (2005), and adopting a passive renewal process for All Kids Assist, All Kids Share and All Kids Premium, Level 1 (2006).

All Kids and FamilyCare are administered by the Department of Healthcare and Family Services (DHFS), formerly the Department of Public Aid (DPA). DHFS has two centralized All Kids Units to process applications, one in Chicago and one in Springfield. Through an interagency agreement, the Department of Human Services (DHS) local offices, referred to as “Family Community Resource Centers” (FCRCs), also process applications and are authorized to determine eligibility. Case files for children and families in All Kids Assist, FamilyCare Assist, and Moms & Babies (all Medicaid and Medicaid-expansion programs) are maintained by DHS local offices. The centralized All Kids Units maintain case files for those approved for All Kids/FamilyCare Share, Rebate and Premium programs.

Finally, Illinois has developed an extensive network of hundreds of partners around the state to assist with outreach to, and enrollment of, children and families into its public health care programs. In 1999 the State began entering into agreements with community-based organizations, faith-based organizations, local governments and agents, medical providers, schools, and other organizations for help in reaching needy families and to help families applying for coverage. These entities, referred to as “All Kids Application Agents” (AKAAs, formerly, “KidCare Application Agents”) are trained in the state’s application processes and certified to provide technical assistance to families on program elements and policies. The State uses SCHIP outreach funds to make Technical Assistance Payments (TAPs) of \$50 to AKAAs for each completed and approved application.

History and Design of the CKF Program in Illinois

The Illinois Maternal and Child Health Coalition (IMCHC), based in Chicago, served as the State grantee in Illinois for both CKI (January 1999 through December 2001) and CKF (January 2002 through June of 2006). IMCHC was founded in 1988 as a coalition concerned with expanding Medicaid coverage and since then has been involved in many Medicaid and health care related issues, including the design of the State's SCHIP program. With a pre-existing coalition structure and a mission to improve the health of women and children in Illinois, IMCHC was well positioned to assume the CKI and CKF State grantee roles. IMCHC also provided consistent project staffing across the CKI and CKF grant periods with both the project director and lead staff person on board from beginning to end.

As the State grantee, IMCHC oversaw a statewide coalition, organized statewide outreach, worked with state policy-makers and funded local projects to accomplish the CKF goals in Illinois. The IMCHC convened and staffed the Covering Kids Illinois Coalition with monthly meetings co-chaired by the Illinois Department of Human Services, the Chicago Federation of Labor and the Illinois Primary Health Care Association. The business of the Coalition was organized around five working committees: Policy; Schools; Hospitals and Health Care Providers; Faith; and Business. The primary focus of the Coalition was to recommend to the state procedures to coordinate and simplify enrollment and retain enrollees in Medicaid and SCHIP.

IMCHC published a monthly newsletter to inform partners throughout the state of policy updates and of state and local program activities. IMCHC also coordinated two annual outreach campaigns (the "Back-to-School Campaign" in the fall and the "Faith, Health, and Unity Campaign" in the spring), an annual "KidCare Conference" for application agents, advocates and providers, as well as a calendar of other presentations, training sessions and events designed to promote the goals of the program. IMCHC funded two local projects during the CKF grant period: one was a continuation of a project funded in the earlier CKI grant period and the other was an expansion of a project operated in the City of Decatur and Macon County under the CKI grant that grew to include 16 central Illinois counties, all in the 217 area code region.

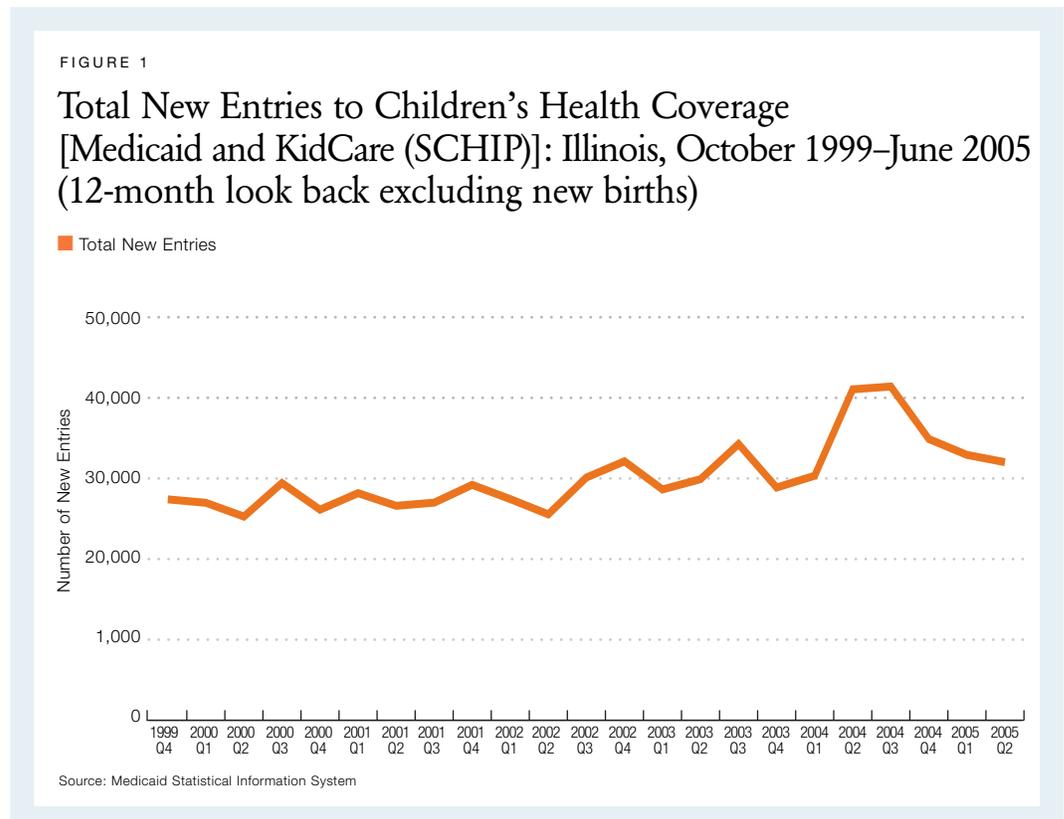
1. **Chicago/Cook County Coalition.** This coalition was originally organized as a CKI local project with the Metropolitan Chicago Healthcare Council, Children’s Health Insurance Access Project as the lead agency. Under CKF in 2002, the local grantee for the Coalition changed to the Westside Health Partnership. Given the size and diversity of the population in the Chicago/Cook County area, coordination concerns led to the development of a Leadership Team to serve as a steering committee to the larger Coalition body. This Team met monthly, while the full Coalition met every other month. The project targeted African-American, Asian-American, Latino/Hispanic American and immigrant families. The particularly large immigrant population in Chicago led to the development of an Immigration Committee to address questions and concerns related to residency, citizenship, etc. With 85 percent of students in Chicago public schools living at or below poverty level, the Coalition formed a special alliance with the school system to conduct outreach to families.

2. **The 217 CKF Coalition.** This local Coalition was formed in 2002 and was coordinated through the Campaign for Better Health Care (CBHC) headquartered in Champaign, Illinois. The sizable geographic area covered by this Coalition included a variety of urban, rural and farming communities. Regular communication with Coalition members and partners was facilitated through the use of electronic list-serve mailings. The 217 Coalition met every other month and the responsibility for chairing the Coalition was shared between CBHC and the Springfield Department of Public Health. To better facilitate member attendance, meetings were held in different locations within the area. The work of this coalition targeted coordination with the free and reduced lunch programs with schools, work with hospitals to institutionalize enrollment of uninsured new mothers, and the development of a rural outreach kit that could be used in smaller towns and farming communities. The 217 CKF Coalition also supported the state-level policy work primarily carried out by IMCHC by helping to “put a face” on health care issues. Through the CBHC helpline (which families call for service referrals), the 217 CKF Coalition identified families affected by and willing to speak out on various policy issues.

While leadership and staffing at the State grantee level was stable and consistent throughout both the CKI and CKF grant period, frequent administrative turnover occurred at the local coalition level. During the CKF grant period (2002–2006), the 217 CKF Coalition had three project directors. The other part-time 217 staff position was filled by Vista volunteers who, by design, each stayed only one year. As a result, State grantee project staff provided additional technical and direct support and supervision including attendance at most local coalition meetings. The Chicago/Cook County Coalition had two project directors during the CKF grant period but, according to State Grantee staff, was less reliant on State grantee staff for direct support and assistance than the 217 CKF Coalition.

Findings

Figure 1 illustrates the trend of new Medicaid and SCHIP enrollments per quarter over more than a five-year period that covers nearly both of the CKI and CKF grant periods. Figure 1 uses federal MSIS data adjusted to include only “new entrants,” defined as a child entering any Medicaid or SCHIP program component who had not been previously enrolled in any component within the past 12 months, and excluding new births.



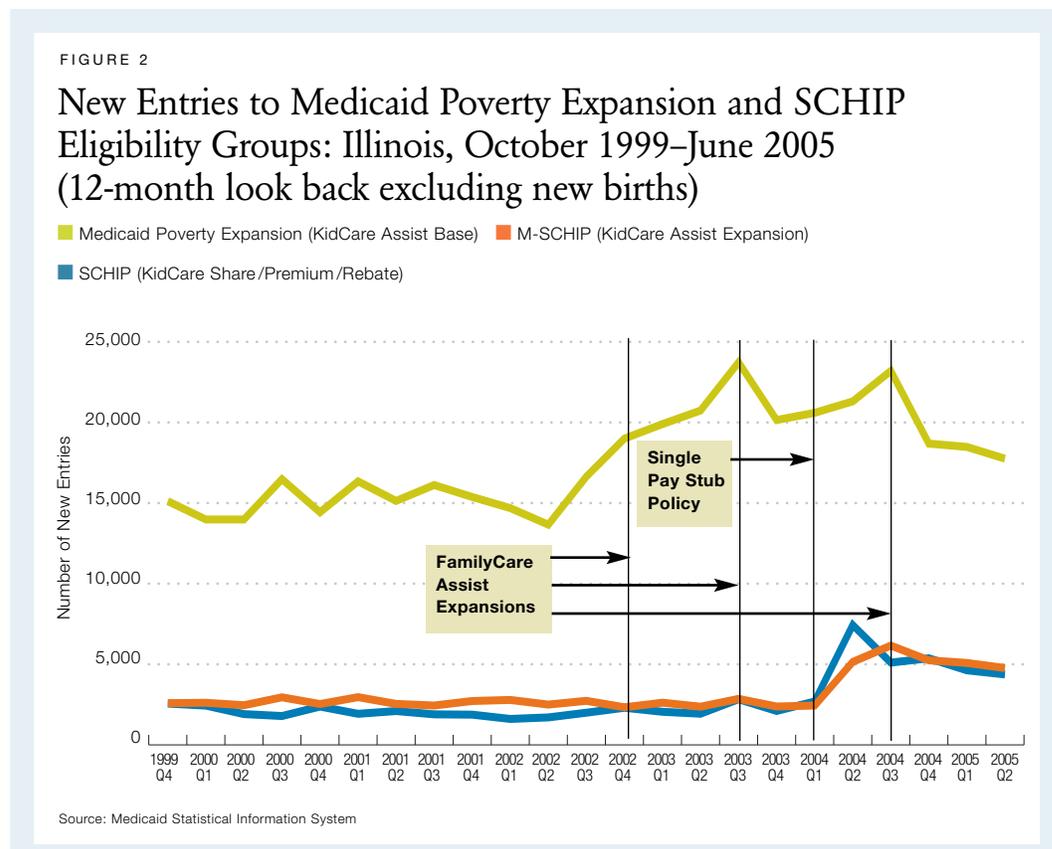
Throughout 2000, 2001 and the first two quarters of 2002, the number of new entrants remained relatively level hovering between 25,000 and 30,000 per quarter. From the fourth quarter of 2002, however, new entries reached higher levels than previously, a positive trend that peaked in the second and third quarters of 2004 at over 40,000 new entrants per quarter.

Several expansions in FamilyCare eligibility for adults coincided with increases in the number of children being enrolled in the Medicaid Poverty Expansion (“KidCare Assist Base”) and Medicaid expansion portion of SCHIP (KidCare Assist Expansion) indicating a possible causal relationship.

The income limit for parents and caretakers in FamilyCare Assist was first increased in October 2002 from 38 percent to 49 percent FPL. This expansion coincided with the positive trend in new child entrants that began in the fourth quarter of 2002 (Figure 1). Concurrent with the KidCare Premium expansion in July 2003, the FamilyCare Assist income eligibility level was expanded a second time from 49 percent to 90 percent of the FPL. Again, this increase coincided with an increase in new child entrants in the third quarter of 2003. Finally, in September 2004 the income eligibility level for FamilyCare Assist was increased a third time to 133 percent of the FPL corresponding to the peak in new child enrollments in the third quarter of 2004 (Figure 1).

Figure 2 separates the enrollment trends for the Medicaid Poverty Expansion eligibility category (KidCare Assist Base), the Medicaid expansion portion of SCHIP—or M-SCHIP (KidCare Assist Expansion), and the remaining SCHIP eligibility categories (KidCare Share, KidCare Premium and KidCare Rebate). In 2002 and 2003, new entrants in all SCHIP categories combined remained relatively flat, averaging approximately 4,600 per quarter, despite the FamilyCare Assist income eligibility increases that occurred in October 2002 and July 2003. Over the same period, however, new entrants in the Medicaid Poverty Expansion eligibility category grew significantly. Children in this eligibility category had family incomes at or below 100 percent of the FPL if they were age six through 18 or had family incomes at or below 133 percent of the FPL if they were aged five and under. Thus, children in the Medicaid Poverty Expansion eligibility category were much more likely to have parents affected by the FamilyCare Assist income eligibility expansions than children enrolled in the higher income SCHIP eligibility categories—especially the first two expansions which increased the FamilyCare Assist income limit to 90 percent of the FPL.

For all three eligibility categories (M-SCHIP, Medicaid Poverty Expansion and SCHIP), Figure 2 shows enrollment increases in the first two quarters of 2004 (although the M-SCHIP increase in the first quarter is very small). These increases could be related to a significant policy change in the state’s income verification requirements (discussed below) that was effective in January 2004. In the third quarter of 2004 when the third FamilyCare Assist expansion occurred, Figure 2 reveals a further increase in new entrants for the M-SCHIP category as well as for the Medicaid Poverty Expansion category but not for the higher income SCHIP category. Children in the M-SCHIP (KidCare Assist Expansion) had family incomes between 100 percent and 133 percent of the FPL and therefore would have been more likely to have parents affected by the third FamilyCare Assist income eligibility expansion to 133 percent of the FPL than children enrolled in the higher income SCHIP eligibility categories. The correlation between the timing of the third FamilyCare Assist eligibility expansion and the additional third quarter increases in new child enrollments in the Medicaid Poverty Expansion category and the M-SCHIP category provides further evidence of a possible causal relationship between FamilyCare expansions and children’s enrollment.



CKF-funded media campaigns in 2002 and 2004 were credited with contributing to the upward trend in new entrants that began in 2002 and continued into 2004.

In January 2002 the CKF state grant allowed IMCHC to continue outreach begun under CKI. The summary of events and activities in Table 2 shows that significant statewide media and public relations campaigns were launched in early 2002. State staff interviewed indicated that although the state administration and legislature were supportive of public health insurance issues, and in particular recognized the importance of outreach, the state had invested little in media campaigns. Reported state budget constraints no doubt played a role in this reality. State staff credited the availability of CKF grant dollars as key in being able to finance a significant and successful outreach campaign.

A second strong media surge occurred in late 2002 when Illinois was selected as one of six states to participate in an RWJF-funded national publicity campaign. Under this special grant, GMMB, a strategic communications firm located in Washington, D.C., that managed the CKF communications campaign for RWJF, pitched national public service announcements through local media outlets in Illinois and the other five selected states. After declining levels of new entrants in the first two quarters of 2002, the positive trend in new entrants that began in the third quarter of 2002 (see Figures 1 and 2) may be the result of this effort. Finally, a \$200,000 RWJF grant given to IMCHC in January 2004 to publicize FamilyCare and reach out to parents and caretakers may have contributed to the considerable increases seen in children entering Illinois' KidCare program in 2004.

Universally, interviewees agreed that a key complement to CKF's important public relations investment was the targeted outreach they supported. Primary among them was the Back-to-School Campaign that occurred each fall, beginning under CKI in 1999 and continuing through the CKF grant period. Piggy-backing on the national promotion, numerous events were organized across the state to get the word out about public health insurance options and to get children enrolled. A review of the quarterly online reports submitted by IMCHC and CBHC, found that the greatest number of outreach activities was reported in the 3rd quarter, from July through September, in each of the four years of the CKF grant period. In 2003 alone, as many as 150 outreach events were reportedly held during these back-to-school months.

Simplification of income verification requirements was seen as the single most significant policy change affecting KidCare enrollments.

In January 2004 Illinois expanded the income limit for KidCare Rebate from 185 percent of the FPL to 200 percent. At the same time, the state made a significant policy change in the state's income verification requirements. Effective January 2004, families were required to provide only a single pay stub as proof of earned income rather than the previously required four weeks of verification. Without exception, all parties interviewed mentioned the significance of this policy change. The increase in new enrollments of both Medicaid and SCHIP-eligible children during 2004, evident in both Figure 1 and Figure 2, is consistent with this belief. The spike in SCHIP enrollments following the policy change appears to be more pronounced, however, which may be attributable, at least in part, to the KidCare Rebate expansion. While KidCare Rebate enrollment levels were modest at that time (a total reported enrollment of 4,900 in April 2004⁶), it is possible that persons encouraged to apply for KidCare Rebate following the expansion were determined eligible for another KidCare component instead.

The reduction in the amount of income documentation needed by families not only simplified the application process for families, but also simplified the processing of applications. State staff reported a 90-day backlog in processing applications in the fourth quarter of 2003. The change to a single pay stub along with revisions made to the way applications were processed helped alleviate the backlog. The decrease in new entrants seen from the third quarter to the fourth quarter in 2003 followed by the increase in new entrants that began in the first quarter of 2004 (Figure 1) may be partially explained by this phenomenon.

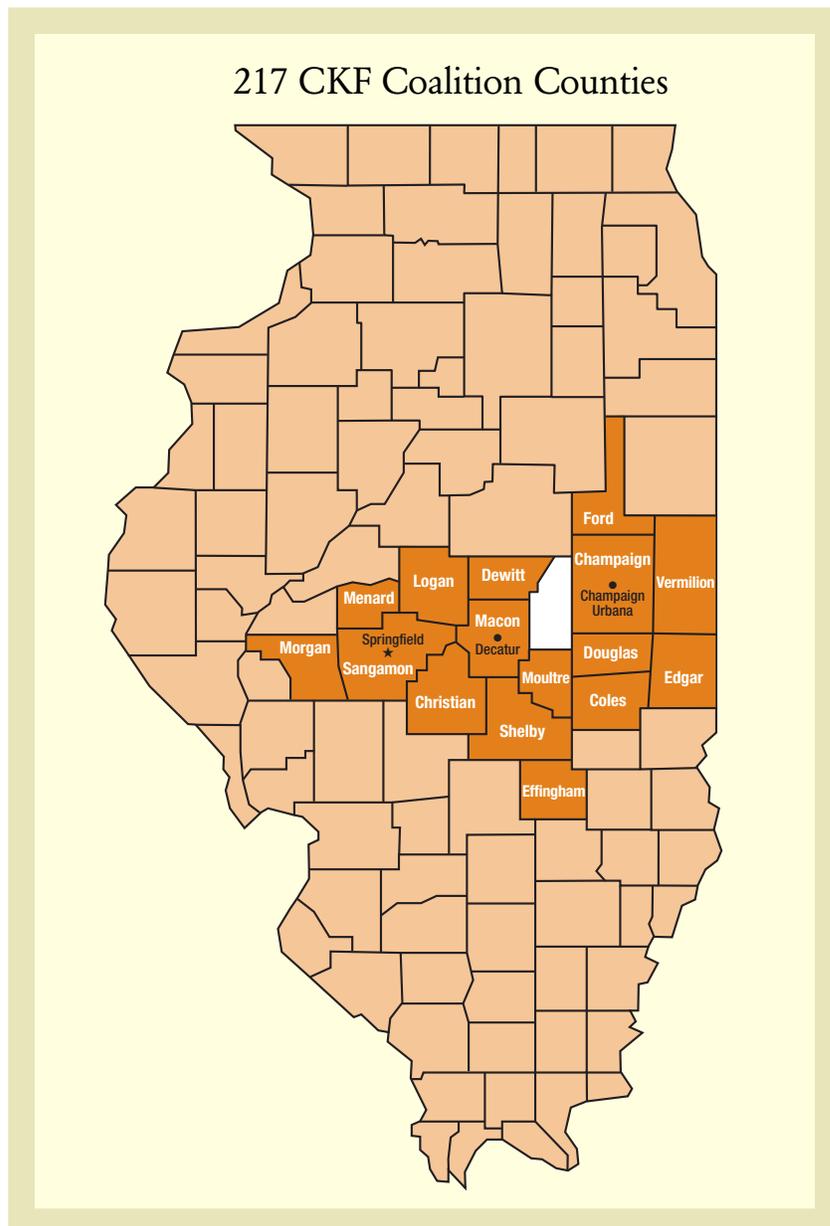
CKF was actively involved in the design and implementation of key policy changes and coverage expansions.

Since the passage of SCHIP in 1997, the Illinois General Assembly and both Republican and Democratic Governors have supported health care coverage expansion for children and families. At the same time, interview responses indicate that the CKF coalitions and staff were actively engaged in promoting the expansion of coverage and key policy changes in the KidCare program, including the simplification of income verification requirements, use of passive renewal processes and other changes. State staff placed a high value on CKF expertise and the technical assistance provided by CKF grantee staff and coalition members and indicated that frequent formal and informal contacts occurred between CKF staff and state Medicaid staff during which policy changes were discussed. State staff also specifically mentioned that their participation in the CKF multi-state process improvement collaborative had influenced the implementation of the passive renewal process in 2006.⁷ Nevertheless, given the very favorable climate in the state for health care coverage, CKF's role in causing rather than encouraging the policy changes and coverage expansions is not clear.

Local partnerships strengthened state-level outreach and policy reform efforts.

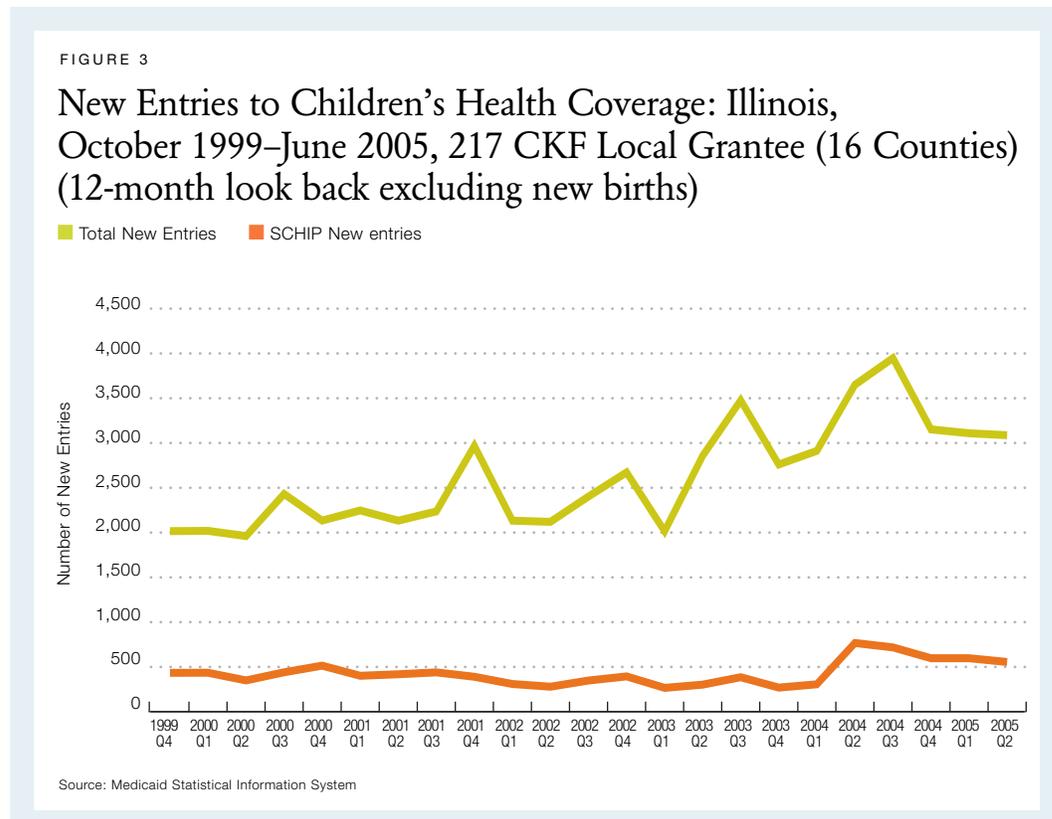
As the State grantee, IMCHC staff expressed that one of its key tenets was to develop and maintain strong and diverse partnerships, particularly with respect to local entities that could play key roles in connecting directly with families. The value the State grantee placed on partnership-building is evidenced by the breadth of membership on the State Coalition as well as by IMCHC's relationship with the coalitions of the two local projects. The State Coalition included numerous community-based organizations, local and regional public agencies, health providers, social service organizations, schools, and businesses. For example, the State grantee's June 2002 report on the CKF Online Reporting System showed that 52 of the 67 State Coalition members represented entities other than state governmental agencies. Also, the Illinois Department of Human Services, the Chicago Federation of Labor, and the Illinois Primary Health Care Association served as co-chairs for the Coalition thus creating broad support and a shared sense of ownership. With respect to the two local coalitions, State grantee staff saw it as their role to help coalitions get organized, pull together coalition members, as well as provide leadership and direction to coalition efforts.

The existence of this level of support was reinforced whole-heartedly by the comments of the Executive Director for the Campaign for Better Healthcare, which operated the 217 Coalition. The Campaign for Better Healthcare viewed the 217 CKF Coalition as an extension of the State Coalition and the project staff as working directly with IMCHC. From the local point of view, the 217 CKF Coalition served as a supportive arm of the larger statewide effort and as a key link to local schools, hospitals, day care centers, Farm Bureau agencies, DHS offices, and most importantly families.



Connections with the local teacher’s union were offered as one example where local involvement was key in successfully coordinating communication with families potentially eligible for both the school’s free-lunch program and KidCare. Familiarity with local organizations, such as with the individual staff of DHS offices, allowed for the development of relationships directly with persons who were the “doers” in an organization, increasing the effectiveness of the partnership. Finally, and most importantly, the local projects helped make connections with families, by “putting faces to the issues.” A helpline, staffed by a Vista volunteer with the Campaign for Better Healthcare, brought families who were struggling with health care issues to the forefront. Families were recruited to speak publicly about their issues and empowered to advocate for themselves and their children.

The 217 CKF Coalition was geographically large, encompassing 16 counties in central and east central Illinois including both urban and rural areas. Figure 3 illustrates the trend in new Medicaid and SCHIP enrollment in the 217 CKF Coalition counties from October 1999 through June 2005. The overall pattern for the 217 CKF Coalition counties is similar to the statewide pattern.



After a modest increase from 2000 to 2001, the number of new entrants during 2001 and the first two quarters of 2002 remains relatively stable—with one exceptional surge in the fourth quarter of 2001—averaging approximately 2,300 per quarter. Beginning in the third quarter of 2002, a more positive trend begins, peaking in the third quarter of 2004 at over 3,900 new entrants.

While the formation of the 217 CKF Coalition in 2002 might have contributed to the greater enrollments gains that began that year, the overall consistency of the state-level and local-level data suggests that the same factors driving enrollment at the state level (discussed above) also drove enrollment trends within the 217 CKF Coalition counties.

Conclusions

This case study suggests that expansions of adult coverage in the FamilyCare program were associated with significant enrollment increases for children between 2002 and 2006. Simplification of KidCare income verification requirements and CKF-funded outreach campaigns also appeared to be associated with enrollment increases during this time period.

While the CKF coalitions and staff were actively engaged in promoting and influencing these and other coverage expansions and key policy changes, the favorable climate in the state for health care coverage makes it difficult to determine whether CKF efforts played a role in causing rather than encouraging policy changes and coverage expansions. Indeed, since the passage of SCHIP in 1997, the Illinois General Assembly and both Republican and Democratic Governors have been very supportive of advancing health care coverage for children and families, even during periods of state fiscal difficulties.

As a result, Illinois has been widely recognized as a leader in providing health care for children. During the period encompassed by the CKF grant, Illinois experienced SCHIP and Medicaid enrollment increases that were among the most significant in the nation. With the launch of All Kids in 2006, Illinois became the first state to adopt a universal coverage program for children and is now a model for other states considering similar initiatives.

Endnotes

1. Prior to 1998, Illinois did not go beyond the federal minimum standards with one exception: older teenagers not yet included in the federal mandate were covered if their household income was below 50 percent of the FPL. Jack A. Meyer and Stephanie E. Anthony. *Health Policy for Low-Income People in Illinois*. The Urban Institute, December 1998.
2. Vernon K. Smith, David M. Rousseau and Molly O'Malley. *SCHIP Program Enrollment: December 2003 Update*. Kaiser Commission on Medicaid and the Uninsured, July 2004 (Pub# 7134).
3. Eileen R. Ellis, Vernon K. Smith and David M. Rousseau. *Medicaid Enrollment in 50 States: June 2004 Data Update*. Kaiser Commission on Medicaid and the Uninsured, September 2005 (Pub# 7349).
4. Vernon K. Smith and David M. Rousseau. *SCHIP Program Enrollment: December 2004 Update*. Kaiser Commission on Medicaid and the Uninsured, July 2004 (Pub# 7348).
5. Eileen R. Ellis, Vernon K. Smith, David M. Rousseau and Karyn Schwartz. *Medicaid Enrollment in 50 States: June 2005 Data Update*. Kaiser Commission on Medicaid and the Uninsured, December 2006 (Pub# 7606).
6. Sharon Silow-Carroll and Tanya Alteras. *Stretching State Health Care Dollars: Building on Employer-Based Coverage*. The Commonwealth Fund, October 2004 (Pub# 781).
7. To simplify the renewal process for families, new procedures were implemented for *KidCare Assist*, *KidCare Share* and *KidCare Premium* renewals. Effective with renewals mailed in February 2006, families with children enrolled in these programs with no changes to report did not have to return the renewal form to continue receiving medical benefits for the children. Illinois Department of Human Services, *Quality Alert Memorandum*, February 2, 2006, accessed on January 8, 2008 at www.dhs.state.il.us/page.aspx?item=21506.

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