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Covering Kids & Families[®] Evaluation

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

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Contents

- 1 Background**
- 2 Introduction**
- 3 State Policy Context**
- 5 History of the CKI/CKF Program in Missouri**
- 7 State-Level Findings**
- 12 Local Area Findings**
- 16 Lessons Learned**
- 18 Endnotes**
- 19 Sources**

Tables and Figures

- 4 TABLE 1**
Key Events in Missouri's Child & Family Health Insurance History (1995–2006)
- 7 FIGURE 1**
Quarterly New Entries in Public Health Coverage (via Medicaid, TANF, and M-SCHIP Components of MC+ Program) Missouri, January 1999–June 2004
- 8 FIGURE 2**
Quarterly New Entries in M-SCHIP Component Missouri, January 1999–June 2004
- 10 FIGURE 3**
Quarterly New Entries in Public Health Coverage (Medicaid Poverty Expansion and TANF Populations) Missouri, January 1999–June 2004
- 10 FIGURE 4**
Monthly Total Enrollment in Public Health Coverage (Medicaid and M-SCHIP Populations) Missouri, July 1994–December 2006
- 11 FIGURE 5**
Monthly Total Enrollment in M-SCHIP Component of MC+ Program Missouri, August 1998–December 2006
- 13 FIGURE 6**
Quarterly New Entries to Public Health Coverage, Kansas City LINC Project January 1999–June 2004
- 14 FIGURE 7**
Quarterly New Entries to Public Health Coverage, ARCHS/St. Louis January 1999–June 2004
- 16 FIGURE 8**
Quarterly New Entries to Public Health Coverage, Washington County C-2000 Partnership January 1999–June 2004

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 the Robert Wood Johnson Foundation's investment in the *Covering Kids & Families (CKF)* program, as well as to study factors that may have contributed to, or impaired, its efforts.

The evaluation focuses on these key issues:

- Documenting and assessing the strategies and actions of CKF grantees and their coalitions aimed at increasing enrollment of children and families and the barriers to their implementation.
- Assessing the effectiveness of CKF grantees and their coalitions in conducting outreach; simplifying the application and renewal process; and coordinating efforts by existing health insurance programs to expand coverage measuring progress on CKF's central goal—expanding enrollment and retention of all eligible individuals into Medicaid and State Children's Health Insurance Program (SCHIP).
- Assessing the sustainability of CKF after RWJF 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 program 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 new enrollment trends from 1999 through late 2004 in Medicaid and SCHIP for children in Missouri. In particular, the study examines the relationship between new enrollment trends during this time frame and the major outreach strategies and policy changes that took place in Missouri. In order to look at this relationship during more recent time periods, for which data on new entries are not available, the study also examines overall trends in enrollment from 1994 through 2006. Ideally, we would examine the relationship between enrollment and policy by analyzing the impact of each outreach effort or policy change on Medicaid and SCHIP enrollments. This type of analysis is not possible, however, because many of the outreach efforts and policy changes occurred at the same time. In addition, no state or other geographic area is a defensible comparison group for a rigorous analysis. The case study approach, which combines exploratory data analysis with in-depth interviews, allows us to ascertain where and how CKF's influence was most likely a factor and provides detailed information to complement the ongoing national evaluation of the CKF program.

The child-level enrollment data in the study come from the Medicaid Statistical Information System (MSIS) and were obtained from the Centers for Medicare & Medicaid Services. Using these data, we developed a measure indicating the number of “new entries” into Medicaid or SCHIP from January 1999 through June 2004. A new entry was defined as any child who enrolled in either program and had not been previously enrolled in either program for the previous three months.¹ (Anyone transferring between these programs or quickly reentering one of them was excluded.) We focused on new entries, rather than on all new enrollees or total enrollees, because we expected the number of new entries to be more sensitive to major outreach efforts or policy changes associated with program enrollment. The evaluation team assembled a timeline showing the number of new entries in Medicaid and SCHIP in Missouri from January 1999 through June 2004. This period covers the entire span of RWJF's earlier CKI grant (awarded in May 1999) and the first 22 months of the CKF grant (awarded in September 2002).

During the fall of 2006, we discussed these data with state and local CKF grantees and state officials to obtain their insights on which policy factors and CKF activities may have had an impact on Medicaid and SCHIP enrollments. We gained additional insights from other sources, including pertinent state and project Web sites, the CKF Online Reports,² and demographic and economic data from the U.S. Census Bureau and the Bureau of Labor Statistics. In addition, to extend our analysis past 2004 (the date through which the MSIS data are available), we analyzed data from the state Medicaid office on overall enrollment trends in Missouri through 2006.

State Policy Context

Children's health insurance enjoyed strong political support in Missouri from the passage of national SCHIP legislation in 1997 through the inception of the CKF grant in September 2002. Governor Mel Carnahan was a vocal advocate of expanding access to health insurance, and state Medicaid and Department of Social Services (DSS) leaders were committed to expanding coverage. Governor Carnahan and the state legislature submitted Missouri's Title XXI plan as part of the state's Medicaid Section 1115 demonstration. Approved in April 1998, the plan expanded health coverage for children by extending eligibility to children in families with incomes at 300 percent of the federal poverty level (FPL)—one of only five state SCHIP programs with income thresholds at or above that level at the time (Table 1). The Medicaid Section 1115 demonstration also extended Medicaid eligibility to certain groups of parents, effective February 1999, and attempted to simplify the application process. Since Missouri opted for the Medicaid expansion approach to SCHIP, there was no need to coordinate Medicaid with a separate SCHIP program. The combined Medicaid/SCHIP children's health insurance program was named MC+ for Kids.³

TABLE 1

Key Events in Missouri’s Child & Family Health Insurance History (1995–2006)

| | |
|-----------------------|--|
| March 1995 | Revision to Title XIX Section 1115 Demonstration. Expands eligibility to uninsured children under age 19, up to 200 percent FPL. |
| April 1998 | Title XXI SCHIP Plan is approved. MC+ for Kids, a Medicaid expansion program, extends coverage to children up to 300 percent FPL. Includes cost-sharing provision: for gross income 226–300 percent FPL, premiums range from \$55 to \$218 per family per month, depending on family size and income. |
| February 1999 | Adult components of Section 1115 Demonstration take effect. Parents from the following groups are covered: (1) parents transitioning off Temporary Assistance for Needy Families (TANF); (2) custodial parents; (3) noncustodial parents in the <i>Parents Fair Share</i> employment training program; and (4) new mothers. Eligibility limits range from 100 to 300 percent FPL. |
| May 1999 | RWJF’s CKI initiative begins, led by the Missouri Department of Social Services (DSS). Three local programs are funded: <ul style="list-style-type: none"> • Washington County C-2000 Partnership, Potosi • Local Investment Commission, Kansas City • Area Resources for Community and Human Services, St. Louis |
| September 2002 | RWJF’s CKF initiative begins. State grantee is the Missouri Primary Care Association. Local programs remain the same as for CKI. |
| September 2002 | Missouri submits first SCHIP plan amendment to comply with final SCHIP regulations. |
| November 2002 | Shift in control of both houses of the legislature, leading to diminished support for SCHIP. Leadership at DSS also changes. |
| July 2004 | Missouri submits second state plan amendment to exempt children with special health care needs from the state’s requirements of a six-month period without insurance and a 30-day waiting period. |
| November 2004 | Governor Matt Blunt is elected. |
| April 2005 | Legislation introducing cost-sharing requirements becomes law: <ul style="list-style-type: none"> • Imposes premiums on all households above 150 percent FPL, capped at the following amounts: <ul style="list-style-type: none"> 150–185 percent FPL: 1 percent of income 185–225 percent FPL: 3 percent of income 225–300 percent FPL: 5 percent of income • Affordability test instituted for all families above 150 percent FPL; must show no access to “affordable” health insurance alternatives |
| September 2005 | DSS is asked to enforce annual eligibility checks at renewal. |
| July 2006 | Affordability test is modified to be less burdensome for SCHIP-enrolled families between 151 percent and 225 percent FPL. |

Sources: Interviews with Missouri officials and CKF grantees, Missouri current state plan and fact sheet at www.cms.hhs.gov, Harrington 2002.

The MC+ for Kids program featured cost-sharing and crowd-out provisions from the start. Cost-sharing requirements in the program depend on the income level of the child's family. Between 1998 and 2005, there were no cost-sharing requirements for children in families with incomes below 185 percent FPL, but families paid co-payments if their income was between 185 and 225 percent FPL, and paid both premiums and co-payments if their income was between 226 and 300 percent FPL. There were no changes in eligibility criteria during this period.

In 2002, control of both houses of the Missouri legislature shifted and legislators looked to rein in state spending in a worsening economy. As a result, political support for MC+ for Kids began to wane. In 2005, legislation was passed increasing cost-sharing levels and adding requirements that called for new enrollees to demonstrate that they did not have access to affordable insurance from other sources. In January 2006, premium requirements based on a sliding scale were extended to families with incomes over 150 percent FPL.⁴ In addition, an affordability test was instituted for families with incomes over 150 percent FPL, requiring them to demonstrate that alternative insurance was not available in order to be eligible for MC+ for Kids coverage.⁵ Over time, the legislature also reduced the income eligibility limit for parents, eventually returning to the prior Aid to Families with Dependent Children (AFDC) level of 21 percent FPL.

Efforts toward stricter eligibility standards of MC+ for Kids have abated since 2006, as enrollment has declined. As one state official put it, once large numbers of children were dropped from state coverage, "some legislators realized that some of their own constituents were not pleased and began to step back a little." In July 2006, the affordability requirement for families was loosened, decreasing the amount considered "affordable" for families with incomes from 151 percent to 225 percent FPL.⁶

History of the CKI/CKF Program in Michigan

The Covering Kids Initiative was launched in May 1999 in Missouri and served as the foundation for the CKF project, which operated from September 2002 through October 2006. The state's DSS served as the lead for the original CKI grant. However, following a decline in the state economy that would likely lead to program cutbacks, the state decided that the grant should be moved to a nongovernmental entity. The state identified the Missouri Primary Care Association (MPCA) as a good candidate to lead the CKF grant because of the MPCA's experience in working with the Medicaid and SCHIP-eligible population as coordinator of the state's federally qualified health centers (FQHCs).

Outreach during the CKI grant maintained a relatively low profile, taking place mostly at the local level with a grassroots effort (Harrington 2002). After the transition from CKI to CKF, the new lead grantee, MPCA, focused on how to implement its workplan in a changing policy environment. While the MPCA was not a state entity,

it received state funding, as did many of its member organizations, such as the FQHCs. For this reason, the MPCA staff felt that their outreach efforts and policy initiatives should maintain a low profile so as to not jeopardize their other state-funded programs. The MPCA relied on school nurses and the FQHCs to undertake many outreach activities.

In addition to convening and staffing the state CKF coalition, the MPCA organized back-to-school campaigns in partnership with the FQHCs and school nurses. Other MPCA activities included conducting presentations on the MC+ for Kids program for small business groups and social service workers, and providing feedback to state staff about the impact of policy changes at the local level. The MPCA worked closely with local projects, sharing ideas and materials from national meetings and other states, customizing effective strategies for enrolling hard-to-reach populations, promoting sustainability after the end of the grant, and providing a forum for local projects to communicate with state officials regarding effective and noneffective policies and procedures.

The Local Investment Commission (LINC) of Kansas City is one of three local CKF projects, all of which also led local outreach efforts under the original CKI grant. LINC is a citizen-led community intermediary that organizes services for the working poor using neighborhood-based decision-making processes. Founded in 1992 to reform social services in Kansas City, LINC organizes school-based site councils to direct neighborhood-level efforts, and supports volunteer engagement in policy issues. Having performed outreach during the rollout of the MC+ for Kids program, LINC had experience with state health insurance programs and was a natural fit for the CKI program. LINC's CKF work served Cass, Clay, Jackson, Johnson, Lafayette, Platte and Ray counties.

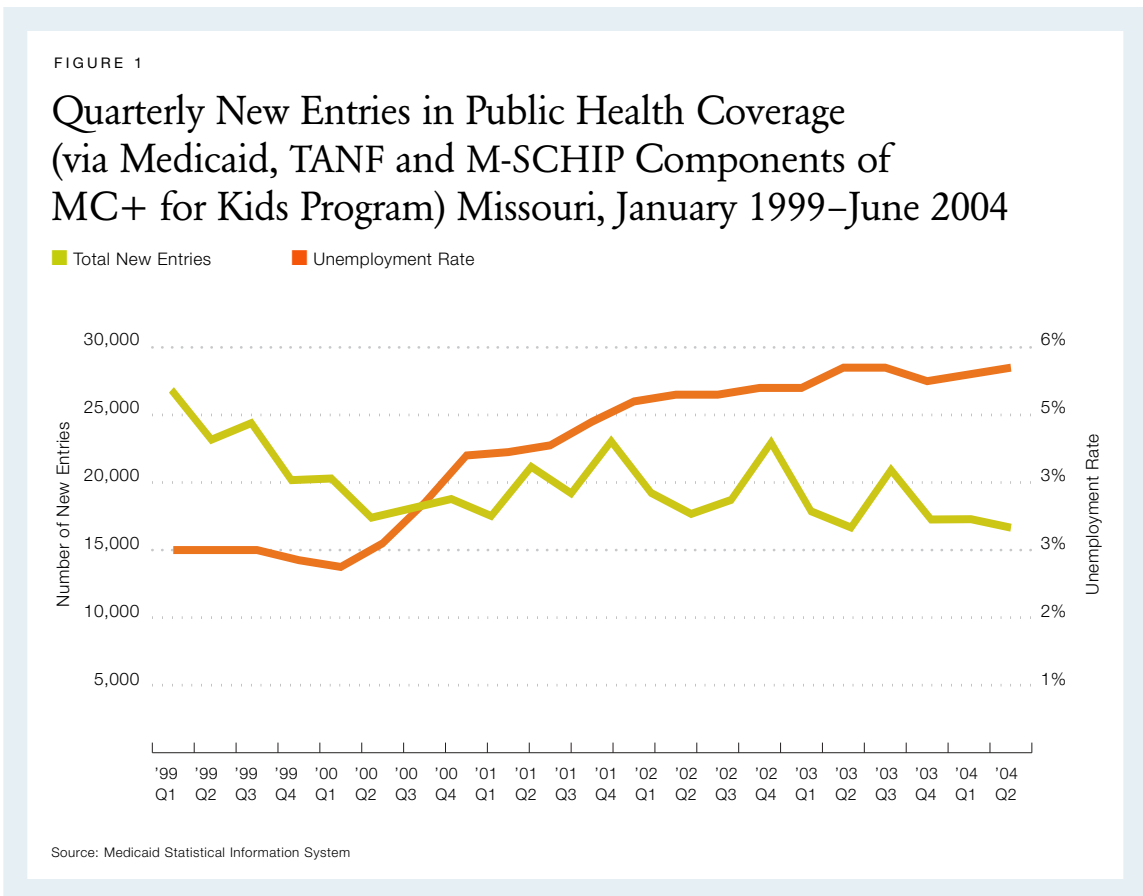
The second local grantee, Area Resources for Community and Human Services (ARCHS) of St. Louis, is one of 21 community partnerships established by the state of Missouri. ARCHS creates strategic community partnerships in order to leverage resources to serve the greater St. Louis area. In the early 1990s, members of ARCHS were involved in a coalition that advocated for universal health coverage. ARCHS' outreach and enrollment work in the health committee focused on health, education, and welfare-to-work activities. They used CKF funding to support staff members and to create and distribute materials. ARCHS developed strong relationships through their local coalition, which served as a forum for reviewing outreach strategies and materials and developing ideas for future efforts.

The third local grantee, Washington County C-2000 Partnership, is a nonprofit social service organization that has served residents of this rural county since 1995. The partnership was founded to combine the efforts of multiple, overlapping social service agencies to identify and address the needs of Washington County residents. The programs rely on community-based outreach and services to improve the health, health care and employment opportunities of the County's low-income families and individuals. CKF funding was used to support staff members in disseminating information at local fairs,

schools, doctor’s offices and large retail stores, and in providing enrollment and other forms of assistance with the MC+ for Kids program. The partnership’s CKF work served Washington County, an area with a sparsely-dispersed population of approximately 20,000, with more than half of the children eligible for free or reduced-price school meals.

State-level Findings

Links Between Enrollment and Major Policy Changes. The number of children entering public health insurance in Missouri started off high in 1999 and then declined over time (Figure 1). In the first quarter of 1999, nearly 27,000 children entered the MC+ for Kids program, which includes both traditional (Title XIX) Medicaid and the state’s new SCHIP program. From there the number of new entries declined steadily to 17,000 in the second quarter of 2000, then fluctuated between 17,000 and 20,000, and finally settled at about 16,000 in 2004. This decline occurred at the same time as a sharp rise in the unemployment rate, a surprising result if one expects the number of children receiving public health insurance to increase during difficult financial times.

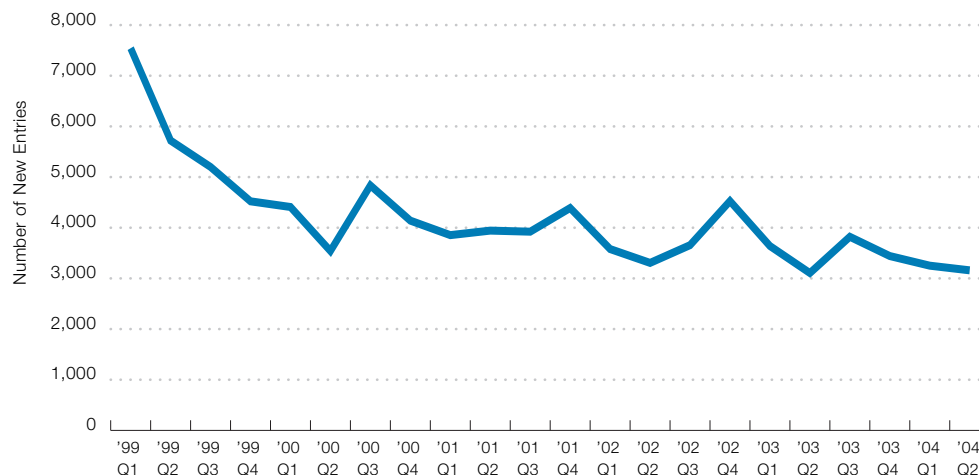


Enrollment in MC+ for Kids through the SCHIP eligibility category started strong in Missouri (Figure 2). SCHIP new entries from 1999 through 2004 show a pattern similar to that of the overall public coverage programs described above, in which the numbers of new entries were initially high and subsequently tapered off over time. The number of new entries in SCHIP was nearly 8,000 in the first quarter of 1999, hovered around 4,000 for several years, and declined to about 3,000 in the second quarter of 2004.

The early trend for new entries into MC+ for Kids through the Medicaid poverty expansion eligibility category followed much the same pattern as that of SCHIP (Figure 3).⁷ In the first quarter of 1999 about 14,000 children newly entered the Medicaid expansion group. The number of new entries then declined over the next several quarters similar to the SCHIP population. While our new entry data do not precede the first quarter of 1999, this initial high point likely represents a spike in enrollment in the first half of 1999.⁸ The drop in new entries to the Medicaid expansion group in 2001–02 reflects an administrative change, as eligibility for some children was shifted from Medicaid expansion into the TANF program group.

FIGURE 2

Quarterly New Entries in M-SCHIP Component Missouri, January 1999–June 2004



Source: Medicaid Statistical Information System

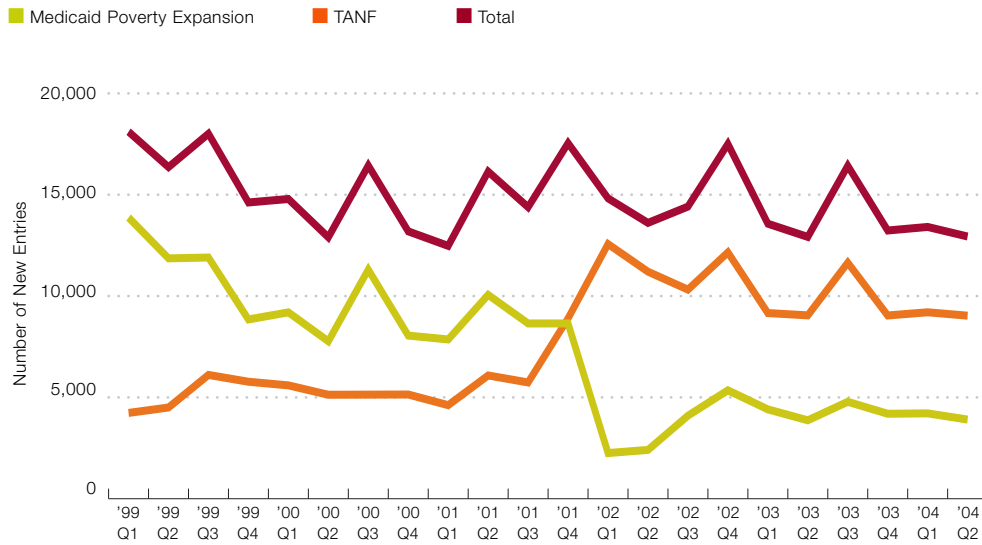
In contrast to the SCHIP and Medicaid expansion groups, the trend in TANF-based enrollment was not at a relatively high point during the first quarter of 1999 (Figure 3). Because TANF enrollment formed their basis for Medicaid eligibility, families in the TANF group were likely to be unaffected by the SCHIP simplification policies that the state adopted at this time—the use of a one-page mail-in form and the elimination of the face-to-face interview. However, this was not the case for families in the Medicaid expansion group, for whom simplification steps may have been very meaningful. The fact that *only* the SCHIP and Medicaid expansion groups display relatively high numbers of new entries during the early part of 1999 thus suggests that these simplification policies contributed, at least in part, to more families applying for Medicaid coverage.

To supplement the trend data on new entries, which were available only through mid-2004, we obtained data from the state on the total enrollment of children over a longer period, from July 1994 through December 2006 (Figure 4).⁹ The trends in total enrollment shown in Figure 4 suggest that the patterns of new entries in Figures 1 through 3 represent noteworthy performance, as the state both expanded coverage to new children and retained those already enrolled. For several years prior to SCHIP (between 1994 and 1998), there was little change in overall children’s enrollment in the Missouri Medicaid program. However, in the year the SCHIP program began (August 1998 to August 1999), children’s enrollment in public coverage started to accelerate, increasing from approximately 330,000 to 400,000, reinforcing the notion that changes related to the SCHIP expansion may have contributed to a large overall increase in children’s enrollment in public coverage. Between 2000 and 2004, total enrollment continued to grow, though more slowly. At its peak in March 2005, the MC+ for Kids program had 546,000 enrollees, a 65 percent increase in enrollment compared to the month before SCHIP was implemented.

Total enrollment began to decline in 2005. From March 2005 to December 2006, the number of children enrolled in public coverage dropped by over 70,000, from 546,000 to 472,000 (Figure 4). A major legislative change to the MC+ for Kids program in 2005 increased cost sharing, imposing new cost-sharing requirements, expanding the “affordability test,” and requiring more families to pay premiums and co-pays (see Table 1). As a result many more families had to pay premiums, clearly illustrated by the surge of 27,000 additional children enrolled in the premium portion of SCHIP in December 2005 and by the precipitous drop of 45,000 in the number of nonpremium SCHIP enrollees (Figure 5). Also during this period, the governor directed the DSS to prioritize eligibility renewal, a notable change from a previous unwritten policy of limiting staff resources for this task. As a result of these policy changes many children dropped from the program; enrollment in SCHIP decreased by approximately 28,000 children, or nearly 30 percent of the February 2005 SCHIP caseload.

FIGURE 3

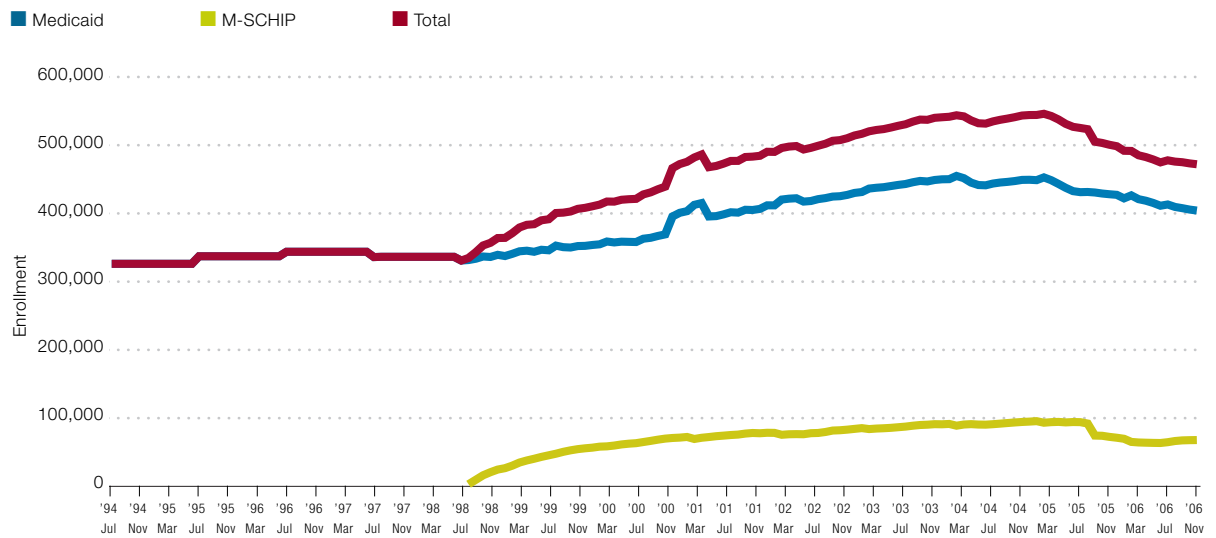
Quarterly New Entries in Public Health Coverage (Medicaid Poverty Expansion and TANF Populations) Missouri, January 1999–June 2004



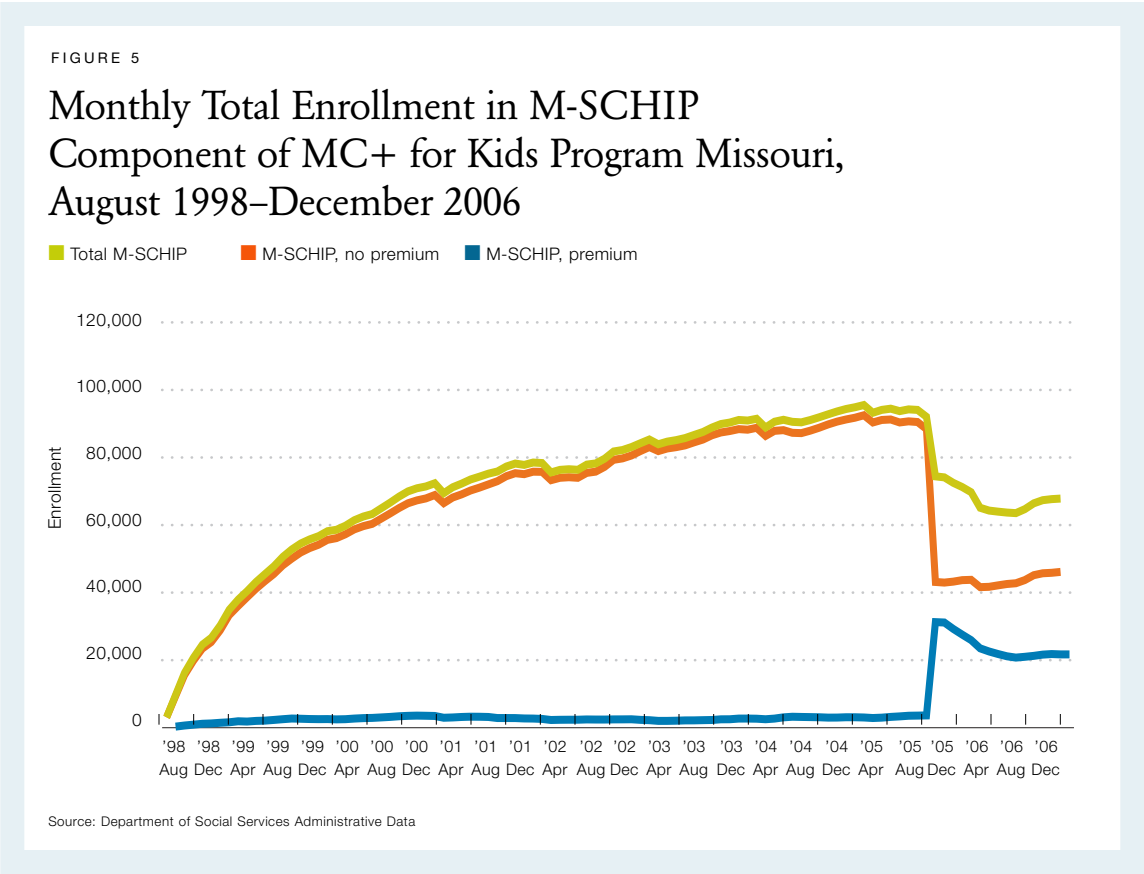
Source: Medicaid Statistical Information System

FIGURE 4

Monthly Total Enrollment in Public Health Coverage (Medicaid and M-SCHIP Populations) Missouri, July 1994–December 2006



Source: DSS Administrative Data



The Role of Covering Kids & Families. RWJF’s funding of CKI and CKF was used by the state grantee to support state level efforts to increase enrollment, simplification, and outreach in Missouri. The CKI program, which was based in the state Medicaid agency from 1998 to 2001, funded an outreach coordinator and an administrative assistant and paid for promotional items. As part of major outreach efforts undertaken at the inception of the SCHIP program, the MC+ for Kids application was simplified to one page, the face-to-face interview requirement was eliminated, and a call-in number was set up to process applications. The state also developed collaborative outreach efforts with state and local school lunch programs, local health departments, the Missouri Hospital Association and primary and secondary schools. Though RWJF funding provided additional resources to the state, its effect on policy may have been modest since political enthusiasm for SCHIP was so high during this period that major policy changes would have likely occurred with or without RWJF support.

By the time the CKF grant was set to begin in 2002, state level support for expanding public coverage had begun to wane. As a result, the state decided not to reapply as the lead site for the CKF grant. Instead, the state recommended that the MPCA lead the Missouri CKF initiative. This transition coincided with a shift in the emphasis of the state on MC+ for Kids outreach efforts. The DSS dismissed CKI-funded staff in

its state office and other employees at local DSS phone centers—for example, four of the six phone center staff members in the Jackson County office were dismissed. One state informant viewed these changes as appropriate; he believed that the program had become “routine” by this point, making sizable outreach efforts unnecessary.

In its new role as lead site for CKF, the MPCA reported limited communication with the state DSS and limited support for statewide outreach efforts. Relying on state funding for some of its other activities, the MPCA only cautiously advocated for new outreach or simplification policies. For example, the state CKF coalition advocated for a presumptive eligibility policy that would ensure the enrollment of children who arrive at the hospital without adequate information. While this policy was eventually implemented, it was limited to four hospitals in the state and the grantee was unable to press for further expansion. Other policy changes proposed by the state grantee that were not adopted include adding a health insurance question to the school enrollment form, making the reading level of the MC+ for Kids application more appropriate, clarifying that only the applicant’s social security number (and not those of other family members) was required, and simplifying the request for reporting of income.

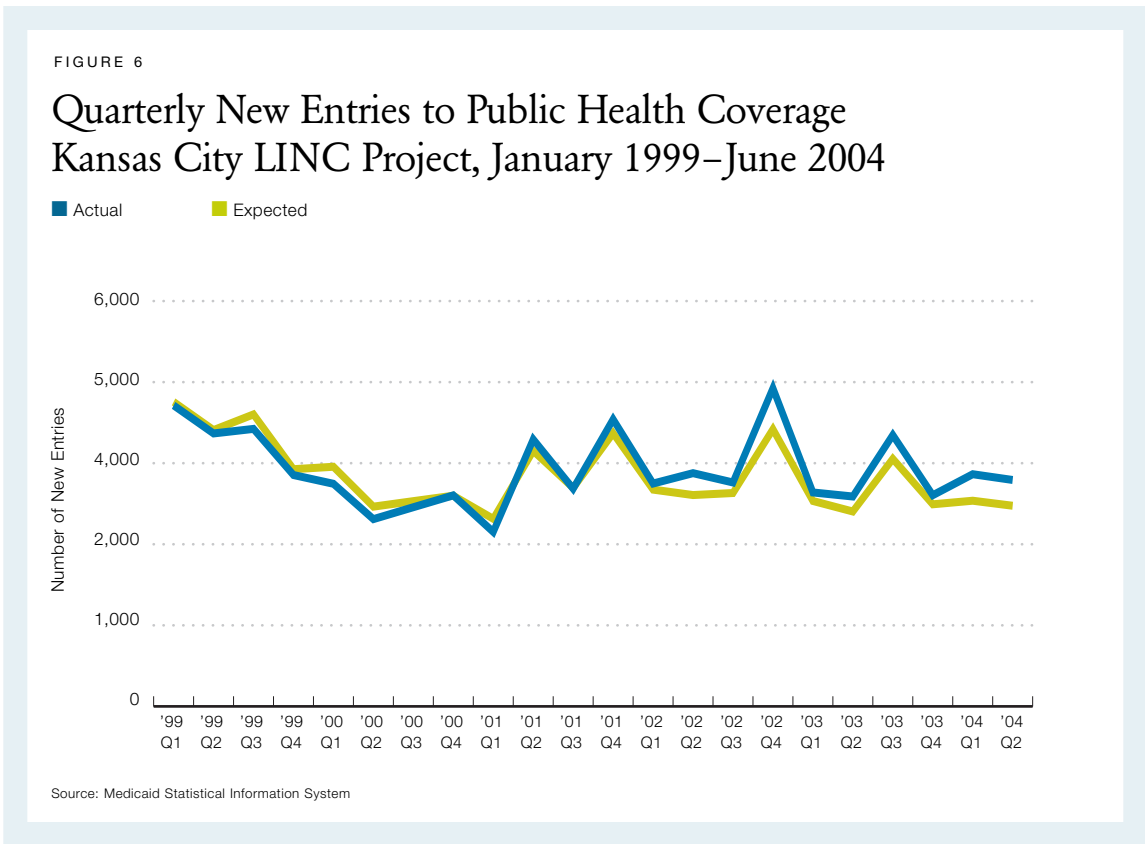
Though limited in its collaboration with the state, the MPCA did have success in its role as coordinator of the local programs. Successful efforts included not only support for the CKF local sites, but also broader efforts implemented through community health centers and schools. For example, when the state made review of eligibility renewal a priority in 2002, the state grantee developed radio announcements and print pieces for local sites alerting enrollees to read their mail and update their eligibility information. The MPCA also used its ties to school nurses and community-based health centers to strengthen back-to-school health insurance awareness-raising campaigns, and school-based enrollment initiatives.

Local Area Findings

Our analysis of local trends focuses on the three local projects supported by CKF: (1) Kansas City LINC, serving Kansas City and its surrounding counties; (2) ARCHS, St. Louis, which targets St. Louis city and county; and (3) Washington County C-2000 Partnership, operating in a rural county in the eastern region of the state. Each of these local grantees received funding through both CKI and CKF. To explore the possibility that the activities of these local programs might have affected the number of children enrolling in public coverage, we compare the new entry trends in their catchment areas with the trends we would have expected, given local characteristics.¹⁰ To the extent that the actual trends in these areas exceed expectations, they suggest that local outreach activities were more successful than they would have been without the CKF efforts.¹¹

In the area served by Kansas City LINC, enrollment trends exceeded expectations for overall public health coverage for children and for SCHIP enrollments after the first quarter of 2001 (Figure 6). For example, in the fourth quarter of 2002, there were about 4,900 new entries in the LINC catchment area, roughly 500 (or 11 percent) more than expected.

While it is not clear how much LINC contributed to these higher-than-expected entries, the program adopted innovative enrollment strategies not used elsewhere in the state. CKF funding provided resources for LINC to introduce a “site council” outreach approach. That is to say, LINC used an existing network of school volunteers and site coordinators to undertake a comprehensive, school-based strategy that tailored outreach efforts to the needs of individual schools. Efforts focused on finding eligible children, educating families about the MC+ for Kids program, and promoting awareness of retention issues. This community-centered, neighbor-to-neighbor approach became a vital source of information about the program, and built on the experiences of site council members who had family members enrolled in the program. LINC also helped



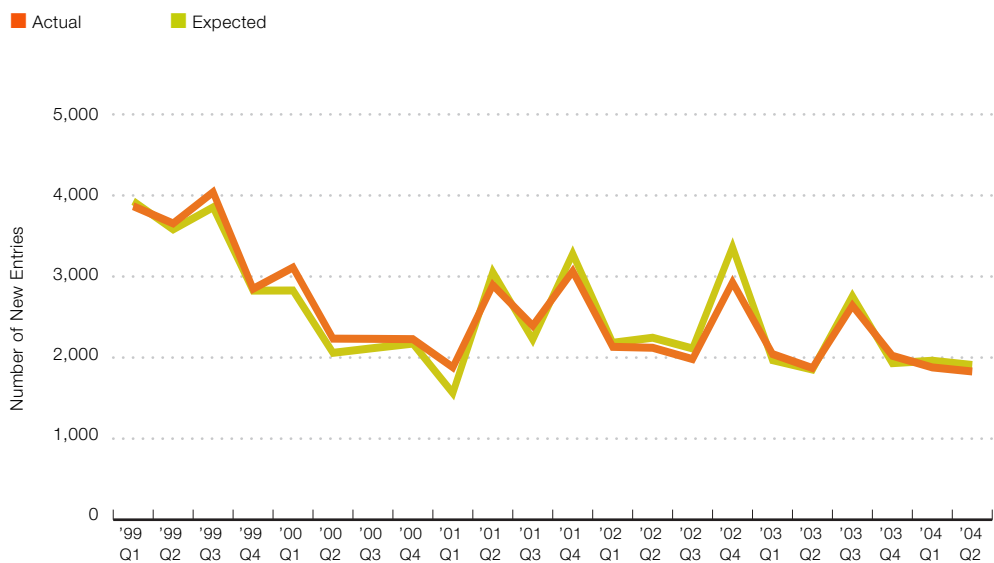
arrange monthly meetings with state MC+ for Kids enrollment workers and distributed information in schools and neighborhoods. LINC firmly believes that its neighborhood-based approach to outreach, based on site-specific strategies tailored to the needs of the local community, was effective.

LINC’s close relationship with the local DSS office in Kansas City may have also contributed to enrolling more children than expected during the study period. While important changes in priorities occurred in the DSS office in Jefferson City, the state capital, such changes did not occur in Kansas City, allowing LINC to maintain a strong relationship with the local DSS office. This relationship developed over years of collaboratively assisting residents enrolled in state programs, most notably MC+ for Kids and a Welfare to Work pilot program in Jackson County.

ARCHS, the CKF grantee in St. Louis, shows an enrollment pattern similar to the state-level trend, with high numbers of new entries in 1999 declining by 2000 and leveling off for the remainder of the data period (Figure 7). The similarity with the rest of the state is not surprising, since this major urban area captured a large percentage of

FIGURE 7

Quarterly New Entries to Public Health Coverage ARCHS/St. Louis, January 1999–June 2004



Source: Medicaid Statistical Information System

statewide enrollment. Actual new enrollment was greater than predicted until the first quarter of 2001, suggesting that ARCHS may have had relative success enrolling children during this early period. During this period, ARCHS dedicated considerably more resources to outreach than it did after 2001. ARCHS used CKF support to pay for staff, including two full-time employees who focused exclusively on outreach. These staff members focused their efforts on outreach in schools and marketing in the community, to raise awareness of MC+ for Kids and encourage families to apply. School nurses and parent liaisons were particularly important to these early outreach efforts, placing calls and visiting homes to follow up on children eligible for enrollment. Another major effort during this time period was outreach to the Hispanic immigrant community. ARCHS staff used input from focus groups to help tailor ads to Hispanic residents, and formed a close collaboration with La Clinica, a nearby Latino community health center.

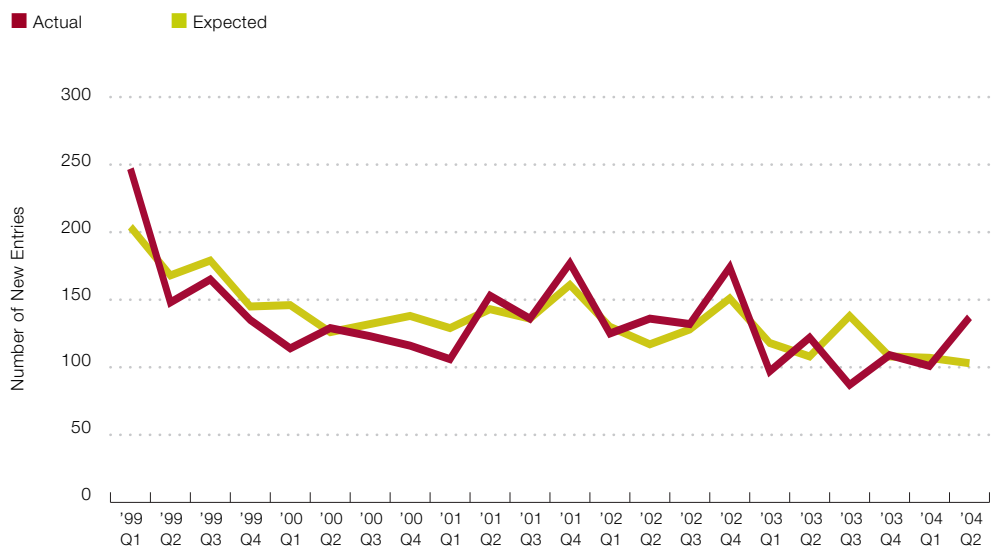
ARCHS staff cited CKI support as central to its early efforts; the CKI funding paid for staff and materials and helped build momentum within the organization. By the time the CKF grant was awarded in September 2002, however, state support for children's coverage had begun to wane and the momentum within ARCHS had slowed. In 2002, ARCHS experienced a decline in resources, leading it to scale back outreach staff. At the same time, organizational changes to the school system diminished the liaison role of school nurses. While there is no way to be certain, these changes may have contributed to the closing of the gap between actual and expected enrollment seen after the start of 2001.

Washington County displays a somewhat different trend than the state or the other two local CKF sites at the beginning of the data period (Figure 8). The number of new entries into the MC+ for Kids program started quite high, with nearly 250 enrollees in the first quarter of 1999, but then declined to 115 in the first quarter of 2000. From there, the number of enrollees fluctuated for several quarters, from a high of 175 to a low of 90. The county showed more enrollments than expected in some quarters, and fewer than expected in others. New entries may have leveled off after the inception of SCHIP as Washington County residents became more familiar with the program. A Washington County C-2000 Partnership staff member commented that because the county had a relatively small population (20,000) and a large number of MC+ for Kids-eligible individuals (56 percent of students were eligible for the free or reduced-price school lunch program), most families eventually became knowledgeable about the benefits available to them and there was little stigma surrounding public health insurance.

The Washington County C-2000 Partnership took a fairly traditional approach to outreach and its efforts appear to have been well-designed and implemented. The partnership: (1) made MC+ for Kids applications available at a variety of locations, including schools, doctor's offices and large retail stores; (2) chose a strong spokesperson

FIGURE 8

Quarterly New Entries to Public Health Coverage Washington County C-2000 Partnership January 1999–June 2004



Source: Medicaid Statistical Information System

for the program; (3) spread the word about the MC+ for Kids program at local fairs and events; and (4) worked with school nurses. As with LINC, Washington County C-2000 Partnership staff members pursued a close relationship with the local DSS in Potosi and believe this relationship contributed to sustained enrollment even after the 2005 policy changes.

Lessons Learned

The experience of the Missouri CKI and CKF programs reflects a two-part story. In the late 1990s, the state adopted a program that many people, inside and outside Missouri, viewed as a model. The program raised the eligibility level to 300 percent of the FPL; replaced face-to-face interviews with simplified, mail-in applications available at a variety of locations; allocated substantial funding for school- and community-based outreach; and focused the work of DSS offices on enrolling children. The result of these efforts was a total MC+ for Kids enrollment increase of over 165,000 children between July 1998 and March 2002, more than 75,000 through SCHIP and approximately 90,000 through Medicaid. Since Medicaid eligibility levels did not change, the increase in Medicaid enrollment is especially striking and strongly suggests that the simplification policies adopted at the time of the SCHIP expansion had spillover benefits for families traditionally eligible for Medicaid.

By 2002, a downturn in the economy, combined with political change, had begun to slow the momentum for children's coverage in the state. These factors eventually led to a sharp decline in total enrollment, despite high statewide unemployment. The state DSS, which had served as an effective state grantee for CKI, declined to take on this role with the CKF grant, and recommended that MPCA apply for the state CKF grant. Over the subsequent four years of the grant, the MPCA experienced some difficulty communicating with the DSS and promoting enrollment, simplification and outreach. The MPCA had more success at the local level, using its connections with community health centers and school nurses to promote coverage at the grassroots level. In addition, at least two of the local CKF grantees were able to maintain the outreach programs they developed originally under CK and to foster a positive relationship with the local DSS offices.

By mid-2005, the loss of momentum for outreach and simplification, combined with an increase in state attention on enforcing renewal requirements, and a policy change requiring more families to pay premiums all contributed to a decline of about 70,000 children in MC+ for Kids—the first coverage drop in over a decade. For CKF, this experience illustrates the challenges of collaborating with a state agency in a constrained economic and political environment. Achieving the goals established for the state CKF grantees—particularly, to promote simplification and coordination policies—proved unrealistic due to lack of communication between the state grantee and DSS. Placed under increasing pressure by both the legislative and executive branches to rein in the MC+ for Kids program costs, the DSS could not respond to the CKF grantee's goals and priorities.

In the end, the state CKF grantee appears to have experienced at least some success with low-profile, community-based initiatives and those led by the local CKF projects. The grantee turned to the FQHCs and to school nurses throughout the state who could undertake outreach. At the same time, it distributed materials to the local CKF projects which implemented outreach activities in their respective areas. Nevertheless, many of the grantee's efforts to protect earlier enrollment and retention gains were hampered by the constrained fiscal and political environment.

Endnotes

1. For the case studies in most other states, our definition of a new entry has been more restrictive, including only children who have gone 12 or more months without prior Medicaid or SCHIP coverage. For this case study, we have chosen a three-month definition in order to examine the trend in new entries during an earlier point in time (the first quarter of 1999 as opposed to the last quarter of 1999) during which there was large enrollment growth in the MC+ for Kids program. The trend for Missouri is similar under either definition.
2. CKF grantees were required to report regularly on program activities through an online reporting system.
3. The MC+ for Kids program piggybacked on “Managed Care Plus,” a plan founded in 1995 that sought to provide health services across the more populated areas of the state through managed care. While many Medicaid beneficiaries receive services through managed care, managed care has not expanded to many rural regions. The name MC+ for Kids is derived from this program.
4. Premiums were set at 1 percent, 3 percent and 5 percent of family incomes, for families earning 150 percent to under 185 percent; 185 percent to under 225 percent; and 225 percent to 300 percent FPL, respectively (Ferber 2006).
5. The original legislation defined “affordable” insurance as having premiums of \$342 per month or less (Ferber 2006).
6. The revised legislation reduced the “affordable” premium amount to \$209 per month for families with incomes from 151 percent to 185 percent FPL, to \$255 per month for families with incomes from 186 percent to 225 percent FPL, and increased the affordable premium amount to \$375 for families with incomes from 226 percent to 300 percent FPL (Ferber 2006).
7. The Medicaid expansion group includes children ages 1 to 18 in families earning between 100 and 185 percent FPL (with the eligibility limit depending on the age of the child), excluding those enrolled through enrollment in TANF.
8. Total enrollment data (shown later in Figure 4) supports this assumption. The first quarter of 1999 began a period of enrollment growth after years of relatively flat enrollment.
9. Data are available yearly from July 1994 through July 1998, and then monthly from July 1998 through December 2006. Because the trends in total enrollment are heavily influenced by program retention, we are less able to establish links between changes in these trends and specific outreach and simplification policies aimed at increasing the numbers of enrolled children. Nevertheless, these trends provide at least some indication of enrollment activity over a more extended period.

10. Expected enrollment is based on a forecasting model that predicts, for each county in the state, the number of children enrolling in Medicaid or SCHIP in each quarter. Inputs to the model include the demographic characteristics of children and families in the county, most notably the number of children below 200 percent of FPL. All these variables are obtained from Census Bureau data; some, but not all, are time varying (depending on whether the Census Bureau updated them after 2000). The model also includes the local unemployment rate, obtained from the U.S. Department of Labor, Bureau of Labor Statistics.
11. Caution must be used in interpreting differences in the trend between expected and actual new entries, because the expected trend is estimated imprecisely, which leads even fairly large differences in a given quarter to be statistically insignificant. Our main focus, therefore, is on whether the differences persist over several quarters.

Sources

Harrington M. *Congressionally Mandated Evaluation of the State Children's Health Insurance Program, Site Visit Report: The State of Missouri's MC+ for Kids Program*. Report submitted to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Princeton, NJ: Mathematica Policy Research, Inc., January 2002.

Ferber J. *Measuring the Decline in Children's Participation in the Missouri Medicaid Program*. Legal Services of Eastern Missouri, Inc., March 2006. Unpublished.



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