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Covering Kids & Families® Evaluation

*Case Study of Kentucky: 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 will continue through November 2008.

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/coverage/product.jsp?id=20929.

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.

Introduction

This case study discusses the trends in new enrollment of children in Kentucky's Medicaid and SCHIP from 1999 to 2005. In addition, we examine the trends in retaining children in these programs. In examining these trends, we are particularly interested in their potential links to major policy changes that took place in Kentucky, especially those associated with the CKF grant. Ideally, we would examine such links through a formal impact analysis that estimates the effect of individual policy changes on the number of children enrolling or remaining in Medicaid or SCHIP. This type of analysis is not possible, however, because no state or other geographic area provides a defensible comparison group for a rigorous analysis. The case study approach, which combines exploratory data analysis with in-depth interviews with key informants, allows us to assess the potential influence that policy changes have had on new enrollments and retention.

The main data source for the study is child-level enrollment data from the Medicaid Statistical Information System, which we obtained from the Centers for Medicare & Medicaid Services. Using these data, we developed two main measures. The first, which we used to study program enrollment, measures the number of “new entries” in Medicaid or SCHIP during each month from 1999 to mid-2005. New entries include all children who have newly enrolled in one of these programs and have not been enrolled in either of them in the past three months. Thus, they exclude children who have transferred between these programs or re-enrolled in one of them after a short time. We focus on this measure rather than on a count of all new enrollees, or of overall enrollees, because we expect new entries to be more sensitive to major policy changes (or outreach efforts) that could affect new enrollment.

The second measure, which is used to study program retention, reflects the proportion of new entries who remain enrolled after one year and other selected periods. As a further measure of retention, we also estimate the extent of program “cycling” among these children—which we define as the proportion of new entries who disenroll from coverage and then re-enroll within four to 10 months. Our hypothesis is that many children who cycle out and back into coverage remain income-eligible during their period of disenrollment; thus, policies that successfully improve retention should be associated with lower rates of cycling.

With these measures, the evaluation team assembled a series of graphs showing trends in the number of new entries (and the proportion of retained new entries) in Medicaid and SCHIP from 1999 to mid-2005. This span covers the entire period of RWJF's original CKI grant to the state (awarded in mid-1999) and the subsequent CKF grant (awarded in January 2002). In the summer of 2006, we discussed these data in detailed interviews with the state CKF grantee and state officials. During these interviews, we asked informants to identify the key changes taking place in state and local enrollment policies and outreach practices, and whether and how these might account for the trends seen in new entries. We gained additional insights from other sources, including a Web-based grantee reporting system, program documents, and demographic and economic data from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics.

Findings indicate that the SCHIP expansions in mid-1999 resulted in dramatic and sustained growth in the public insurance coverage of children in Kentucky. This growth included large spillover gains to the Medicaid program, which added more than 100,000 children to its rolls during the study period. Evidence points to highly organized and sustained, local outreach efforts through the CKF grantees and several partner organizations as a key factor in sustained growth. These local efforts appear to have had a countervailing effect on state policies that might have otherwise slowed the growth in coverage of children in the state.

State Policy Context

Kentucky implemented KCHIP, its SCHIP program, in several phases (Table 1). First, in July 1998, Kentucky implemented a modest Medicaid expansion program (M-SCHIP), which expanded coverage to children ages 14 to 19 up to 100 percent of the federal poverty level (FPL). As with the existing Medicaid program, the state required face-to-face interviews for initial applications to KCHIP. One year later, in July 1999, the state instituted a further M-SCHIP expansion, extending coverage to children ages 1 to 19 up to 150 percent of the FPL. Finally, in November 1999, Kentucky implemented a separate (S-SCHIP) program that was modeled on the State Employees Health Benefits Plan.¹ The S-SCHIP program provided coverage to children between 150 percent and 200 percent of the FPL, functioned as a Medicaid look-alike and did not require cost sharing.

TABLE 1

Key Events in Kentucky's Child Health Insurance Coverage History, 1998–2005

July 1998	<p>Kentucky implements Phase I of its Kentucky Child Health Insurance Program (KCHIP).</p> <p>Features include:</p> <ul style="list-style-type: none"> • Medicaid expansion covering children ages 14 to 19 at or below 100% Federal Poverty Level (FPL) • Face-to-face application • Six-month waiting period for new enrollees.
January 1999– December 2001	<p>Robert Wood Johnson Foundation's <i>Covering Kids Initiative</i> (CKI) begins. University of Kentucky Center for Health Services Management and Research is lead agency for the state coalition.</p> <p>Two local pilot projects receive CKI funds.</p>
July 1999	<p>KCHIP Phase II implemented.</p> <p>Features include:</p> <ul style="list-style-type: none"> • Medicaid expansion covering children ages 1 to 19 up to 150% FPL • Six-month waiting period for new enrollees. <p>Requirement for face-to-face interview is dropped for all KCHIP.</p> <p>Two-page, mail-in application implemented.</p>
November 1999	<p>KCHIP Phase III implemented.</p> <p>Features include:</p> <ul style="list-style-type: none"> • Separate SCHIP program covering children from 150% to 200% FPL • Medicaid look-alike program, with exceptions • Six-month waiting period for new enrollees • No cost sharing • Shared application with Medicaid • Medicaid and KCHIP eligibility determination performed by local Department for Community Based Services (DCBS) offices.
July 2000	<p>Written verification of income eliminated for Medicaid and KCHIP.</p>
June 2001	<p>Written proof of income and proof of child-care expenses resumed for initial mail-in applications to Medicaid and KCHIP.</p>

TABLE 1 continued

Key Events in Kentucky's Child Health Insurance Coverage History, 1998–2005

**January 2002–
December 2002**

Robert Wood Johnson Foundation's *Covering Kids & Families* program (CKF) begins.

University of Kentucky Center for Health Services Management and Research is lead agency for the state coalition.

Local pilot projects receive CKF funds.

July 2002

Kentucky replaces mail-in initial applications with face-to-face interviews at local DCBS offices for Medicaid and KCHIP.

Six-month waiting period dropped for Medicaid expansion program.

August 2002

Kentucky implements \$1 co-payment for pharmacy prescriptions for 18-year-olds.

November 2003

Kentucky institutes premiums of \$20 per family per month for Separate SCHIP program enrollees.

Source: Interviews with Kentucky officials and CKF state grantee

At the time of its second M-SCHIP expansion in July 1999, the state took two important steps to simplify and coordinate enrollment. The state dropped the requirement of a face-to-face interview for both SCHIP and Medicaid, allowing applications for KCHIP to be submitted by mail. In addition, Kentucky adopted a short, two-page application that could be mailed in for processing at local Department for Community Based Services (DCBS) offices, located in every county in the state. The DCBS offices provided eligibility determination for Medicaid and KCHIP.

With the implementation of a separate program component in KCHIP in the fall of 1999, the state undertook an extensive outreach campaign. The campaign, which included the participation of country singer Naomi Judd and other celebrities, combined statewide television advertising with radio and print advertising in major markets. In addition, Kentucky collaborated with numerous local organizations on outreach. For example, the state contracted with the Kentucky Department for Public Health to provide outreach at local health departments and to manage the KCHIP information hotline. The state revised its Free and Reduced Meal Program application, distributed to students during the Back-to-School Campaign, adding a check box to request KCHIP and Medicaid information. The state also contracted with the University of Kentucky Farmworkers Health Program to provide translation services and door-to-door outreach in 11 counties with large Hispanic populations.

Kentucky's outreach campaign appears to have had immediate success as enrollments in both Medicaid and KCHIP soared during the second half of 1999 and into 2000. Indeed, the growth in Medicaid was so rapid that it surprised many in the state, and a conventional wisdom developed that for every child found eligible for KCHIP, two children were found eligible for Medicaid. Unfortunately, the apparent effectiveness of the state's outreach created a financial challenge; within a couple of years of the KCHIP expansion, the number of children enrolling in the program exceeded the number projected by the federal government and Medicaid enrollments continued to swell. Burdened by these costs, the state began to scale back its outreach and, by 2002 (the start of the CKF grant), Kentucky effectively ended its statewide outreach efforts.

In July 2000 the state eliminated its requirement for written proof of income at the time of the initial application. Applicants were allowed to attest to their income, and DCBS eligibility staff used the state's Income Verification and Eligibility System to verify self-declared income. Following this policy change, state audits indicated that this verification process was prone to errors, largely because the database was incomplete and out-of-date. In response to this concern, the state resumed requiring written proof of income, as well as proof of child-care expenses, in June 2001.

One year later, the state reinstituted face-to-face interviews for new applicants and dropped the six-month waiting period for children enrolling in the Medicaid expansion program.² Significant debate surrounded the reinstitution of face-to-face interviewing. On the one hand, many supporters of the policy change argued that it allowed the state to consider families' eligibility for all public benefits (for example, food stamps), not just for health insurance coverage of their children. On the other hand, opponents argued that it would slow enrollment in KCHIP and Medicaid by imposing further burden on the families applying for coverage.

Finally, in late 2003, the program implemented premiums of \$20 per month for children in the separate program component. The adoption of premiums was made in response to concerns about the program's costs and a growing view that families of the enrolled children should share more directly in these costs.

History of the CKI/CKF Program in Kentucky

Before Kentucky implemented its KCHIP program, it convened a "KCHIP advisory coalition" that consisted of children's advocacy organizations to help plan the new program. That group became the foundation for Kentucky's statewide, CKI coalition—a broader group that included the advocates, community-based organizations, government agency representatives, and members of the business community. The University of Kentucky became the lead agency for Kentucky's CKI program in January 1999. The CKI grant funded the following two local projects:

1. Community Health Alliance, which changed its name to Partners for a Healthy Louisville (PHL) in 2000, is a nonprofit organization charged with improving the health and wellness of the Louisville population. It partnered with the health department, schools, businesses and medical providers to provide outreach in Jefferson County.
2. Harlan Countians for a Healthier Community (HC) Coalition is a nonprofit organization that partnered with local health departments and schools to provide outreach in rural, low-income Harlan, Whitley, Knox and Bell counties.

During the three-year CKI grant period, the CKI state coalition focused on improving its partnership with the state and building its ties to local organizations. The state coalition used a portion of its grant to pay for one full-time outreach coordinator who worked out of the state KCHIP offices. The outreach coordinator helped manage outreach activities that the state conducted in conjunction with health departments, schools and other organizations. For example, the outreach coordinator organized the assembly of program information packets that were distributed to every school child near the start of the school year. Toward the end of the CKI grant, however, the growing cost pressure on the KCHIP and Medicaid programs began to strain the close coordination between the coalition and the state, and in 2002 (as the state ended its outreach), the CKI-funded outreach coordinator left the state office.

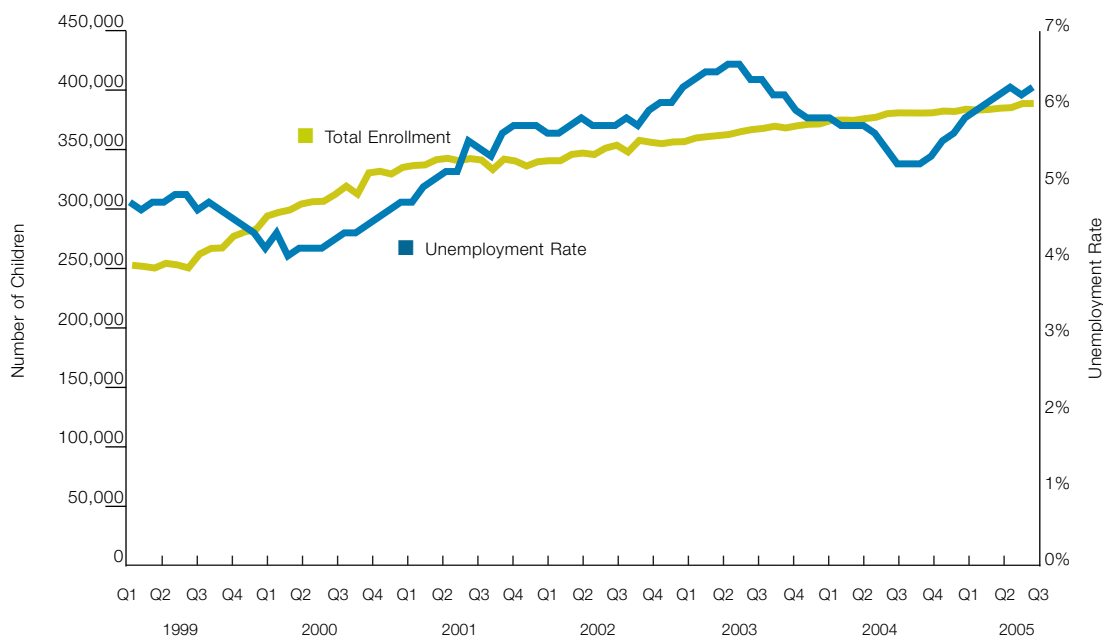
The CKF grant began in January 2002 with an award of \$950,000 (over four years) to the original CKI grantee at the University of Kentucky. Half of this grant went to state-level activities, while the other half provided support to three local programs.³ Throughout the CKF grant period, the state grantee continued to manage and sustain a “network of networks” including several significant local organizations dedicated to improving child and family welfare in Kentucky. These networks (discussed in detail below), were largely born out of the original KCHIP advocacy coalition, which introduced these local organizations to the importance of children’s coverage and the opportunities that KCHIP expansion offered for promoting it. Through these networks, the state grantee was able to distribute outreach materials and gain local perspectives on key policies and processes, such as the enrollment process in DCBS offices across the state. In these respects, the network served a role similar to that of the local CKF sites, creating a relatively broad base of local advocacy from which to promote children’s coverage.

Findings

As suggested above, total enrollment of children in public insurance coverage (Medicaid and KCHIP) increased dramatically during the period of the study, rising from roughly 250,000 children at the start of 1999 to nearly 380,000 children in mid-2005 (Figure 1). Enrollment growth is evident throughout this period, with the most significant increase occurring in the 18 months after the KCHIP expansions in mid-1999. Economic conditions may explain at least some of the persistence in enrollment growth. As seen in Figure 1, the unemployment rate in Kentucky rose from a low of about 4 percent in early 1999 to a high of more than 6 percent in 2003. Informants also reported a decline in the availability of employer-sponsored coverage over this period, which could further increase reliance on public insurance.

FIGURE 1

Trends in the Number of Children Enrolled in Public Insurance Coverage (KCHIP or Medicaid) and the Unemployment Rate, 1999–2005

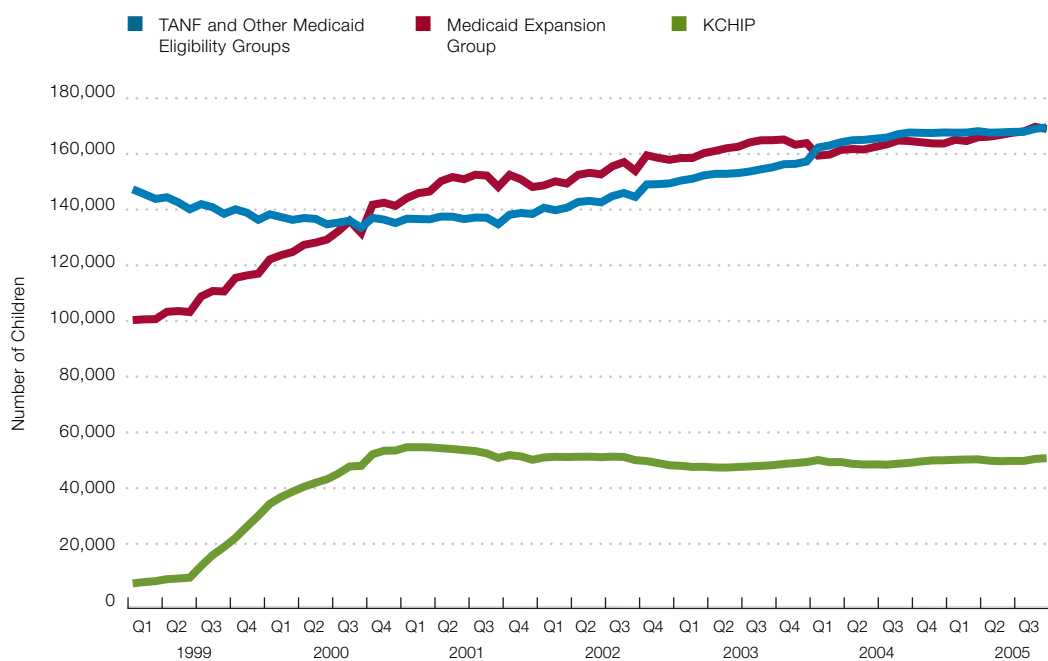


Source: Enrollment data from the Medicaid Statistical Information System. Unemployment data are from the U.S. Bureau of Labor Statistics.

The growth in overall enrollment was reflected in both major eligibility categories of the (Title XIX) Medicaid program: those eligible for Temporary Assistance to Needy Families (TANF), and the poverty expansion groups (Figure 2). For example, the number of children enrolled in the Medicaid poverty-expansion rose steadily, from roughly 100,000 at the start of 1999 to 162,000 in mid-2005. Not surprisingly, the KCHIP expansions during 1999 (that is, the Phase II and Phase III expansions) also contributed significantly to the rise in public insurance coverage seen in Figure 1; KCHIP enrollment increased from just 6,000 at the start of 1999 to more than 50,000 by mid-2005. However, in contrast to Medicaid, the growth in KCHIP enrollment was concentrated in a relatively short time—from mid-1999 through the end of 2000. Indeed, despite a slowing economy, overall KCHIP enrollment actually trended down slightly for the remainder of the study period, from 2001 to 2005. Reasons for this coverage pattern in KCHIP are explored below, first as part of an analysis of new enrollment trends (in public coverage) and second, as part of an analysis of retention trends.

FIGURE 2

Trends in the Number of Children Enrolled in Public Insurance Coverage, by Eligibility Type, 1999–2005



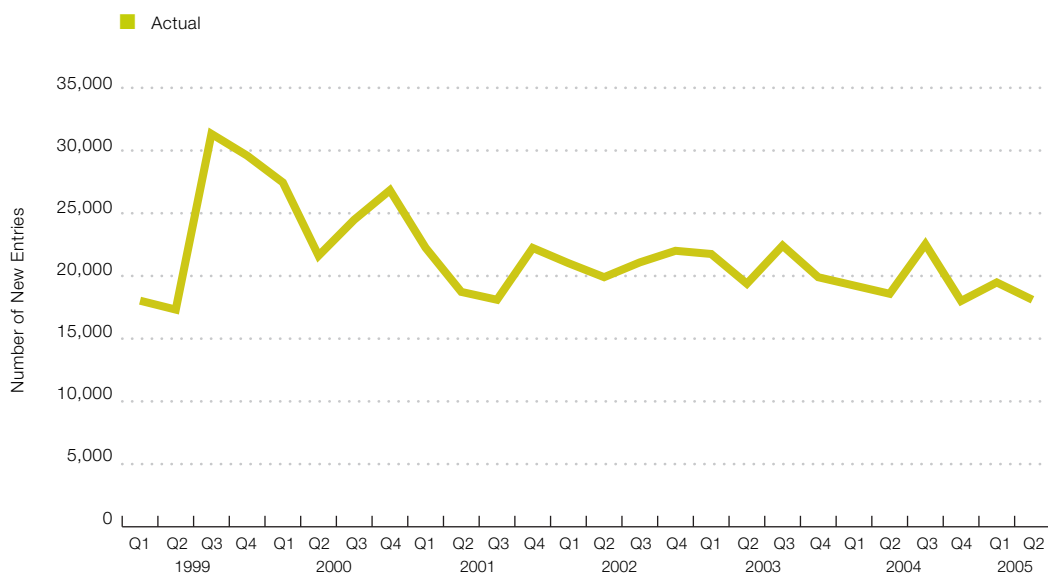
Source: Medicaid Statistical Information System

New Enrollment

While overall enrollment in public coverage shows sizeable and fairly steady growth over the study period, the trend in new entries—that is, children enrolling in KCHIP or Medicaid who had not been enrolled for at least four months—shows three distinct patterns (Figure 3). First, following the expansions in KCHIP in 1999, the number of new entries spiked significantly—rising from a low of 17,300 in the second quarter of 1999 to more than 30,000 in the third quarter. Second, after this peak, the number of new entries declined over a roughly two-year period, reaching a low of about 18,000 in the third quarter of 2001. Third, for the remaining four years of the study period, the trend remained relatively flat; the number of new entries fluctuated modestly between about 18,000 and 22,000 per quarter from mid-2001 to mid-2005.

FIGURE 3

Trend in the Number of New Entries to Public Coverage (Medicaid and KCHIP), 1999–2005



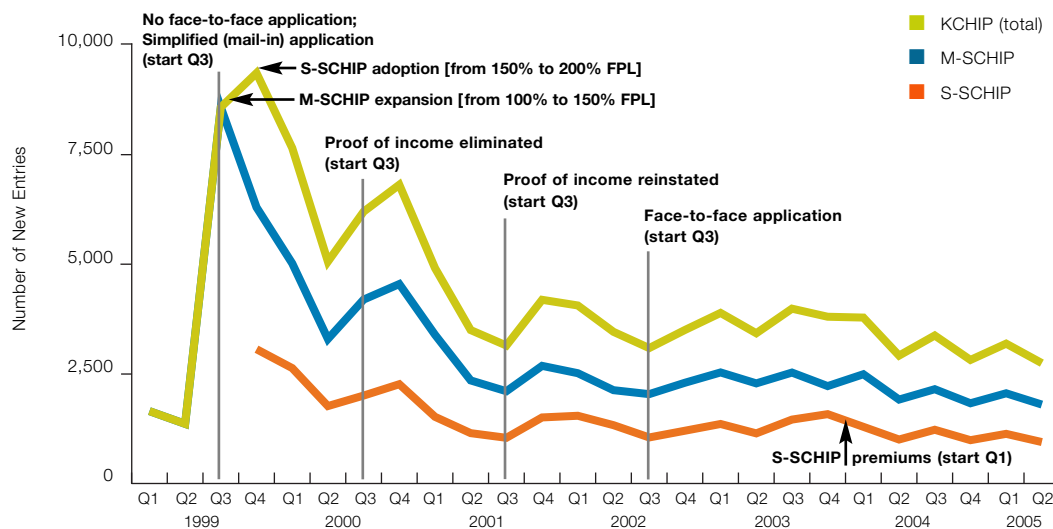
Source: Medicaid Statistical Information System

Note: New entries are children enrolling in Medicaid or KCHIP who have not been enrolled in either program for the past three months.

Not surprisingly, the initial spike in new entries is closely associated with the KCHIP eligibility expansion (Figure 4). Following the initial expansion in KCHIP eligibility in 1999 (from 100 percent to 150 percent of the FPL), the number of KCHIP new entries increased from 1,500 in the second quarter of 1999 to more than 7,000 in the third quarter of 1999. Then, with the adoption of an S-SCHIP model (further expanding KCHIP eligibility from 150 percent to 200 percent of the FPL), the number of new entries rose further—to more than 9,000 new entries in the fourth quarter. After this spike, the number of KCHIP new entries fell sharply in the first half of 2000, only to rebound in the second half of 2000 after the state adopted a policy of income self-declaration (removing the need for families to prove that their income was within the eligibility range). Following this brief rebound, the number of new entries continued to fall until it leveled off at 3,000 to 4,000 per quarter from 2002 on. Given that overall enrollment in KCHIP remained roughly flat after 2001 (see Figure 2), this “new entry rate” of 3,000 to 4,000 per quarter appears sufficient to maintain the size of the program but not sufficient to expand it.

FIGURE 4

Trends in the Number of New Entries to KCHIP, by Component, 1999–2005



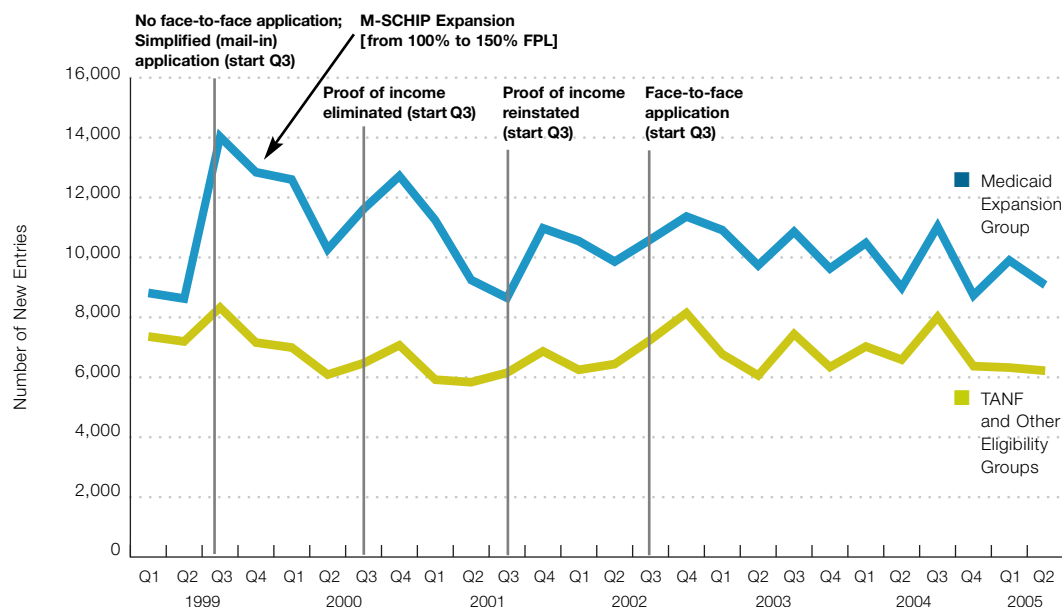
Source: Medicaid Statistical Information System

Note: New entries are children enrolling in Medicaid or KCHIP who have not been enrolled in either program for the past three months.

As reported by case study informants, new Medicaid enrollment also appears to have grown sharply in response to the KCHIP expansions and the coinciding outreach efforts—rising from about 8,600 new entries in the second quarter of 1999 to about 14,000 in the third quarter (Figure 5). Much like KCHIP, this spike trended down over the next couple of years. However, throughout the study period, the number of Medicaid new entries remained well above the levels seen before the KCHIP expansions in the second half of 1999. For example, in 2002 and 2003, the number of Medicaid new entries hovered around 10,000 new child entries per quarter, about 20 percent higher than the levels seen in the first half of 1999. Given that overall enrollment in the Medicaid program continued to grow throughout the study period, this new entry rate of 10,000 children per quarter appears to have been sufficient to increase the program’s size.

FIGURE 5

Trends in the Number of New Entries to Traditional Medicaid, by Eligibility Group, 1999–2005



Source: Medicaid Statistical Information System

Note: New entries are children enrolling in Medicaid or KCHIP who have not been enrolled in either program for the past three months.

Two factors could explain the persistent growth seen in Medicaid, but not in KCHIP, following the KCHIP expansions (Figure 2). The first is the adoption of two important policy changes that coincided with the M-SCHIP expansions in mid-1999: (1) the removal of the face-to-face application requirement at the county social services office, and (2) the creation of a simplified application form that families could use to apply for both Medicaid and KCHIP at the same time. The second factor, cited by several case study informants, is that the combination of the state's KCHIP expansion with major statewide outreach dramatically raised awareness about *all* public health insurance coverage, and reduced any stigma associated with enrolling. This “spillover” of the KCHIP outreach to Medicaid-eligible families resulted in a significant rise in Medicaid enrollment, despite the fact that the state's rules for Medicaid eligibility did not change.

While we cannot disentangle these two factors, available evidence suggests that they may have reinforced one another, generating much more persistent gains in enrollment than would have resulted from either one individually. In two prior case studies in southern states, Arkansas and Virginia, the study team for the CKF evaluation has found a close link between the elimination of face-to-face interviewing and large, persistent gains in new SCHIP and Medicaid enrollment (Walls et al., 2006; Howell et al., 2006). It therefore seems reasonable that this policy change would contribute similarly to the large gains in Medicaid and KCHIP enrollment in Kentucky.

A challenge to this notion is that the later trends in Figures 4 and 5 show no drop in the number of new entries in either program when the state reinstituted face-to-face interviewing in mid-2002. Certainly, a decline in the state's economy during this period might help explain this lack of a clear link. However, a second—perhaps more critical—factor may have been the substantial local outreach that was taking place in Kentucky throughout this period. In particular, as we discuss in the section below about the role of CKF, the school-based outreach in Kentucky was uniquely widespread and substantive, contributing to gains in Medicaid enrollment that could potentially counteract the effects of state policy.

Retention

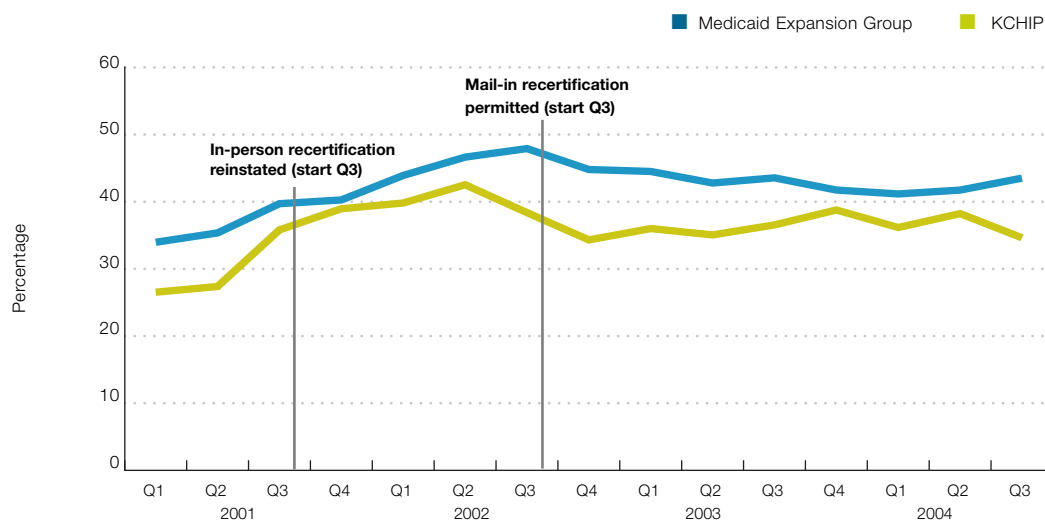
Changes in total enrollment are the result of not only the number of children who join KCHIP or Medicaid but also the number who stay enrolled. To explore this second aspect of total children's enrollment, and its possible links to policy, we examined two retention measures. The first is the proportion of newly enrolled children (that is, “new entries”) who leave Medicaid or KCHIP within 18 months after enrolling.⁴ The benefit of this measure is that it offers a way to detect major shifts in children's retention over time without the need for complex statistical modeling. Like most measures of retention, however, its limitation is that it cannot distinguish children who leave SCHIP or

Medicaid who are still eligible for public coverage (for whom policy should encourage retention) from the children who are no longer eligible. In an effort to disentangle these two groups, we examined a second measure—the proportion of new entries who leave KCHIP or Medicaid in this same 18-month period *and* subsequently cycle back onto public coverage (within four months to 10 months).⁵ The assumption that we make with this measure is that children who cycle often remain eligible for public coverage while they are disenrolled. If true, we would expect this measure to be relatively sensitive to policies aimed at improving retention of eligible children; thus, for example, the trend in the cycling rate would be expected to fall following a policy that simplified the renewal process.

Findings based on our first measure show a fairly clear link between program retention and the use of in-person recertification (Figure 6). Following the adoption of the policy in mid-2001, the proportion of children disenrolling within 18 months rose in both programs. Children in KCHIP experienced the most noticeable change. In the two quarters prior to the policy, about 27 percent of children left the program after redetermination; following the policy, this rate rose to about 36 percent and continued

FIGURE 6

Trend in Rate of New Entries Who Leave Public Insurance Coverage Within 18 Months of Enrollment, 2001–2004



Source: Medicaid Statistical Information System

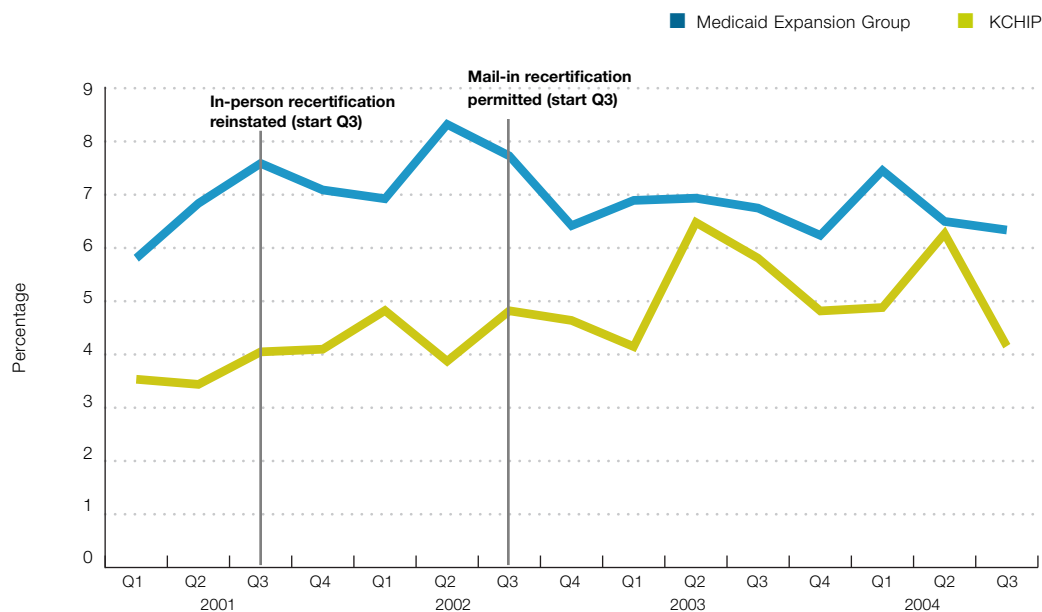
Note: New entries are children enrolling in Medicaid or KCHIP who have not been enrolled in either program for the past three months.

to rise until it peaked at 42 percent a year later. When this policy was revoked in mid-2002, exit rates fell (as we would expect) but remained well above the rates seen before in-person recertification was adopted.

Trends in cycling offer further evidence of a link between in-person recertification and retention of *eligible* children, though the evidence is less consistent (Figure 7). With respect to Medicaid, the rate of cycling in the poverty expansion group had only a minor change when the state reinstituted in-person recertification in mid-2001, rose slightly in the third quarter (just after the policy was implemented) and then declined for the subsequent two quarters. However, when the policy was dropped in mid-2002, rates of cycling fell appreciably. In the third and fourth quarters of 2002, rates of cycling declined notably and then remained relatively low for the remainder of the study period. With respect to KCHIP, the rate of cycling also trended slightly upward after the adoption of in-person recertification in mid-2001. However, when the policy was dropped in

FIGURE 7

Trend in Rate of New Entries Who Leave Public Insurance Coverage Within 18 Months and Cycle Back, 2001–2004



Source: Medicaid Statistical Information System

Note: New entries are children enrolling in Medicaid or KCHIP who have not been enrolled in either program for the past three months.

mid-2002, the trend in the cycling rate was essentially flat in the next quarter and then *rose* sharply in 2003. This rise is unexpected, given that the policy was intended to ease the burden of renewal for families (by allowing them to mail in their renewal form).

Role of CKF

As noted above, the original CKI coalition grew out of a group that had helped advocate for and develop the state's KCHIP program. This role enabled the CKI coalition to form close ties with KCHIP administrators and to work with them on efforts such as the use of CKI funds to support a full-time, state outreach coordinator, as well as the state coordination of annual back-to-school outreach. This close relationship continued for much of the original CKI grant. As costs grew during 2001 and 2002, however, both the governor and state policy-makers began to scrutinize the procedures of the KCHIP and Medicaid programs and to question whether certain procedures (most notably dropping income verification) had allowed ineligible families to enroll. This scrutiny made it increasingly difficult for state administrators to work as explicitly with the state CKF grantee and its broader, advocacy-based coalition. Finally, in 2002, as Kentucky struggled to cover children already enrolled, the state decided to no longer maintain an office for the CKF-funded outreach worker. This change effectively ended the state's close coordination with the CKF grantee, and marked the end of its investment in outreach and media, which had been so prominent after the KCHIP expansions.

With the loss of state investment by 2002, the responsibility for outreach to eligible families fell entirely to the local communities in Kentucky, elevating the importance of the network of locally based outreach that the CKI coalition had helped piece together during the early days of KCHIP. According to the state grantee and other informants, the most effective outreach partners were those that were focused on health, most notably the Family Resource Youth Services Centers (FRYSCs). The FRYSCs, which arose after the Kentucky education reform movement of the late 1980s, are housed mostly in elementary schools with large numbers of low-income children. Each FRYSC functions essentially as an in-school, social services agency, connecting low-income families around the state with needed support and services. (Currently, the FRYSCs serve children in more than 1,000 schools statewide, putting them in direct contact with low-income families whose children might be eligible for Medicaid or KCHIP.) A second important organization in this local network is the U.S. Department of Agriculture's Cooperative Extension Service, which has workers in every county of the state providing special education sessions to 4H and homemakers' clubs. Other organizations in the state coalition's loose network include the Kentucky Extension Association of Family and Consumer Sciences and the Kentucky Homeplace program, both of which continue to conduct outreach to low-income families about KCHIP and encourage them to apply for insurance coverage.

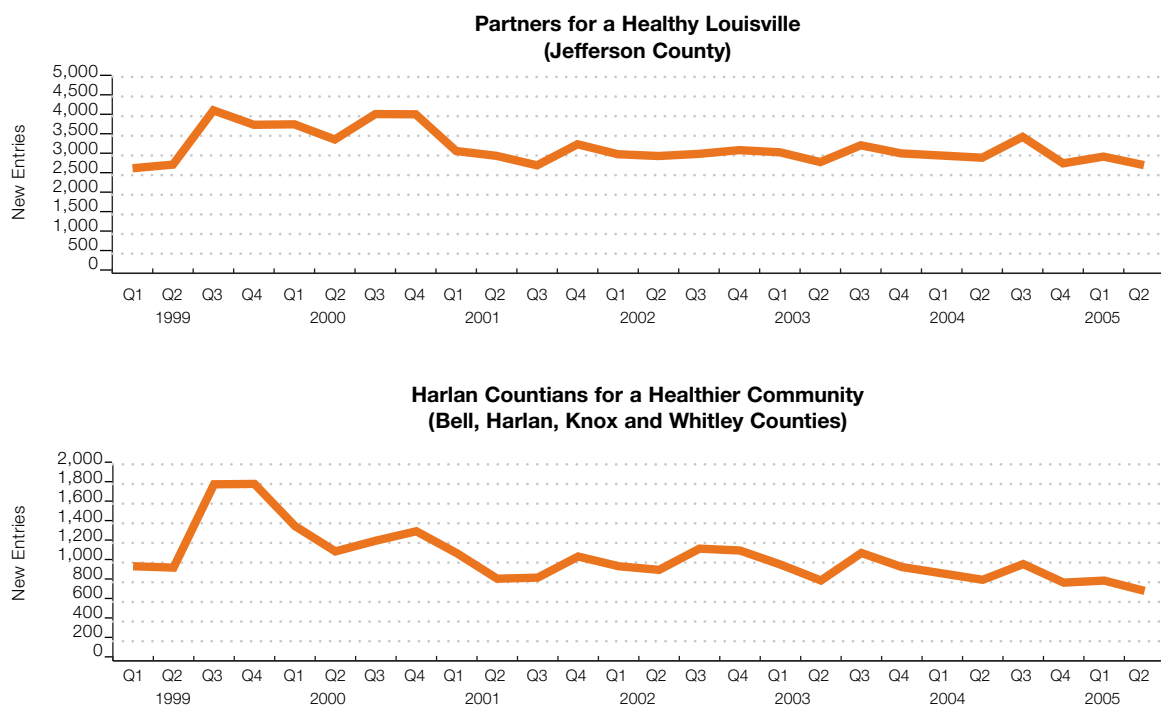
At the same time that the state coalition worked to build meaningful relationships with local organizations, the local CKF grantees helped identify and design effective activities for these organizations. In particular, the urban-based grantee, Partners for a Healthy Louisville (PHL), focused on reaching families with the help of other organizations, especially schools and the local department of health. With the support of the local health department, PHL distributed information about KCHIP and Medicaid at “Super Shot Saturday,” a back-to-school event providing immunizations to area school children. Following “Super Shot Saturday,” PHL sponsored a competition among Louisville’s elementary schools that provided funding for outreach workers to those schools that had higher immunization rates. PHL also oversees the Health Promotion Schools of Excellence program, which provides information on KCHIP to one-third of Louisville’s schools as part of a broader health curriculum.

Finally, the state CKI/CKF grantee focused attention on state policy reform using a combination of anecdotal stories, data collection and formal evaluations of the state’s programs and policies. For example, through the local CKI/CKF grantee in Louisville and other local networks, the state grantee conducted a series of “mystery shopper” activities to document and evaluate the experiences of families applying for coverage in local DCBS offices. These efforts exposed a variety of procedural inconsistencies across local offices. For example, PHL staff documented how some DCBS offices were requiring families to arrive in-person simply to make an appointment, a violation of state and federal rules. The state grantee also completed an evaluation of how the adoption of premiums affected S-SCHIP coverage, concluding that it resulted in significantly reduced enrollments. These findings were shared with KCHIP and other state program administrators, with whom the CKF grantee has maintained a positive working relationship.

Trends in new entries in the areas served by both PHL and the second local grantee, Harlan Countians for a Healthier Community Coalition, differ modestly from those seen in the rest of the state (Figure 8).⁶ In Jefferson County, the site served by PHL (which includes Louisville), the number of new entries rose sharply following the KCHIP expansion in mid-1999 much like the rest of the state. However, in contrast to the rest of the state, this high level persisted for the next several quarters before finally declining during 2001, a possible indication of relatively effective outreach in the early grant period. After this decline, the trend settled down in 2002 and remained nearly constant for the rest of the study period (at around 3,000 new entries per quarter).

FIGURE 8

Trend in New Entries to Public Insurance Coverage, Local CKF Grantee Sites



Source: Medicaid Statistical Information System

Note: New entries are children enrolling in Medicaid or KCHIP who have not been enrolled in either program for the past three months.

In the counties served by the Harlan County coalition, the increase in new entries following the KCHIP expansion is notably sharp—rising from about 1,000 new entries per quarter in the first half of 1999 to more than 1,800 new entries in the second half (an 80 percent increase).⁷ This rise may reflect relatively effective outreach by the grantee following the KCHIP expansion. (Unfortunately, we were unable to interview the grantee for this report, and so have little information with which to examine this possibility further.) After 1999, the trend in new entries fell sharply in the Harlan County site, reaching levels well below the 1999 threshold (of 1,000 new entries per quarter) and remaining at or below this threshold for the rest of the study period.

Discussion

Kentucky offers a compelling illustration of the long-term spillover benefits that can result from expanding children's coverage. Buoyed by the state's media and outreach efforts to promote the newly expanded KCHIP program and by major policy changes to simplify the application process, enrollment in KCHIP grew rapidly and within six months exceeded the level targeted by the state. Moreover, to the surprise of many state policy-makers, and even child advocates, enrollment in Kentucky's Medicaid program boomed. Just one year after the expansion in KCHIP, enrollment in Medicaid grew by more than 50,000 children—equal to the total number of children enrolled in KCHIP. And growth did not stop there. Despite the loss of state-level marketing and the reversal of policies aimed at simplifying the application process—changes that appear to have blunted growth in KCHIP—Medicaid enrollments continued to rise throughout the study period. As a result, five years after the KCHIP expansion, the state's Medicaid program had *added* 150,000 children to its rolls, an increase of 60 percent.

While the downturn in the state's economy probably explains some of Kentucky's Medicaid enrollment growth from 1999 to 2005, sustained local support for children's coverage may have played an equal, or even greater, role in enrollment growth. Building on the excitement generated by the KCHIP expansion and the statewide marketing and media outreach that followed, the state CKI/CKF grantee and its coalition members secured support for children's coverage among several major grassroots organizations. In particular, the support of the school-based FRYSCs—entities created to promote the well-being of school-aged children in the state—appears to have been critical to state coverage efforts. Operating in hundreds of schools around the state serving large numbers of children from low-income families, staff at the FRYSCs functioned essentially as an extensive local outreach network, identifying uninsured children and assisting families with the application process. In the face of state policy changes that might otherwise curtail program growth, most notably the reintroduction of face-to-face applications, the FRYSCs and other local groups maintained the momentum for children's coverage in Kentucky, contributing to sustained growth in the numbers of children enrolled in public health insurance programs.

Endnotes

1. In contrast to the Kentucky Medicaid program, Kentucky's separate SCHIP program benefit did not include Early Periodic Screening, Diagnosis and Treatment (EPSDT) services or non-emergency transportation.
2. The six-month waiting period still applied to children seeking coverage in the separate SCHIP program, although exemptions were made in cases of divorce, job loss and death.
3. This included the two original CKI local programs, and a third local coalition that served Boone, Campbell and Kenton counties in northern Kentucky. This third coalition is not part of the case study.
4. We chose this 18-month period because it includes the period of (initial) annual redetermination, the point when most disenrollments from public health insurance occur. While we considered using a shorter time frame, closer to 12 months, disenrollments in Kentucky tend to peak between 12 and 18 months after enrollment, suggesting some delay in when families are disenrolled for failing to redetermine their eligibility.
5. We set the minimum start date for cycling back at four months to avoid picking up very short periods of disenrollment that could reflect administrative errors that were quickly corrected but show up in the administrative data. The maximum period of 10 months is chosen because it allows enough time to observe some cycling behavior, but remains short enough to assume many of the children were without coverage in the intervening months. Findings based on alternative time frames vary little from those discussed above.
6. See Appendix Figure 1 for a comparison of the trend in new entries in the two grantee sites with the predicted trend. (The predicted trend is based on a forecasting model that relies on census and unemployment data to estimate the number of new entries in each county in the state over time.) This comparison can be useful for identifying any time periods in which the actual number of new entries exceeded the level predicted—a possible signal of effective outreach by the CKF grantee. However, in relatively large counties (such as Jefferson), the model tends to fit the actual trend in new entries closely, making it a less discriminating tool for evaluating the efforts of a local grantee.
7. The estimated enrollment trend from the forecasting model also indicates that the Harlan County site did notably well enrolling children immediately after the KCHIP expansion, as the number of new entries in the second half of 1999 far exceeded the level predicted (see Appendix Figure 1; lower panel). Unfortunately, we lack sufficient detail on the Harlan County site to examine the source of this trend.

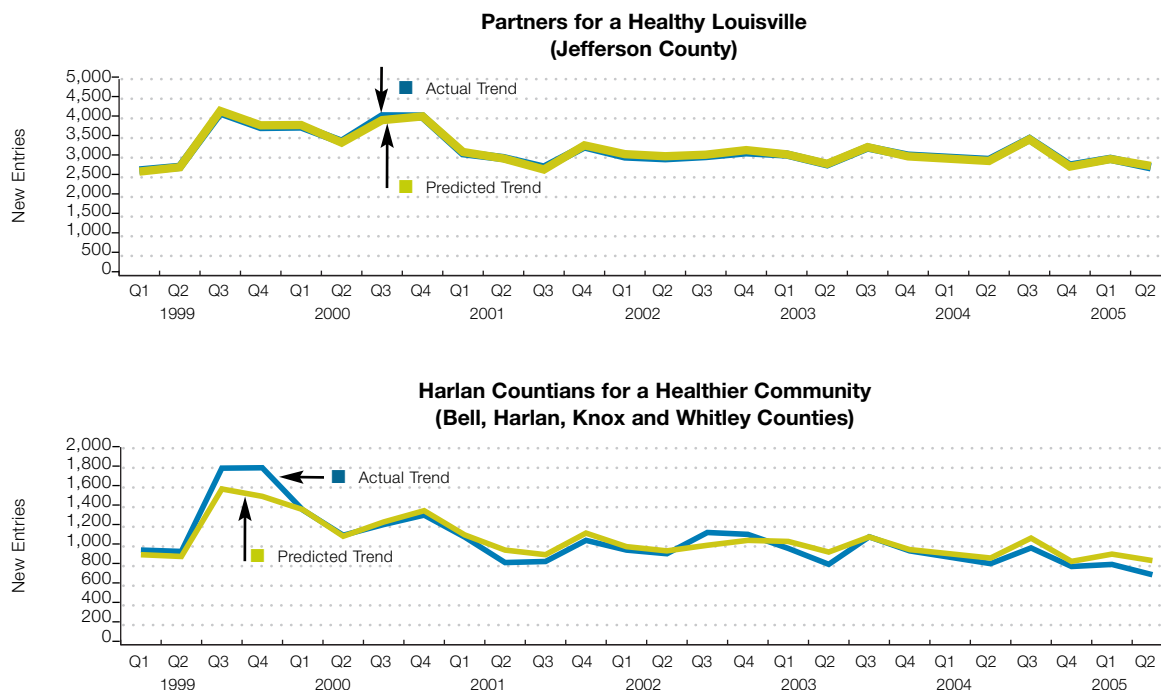
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Appendix: Figure 1

APPENDIX: FIGURE 1

Comparison of the Trend in Actual and Predicted New Entries, Local CKF Grantee Sites



Source: Medicaid Statistical Information System

Note: New entries are children enrolling in Medicaid or KCHIP who have not been enrolled in either program for the past three months. Predicted enrollment is based on a forecasting model that predicts, for each county and city in the state, the number of new entries in each quarter. Covariates include the demographic characteristics of children and families in the county, taken from Census 2000. Examples include the number of children below 200 percent of FPL, and the population that has just moved into the county from out of state. The model also includes the local unemployment rate, obtained from the U.S. Bureau of Labor Statistics.



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