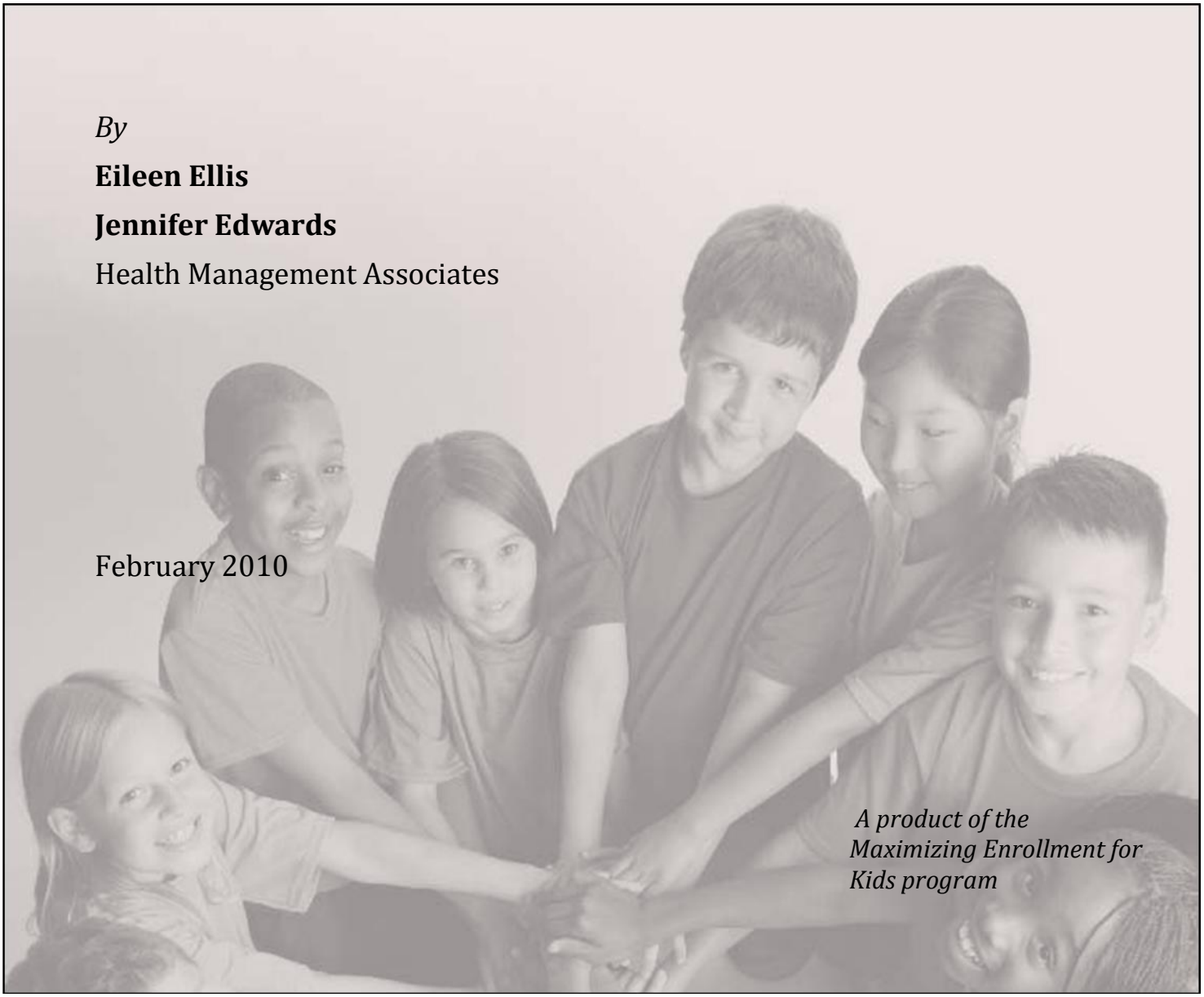
Maximizing Enrollment in Illinois:
Results from a Diagnostic Assessment of the State's Enrollment and Retention Systems for Kids

A Maximizing Enrollment for Kids Diagnostic Assessment Series



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This report is a product of the Maximizing Enrollment for Kids program, a $15 million initiative of the Robert Wood Johnson Foundation (RWJF) to increase enrollment and retention of children who are eligible for public health coverage programs like Medicaid and the Children's Health Insurance Program (CHIP) but not enrolled. Under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office, Maximizing Enrollment for Kids aims to help states improve their systems, policies and procedures to increase the proportion of eligible children enrolled and retained in these programs.

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Executive Summary

In February 2009, Illinois was selected as one of eight grantees of the Robert Wood Johnson Foundation's (RWJF) *Maximizing Enrollment for Kids* program, with the goal of helping states enroll and retain more eligible children in Medicaid and the Children's Health Insurance Program (CHIP). In the first year of the grant, the National Academy for State Health Policy (NASHP), serving as the National Program Office on behalf of the RWJF, collaborated with Health Management Associates (HMA) on a baseline assessment of each state's policies and processes for enrolling and retaining children in coverage. The authors reviewed states' reports and policies, conducted onsite interviews with stakeholders in children's health insurance programs, and reviewed published research about the impact of policies on coverage. This report summarizes the information gathered, distilling the strengths, challenges, and opportunities for improvement in Illinois' work to maximize children's health insurance enrollment.

Findings

Illinois was the first state in the nation to guarantee comprehensive healthcare coverage to all uninsured children irrespective of family income or immigration status. "All Kids" includes the Illinois Medicaid and CHIP programs and a state-sponsored component for higher income families with premiums that increase with income.

Illinois' goal is "to enroll all uninsured eligible children in Illinois in All Kids and to ensure that they remain enrolled throughout childhood."[1] To this end, through legislative and state agency efforts, including the use of advisory task forces, Illinois has sought to identify and implement varied methods to improve the application and renewal processes for All Kids.

Based on site visit interviews, review of materials provided by Illinois, and knowledge of best practices across the states, the following themes emerged:

- **Illinois has made children's health coverage universally available, reducing barriers and complexity for children.** All Kids offers comprehensive healthcare coverage for all uninsured children in Illinois.[2] Without complicated eligibility criteria, marketing and outreach are easier and families can more clearly understand the availability of coverage for them.
- **Application assistance helps those families for whom knowledge of their eligibility for coverage and other administrative barriers are problems.** The use of community-based All Kids Application Agents, who receive a fee for completed applications, greatly expands the reach of the All Kids program, both geographically and in terms of language and cultural diversity. Application Agents also increase the proportion of applications that are already complete when they are received by the State.
- **In addition to the use of community based Application Agents, Illinois has a strong partnership with community-based organizations that assist with outreach to uncovered children.** The Chicago Public Schools is a particularly active partner in outreach and providing enrollment assistance.

[1] Grant application to the Maximizing Enrollment for Kids program, 2008.

[2] In April 2008, 93 percent of All Kids enrollees were in families with incomes below 134 percent of the federal poverty level (FPL).

- **Simplifications and data matching help enroll and retain eligible children in coverage. Illinois has taken away much of the documentation burden that can deter enrolled children from staying in the program at the time of renewal.** Illinois also uses data matching to find eligible children in other public programs, as well as to find income data for enrollees at renewal. Both of these initiatives require good information system capacity, cooperation with other agencies, and a commitment of agency resources.
- **Strong leadership commitment preserves access to care, even in difficult economic times**. Despite severe budget constraints and significant under-funding of HFS's medical programs this budget year, Illinois has maintained strong support in both the executive and legislative branches for an initiative that supports health care coverage for all children in the State.

While Illinois has many strengths, the following challenges may affect enrollment and retention:

- **The state budget crisis continues.**
- **Information systems are old, and impede the State from pursuing some of the simplifications that require system support.** The state has adopted many simplifications in its application process and has adopted an even simpler renewal process. Even so, some technology changes could reduce the number of abandoned applications. E-signatures, document scanning, and third-party data matching could reduce application burdens on families and workers. Legacy computer systems, such as the Client Information System (CIS), and the resulting heavy reliance on paper processing and paper case records create challenges for processing applications (especially across locations) and for case maintenance.
- **Analyzing the patterns of children moving on and off of coverage (churning) would help IL determine the extent to which such movement may contribute to the uninsurance rate of Illinois children.** Inaccurate addresses and non-response to renewal letters may be contributing to an as yet unknown level of "churning" by children who are actually eligible for coverage. State staff has little time to conduct follow-up when application or renewal documents are incomplete, potentially leading to disenrollment of some children who are eligible for continued coverage.

The assessment identified the following as important opportunities to improve policies and processes that will increase the number of eligible children enrolled in the All Kids program:

- Target outreach efforts efficiently
- Learn more about the proportion and characteristics of families who churn
- Improve contact information
- Simplify enrollment procedures further to reduce the number of applications abandoned or denied due to incomplete information
- Improve efficiency and accessibility of application and renewal processes
- Expand the roles of All Kids Application Agents, including the Chicago Public Schools and other community-based organizations, in their efforts to help the state pursue renewals of eligible children and families to improve overall retention rates, to the extent permissible under law.

Introduction

As many as five million children in the United States may be eligible for but not enrolled in Medicaid or CHIP programs in their state and a third are estimated to have been covered in the last two years. *Maximizing Enrollment for Kids*, a national program of the Robert Wood Johnson Foundation (RWJF), aims to address these problems by helping states improve the identification, enrollment and retention of eligible children. Directed by the National Academy for State Health Policy (NASHP), *Maximizing Enrollment for Kids* is a $15 million initiative that RWJF launched in June 2008. In support of enrollment and retention goals, the initiative also aims to establish and promote best practices among states.

To achieve these goals, the program includes:

- A standardized diagnostic assessment of participating states' enrollment and retention systems, policies and procedures;
- Individualized technical assistance to help states develop and implement plans to increase enrollment and retention of eligible children, consistent with the findings of the assessment, and to measure their progress; and
- Participation in peer-to-peer exchange to share information regarding challenges and discuss solutions and effective strategies with other states.

Through a competitive application process, eight states were selected to receive four-year grants of up to $1 million to participate in the program: Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin. This paper reports on the diagnostic assessment of Illinois.

The economic and political environment at the time of this assessment (March - June 2009) provides important context for understanding the status of children's health insurance programs and the opportunities emphasized in this report. During the development of the assessment protocol in late 2008 and throughout the spring of 2009, the United States was in a deep recession with high unemployment leading to a greater demand for public health insurance coverage. State budgets were greatly depressed, two-thirds of states were facing budget shortfalls, and the outlook was for worse shortfalls for about the next three years. There was an enormous tension in most states about how to maintain access to insurance and still balance the budget.

In early 2009, Congress passed the American Recovery and Reinvestment Act (ARRA) to help buffer the impact of the recession on individuals and states. Medicaid relief for 2009 was included, contingent upon states not reducing Medicaid eligibility levels from 2008 levels. About the same time, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA), a law continuing the Children's Health Insurance Program (CHIP). It expanded funding to states that meet enrollment and retention performance incentives. The tension of the recession and the opportunities to obtain new funding for simplifications and expansions serve as a backdrop for state assessments.

Methodology

NASHP has partnered with Health Management Associates (HMA) to complete the Diagnostic Assessment phase of the program. In consultation with NASHP, HMA designed and administered a set of data collection and interview protocols to complete an assessment of the strengths, weaknesses and potential opportunities associated with each participating state's enrollment and retention systems, policies and procedures and external environment.

The diagnostic assessment centers on six areas:

- Enrollment and Renewal Simplification and Retention Policies
- Coordination between Medicaid and CHIP and Other State Agencies
- Analytic Capacity for Program Management and Decision-making
- Client-Centered Organizational Culture
- Non-Governmental Partnerships and Outreach
- State Leadership

In March 2009, information was collected from each state in advance of onsite interviews. Each state provided annual or progress reports on Medicaid and CHIP; trend data on program enrollment and disenrollment, and the number of uninsured children; policy and procedure manuals related to enrollment and renewal; process flow charts for enrollment and renewal; interagency agreements that would affect enrollment and renewal, such as with a sister agency that conducts intake interviews; and contracts with third party vendors who handle enrollment, retention, or a call center.

Each state was then asked to fill out a 20-page questionnaire that requested states to describe key components of its enrollment and renewal practices and outcomes. The questionnaire addressed the six themes identified above.

Based on the findings from the pre-site visit materials and questionnaire, an interview guide was developed to be used during a two day site visit in each state. During the visit to each state, interviews included state program staff as well as people outside the program whose views would help identify current strengths of the program and new opportunities to cover and retain more children. The type of people interviewed included: the Governor's health policy director, state legislators or staff of the legislative health care committees, policy advocates, organizations that work directly with families in completing applications, officials from sister agencies or bureaus, such as public health, and health plans involved in enrollment and retention. The names of interviewees in Illinois are listed in Appendix I.

The findings in this report are based on information collected from the state, a recent review of the literature,[3] and experience from our work in numerous states, to distill the opportunities states have to improve enrollment and retention of children in coverage. While many opportunities were identified, this report highlights those we thought would have the greatest impact on children's coverage and be administratively and politically feasible.

Findings across all eight states' assessments are published in a separate report.

[3] Victoria Wachino and Alice M. Weiss, "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children," National Academy for State Health Policy for Robert Wood Johnson Foundation, February 2009. Accessible at: www.nashp.org/files/Max_Enroll_Report_FINAL.pdf.

About Illinois' Health Insurance Programs for Children

Illinois was the first state in the nation to guarantee comprehensive health care for all uninsured children. Medicaid, CHIP, and additional state-funded children's coverage are all components of the State's "All Kids" Program. Coverage without premiums is available for children in families with incomes at or below 150 percent of the federal poverty level (FPL). Co-payments begin for families with income above 133 percent of FPL.

Illinois claims federal reimbursement for Medicaid eligible children in families with incomes at or below 133 percent of FPL and currently claims federal reimbursement for CHIP-eligible children in families with income above 133 percent up to and including 200 percent of FPL.[4] All uninsured children in families with incomes above 200 percent of FPL are eligible to enroll in the currently state-funded component of All Kids, which requires families to pay copayments and premiums on a sliding scale. Undocumented children not eligible for Medicaid or CHIP are eligible for state-funded coverage at any income level.

All Kids has ten income categories. The amount of the premiums and the limits on total copayments both vary based on income category.[5]

At state expense, Illinois also offers families in the income range 134-200 percent of the FPL that have existing employer-based or private coverage the option to receive a rebate for a portion of their premium.

Illinois is currently seeking approval to expand its CHIP coverage to families with incomes up to 500 percent of the federal poverty level. These higher income families would continue to pay premiums and copayments on a sliding scale.

Enrollment in Public Health Insurance Programs

In April 2008, 1.43 million children were enrolled in some component of the All Kids program in Illinois, representing 42 percent of all children in the State and a growth of 45 percent in the number of publicly insured children since January 2003. While Illinois provides coverage for uninsured children at any family income level, nearly all All Kids children (93 percent) are enrolled in the traditional Medicaid component of All Kids. As of April 2008 the enrollment distribution was as follows:

FPL	Enrollment	Proportion
<134%	1,331,841	93.0%
134%-200%	84,290	5.9%
>200%	15,675	1.1%
Total	**1,431,806**	**100%**

[4] Medicaid covers infants born to Medicaid eligible women with incomes up to and including 200 percent of FPL.

[5] Gifford, K., G. Morgan, D. Marks, and C. Trenholm; Covering Kids & Families Evaluation, Case Study of Illinois: Exploring the Links Between Policy, Practice and the Trends in New Medicaid/SCHIP Enrollments. Robert Wood Johnson Foundation, January 2008. www.rwjf.org/pr/product.jsp?id=30575.

In addition to expansions of coverage for children, Illinois has expanded its FamilyCare program over the same time period, providing coverage for parents or caretakers in families with incomes up to 185 percent of FPL. As with children, parents or caretakers must pay premiums for coverage if family income exceeds 150 percent of FPL. State staff indicate that expanding parental coverage has helped increase enrollment in children's coverage.

Despite relatively generous public programs, the Current Population Survey (CPS) indicates that 8.3 percent of Illinois children, or nearly 280,000 children, remained uninsured in 2007. State administrative data, as well as the research on CPS, indicate the CPS likely overstates the number of uninsured children. Illinois has launched a state-specific survey to refine the estimates of the total number of uninsured children and attempt to provide additional information on the characteristics of uninsured children.

Leadership and Political Context

There has been long term bi-partisan support for children's coverage in Illinois. Beginning in 1997, four governors and successive General Assemblies have supported expansions of what was first KidCare and then All Kids. Nonetheless, many of the simplification strategies adopted by the state, such as elimination of the family asset test, have been continually challenged. These challenges have increased in the current fiscal environment.

The Department of Healthcare and Family Services (HFS) is responsible for policy for All Kids and FamilyCare and is also the state agency responsible for administering Medicaid and CHIP programs. As is true in many states, a second state agency, the Department of Human Services (DHS), shares the responsibility for eligibility determination and enrollment for the state's means-tested healthcare programs, including All Kids. HFS accepts applications for All Kids and FamilyCare, makes eligibility determinations for all applications received regardless of family income and maintains cases for families with income above 133 percent of the FPL. DHS accepts applications for All Kids and FamilyCare, makes eligibility determinations for all applications received regardless of family income, and maintains the cases for families with income at or below 133 percent of the FPL as well as for pregnant women up to and including 200 percent of the FPL and their infants once born. DHS also administers many other means-tested public benefits such as SNAP (Food Stamps) and TANF. DHS has local offices (called Family Community Resource Centers) throughout the State.

Applying for and Renewing Coverage

Families may apply for All Kids coverage through either DHS or HFS. HFS accepts only applications for medical benefits. DHS accepts all applications, both those designed for families seeking only medical benefits as well as those who wish to apply for another means-tested program. Both departments accept online and mail applications. DHS also takes applications in person. Illinois also uses All Kids Application Agents (AKAAs) located in health centers and community organizations throughout the State to assist families in completing the application and collecting required documentation. The AKAAs receive a technical assistance payment (TAP) of $50 for each successful application.

Illinois offers the option of administrative renewals for most children receiving only medical benefits if family income is at or below 200 percent of FPL. The administrative renewal option uses current data on file to automatically pre-populate the renewal forms. If the family has had no change in circumstances, the children are automatically renewed without any action on the part of the family. Families containing persons who receive assistance through the Supplemental Nutrition Assistance Program (SNAP) can also benefit from a similar administrative renewal process if they are recertified for SNAP assistance. Administrative renewal has had a positive impact on enrollment retention.

Some families' needs are better served through the traditional renewal process. These families may include parents or caretaker relatives who are required to meet spend-down, may be receiving state funded premium assistance or may be receiving Transitional Medical Assistance. Parents and caretaker relatives are required to provide verification of their income each time there is a change and at renewal if they wish to continue receiving medical benefits for themselves.

Priorities Identified by the Grantee

In their grant application, Illinois identified the following priorities, which will be considered along with opportunities identified in this report, as they work with NASHP to plan the use of grant funds:

- Improve the web-based application process by assessing methods to increase the approval rates for web-based applications, including e-signature and document scanning options;
- Develop third party interfaces for those outreaching to families in community or school settings;
- Establish a more "permanent" eligibility card – a card good for 6 or 12 months to replace the monthly paper card currently issued;
- Improve the State's ability to update addresses for enrollees (errors currently lead to cancellations), including through web-based updates and a proposed call center; and
- Analyze the case maintenance and renewal process to decrease cancellations for children who remain eligible, including conducting trainings to improve eligibility determinations and retentions.

Findings from the Diagnostic Assessment

1. Enrollment and Renewal Processes and Policies

Current Approach to Enrollment

In Illinois, children can apply for health benefits through one of four means: by mail, in person at a DHS office, online, or working with an application agent in the community. Illinois has had a single application for children's coverage programs, regardless of funding source, since 1998. Various efforts have been made to simplify the application over time. As of 2009, there is a common application for all means-tested health care for parents and other caretaker relatives, children and pregnant women. A second application, available for families seeking health insurance and other public means-tested benefits such as cash assistance or food stamps (SNAP), is also a joint application for medical benefits.

There is no asset test for any parent or other caretaker relative or children's coverage and no face-to-face interviews are required for All Kids and FamilyCare. Income verification has been simplified; only one pay stub from each source has been required since January 2004. Illinois has also adopted 12 months continuous eligibility for children.

Illinois has two web-based application options available for families and children. Web-based applications have the benefits of being easy to obtain and easier to complete accurately due to embedded skip patterns and prompts. However, Illinois' online applications fail to fully automate the application process in that they still require that certain documents be faxed, mailed or delivered to a state agency, including a pay stub, a signed signature page from the application, and verification of citizenship (e.g. birth certificates). In the early years of implementation of web-based applications, documentation requirements presented a major barrier to successful enrollment. Illinois reports that when the online application was first implemented the denial rate for web-based applications was 51 percent. Clearer statements of the documentation requirements on application materials and the addition of reminder letters to families reduced the level to 33 percent. Today, State staff report that current rates of applications abandoned or denied due to lack of documentation are similar for paper applications and online applications, and that both rates are around 10 percent.

Under the current process, Illinois uses third-party data matches to verify Social Security income and unemployment benefits, meaning they obtain information from existing databases in lieu of asking for documentation. For earned income they require a pay stub. Illinois has no current plans to move to self-declaration of income . HFS staff are concerned about the age of income data available electronically, and the risk of being penalized by an audit. HFS staff also believe the pay stub requirement is not more of a barrier than the paper signature page. They usually receive both the pay stub and the signature page, or neither one. Illinois allows self-declaration of income in considering children's eligibility if a parent is paid in cash and the employer will not provide a written statement of earnings.

Applications are processed by two different state agencies, the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS). HFS's Bureau of All Kids (BAK) serves as the Central Processing Unit (CPU). BAK receives mail or online applications filed using the All Kids application. Follow-up communication with families occurs via phone and mail, and not in person. When BAK receives web-based applications, these applications must be "married" with the corresponding paper documentation. About 65 percent of the applications received by BAK are

internet applications. All incoming Internet applications are logged and held until the corresponding documentation is received. The documents are then combined in a paper file that is available to BAK intake workers. The files are organized by date so that the oldest files are processed first.

DHS has local offices throughout the State that provide a full range of human services including assistance in enrollment in All Kids and FamilyCare, food stamps (SNAP), AABD, GA and cash assistance. DHS receives applications in person, by mail or through the DHS website which is separate from the HFS website and uses a different multi-program online application. Both applications are accessible and may meet different applicants' needs. Web applications are processed within 45 days (Illinois has adopted the Medicaid standard of promptness for all children's medical assistance), but most children can be covered immediately under presumptive eligibility (PE).

DHS reports that very few of the online or mail applications can be processed without additional follow-up. Families that apply in person usually have the majority of the required documentation with them. Both DHS and HFS staffs authorize PE when an application is received and the:

- Declared family income is equal to or less than 200% of the FPL;
- Child did not start receiving PE coverage within one of the last 12 months; and
- Worker has no knowledge that the child does not meet federal citizenship/immigration requirements

The family has 10 days to submit required documentation. Some local offices will call a family to remind them that they are waiting for a pay stub not received within the 10-day period from the processing of the application. However customers can also call and request additional time without penalty.

Advocates perceive systems issues may create barriers to enrollment, including too many dropped calls at DHS, lost faxes, lost client paperwork, and full voice mailboxes. Advocates also indicate that culture varies from office to office, but that DHS workers are sometimes disrespectful of clients, which may deter successful enrollment. State staff attribute barriers to low staffing levels.

Illinois encourages providers to assist patients to apply. For children, submission of an application may trigger PE which covers services already provided. While some states report that a significant proportion of families receiving assistance through PE never complete the application process, Illinois indicates that the denial rate for new applicants did not increase when they implemented PE.

Illinois has trained application assisters - All Kids Application Agents or AKAAs - located at 1200 sites throughout the State. State staff members serve as AKAA trainers. Community-based organizations (including faith-based organizations, social service agencies, day care centers, local government, unions, medical providers, school districts and licensed insurance agents) are home to AKAAs. It is not surprising that the most active AKAAs are at health centers. A $50 Technical Assistance Payment (TAP) is issued for each completed application that results in an enrollment. The Illinois *Maximizing Enrollment for Kids* grant application indicates that over 85 percent of applications received from AKAAs are approved and that Illinois has paid over $9.7 million in TAP payments since July 2003. HFS staff indicate that applications received from an AKAA are much more likely to be complete than applications submitted without an AKAA –whether by mail or online.

Applications are available in English and Spanish and fact sheets about the program are available in 16 languages. Many AKAAs are bilingual. Advocates like the fact that they can refer families to AKAAs that speak the language of the family.

If a child is eligible for All Kids subject to payment of a premium, the enrollment occurs before the payment of the first premium. The family receives an enrollment notice that indicates the amount of the premium and that they should contact HFS if they don't want to pay the premium. The advantage of this approach is that children are quickly enrolled in coverage. The downside is that a debt is incurred that the family may not want to pay, especially if they are at the higher premium levels.

HFS reports that the processing time for new applications was19 days from date of receipt for the mail or web-based applications received at BAK, as of June 2009. For the DHS, which processes applications submitted via mail, phone, online and onsite, the processing standard of 45 days is met at least 93 percent of the time.

Current Approach to Renewal and Retention

To streamline the renewal process and improve retention for children, Illinois implemented two renewal processes that ease the burden of submitting completed forms and verifications. Most children with incomes at or below 200 percent FPL are eligible for administrative renewal. Administrative renewal forms are pre-populated with data regarding active household members, income and health insurance. If there are no changes in the family's circumstances, the family is not required to return the form. Eligibility for the children is automatically renewed.

The other renewal process eases the burden of duplicative renewal/recertification requirements for families receiving both medical and SNAP benefits. Recertification of SNAP benefits automatically meets the renewal requirements for All Kids. Each time SNAP benefits are recertified, an All Kids renewal is recorded. Some SNAP benefits are recertified more frequently than once annually. Each All Kids renewal resulting from a SNAP recertification resets the 12-month clock for a child's continuous All Kids eligibility. In the event that SNAP benefits are not recertified, the child's eligibility continues through the end of the 12-month continuous eligibility period in effect at the time of the SNAP review.

For cases including both children and adults, families receive a pre-populated renewal form. Adults who wish to continue receiving medical benefits are given the option to complete and return the renewal form or complete the renewal process over the phone. The only verification required is current income. Adults who do not respond to the renewal letter lose their medical benefits. However, the children continue to receive coverage for an additional year under the administrative renewal provision if there is no indication that the family's circumstances have changed.

The monthly disenrollment rate has averaged about 1.3 percent from 2004 through 2008 and was less than one percent in 2008. While this is a low number in percentage terms, the disenrollment of nearly 15,000 children each month merits further analysis. What is not known is the extent to which these children were actually eligible for continuing coverage and later re-enrolled in the program.

Based on the policies described above, in particular the administrative renewal policy, churning may be less likely in Illinois than in some other states. Even so, Illinois indicates that there are avoidable cancellations. The State provided data on reasons children's medical cases were closed in June 2008. Just over 50 percent of the cases closed in that month were closed due to failure of the family to return forms or supply documentation, or due to inability to locate the family.

Some Illinois staff indicate that the use of monthly paper All Kids eligibility cards may have an adverse impact on retention. One of the challenges is getting the monthly All Kids cards to the families when the address information is inaccurate. The State recognizes this challenge and wishes to move to a

more permanent eligibility card. The *Maximizing Enrollment for Kids* initiative may contribute to this initiative.[6] This problem, however, poses a program integrity dilemma for the state. The lack of valid addresses limits the state's ability to assure that enrolled children remain Illinois residents.

If children lose eligibility due to non-payment of premiums, per state law, they must "sit out" for three months, pay all debt for prior premiums and pre-pay the next premium. This is a more stringent penalty than exists in many other states.

New Initiatives

Illinois will likely use the Social Security matching system for citizenship documentation established in CHIPRA when it becomes available next year. The application form already requires that those who declare that they are citizens provide a social security number or proof that they have applied for one. State law enacted in 2005 created the "Task Force on Access to Benefits and Services" (or the ABS Task Force). The charge of the ABS Task Force was to review and analyze policies and procedures related to application and eligibility determination processes for cash, food stamps (SNAP) and medical assistance programs. The task force included a broad cross-section of state agency and stakeholder representatives. It issued a report in May 2008. Many recommendations of that task force are reflected in the Illinois grant application for this program and are consistent with the results of this diagnostic assessment.[7]

Strengths

Illinois enrollment and renewal processes and policies for children demonstrate many outstanding features:

- **Scope of coverage.** The completeness of the coverage options (such that all children are either eligible for private coverage or a public program) has simplified the dialogue about enrolling and retaining children in coverage. Further, aligning all children's programs under one name minimizes public confusion about eligibility and application processes.
- **Family coverage.** The family application and high parent-eligibility levels aid state efforts to reach and enroll children.
- **Simplified documentation and administrative renewal.** While Illinois still requires verification of income for new applications, income documentation is reduced to a single pay stub or document for each source of income and no income documentation is required at renewal for children in families with incomes below 200 percent of FPL if income is unchanged since the last renewal.
- **Application assistance.** The use of AKAAs is a great strength of the Illinois process:
  - AKAAs can submit copies of required verifications, reducing the burden for families.

[6] While the issuance of monthly cards is an administrative burden, state staff also noted that there are some benefits to use of monthly cards. One benefit is that the "temporary" cards increase the incentive for clients to provide updated address information.

[7] The "Access to Benefits and Services Report" is available at http://www.hfs.illinois.gov/assets/0708_access.pdf

- AKAAs are located in many communities where potential applicants may have limited English proficiency. The presence of community-based AKAAs reduces language and cultural barriers for non-English-speaking applicants, greatly increases the number of sites where applications can be made, and increases outreach to individuals that may not otherwise be aware of All Kids.
- The AKAAs reduce the administrative burden on the State by increasing the likelihood that applications will be complete and submitted by eligible individuals, reducing the State burdens to correspond with applicants and process applications of ineligible individuals.

- Illinois has adopted most of the simplification strategies endorsed in CHIPRA:
  - 12-month continuous eligibility – since 2001
  - No asset test – since 1998
  - No requirement of a face-to-face interview – since 1999
  - Joint application and renewal forms regardless of funding – since 1998
  - Presumptive eligibility – since 2004
  - Administrative renewals – since 2006
  - Express Lane eligibility through the SNAP/TANF agency

Challenges

While Illinois has made great progress in streamlining and simplifying the application and renewal processes, several challenging issues remain:

- **Stigma.** Staff believe some eligible families do not enroll because they are not aware that they qualify. In addition, for some there is a stigma associated with receiving state benefits or a fear of repercussions related to the "public charge".
- **Returned mail.** One thousand All Kids-enrolled children each month lose coverage when returned mail (two pieces) results in a termination. Addresses are not always easily updated. Due to staffing shortages, returned mail at the BAK, such as member handbooks, sits in tubs without being reviewed for possible leads. In some cases the post office or a mail contractor (used by the SNAP program) may have provided information about a forwarding address that does not get entered in the data system. HFS also reports that monthly medical cards that are returned don't get re-processed as the agency would like, again due to lack of staff resources. Some offices make an effort to contact families by phone or to find a new address. The diagnostic assessment confirms the statement in the Illinois grant application that "we believe that there is great opportunity here for detailed analysis with the goal of increasing retention."
- **Complexities of online application.**
  - Individuals applying online must still submit a paper signature. They can choose to print out the signature page from their web-application or have a signature page mailed to them if they have no printer access where they are applying.

- While web applications are viewed by many as beneficial, they may be confusing for some applicants. HFS indicates that they receive web applications from individuals who think All Kids is a new program and already have active cases. Or, a family with an active medical case may use the DHS web application to request enrollment in cash assistance or SNAP.
- While the online application process has been improved, 33 percent of All Kids web-based applications are denied each month. Approximately one-third of the denials resulted from incomplete or abandoned applications. The most common types of information missing from abandoned online applications are income verification and signature pages.

- **Paperwork burden.** Illinois does not create electronic images of required documentation. The process is very paper intensive. AKAAs mail photocopies rather than sending scanned images. Both DHS and HFS are interested in document imaging and electronic case records. Currently, financial and technical barriers exist that prevent Illinois from moving forward.
- **Renewal follow-up.** Small scale testing of changes (using a plan-do-study-act methodology) conducted during the Covering Kids and Families initiative found that making phone calls to families not responding to redeterminations increased retention rates, as did a second mailed reminder. However, State staffing resources as currently allocated may not be sufficient to support this activity and the administrative renewal process now in place reduces the need for additional contact with many families.

2. Interagency Coordination

Current Approach

COORDINATION AMONG HEALTH COVERAGE AGENCIES

As noted previously, Illinois has combined children's coverage funded by Medicaid, CHIP, and a state-funded premium based assistance for children into a single program named All Kids. However, the management of enrollment and renewal processes and children's cases is split between two agencies. The Department of Healthcare and Family Services (HFS) sets all policy for means-tested health care programs in Illinois. The Department of Human Services (DHS) is the home of most income-based public programs, including cash assistance and SNAP (Food Stamps). DHS operates the local social services offices (formerly welfare offices, now called Family Community Resource Centers) throughout the State. Both agencies accept and process All Kids applications from families at any income level. HFS maintains and is responsible for redeterminations of eligibility for children in families with income above 133 percent of the FPL regardless of funding source. DHS maintains and is responsible for redeterminations of eligibility for children in families with income at or below 133 percent of the FPL (most families fall in this income group) and for most infants in families with income up to 200 percent of the FPL. Differences in the traditional roles of both agencies, the size of the children's population they serve, the capacity of their information systems, or perhaps some remaining welfare stigma, create some challenges to inter-agency coordination. It is not clear if these challenges have a tangible effect on enrollment and retention of children. However, as a strategy for reaching more children, both the linkage with the cash assistance program and the insurance-only application succeed in reaching families.

Both DHS and HFS use the same eligibility data system to process applications for All Kids. BAK in HFS receives and processes applications for medical benefits for All Kids, FamilyCare, and Mom & Babies Health Insurance. If children or adults in families with income at or below 133 percent of the FPL or pregnant women are determined eligible, BAK opens the case and then mails the case file to the appropriate DHS FCRC for maintenance. Similarly, if a local DHS FCRC determines that children or adults in families with income above 133 percent of the FPL are eligible, staff opens the case and then mails the case file to BAK for maintenance. The numbers of cases transferred are significant. HFS transfers about 4,200 cases to DHS each month. BAK staff route the case to the appropriate local DHS office based on the zip code of the enrollee(s).

COORDINATION BETWEEN HEALTH INSURANCE AND OTHER PUBLIC PROGRAMS

Illinois has worked with the State education department to test a method to find eligible but unenrolled children in the public schools. In Illinois, the application for the free and reduced school lunch program (National School Lunch Program or NSLP) has a check-box to indicate interest in or need for medical coverage. However, each school district creates its own NSLP forms and the documents are not stored electronically. Review of forms in one school district found that parents were erroneously indicating their children were not covered. More information about the work of the Chicago Public Schools to identify and enroll children is in the Partnerships and Outreach section, below.

HFS has considered using income tax data to find eligible, unenrolled children. State law, however, prohibits the Illinois Department of Revenue (DoR) from sharing tax return data. However, DoR has placed an advertisement for the All Kids program on the income tax booklet.

New Initiatives

Several years ago, pursuant to state law, the Task Force on Access to Benefits and Services was appointed to "review and analyze policies and procedures concerning the application process and determination of eligibility for cash, food stamps and medical assistance programs. The task force included a broad range of community stakeholders. HFS and DHS provided staff support. At the recommendation of the ABS Task Force, "No Wrong Door" legislation is pending that requires the state to permit people to apply for assistance or update their information at any DHS office. DHS and HFS are supportive of the initiative, but point out that an essential requirement for implementation is development and financing of the required IT infrastructure.

Strengths

- **Single eligibility data system.** DHS and HFS use the same eligibility data system, making it easier for them to coordinate and share data. While there is a lot of paper transferred between departments, there was no indication of any problems with transfer of cases. In particular, the fact that both agencies can complete the initial enrollment or redetermination for All Kids is an asset. This feature reduces the risk of failure to claim federal reimbursement from the appropriate federal program, Medicaid or CHIP.

- **Children receiving other benefits are linked to health insurance.** DHS checks TANF and SNAP application data to be sure that there are no children enrolled in cash or food assistance who lack medical assistance and can assure that families who apply for SNAP or cash assistance take advantage of All Kids. Data on the number of children who benefit from this step were unavailable.

Challenges

- **Legacy system.** The current Client Information System (CIS) which houses the eligibility data for all public assistance programs managed by DHS, as well as medical eligibility, is a legacy system that limits analysis and information sharing.

3. Analytic Capacity for Program Management and Decision-Making

Current Approach

- **Program management.** HFS staff report that existing information technology works well for intake but can be problematic for case maintenance. They have developed ways to work around some system deficiencies. CIS is a legacy system that is older than Illinois' Medicaid Management Information System (MMIS). (The State has engaged a planning vendor to assist with procurement of a new MMIS system.) The CIS system creates barriers to information sharing between local offices. As a result, DHS doesn't have a system of electronic records that can be viewed by any local office or BAK.
- **Decision-making.** Illinois was an early adopter of a medical data warehouse which enables the State to analyze data related to medical claims and client eligibility data. The data warehouse includes demographic information on clients and current and historical coverage information including length of time on assistance. The state has not yet developed the kinds of data reports that could make full use of the data warehouse in relation to enrollment. State staff believes it could be useful in analyzing retention rates and the extent and causes of breaks in eligibility.

New Initiatives

The Illinois Department of Human Services is the result of the consolidation of several agencies of state government. DHS comprises large portions of what were formerly the Departments of Public Aid and Public Health as well as the former Departments of Mental Health and Developmental Disabilities, Alcohol and Substance Abuse, and Rehabilitation Services. Each agency brought with it a legacy IT system.

Recognizing the limitations of its internal systems, DHS, in partnership with five other state agencies (HFS, the Departments of Public Health, Children and Family Services, Aging, and Employment Security), has articulated Illinois' need for a complete redesign of its human services data systems. These six agencies have collaborated to initiate development of a Framework for Integrated Service Delivery and jointly authored a planning advanced planning document that recently received conditional federal approval.

This technology project is designed to transform access and customer services for those seeking assistance from any of the six health and human services agencies. The ability to share data across programs and between agencies more easily will enable the State to do better screening and

enrollment for programs like All Kids based on information already in the system for other assistance programs. However, in light of the current Illinois state budget crisis it is not clear that "the Framework" will be funded in fiscal year 2010 or beyond.

Strengths

- **Closure data.** Unlike many states, Illinois has good data on case closure reasons that can be used to target strategies to reduce churning and to measure changes in churning rates.
- **Application denial data.** Illinois also is able to produce data on the number of applications denied due to abandonment or failure to provide documentation. This data can be used by the state in its continuous quality improvement process to identify opportunities for further simplification and process improvement.

Challenges

- **Paper burden.** Even with online applications, Illinois' case maintenance is largely based on paper. More records and documents could be moved to electronic versions. Section I of the ABS Task Force report includes recommendations to align and further develop existing electronic application systems.[8]
- **Electronic application complexity.** While both HFS and DHS have automated application processing systems, DHS workers must use between 15 and 17 more screens than their HFS counterparts due to the eligibility considerations for all potential benefits to ensure every applicant gets the most help for which they qualify. Skip patterns that allow workers to choose health insurance eligibility determinations could increase worker efficiency but could also result in applicants not receiving all potential benefits. A further complication is that DHS uses this process to fulfill the requirements of state law that any application be considered for all benefits potentially available to the applicant.
- **Data silos.** DHS has a data warehouse with some of the eligibility data for cases that have been enrolled. The CIS system currently in use by DHS and BAK does not allow workers in one local office to update or change eligibility data for cases in another office unless they are on the same hardware "node," or part of the system.
- **Lack of data on churning.** Staff indicated that Illinois has not had an opportunity to analyze the rate of "churning" in All Kids enrollment. They indicate that they currently have limited ability to analyze children's eligibility patterns and trends over time. Development of more robust use of the medical data warehouse to analyze enrollment could be profitable. Other approaches, such as examining one month of disenrollment based on small scale data collection or using the plan-do-study-act (PDSA) cycle as a method to test small scale changes in processes could be considered.

[8] The priority recommendations of the ABS Task Force are included in Appendix II.

4. Client-Centered Organizational Culture

Current Approach

Illinois has worked hard to remove the welfare stigma of medical benefits for families and children, first with the KidCare name and more recently with All Kids. Staff are confident these changes have increased acceptability of the program and led to more applications. DHS has also sought to create a more consumer-friendly environment. The local DHS offices are now called Family Community Resource Centers. DHS implemented a "GEM" Platinum Customer Service Program which is awarded to local office staff that "Go the Extra Mile" by providing excellent customer service when working with the families they serve.

Despite these changes, DHS indicates that some parents do think of these offices as still having the welfare stigma, and so may not want to use them for health insurance. While many workers do have a welcoming attitude toward customers and want to help families get benefits, including at the enrollment sites we visited, understaffing at DHS offices can contribute to long waits and negative customer experiences.

The availability of an online application and the introduction of AKAAs in the community both attempt to give families more, acceptable options for seeking health benefits.

STAFF TRAINING, WORKLOAD AND PERFORMANCE REVIEW

DHS indicates that in general more training is needed.

DHS and HFS have a joint process to get input on the development of policies and procedures. Proposed new policies or modifications are circulated to DHS and HFS staff. The Policy Action Coordinating Team (PACT) process allows staff to submit comments on new or revised policy. A PACT meeting is then held to review comments received during the circulations process.

DHS and HFS have different strategies to enable staff to otherwise share ideas to improve performance. HFS has an "All Kids Committee" with voluntary membership. Interest in participation ebbs and flows over time. The group develops suggestions to improve the process. They are currently working on customer service (phone center) which is an understaffed area. The DHS approach may vary by local office. DHS workers may be encouraged to share ideas to improve processes with the local office manager. Some experiments work and others don't.

DHS offices have seen a continuing increase in the number of enrollees while staff levels have been reduced. At the same time the number of policies and procedures has also increased. In addition to longer processing times, the workload has potentially created more errors.

Eligibility workers are evaluated based on accuracy rates, productivity reports, and sample case reviews.

New Initiatives

The Framework initiative mentioned above includes components that would increase access to services at more locations and at more times during the week. In addition, the Framework may add a call center that could receive updated information, such as address changes, from clients.

Currently DHS's Bureau of Customer Support and Services takes change reports 24 hours a day, seven days a week. The Bureau also processes address changes and forwards other changes to the appropriate FCRC so that appropriate action can be taken.

Strengths

- **Rebranding with new, inclusive name.** The re-naming of the program and the fact that all children in the State are truly potentially eligible, irrespective of family income, reduces the stigma of the program and clearly communicates that all Illinois children can be enrolled in All Kids.
- **Application options.** The use of AKAAs gives Illinois access to a greater number of bilingual, bicultural individuals to assist with applications than would likely be true of a state staff model.

Challenges

- **Stigma and understaffing create barriers for some families.** The site visit generated several reports of negative customer experiences in Family Community Resource Centers. Even with the change of name and terminology, these agencies still may carry a stigma. In some cases, customers may have negative experiences due to understaffing and extremely large caseloads.
- **Systems issues create barriers and perpetuate families' negative beliefs about Medicaid.** Clients may also feel that they are not valued when voice messages are not returned, forms are lost, and waiting times are long. Although these issues are affected by staffing levels and may not be easily addressed in the current budget environment, there may be opportunities for states to use technology improvements to lessen staff caseload burdens to improve their customer service. The costs of IT improvements in the current environment, however, can also be prohibitive.

5. Non-Governmental Partnerships and Outreach

Current Approach

Advocates report that they have good relationships with state agencies, which include them on advisory committees and take their phone calls. More often than not, the executive branch agencies and the advocates are on the same side in legislative testimony.

Outreach is a shared activity with the agencies and community-based organizations. HFS and DHS both conduct outreach to potentially eligible families. HFS has dedicated 12 full time outreach staff focusing on hard to reach populations, including people with language and other barriers. DHS has staff that attend monthly meetings of local medical providers to share information on assistance programs. Local DHS staff also take applications to "breadlines". They note that reaching the working poor is challenging due to work schedules. Another challenge is outreach to non-English speakers who have issues beyond language barriers, such as mistrust of the system, lack of understanding, and fear. All Kids fact sheets have been translated into 16 languages and are available for download from the HFS website. Outreach is also targeted at rural populations, teens and young women.

Greatly expanding on their own, internal capacity, Illinois has partnerships with community based organizations supporting over 1,200 sites offering outreach and application assistance (AKAA's). Currently, rather than making outreach grants, as many states provide, IL pays a Technical Assistance Payment (TAP) for each complete application that results in a successful new enrollment. TAP payments have been effective at bringing in new applications that are complete and meet program criteria. Of the applications received at the Central Processing Unit (CPU) (which make up nearly half of all applications received) in the first half of 2009, AKAA-assisted applications qualified for TAP payments 89% of the time. AKAA's assisted with approximately 40 percent of all applications received at the CPU.

CHICAGO PUBLIC SCHOOLS

One of the largest community partners is the Chicago Public School system, which has a Children and Family Benefits unit that works with families to insure that children and their families are enrolled in medical, nutrition, and economic supports as appropriate. In an unusual alignment of health and education policy, the school district funding formula has an incentive for higher rates of insurance coverage among pupils. The program also enhances revenues for CPS when students not enrolled in Medicaid receive Medicaid-reimbursable services.

Many families trust the schools more than other branches of government, so schools can be a good enrollment site. Further, it can accurately target the eligible population. Eighty-two percent of students in Chicago Public Schools qualify for the National School Lunch Program, so most also qualify for All Kids.

Chicago Public Schools promote the program in several ways. Three times a year families receive a leaflet about All Kids (back to school, fall report card, and spring report card). They also receive three automated calls from the school system. Families may also receive a targeted letter from the principal. However, workers know that personal contact works best. If their workload permits, Children and Family Benefit unit workers place personal phone calls to families the school believes do not have coverage. If it is a telephone enrollment and the family does not complete the paperwork for the application, unit workers make follow-up phone calls.

The Children and Family Benefits unit has a staff of 14. Unit staff indicate that there is significant under-enrollment of Latino children in All Kids, and have therefore placed many bilingual, bi-cultural staff in host schools. Children and Family Benefits uses a computerized tool system to input client information and create a printed application to send to the family. They ask the family to sign and return with required verification. The applications are then sent to DHS local offices based on zip code. Children and Family Benefits has a DHS liaison for each zip code. Success requires collaboration and commitment at all levels of DHS.

Even with this initiative, Chicago Public Schools estimates that there are still 85,000 children in the city schools who are eligible for All Kids but not enrolled. Chicago Public Schools would like to receive lists of scheduled redeterminations so that they could work with families to reduce churning. They might also be able to help reduce the number of bad addresses. Thirty percent of students move during each school year. One AKAA also said they would like to assist with scheduled redeterminations, even if no TAP payments are involved.

Strengths

- **Advocate support.** Illinois DHS and HFS have good relationships with the advocacy community.
- **School partnership.** The alignment of funding incentives at The Chicago Public Schools, and the commitment of CFB workers, targets some of the most vulnerable and hard to reach minority communities.
- **Leveraging community assistance.** The use of AKAAs creates natural partnerships between the State and entities that do outreach related to medical assistance for children.

Challenges

- **Expanding the roles of AKAAs.** Chicago Public Schools and other school districts and AKAAs might play a greater role in helping the state pursue renewals of eligible children and families – one way would be to give them lists and have them work with "their" All Kids enrollees who are scheduled for redetermination so they could remind families of the need for required information. State staff expressed serious reservations over the extent to which, under HIPAA provisions, information about children's redetermination dates could be shared, as the state would have a limited ability to assure the family still had a relationship with the AKAA. Any movement in this direction would require careful review.

6. State Leadership

Current Approach

There has been long term bi-partisan support for children's coverage in Illinois. Beginning in 1997, four governors (two Republicans and two Democrats) and successive General Assemblies have supported expansions of what was first KidCare and then All Kids. Nonetheless, many of the simplification strategies adopted by the state, such as elimination of the family asset test, have been continually challenged. These challenges have increased in the current fiscal environment. While the budget deficit looms, the governor has maintained support of All Kids. In charging his Taxpayer Action Board, which worked on strategies to reduce Medicaid spending he directed them not to recommend cutting eligibility. In addition the Governor's chief of staff was formerly a children's advocate, giving children's issues an experienced voice in executive branch leadership.

While there is bi-partisan support for children's coverage in the Illinois legislature, no particular member would be seen as legislative champion for the All Kids or FamilyCare programs right now. In the past, concerns about spending have created some rifts between Democrats and Republicans. The bill that created All Kids included an enhanced primary care case management program to reduce inappropriate or unnecessary medical spending. The savings were to pay for the cost of subsidized coverage for all children. One interviewee (not affiliated with the All Kids program) said that some in the Republican caucus have raised concerns that the savings realized are less than the expenses incurred. However, no cuts to children's coverage are under consideration at this time.

New Initiatives

Governor Quinn recently signed legislation (Public Act 96-0326) allowing day labor groups (temporary worker agencies) to become AKAAs. These entities will be able to offer application assistance to persons they employ but under the law they will not receive TAP.

Strengths

- **Commitment to children's coverage.** While there may be disagreements on specifics, political support for medical assistance for children is strong and bi-partisan in Illinois.

Challenges

- **State budget deficit eclipses other initiatives.** Illinois' budget crisis has generated increased scrutiny of all state spending. As one of the largest items in the state budget, All Kids and other medical programs have received particular emphasis for spending reductions. No other challenges with State leadership were observed through the diagnostic assessment process.

Opportunities

Based on our understanding of Illinois' current practices, systems, and partnerships, we have identified opportunities to help the State realize its goal of maximizing enrollment of eligible children. For the purposes of this report, no consideration has been given to the relative cost of these suggestions. The authors recognize that many could be financially prohibitive, especially given the current economic climate, and would likely require additional funding beyond what is provided through the Maximizing Enrollment for Kids program to accomplish them.

Target outreach efforts efficiently. Use existing information to identify and enroll children who are already "known" to the system.

1. Explore using existing data to identify children who started but didn't complete applications, children who lost coverage due to cancellation, and children who did not renew on time. Once the extent of the problems and causes can be determined, explore strategies for addressing them.
2. Consider expanding the use of inter-agency partnerships to find eligible children, including families eligible for employment assistance. Explore the possibility of outreach to families based on income tax data, as is being done in New Jersey and Maryland.
3. Use data newly available through American Community Survey in place of CPS to identify characteristics of the uninsured.
4. Longer term solutions, following the Framework initiative and ABS Task Force recommendations and, depending upon available funding, should greatly expand the electronic interfaces for All Kids. These would include improving connectivity between existing eligibility systems and interfaces with other state databases for purposes of documentation.

They would also include interfaces that allow AKAAs and others to electronically monitor the status of applications. The system could also be designed to create reports to schools, health centers, and others to assist their clients in navigating the redetermination process.

Learn more about the proportion and characteristics of families who churn. Develop reports from the data warehouse on the number of children that leave All Kids and return within three months (or six months) and assess any patterns to identify opportunities for process improvements. Focus groups or a survey of a small group of families may be informative.

Improve contact information. The most important barriers may be that families do not know when they need to renew coverage, or they do not know how. If so, Illinois could work to improve contact information, as well as to provide families with more personalized assistance.

1. Reduce the number of children disenrolled due to bad addresses:
    a. Provide more opportunities for families to report a change of address, including a web-based option as discussed in the grant application. (This is consistent with the recommendation for other alternative means of reporting case information suggested in the ABS task force report.)
    b. Test a model that checks phone and address information at every client contact.
    c. Have staff review 100 returned member booklets at HFS to determine how many provide "forwarding address" information. Send cards to these forwarding addresses and assess the return rate.
    d. Review methods used in Louisiana and other *Maximizing Enrollment* states to stay current with client addresses.
2. To the extent permitted under HIPAA, consider using community partners to contact families that have not responded to requests for documentation at redetermination. Provide information, as appropriate, on which families need personalized assistance to organizations such as Chicago Public Schools that want to partner in reminding families that redeterminations are due.

Simplify enrollment procedures further to reduce the number of applications abandoned or denied due to incomplete information. Some of the strategies other states have found useful include e-signatures and document scanning.[9] When Social Security Administration data becomes available in 2010, Illinois may want to use that for citizenship and identity documentation.

Improve efficiency and accessibility of application and renewal processes.

5. Review the number of "screens" that are part of the eligibility processing for medical-assistance only cases at DHS offices and eliminate the ones that are not needed.
6. Encourage DHS and HFS staff to make efficiency suggestions that are tested through PDSA cycles. These might include modified procedures, changes in the way tasks are assigned to staff, revised hours of work, etc.

[9] Since staff indicate that most web-based applications are either followed with BOTH the income documentation and the signature page, or that neither document is received, implementation of only e-signature may not improve the rate of completions of web-based applications. Implementation of electronic document submission should increase the proportion of web-based applications since AKAAs would be able to submit applications and documents together electronically.

7. Test the ABS task force recommendation to expand local office business hours. Track impact on enrollment and retention rates.
8. Increase the flexibility of the location of application submission, another recommendation of the ABS task force. The recently enacted “No Wrong Door” initiative offers an opportunity to improve the access for families, as does implementation of a call center as a component of the Framework.
9. Implement recommendations of the “Limited English Proficiency” work group to improve the delivery of services to individuals with limited or no fluency in English.
10. The case maintenance systems at HFS and DHS could also be improved if files were totally electronic, including images of any paper documents.

Appendix I:

Diagnostic Assessment Interview Participants

Name/Title	Organization
Melissa Black, Aide to Senate	Senate Democratic Staff
Jacquetta Ellinger, Deputy Administrator, Division of Medical Programs	Department of Health and Family Services (HFS)
Lynne Thomas, Chief, Bureau of All Kids	HFS
Gretchen Grieser, Chief, Office of Outreach	HFS
Joe Holler, Chief, Bureau of Rate Development and Analysis	HFS
Shanan Smith, Bureau of Rate Development and Analysis	HFS
Katey Staley, Bureau of Rate Development and Analysis	HFS
Matt Werner, Consultant	
Debbie Watkins, Bureau of Medical Eligibility Policy	HFS
Donna Drew, Bureau of All Kids	HFS
Tracy Keen, Bureau of All Kids	HFS
Sharon Dyer-Nelson, Manager, Director's Office, Human Capital Development	DHS
Roxanne Singer, Administrator	DHS Sangamon County Family and Community Resource Center
John Bouman, President	Sargent Shriver National Center on Poverty Law

Appendix II:

Task Force on Access to Benefits and Services Priority Recommendations

The ABS Task Force made many recommendations to improve benefits and services for public assistance programs administered by the Department of Human Services and the Department of Health and Family Services. The task force identified the following nine items as their highest priority recommendations, listed in descending order of priority:

1. Build technological capacity – Build/align/operate joint electronic systems to document and verify eligibility (Section III)
2. Align and further develop existing state electronic application systems (Section I)
3. Update/implement local office workforce structure (Section XX)
4. Employ adequate levels of bilingual staff to meet assessed need (Section VI)
5. Expand current local office phone system, create email accounts (Section XVI)
6. Pilot the use of extended office hours at local offices (Section IV)
7. Facilitate external use of a data bridge for submission of electronic applications from third parties (Section II)
8. Develop technology infrastructure (to allow alignment of redeterminations) (Section XVII)
9. Establish partnerships with community based organizations to assist with screening and applications submissions (Section V)

The entire report is available at http://www.hfs.illinois.gov/assets/0708_access.pdf.