Children's Medical Caseload

Why the Decline?

Parts I and II | August 2005
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Title: Children's Medical Caseload: Why the Decline? PARTS I and II

Abstract: This two-part report examines why the Children's Medical caseload declined following a series of eligibility policy changes implemented in April 2003. The changes included new signature and income verification requirements, a 6-month eligibility review cycle, and termination of 12-month continuous eligibility.

Part I of this study examined administrative data and found a net decline of 39,085 children on the Children's Medical caseload in the 18 months following the eligibility policy changes. Most of the loss of coverage was attributable to increased exits, as opposed to fewer new entries or increased cycling off and on the caseload.

Part II of this study used client survey data to better understand why children left the Children's Medical program after the policy changes. We found that most "leavers" (60 percent) had non-DSHS coverage at the time of the interview, but almost all uninsured "leavers" were still eligible for DSHS coverage.

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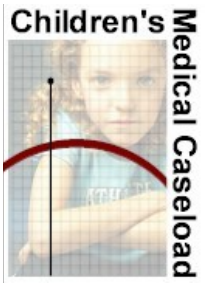
Executive
Summary



AUGUST 2005

Why an interest in Washington State's Children's Medical Caseload decline?

Beginning in April 2003, a series of eligibility changes led to a decline in Washington State's Children's Medical caseload. The policy changes included new signature and income verification requirements, a shorter (6-month) eligibility review cycle, and termination of continuous eligibility.[1]

Among the issues that drive interest in more restrictive eligibility rules for public programs are the potential for cost savings and the appeal of ensuring program integrity. Underlying both issues is the desire to direct limited dollars to people most in need (as defined by eligibility criteria), believing that money spent on the ineligible means coverage denied to the eligible. At the same time there is concern whether the benefits (cost-savings from lower enrollment, increased program integrity) are worth the costs (loss of coverage for eligible children, costs to implement more restrictive eligibility rules). A key objective of this study is to help assess the benefit-cost tradeoff for the eligibility policy changes affecting the Children's Medical caseload.

What this report tells us . . .

Part I of this study examined administrative data and found a net decline of 39,085 children on the Children's Medical caseload in the 18 months following the eligibility policy changes. Most of the loss of coverage was attributable to increased exits, as opposed to few newer entries or increased cycling off and on the caseload.

Part II of this study used client survey data to better understand why children left the Children's Medical program after the policy changes. Key findings include:

- ***Do children leaving the Children's Medical caseload have non-DSHS medical coverage? If not, are they still eligible for DSHS coverage?*** Most "leavers" (60 percent) had non-DSHS coverage at the time of the interview, but almost all uninsured "leavers" were still eligible for DSHS coverage.
- ***Why did the DSHS eligible but uninsured children leave? And do they plan to return?*** Most parents say DSHS made the decision, and about half cite administrative-related reasons. Almost all parents say they plan to reapply for Medicaid.
- ***Do the DSHS eligible but uninsured differ from the kids who exited to other medical coverage?*** They are poorer, more likely to use the emergency room, less likely to have physician or clinic visits, and more likely to be Hispanic.
- ***What might have been the consequences of maintaining 12-month continuous eligibility?*** The 36 percent of "leavers" who were DSHS eligible but lost coverage and were uninsured would likely have remained on Medicaid for another 6 months. The 32 percent of leavers who were "ineligible" would likely have continued on Medicaid for another 6 months.
- ***Are there opportunities to identify more children on Medicaid with private coverage?*** Many "leavers" who remained DSHS eligible had other coverage when interviewed. Enhanced efforts to coordinate benefits or buy into employer-provided coverage may be warranted.

[1] The Governor has since issued an administrative order restoring the 12-month continuous eligibility policy. The return to a 12-month review cycle was effective in May 2005 and restoration of continuous eligibility occurred in July 2005.

Children's Medical Caseload:
Why the Decline?

PART 1

Understanding the Children's Medical Caseload Decline: The First in a Series of Two Analysis
A LOOK AT THE ADMINISTRATIVE DATA

Figures

Table

PART 2

Understanding the Children's Medical Caseload Decline: Part II

WHAT THE SURVEY FINDINGS TELL US

Figures

PART I Children's Medical Caseload | **Why the Decline?**

Understanding the Children's Medical Caseload Decline: The First in a Series of Two Analyses

A LOOK AT THE ADMINISTRATIVE DATA

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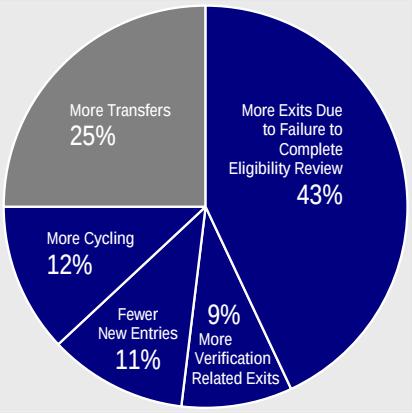
In conjunction with

DSHS Medical Assistance Administration

The Department of Social and Health Services (DSHS) implemented a series of eligibility policy changes beginning in April 2003 that resulted in a significant decline in the Children's Medical caseload. The policy changes included new signature and income verification requirements, adoption of a 6-month eligibility review cycle, and termination of 12-month continuous eligibility. This report uses administrative data to assess the causes of the caseload decline. A second report analyzing client survey is also available.

FIGURE 1
Understanding the decline



Key Findings

- The Children's Medical caseload dropped from 341,322 cases in April 2003 to 289,259 in September 2004, a gross decline of 52,063 cases.
- Increased transfers to other medical coverage account for 25 percent of the gross caseload decline. After accounting for increased transfers, the **net decline** in the Children's Medical caseload was **39,085 cases**.
- Most of the loss of coverage (52 percent) is attributable to increased exits. Increased exits due to failure to complete an eligibility review account for 43 percent of the gross decline, while increased verification-related exits account for 9 percent. In the second phase of this study, client survey data provides more information about the underlying reasons why children left medical assistance.
- The eligibility policy changes have had a modest dampening effect on the number of children entering the Children's Medical caseload. Fewer new entries account for 11 percent of the gross caseload decline.
- Increased cycling off and on the Children's Medical caseload accounts for 12 percent of the gross caseload decline. The cycling increase points to negative impacts from these policy changes to balance against the savings accruing from falling caseloads. These include well-being impacts on children who have gaps in medical coverage, disruption of enrollment in Healthy Options managed care plans, and workload impacts on CSO staff from more frequent eligibility reviews.
- There are indications that the policy changes removed some ineligible children from the Children's Medical caseload – most notably increases in verification-related exits and transfers to SCHIP. However, the increased cycling suggests the caseload decline also reflects loss of coverage for some eligible children. Client survey data will provide estimates of the number of eligible children who lost coverage following the policy changes.

Background

The Department of Social and Health Services (DSHS) implemented a series of eligibility policy changes in 2003 including:

- **Signature requirements** – Beginning in April 2003 applicants were required to sign their Medicaid application document. Previously, signature requirements had been suspended.
- **Income verification** – Beginning in April 2003, applicants were required to provide verification of household income and Community Service Office (CSO) staff were directed to use information sources such as Employment Security Department (ESD) earnings data to verify income. Previously, applicants could "self declare" income without providing documentation.
- **Termination of continuous eligibility and adoption of a 6-month eligibility review (ER) cycle** – In July 2003, a change in state law directed DSHS to terminate 12-month continuous eligibility and adopt a 6-month review cycle for the Children's Medical, SCHIP, and Medical-only Family Medical programs. Previously, children would remain eligible for coverage for a 12-month period, even if their family's income changed.

The main objectives of the study are to understand the impact of these policy changes on the Children's Medical caseload:

- *Did the new eligibility policy rules create barriers to enrollment that caused eligible children to lose medical coverage?*
- *Did the new rules remove ineligible children who had been able to enroll under the old rules (for example, due to less robust income verification)?*
- *Did the shift from 12-month continuous eligibility make some children who would have been eligible under the old rules ineligible under the new rules?*

These potential factors are not mutually exclusive and each may account for part of the caseload decline. This report draws some tentative inferences about the relative importance of these factors from the analysis of caseload trends. The second phase of this study will use survey and ESD earnings data to assess more fully which factors have caused the caseload decline.

DEFINITIONS

The Children's Medical program[1] provides Medicaid coverage to children under age 19 in households with income at or below 200 percent of the Federal Poverty Level (FPL).[2] The Children's Medical caseload includes Mandatory and Optional coverage groups.

- Mandatory – Household income at or below an income standard that varies with age:

Age	Federal Poverty Level
Less than 1 year	185%
1 through 5	133%
6 through 18	100%

- Optional – Household income above the Mandatory standard and at or below 200 percent of the FPL

Other DSHS medical programs for children that are discussed in this report include:

- Family Medical program – Covers families with children under the age of 19 whose income and resources are below Temporary Assistance to Needy Families (TANF) limits
- State Children's Health Insurance Program (SCHIP) – Covers children in households with income above 200 percent but at or below 250 percent of FPL

[1] For the purposes of this study the Children's Medical program is defined to include Medicaid Management Information System (MMIS) program-match combinations H-C, H-M, H-Q, H-S, and H-T.

[2] Child care costs, child support payments, and the first $90 of earned income are deducted from gross household income. There are no resource limitations for Children's Medical coverage. Unborn children are counted as household members to determine household size.

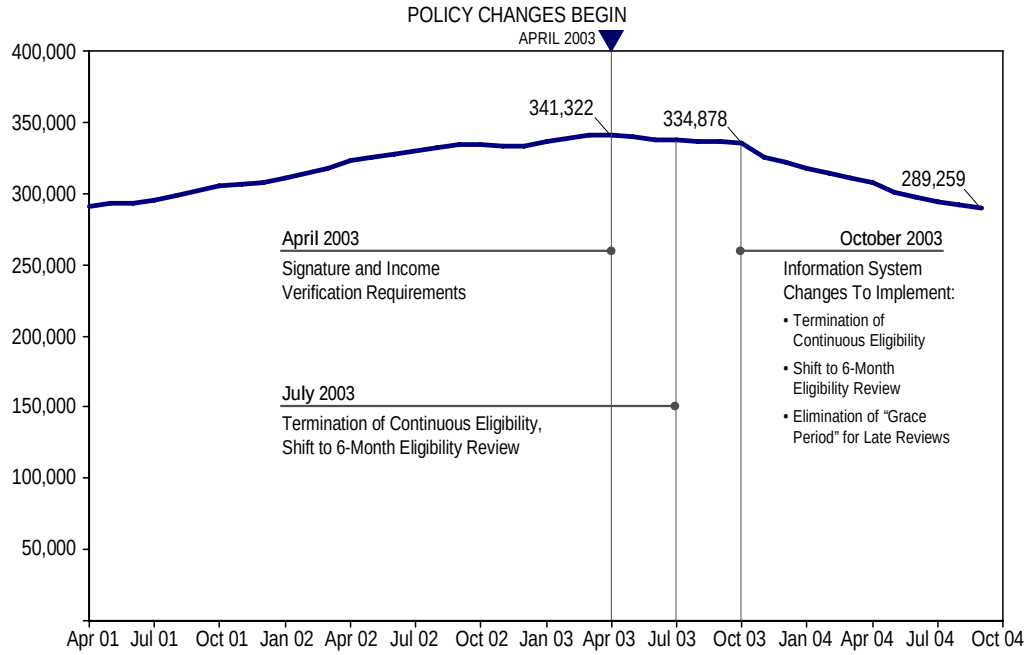
Caseload Decline Begins in April 2003 and Accelerates in November 2003

The Children's Medical caseload started to decline after the implementation of new signature and income verification requirements in April 2003 (Figure 2).[3] The decline that began in April 2003 represented an unprecedented break in a longstanding trend of growth in the Children's Medical caseload. In total, the Children's Medical caseload declined by 52,063 cases in the 18 months from April 2003 to September 2004.

The rate of decline increased after October 2003 following the effective timing of the end of 12-month continuous eligibility.[4] Although the policy changes terminating continuous eligibility and adopting a 6-month eligibility review cycle took effect in July 2003, the programming changes necessary to fully implement these policy changes were not made until October 2003. The January 2004 caseload was the first to have eligibility recalculated for clients who had reported a change in income or household composition, and clients who were previously scheduled for a June 2004 review had their certification period shortened to December 2003.

Ending continuous eligibility and adopting a 6-month review cycle increased the volume of reviews beginning in late 2003, leading to a temporary backlog in eligibility review processing that also helped account for the higher rate of decline in the months after October 2003. The backlog was probably exacerbated by the additional workload associated with Sneede-Kizer processing in preparation for the planned implementation of premiums for Optional caseload children.

FIGURE 2
Children's Medical monthly caseload
SOURCE: OFM Eligibility File



[3] This section draws heavily from material prepared by MAA staff.

[4] Previous analysis by Medical Assistance Administration (MAA) staff found that the extraordinary one-month decline in the Children's Medical caseload in November 2003 was the result of a one-time change to eliminate the extra month of coverage given to clients who submitted their eligibility reviews late in the month. Prior to this change, many clients received one extra month of eligibility due to the mailing date of the 10-day advance notice termination letter.

Drop in Optional Coverage Appears to Account for Most of the Decline . . .

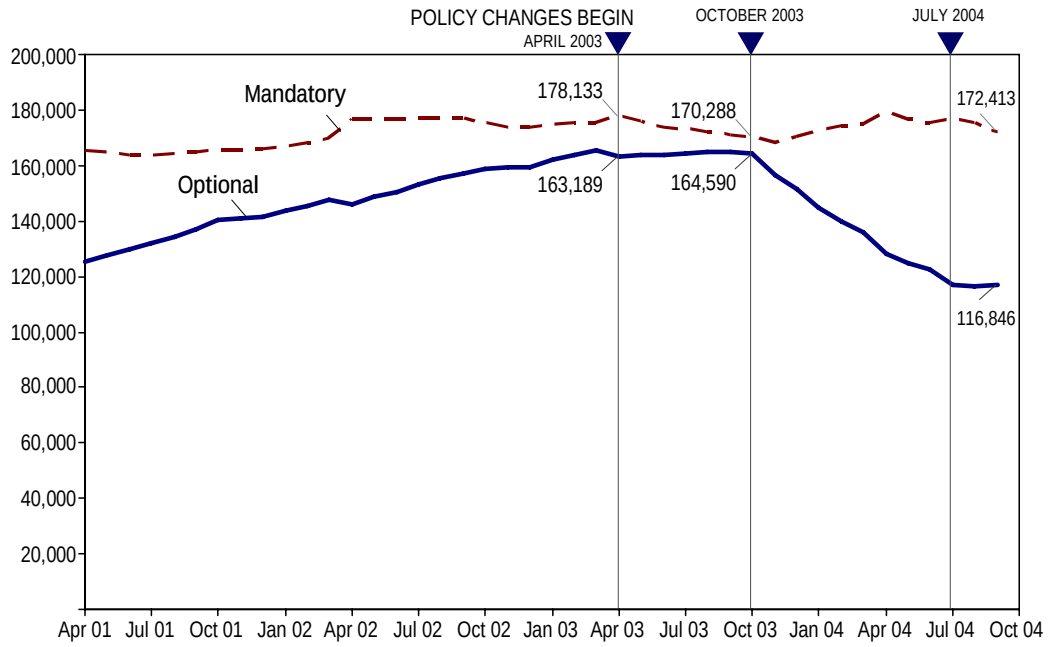
The Optional coverage group grew rapidly in the period leading up to the eligibility changes, increasing from 125,228 cases in April 2001 to 163,189 cases in April 2003 (Figure 3). The Mandatory coverage group generally remained stable over the same period – except for the annual increase in April caused by the recalculation of the Federal Poverty Levels.[5] See the box on page 2 for a description of the Optional and Mandatory coverage groups.

The Optional caseload continued to grow from April 2003 to October 2003 – albeit at a slower rate – while the Mandatory caseload declined by almost 8,000 cases in this period. However, from October 2003 to July 2004, the Optional caseload declined rapidly while the Mandatory caseload increased slightly. After July 2004, the Optional caseload stabilized while the Mandatory caseload started to decline again. The Optional caseload declined by 46,343 cases through September 2004, accounting for 89 percent of the decline in the Children's Medical caseload.

It is possible that the Optional caseload grew more rapidly prior to April 2003 in part because the less stringent income verification requirements then in place allowed ineligible children to accumulate on that part of the caseload. When we examine trends in exit reasons (page 8) we will see some evidence that a higher proportion of Optional children may not have been eligible for coverage, in that Optional children were more likely to exit due to failure to verify income.

This possibility suggests the hypothesis that the Optional caseload declined more rapidly after the policy changes because more stringent income verification and more frequent reviews removed ineligible children from the Optional caseload. However, a closer examination of the timing of the eligibility policy changes and the role of Sneede-Kizer processing (described in the next section) provides evidence that this hypothesis cannot explain most of the caseload decline.

FIGURE 3
Children's Medical monthly caseload by coverage group
SOURCE: OFM Eligibility File



[5] When FPL levels are increased each year, some Optional group children shift to the Mandatory group.

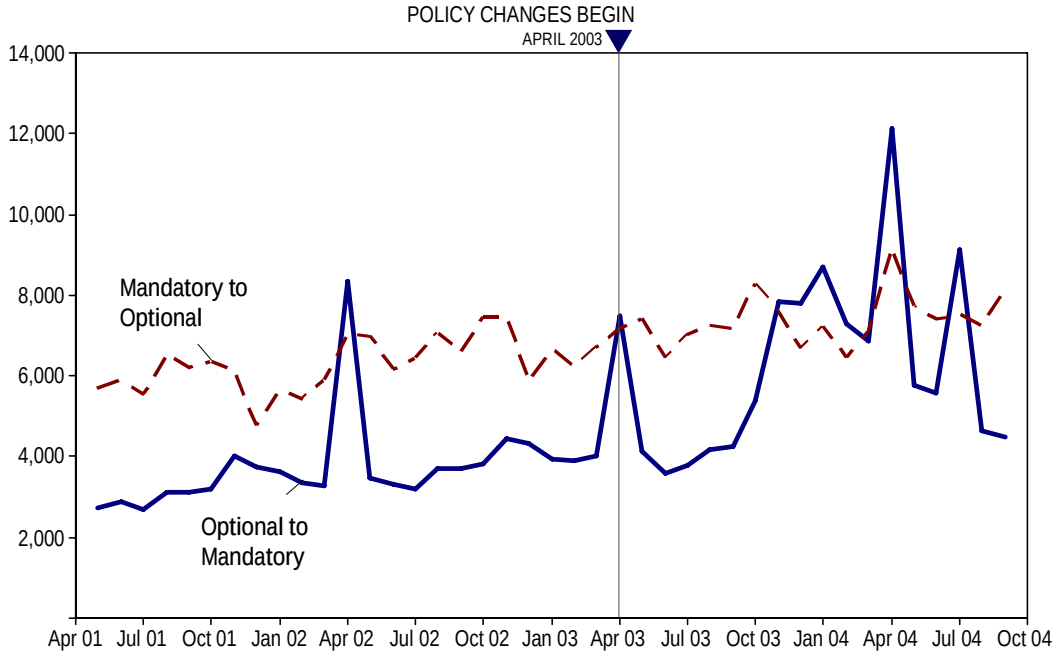
. . . Because Sneede-Kizer Shifted Children to Mandatory Coverage

Figure 4 shows the number of children shifting between the Optional and Mandatory components of the Children's Medical caseload. These are direct month-to-month transitions without a break in coverage. These transitions include children who shift from Mandatory to Optional when crossing an age threshold – even though household income may not change.[6] Consequently, there is a general tendency for shifts from Mandatory to Optional to exceed the number of shifts in the opposite direction. There is also a spike in shifts from Optional to Mandatory each April when the FPL thresholds are changed. More importantly, between October 2003 and July 2004 there were about 27,000 more shifts from Optional to Mandatory coverage, compared to the trend in the prior two years. The policy changes have had little impact on shifts in the opposite direction.

It is likely that most of these transitions were due to Sneede-Kizer processing.[7] Although CSO staff were provided lists of potential Sneede-Kizer families in the Fall of 2003, it appears that processing was completed in the first half of 2004. This means that most of the decline in the Optional caseload between October 2003 and July 2004 period was caused by Sneede-Kizer. Adjusted for the impact of Sneede-Kizer, the Optional and Mandatory caseloads declined by comparable amounts between October 2003 and July 2004.

Returning to Figure 2, we see that after the winding down of Sneede-Kizer processing in mid 2004, only the Mandatory caseload declined. Furthermore, in the April 2003 to October 2003 period – when new income verification and signature rules were the main policy changes affecting the caseload – only the Mandatory caseload declined. These observations suggest that it is unlikely that the Children's Medical caseload declined primarily because ineligible children were removed from the Optional component of the caseload.

FIGURE 4
Transitions within the Children's Medical caseload
SOURCE: OFM Eligibility File



[6] For example, a child living in a household at 125 percent FPL will shift from Mandatory to Optional when turning age 6.

[7] Sneede-Kizer is the name of a class action legal settlement which ruled that children are not financially responsible for their parents or siblings and spouses are financially responsible for each other and their children. Sneede-Kizer rules affect eligibility determinations for families where a child has income or resources; lives with unmarried parents; or lives with an adult who is not their parent.

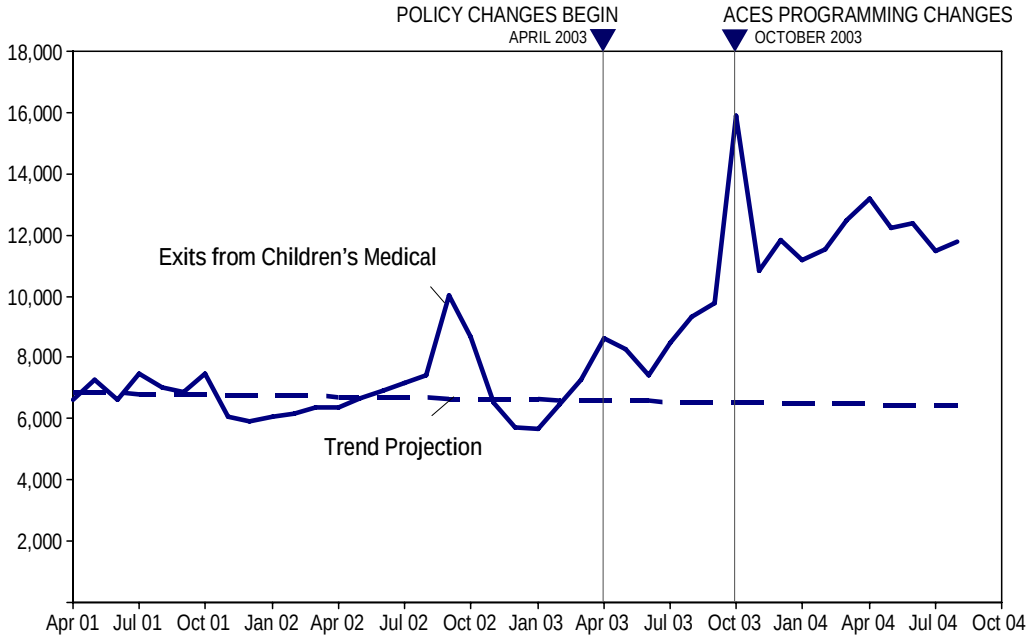
Policy Changes Increased Exits

We next examine the impact of the eligibility policy changes on exits from the Children's Medical caseload. Exits are dated by the last month of enrollment in the Children's Medical program prior to the break in DSHS medical coverage.[8]

Exits from the Children's Medical caseload increased after the imposition of new signature and income verification requirements in April 2003 (Figure 5). Exits spiked in October 2003 with the ACES programming changes to eliminate the one-month grace period for clients returning late eligibility reviews. Throughout 2004, exits were at almost twice the level of a trend projection based on April 2001 to March 2003 data.[9]

Exit rates increased for both the Mandatory and Optional caseload components (not shown separately). However, the Mandatory caseload remained relatively stable after the eligibility policy changes (as shown in Figure 3) because exits were backfilled by an influx of children from the Optional component of the caseload (as shown in Figure 4). The Optional caseload declined rapidly after October 2003 because the increase in exits was reinforced by the outflow of children to the Mandatory component of the caseload.

FIGURE 5
Exits from the Children's Medical caseload
SOURCE: OFM Eligibility File



[8] Exits require a two-month break in medical assistance. Exits are distinct from transitions to other medical coverage groups (e.g., Family Medical or SCHIP), and distinct from transitions to a different income group within the Children's Medical caseload.

[9] The spike in exits in October 2002 was due to the termination of the state-only Children's Medical program. The trend projection was developed after removing this spike.

Exits Increased Due to Failure to Complete Eligibility Reviews, Failure to Verify Income

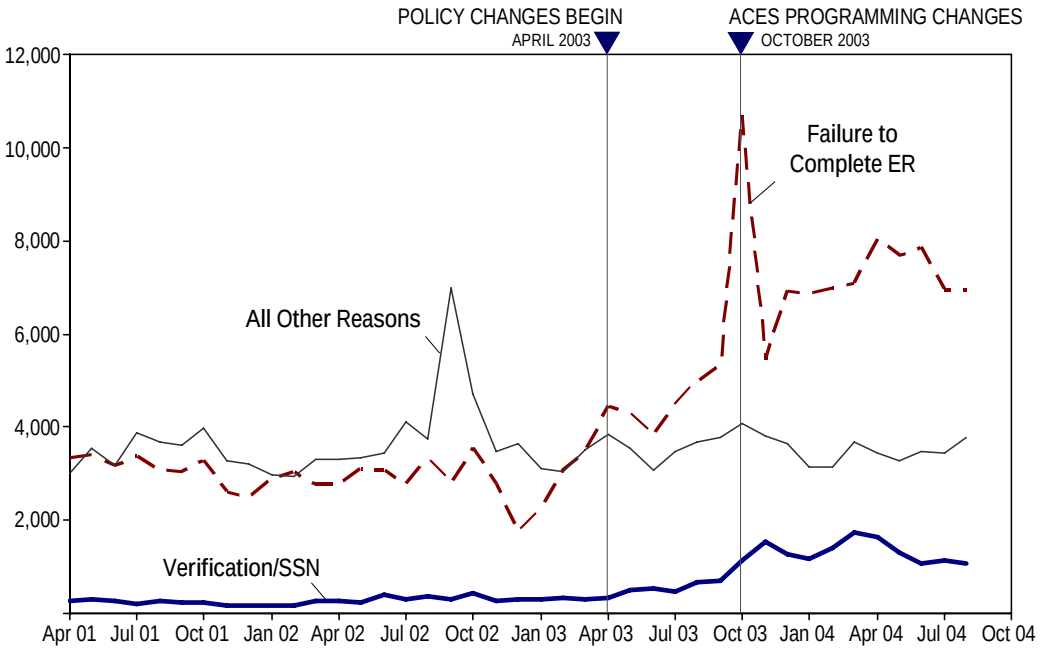
Administrative reasons for exit were extracted from the Automated Client Eligibility System (ACES) and grouped into three categories: (1) failure to complete an eligibility review[10], (2) failure to verify income or provide an SSN[11], (3) and all other exit reasons. Exits due to excess income are almost never directly identified in ACES, so we could not use ACES to identify how many children left the caseload for this reason. Survey data collected in phase two of the study will be more informative in this area.

The eligibility policy changes increased the number of exits due to failure to complete an ER and failure to verify income or provide an SSN (Figure 6). Prior to the policy changes, exits due to failure to complete an ER averaged about 3,000 per month. Exits for this reason began trending up in January 2003, spiked at 10,692 in October 2003 with the ACES programming changes to eliminate the one-month grace period for clients returning late eligibility reviews, and remained in the 7,000-8,000 range after December 2003.

Monthly exits due to failure to verify income or provide an SSN averaged 314 in the 12 months prior to April 2003. Exits for these reasons began increasing in April 2003, peaking at 1,728 in March 2004. Income verification and SSN exits appear to have stabilized at about 1,100 exits per month after June 2004.

The increase in verification-related exits implies that the more stringent income verification requirements removed some ineligible children from the Children's Medical caseload. However, exits identified as verification-related in ACES account for only 9 percent of all exits in the post-change period. The bigger question concerns the underlying reasons why children exiting due to "failure to complete ER" left the caseload. This question will be examined directly with survey and ESD earnings data in phase two of this study.

FIGURE 6
Exits from Children's Medical by ACES exit reason
SOURCES ACES, OFM Eligibility File



[10] ACES assistance unit case closure codes 235, 535, and 538.

[11] ACES assistance unit case closure codes 208, 230, and 552.

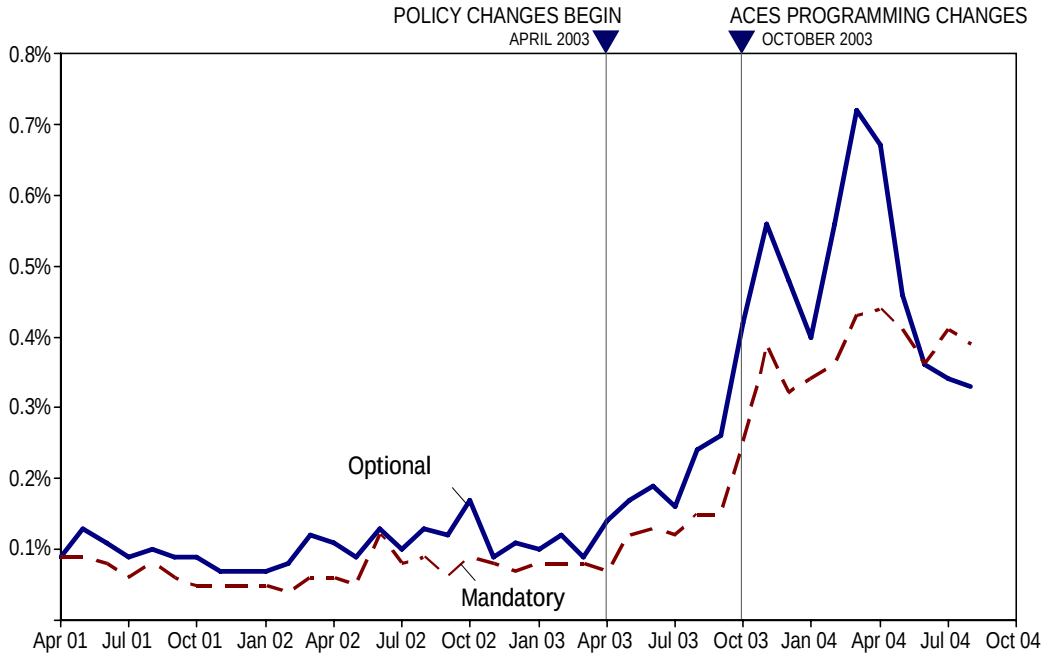
Mandatory Children Now More Likely to Have Verification-Related Exit

We examined differences in the exit reasons associated with children leaving the Optional and Mandatory components of the Children's Medical caseload. The most interesting differences are in the area of verification-related exits.

Over most of the study period, Optional children were more likely to leave the Children's Medical caseload due to failure to provide income verification or an SSN (Figure 7). As discussed earlier, this is consistent with the hypothesis that prior to the policy changes, children who may have been income ineligible were more likely to be accumulating on the Optional part of the Children's Medical caseload.

However, since July 2004 Mandatory children are now somewhat more likely to leave the Children's Medical caseload for a verification-related reason.

FIGURE 7
Verification / SSN exit rates by coverage group
SOURCES: ACES, OFM Eligibility File



We See Little Change in the Characteristics of Leavers after Policy Changes

The eligibility policy changes had only a minor effect on the demographic characteristics of children exiting the Children's Medical caseload.[12] Children leaving in the October 2001 to March 2003 period are generally similar to those leaving in the April 2003 to September 2004 period (Table 1) in terms of their race, gender, and language profiles. However, children leaving after the eligibility policy changes are less likely to be age 19 (that is, they are less likely to have aged out).

In contrast, there are significant demographic differences between leavers and children who remained continuously on the Children's Medical caseload throughout the April 2003 to September 2004 period (stayers). In particular:

- Stayers are more likely than leavers to be Hispanic (23 percent vs. 13 percent), and less likely to be White (54 percent vs. 61 percent).
- Stayers are more likely to speak Spanish (19 percent vs. 8 percent).

Comparisons with children who cycled off and on the Children's Medical caseload are discussed on page 11.

TABLE 1. Demographic characteristics of leavers, stayers, and cyclers

	LEAVERS BEFORE	LEAVERS AFTER	STAYERS AFTER	CYCLERS AFTER	TRANSFERS OUT AFTER
Number of Children	88,336	136,348	146,530	47,065	87,267
RACE	PERCENT	PERCENT	PERCENT	PERCENT	PERCENT
White	61	61	54	52	57
Black	4	4	4	5	7
Asian	7	6	6	5	3
Am.Indian/AK Native	2	2	1	3	3
Hispanic	14	13	23	23	19
Other/Unknown	12	14	7	7	11
GENDER					
Male	52	51	51	50	49
Female	48	49	49	50	51
LANGUAGE					
English	85	87	74	80	86
Spanish	9	8	19	17	10
Other/Unknown	6	5	7	4	4
AGE					
0	3	2	2	1	13
1-5	26	28	32	37	32
6-11	24	27	36	31	27
12-17	22	25	29	26	22
18	7	7	1	4	4
19	18	11	0	0	2

[12] The table presents demographic characteristics for Children's Medical leavers who were not receiving DSHS medical coverage at the end of the observation period. Children who cycled back onto the caseload are counted in the "cyclers" category. Children who transitioned from Children's Medical to another medical coverage group (for example, Family Medical or SCHIP) are included in the "transfers out" category.

Policy Changes Increased Cycling

In addition to increasing the number of exits, the policy changes increased the number of children cycling off and on the caseload (Figure 8). Children starting a new spell on the Children's Medical caseload can be separated into three groups:

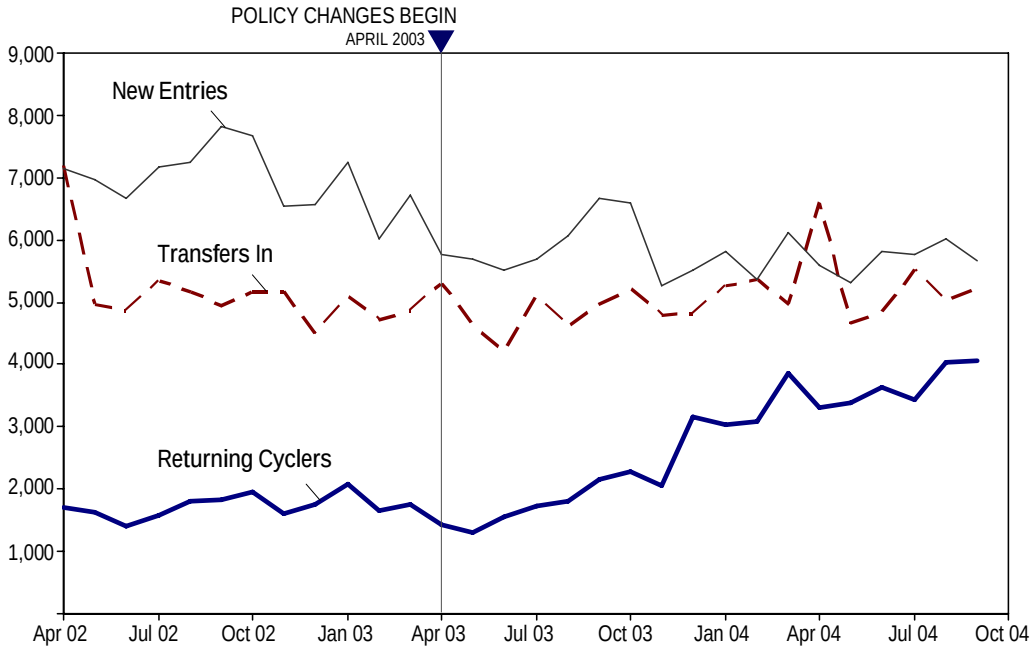
- **Returning Cyclers** – Children returning from a break in Children's Medical coverage of at least one month but not more than 12 months
- **New Entries** – Children who were not eligible for medical assistance in any eligibility category in the previous 12 months
- **Transfers In** – Children who have been eligible for medical assistance within the past 12 months, but were last eligible in a different category (e.g., Family Medical or SCHIP)

In the 12-month period before April 2003, the average monthly number of returning cyclers was 1,729. The number of returning cyclers started trending up in June 2003, increased sharply in December 2003 to 3,167 children, and continued to rise to 4,053 returning children in September 2004.

The impact of increased cycling can be quantified by comparing the tendency of children to have gaps in coverage before and after the eligibility policy changes. This analysis indicates that the increase in cycling accounts for 50,000 fewer months of coverage in the 18 months since April 2003.

In contrast to the increase in cycling, transfers into Children's Medical remained stable at around 5,000 children per month (with spikes each April caused by the FPL changes). The monthly count of new entries has drifted lower, with an average of 5,800 children in the April 2003 to September 2004 period, compared to an average of 7,000 new entries per month in the year prior to the policy changes. The downward drift in new entries appears to predate the eligibility policy changes, and may be related to reduced enrollment outreach in the pre-change period. We discuss transfers and new entries in more detail on pages 12 to 14.

FIGURE 8
Children starting a new spell on Children's Medical
SOURCE: OFM Eligibility File



Increase in Cyclers Returning from Exit Due to Failure to Complete Eligibility Review

Most returning cyclers previously exited due to failure to complete their eligibility review (Figure 9). In the first nine months of 2004, about 75 percent of returning cyclers had previously exited due to this reason, up from 62 percent in the 12 months prior to the eligibility policy changes.

Although the number of cyclers who returned from an exit due to failure to verify income or provide an SSN also increased after the policy changes, these children accounted for only 10 percent of returning cyclers in September 2004.

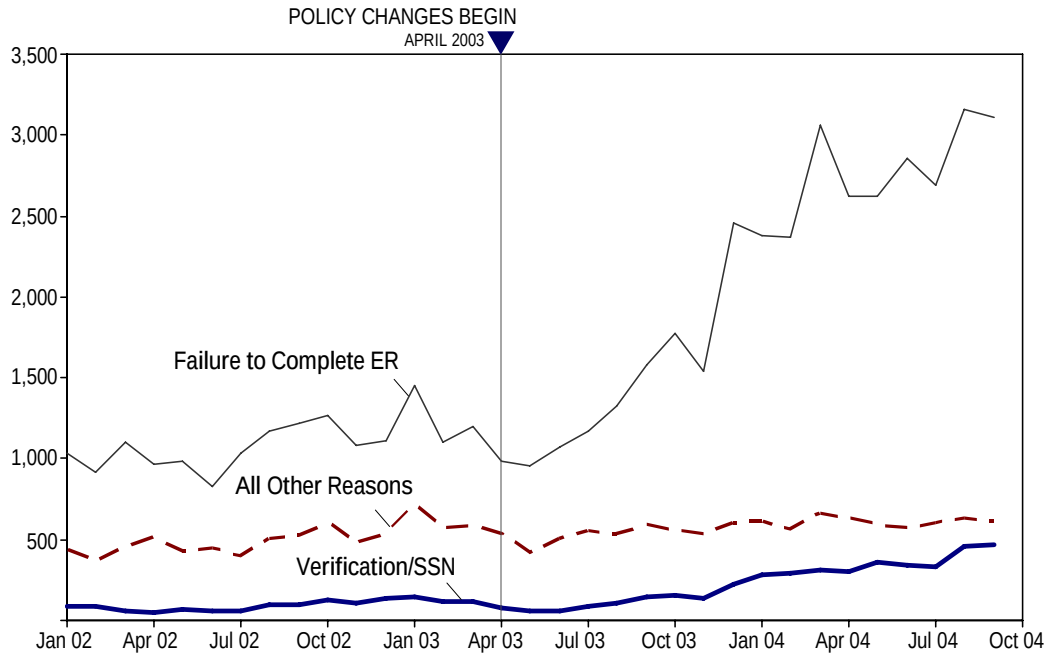
In the year prior to April 2003, 12 percent of exiting children returned to the Children's Medical caseload after a gap in coverage of three months or less. In the April 2003 to September 2003 period, 14 percent of exiting children returned to the Children's Medical caseload after a gap of three months or less. In the October 2003 to May 2004 period this rate increased to 18 percent.

Thus, the monthly count of returning cyclers increased both because the number of exits increased (enlarging the pool of potential cyclers) and because the proportion of leavers returning to the caseload increased. The proportion of leavers returning to the caseload may have increased because the shift from 12-month continuous eligibility made current eligibility more sensitive to fluctuations in household income, and because the shorter certification period puts more eligibility reviews at risk of not being completed in a sufficiently timely manner to avoid a break in coverage.

The number of cyclers returning from a gap of three months or less stabilized at about 2,000 per month from June 2004 to September 2004, suggesting that the cycling rate may have begun to stabilize by the summer of 2004.

Cyclers are similar to stayers in their demographic characteristics (see Table 1, page 9). Compared to leavers, cyclers are more likely to be Hispanic and to speak Spanish. We found no significant changes in the characteristics of cyclers after the eligibility policy changes.

FIGURE 9
Trend in returning cyclers by ACES exit reason
SOURCES: ACES, OFM Eligibility File



Policy Changes Increased Transfers Out of Children's Medical

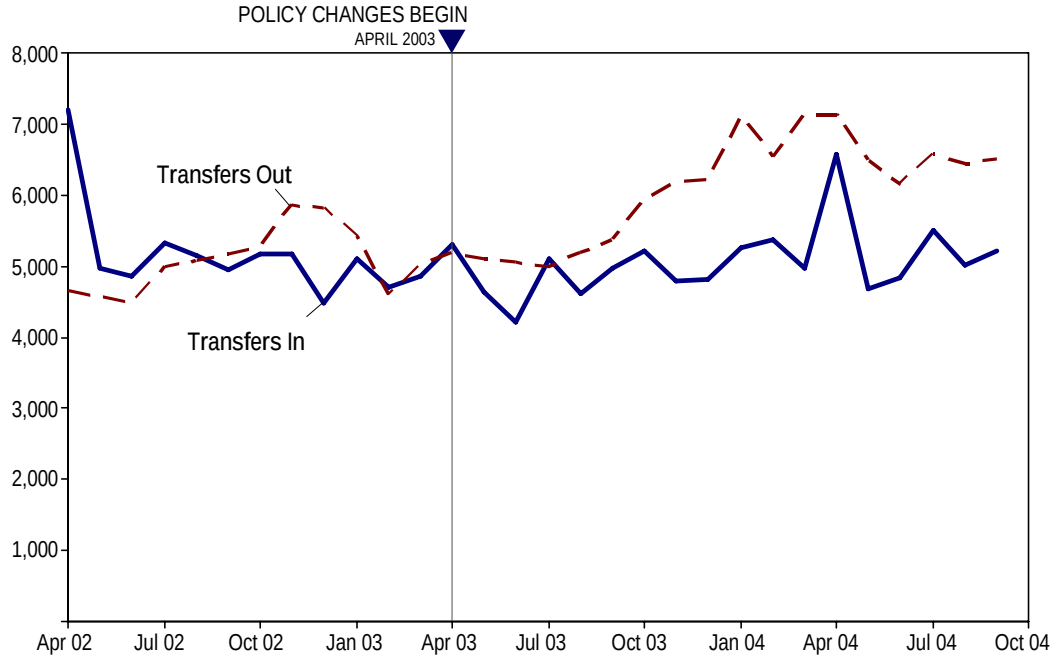
The eligibility policy changes increased the number of children transferring from the Children's Medical caseload to other DSHS medical assistance groups (Figure 10). "Transfers out" include children beginning a new Medicaid or SCHIP eligibility spell who were last eligible for medical assistance on the Children's Medical caseload within the previous 12 months.

In the 12 months prior to April 2003, the average number of transfers in and transfers out were in balance at about 5,000 children per month.[13] After the first set of policy changes in April 2003, the number of transfers out of the Children's Medical program started to increase, peaking above 7,000 in March and April 2004. Transfers out have remained stable at about 6,500 children per month from July 2004 to September 2004.

In the April 2003 to September 2004 period, there were approximately 1,000 more net transfers per month from Children's Medical to other Medicaid or SCHIP coverage, compared to the average in the previous 12 months. By September 2004, there were 12,978 more transfers out of Children's Medical who were still receiving other Medicaid or SCHIP coverage, compared to the number in March 2003.[14]

The increase in transfers out of Children's Medical to other coverage groups accounts for 25 percent of the 52,063 decline in the Children's Medical caseload. After accounting for increased transfers, the Children's Medical caseload declined by 39,085 cases from April 2003 to September 2004.

FIGURE 10
Transfers in and out of Children's Medical caseload
SOURCE: OFM Eligibility File



[13] The annual FPL change accounts for the spike in transfers into the Children's Medical caseload each April.

[14] Specifically, in September 2004, there were 79,270 children enrolled in other Medicaid programs (primarily Family Medical) or SCHIP who had previously been on the Children's Medical caseload in the April 2003 to August 2004 period. This is compared to the 66,292 children in March 2003 who were enrolled in other Medicaid programs or SCHIP who had previously been on the Children's Medical caseload in the October 2001 to February 2003 period.

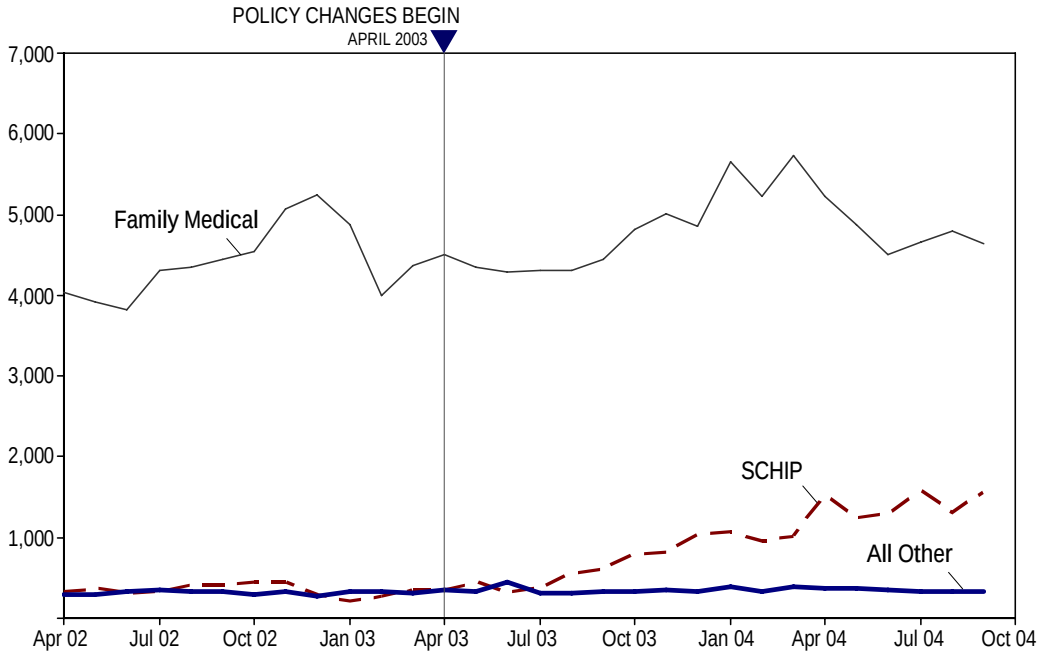
Policy Changes Increased Transfers to SCHIP, Family Medical

The eligibility policy changes increased the number of children transferring from the Children's Medical caseload to SCHIP and Family Medical (Figure 11).

Transfers to SCHIP averaged 1,416 children per month in the most recent 6 months of data, compared to only 348 per month in the year prior to April 2003. The number of transfers to Family Medical also increased in the October 2003 to March 2004 period, but have since returned to levels more comparable to the period before April 2003.

As previously noted, in September 2004 there were 12,978 more transfers out of Children's Medical who remained eligible for other Medicaid or SCHIP coverage, compared to March 2003. Almost all of this increase is accounted for by more former Children's Medical children on SCHIP (6,536 children) or Family Medical (5,097 children).

FIGURE 11
Transfers out of Children's Medical by program
SOURCE: OFM Eligibility File



New Entries onto the Optional Caseload Have Declined

A new entry is defined to be a child beginning a new eligibility spell on the Children's Medical caseload who did not receive DSHS medical coverage in any eligibility category in the previous 12 months.

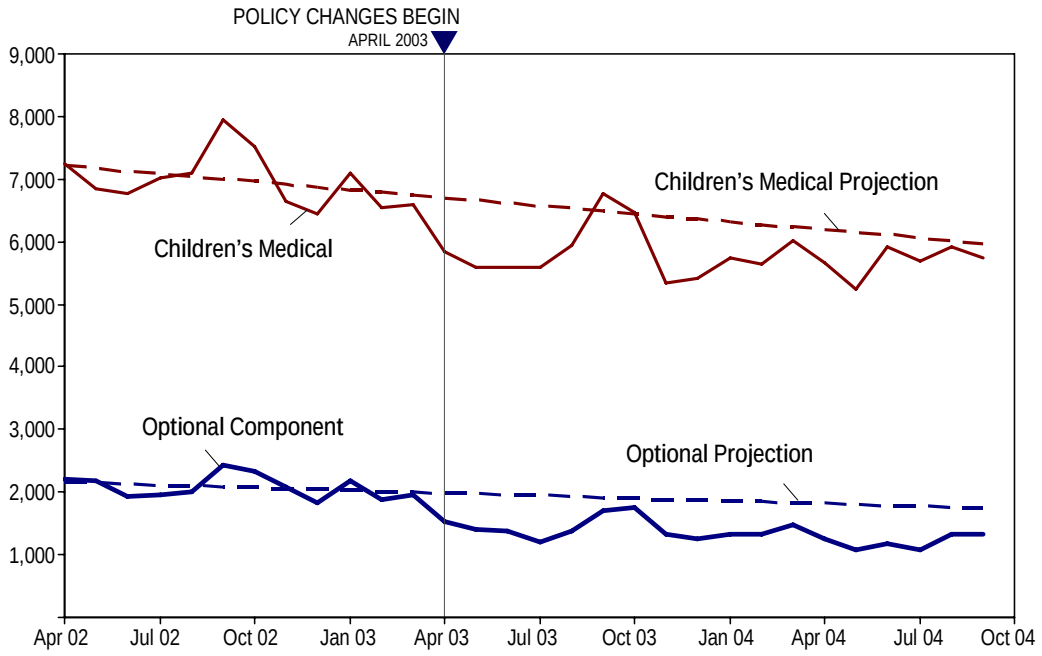
The downward drift in new entries predates the first set of eligibility changes in April 2003 and may be related to earlier reductions in enrollment outreach activities (Figure 12). However, comparing actual new entries to a trend forecast of new entries based on April 2002 to March 2003 data, we find that new entries onto the Children's Medical caseload were below trend in almost every month after March 2003. Overall, there were 10,000 fewer new entries onto the Children's Medical caseload in the April 2003 to September 2004 period, compared to the trend projection.

Perhaps as a consequence of Sneede-Kizer processing, fewer new entries onto the Optional component account for almost all of the overall decline in new entries onto the Children's Medical caseload.

FIGURE 12

New entries to Children's Medical

SOURCE: OFM Eligibility File



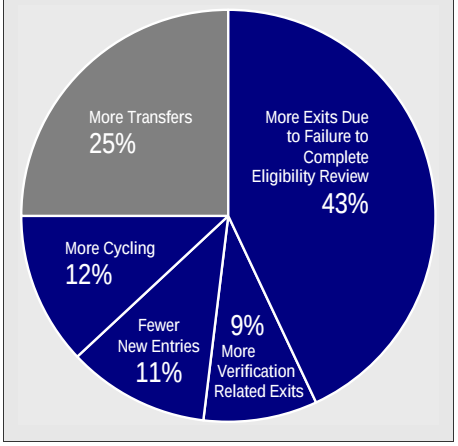
Accounting for the Caseload Decline

Recent eligibility policy changes have had several impacts on the Children's Medical caseload including:

- Increased exits due to failure to complete an eligibility review
- Increased exits due to failure to verify income or provide an SSN
- Fewer new entries
- Increased cycling off and on Children's Medical coverage
- Increased transfers from Children's Medical to SCHIP and Family Medical

Overall, the Children's Medical caseload declined by 52,063 cases between April 2003 and September 2004. Increased transfers to other DSHS coverage groups account for 25 percent of the decline. After accounting for increased transfers, the **net decline** in the Children's Medical caseload was **39,085 cases**.

FIGURE 13
Understanding the decline



Expressed differently, the decline since April 2003 represents a loss of about 409,000 months of medical coverage. We can account for the loss of coverage in the following way (Figure 13):

- About 25 percent of the gap (104,000 months of coverage) is accounted for by increased transfers to other DSHS coverage groups.
- Most of the loss of coverage (52 percent) is attributable to increased exits. Increased exits due to failure to complete an eligibility review account for 43 percent of the total decline, while increased verification-related exits account for 9 percent. In the next phase of this study, client survey data will provide information about the underlying reasons why these children lost coverage.
- The policy changes have had a modest dampening effect on the number of children entering the Children's Medical caseload. The decline in new entries accounts for 11 percent of the total caseload decline.
- Increased cycling accounts for 12 percent of the total caseload decline.

There are indications that the policy changes removed some ineligible children from the caseload, notably the increase in verification-related exits and transfers to SCHIP. However, the increase in the number of children cycling off and on the Children's Medical caseload suggests that the caseload decline reflects loss of medical coverage for some eligible children.

Cycling increased both because exits increased after April 2003 (enlarging the pool of potential cyclers) and because the proportion of leavers returning to the caseload increased. About one in five leavers (18 percent) now cycle back onto the caseload after a gap of three months or less, suggesting that many returning cyclers may have been eligible when they temporarily left the caseload.

It is to be expected that the termination of continuous eligibility and adoption of a 6-month eligibility review cycle would increase the "equilibrium" level of cycling by making current eligibility more sensitive to fluctuations in household income. A shorter certification period also means more reviews at risk of not being completed in a sufficiently timely manner to avoid a break in coverage.

The cycling increase points to negative impacts from these policy changes to balance against the savings that have accrued from falling caseloads, including:

- An impact on the well-being of children who have gaps in medical coverage;
- Enrollment disruptions in Healthy Options managed care plans; and
- A CSO staff workload impact from more frequent eligibility reviews – as evidenced by the processing backlog that developed in late 2003.

Next Steps

This report identified increased exits as the most important factor behind the decline in the Children's Medical caseload. However, in most cases administrative data do not identify the underlying reasons why children left medical assistance. In part two of this study we will interview parents to ask them why their child's medical coverage ended:

- Did family income increase?
- Was other medical coverage available?
- Were new eligibility rules a burden?

We will assess whether the child is likely to currently be eligible for Medicaid or SCHIP and whether the family anticipates reapplying for coverage. We will also use ESD earnings data to assess the underlying reasons why children left medical assistance. The second report is expected to be completed by early April 2005.

TECHNICAL NOTES

The analyses in this report use data from the Office of Financial Management (OFM) Eligibility File and the Automated Client Eligibility System (ACES). For the purposes of this study, the Children's Medical program is defined to include Medicaid Management Information System (MMIS) program-match combinations H-C, H-M, H-Q, H-S, and H-T. The report also uses the following definitions:

- Exits – A minimum two-month break in medical assistance coverage (all categories)
- Cyclers – Children returning to the Children's Medical caseload after a break of at least one month but not more than 12 months
- New Entries – Children starting a new eligibility spell who were not eligible for medical assistance in any eligibility category in the previous 12 months
- Transfers In (to Children's Medical) – Children starting a new spell on Children's Medical who were eligible for medical assistance within the past 12 months, but were last eligible in a different category (e.g., Family Medical or SCHIP)
- Transfers Out (of Children's Medical) – Children starting a new spell on Medicaid or SCHIP who were eligible for medical assistance within the past 12 months and were last eligible on Children's Medical

Additional copies of this report may be obtained from:
http://www1.dshs.wa.gov/RDA/
Olympia, Washington

Washington State Department of Social & Health Services
Research and Data Analysis Division
Report Number 9.74a

Understanding the Children's Medical Caseload Decline: Part II

WHAT THE SURVEY FINDINGS TELL US

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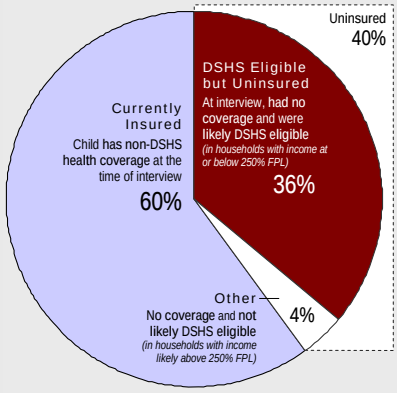
This is the second of two reports exploring why the Children's Medical caseload declined following a series of eligibility policy changes implemented by the Department of Social and Health Services in April 2003. The new policies were implemented under the direction of the legislature and included new signature and income verification requirements, a 6-month eligibility review cycle, and termination of 12-month continuous eligibility.[1] Part I of this study examined administrative data and found a net decline of 39,085 children on the Children's Medical caseload following the eligibility policy changes. Most of the loss of coverage was attributable to increased exits, as opposed to few newer entries or increased cycling on and off the caseload. This report uses client survey data to better understand why children left the Children's Medical program.

FIGURE 1

Most "leavers" have non-DSHS coverage, but most uninsured "leavers" remain DSHS-eligible



What We Found

- ***Do children leaving the Children's Medical caseload have non-DSHS medical coverage? If not, are they still eligible for DSHS coverage?*** Most "leavers" (60 percent) had other coverage at the time of the interview, but almost all uninsured "leavers" were still eligible for DSHS coverage (Figure 1).
- ***Why did the DSHS eligible but uninsured children leave? And do they plan to return?*** Most parents say DSHS made the decision, and about half cite administrative-related reasons. Almost all parents say they plan to reapply for Medicaid.
- ***Do the DSHS eligible but uninsured differ from the kids who exited to other medical coverage?*** They are poorer, more likely to use the emergency room, less likely to have physician or clinic visits, and more likely to be Hispanic.
- ***What might have been the consequences of maintaining 12-month continuous eligibility?*** The 36 percent of "leavers" who were DSHS eligible but lost coverage and were uninsured would likely have remained on Medicaid for another 6 months. The 32 percent of leavers who were "ineligible" would likely have continued on Medicaid for another 6 months.
- ***Are there opportunities to identify more children on Medicaid with private coverage?*** Many "leavers" who remained DSHS eligible had other coverage when interviewed. Enhanced efforts to coordinate benefits or buy into employer-provided coverage may be warranted.

[1] The Governor has since issued an administrative order restoring the 12-month continuous eligibility policy. The return to a 12-month review cycle was effective in May 2005 and restoration of continuous eligibility occurred in July 2005.

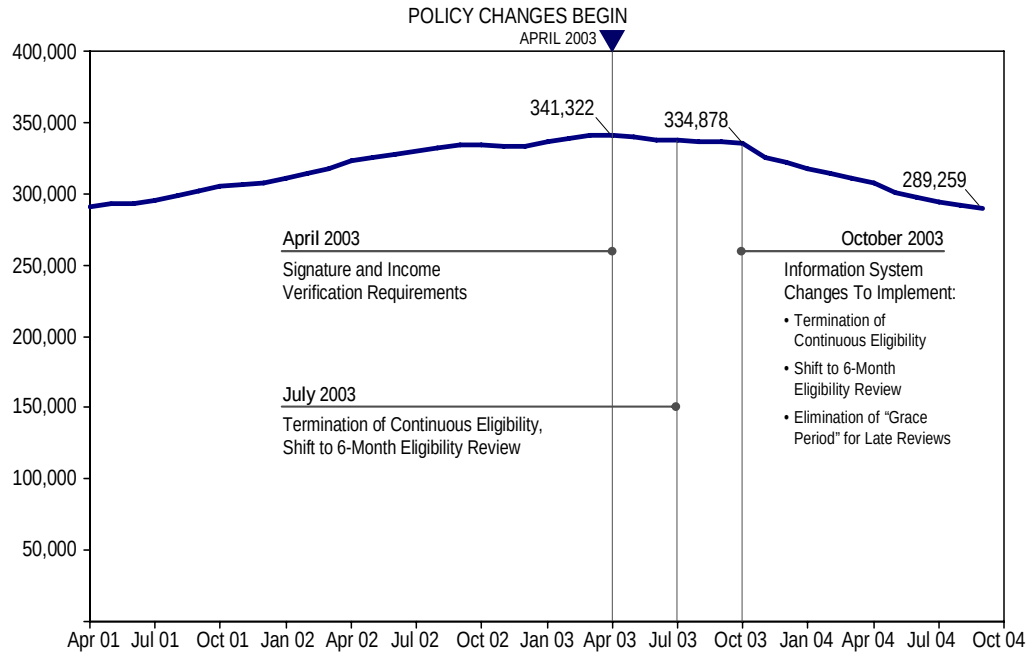
Background

The Children's Medical program[2] provides Medicaid coverage to children under age 19 in households with income at or below 200 percent of the Federal Poverty Level (FPL).[3] In 2003, the Department of Social and Health Services (DSHS) implemented a series of eligibility policy changes affecting the Children's Medical caseload, including:

- **Signature requirements** – Beginning in April 2003 applicants were required to sign their Medicaid application document. Previously, signature requirements had been suspended.
- **Income verification** – Beginning in April 2003, applicants were required to provide verification of household income and Community Service Office (CSO) staff were directed to use information sources such as Employment Security Department earnings data to verify income. Previously, applicants could declare income without providing documentation.
- **Termination of continuous eligibility and adoption of a 6-month eligibility review (ER) cycle** – In July 2003, a change in state law directed DSHS to terminate 12-month continuous eligibility and adopt a 6-month review cycle for the Children's Medical, SCHIP, and Medical-only Family Medical programs. Previously, children would remain eligible for coverage for a 12-month period, even if their family's income changed.

Following these policy changes, the Children's Medical caseload fell from a peak of 341,322 cases in April 2003 to 289,259 cases in September 2004, a "gross decline" of 52,063 cases in 18 months (Figure 2). After accounting for increased transfers to other types of DSHS medical coverage, the Children's Medical caseload experienced a **net decline of 39,085 children** in the 18-month period.

FIGURE 2
Children's Medical caseload declines after policy changes
SOURCE: OFM Eligibility File



[2] For the purposes of this study, the Children's Medical program is defined to include Medicaid Management Information System (MMIS) program-match combinations H-C, H-M, H-Q, H-S, and H-T. Other DSHS medical programs for children that are discussed in this report include the Family Medical program which covers families with children under the age of 19 whose income and resources are below Temporary Assistance to Needy Families (TANF) limits, and the State Children's Health Insurance Program (SCHIP) which covers children in households with income above 200 percent but at or below 250 percent of FPL.

[3] Child care costs, child support payments, and the first $90 of earned income are deducted from gross household income. There are no resource limitations for Children's Medical coverage.

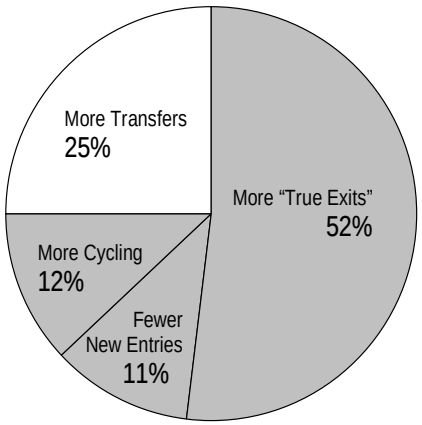
Accounting for the Caseload Decline: Phase I Findings

Among the issues that drive interest in more restrictive eligibility rules for public programs are the potential for cost savings and the appeal of ensuring program integrity. Underlying both issues is the desire to direct limited dollars to people most in need (as defined by eligibility criteria), believing that money spent on *the ineligible* means coverage denied to *the eligible*. At the same time there is concern whether the benefits (cost-savings from lower enrollment, increased program integrity) are worth the costs (loss of coverage for eligible children, costs to implement more restrictive eligibility rules). A key objective of this study is to help assess the benefit-cost tradeoff for the eligibility policy changes affecting the Children's Medical caseload. In particular:

- *Did the new eligibility policy rules create barriers to enrollment that caused eligible children to lose medical coverage?*
- *Did the new rules remove ineligible children who had been able to enroll under the old rules (for example, due to less robust income verification)?*

FIGURE 3
"True exits" account for the largest part of caseload decline

SOURCE: OFM Eligibility File



Phase I of this study analyzed administrative data and found that half of the gross decline in coverage (52 percent) was attributable to more "true exits" – that is, more children leaving the caseload and not returning to any type of DSHS medical coverage (Figure 3). Increased exits due to failure to complete an eligibility review (as recorded in administrative data) accounted for 43 percent of the gross decline, while increased verification-related exits accounted for 9 percent.[4] The eligibility policy changes had a more modest dampening effect on the number of children entering the Children's Medical caseload, with fewer new entries accounting for 11 percent of the gross caseload decline. Increased cycling off and on the Children's Medical caseload accounted for 12 percent of the decline. Increased transfers to other types of DSHS medical coverage – primarily to the SCHIP and Family Medical programs – accounted for the other 25 percent of the gross caseload decline.

Increased cycling provides evidence that the new eligibility policies created barriers to continuous enrollment that caused some eligible children to have gaps in medical coverage.[5] The increase in transfers to the higher income SCHIP program, coupled with an increase in verification-related exits, provides evidence that the new rules removed some ineligible children who previously had been able to enroll in the Children's Medical program.

However, the administrative data can only tell us so much. For most children who left Children's Medical coverage, we only know from administrative data that their case was closed because they did not complete their eligibility review. We do not know why the eligibility review was not completed. *Did household income increase? Did the family obtain private coverage? Did the new rules create barriers to enrollment?*

Phase II of the Children's Medical Caseload Evaluation uses survey data to examine these issues from the perspective of parents of children who left the caseload following the eligibility policy changes (and who, by the time of interview, had *not* returned to the caseload). We are particularly interested in whether substantial numbers of these children **continued to be eligible for DSHS coverage**, in their **current health insurance status**, and in parents' views of **why their children left** the program.

---

[4] Survey data will cast a different light on the exit reasons recorded in administrative data (see page 8). Many children recorded as leaving due to failure to complete an eligibility review or failure to verify income actually left due to increased earnings or due to the availability of non-DSHS medical coverage.

[5] This inference is supported by the finding discussed below (page 5) that 90 percent of children who left the Children's Medical program and were uninsured at the time of the interview remained eligible for DSHS coverage. Given the high rate of eligibility for DSHS coverage among children who left Medicaid and did not return, it is plausible that most children who left the Children's Medical program and returned (usually after a gap of less than 6 months) remained eligible for DSHS coverage during the coverage gap.

Phase II Objectives: What Will We Learn?

Because Phase I showed that increased "true exits" were the most important source of caseload decline, the Phase II survey focused on children who left the Children's Medical caseload and did not return to any type of DSHS medical coverage. The survey data allow us to answer several key questions about children who left the Children's Medical caseload:

- *Do "leavers" have non-DSHS coverage? If not, are they still eligible for DSHS coverage?*
- *For children who are still DSHS eligible but uninsured, why did they leave? To what degree were administrative issues a factor? And do they plan to return?*
- *Do the DSHS eligible but uninsured differ (health status, demographics) from the kids who exited to other medical coverage?*

Ultimately, the survey data will help assess the impact of maintaining a 12-month continuous eligibility policy, allowing us to estimate how many eligible children lost coverage and how many "ineligible" children might have continued in coverage under the 12-month rules.

We interviewed parents of 301 children from a random sample who left the Children's Medical caseload in June, July, or August 2004. Our sample **excluded** children who:

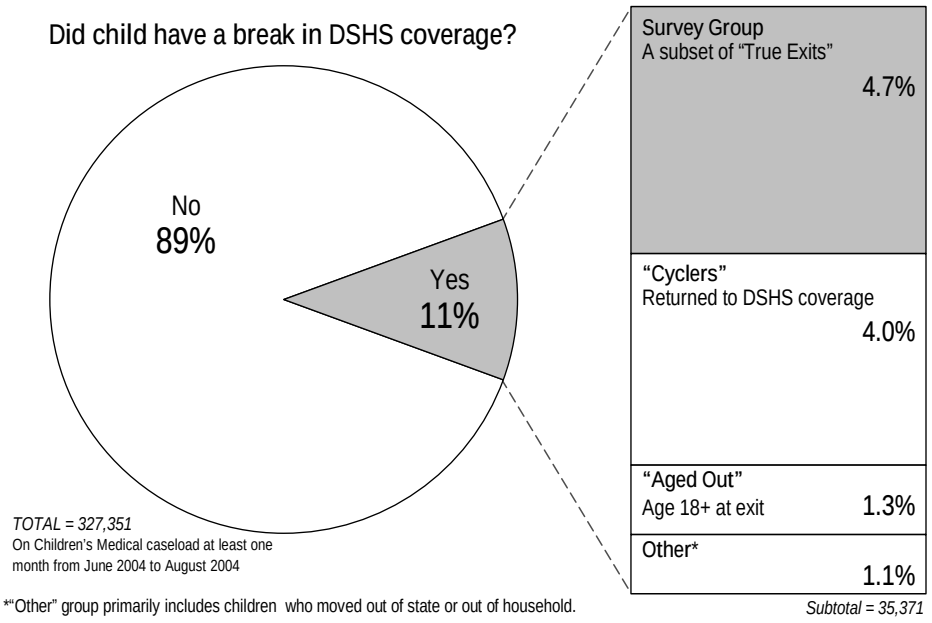
- Transferred to other types of DSHS medical coverage,
- Cycled back onto any type of DSHS medical coverage,
- "Aged out"[6] of coverage, or
- Left the state or left the sampled parent's household.

Data collection was conducted by the Medical Assistance Administration Medicaid Eligibility Quality Control unit from January to April 2005. Interviews were completed six to ten months after exit from DSHS coverage. Survey findings reflect the circumstances of children leaving the Children's Medical caseload and not returning to DSHS coverage. **These findings do not reflect the experiences of children who stayed on or returned to the caseload.** It is also important to note that survey findings cannot distinguish between children who left Medicaid specifically due to the eligibility policy changes and children who would have left Medicaid even if the changes had not occurred. More detail about survey methods is provided in the technical note on page 14.

FIGURE 4

Survey focuses on "true exits"

SOURCE: OFM Eligibility File, Children's Medical Leavers Survey estimates



*"Other" group primarily includes children who moved out of state or out of household.

[6] We excluded from the sample all children who were age 18+ at the time of exit.

Most "Leavers" Have Non-DSHS Coverage, but Most Uninsured "Leavers" Remain Eligible for DSHS Coverage

When we asked parents about their child's current health insurance status, **60 percent of children were reported to have non-DSHS health insurance at the time of the interview**. It is important to keep in mind that this finding pertains to children who left DSHS coverage, not children who are currently enrolled in Medicaid. In addition, we do not have information about the *quality* of non-DSHS coverage for the currently insured. The vast majority of this coverage – 87 percent – was reported to be employer or union provided insurance. An additional 6 percent of children were covered by private self-paid plans, 5 percent were covered by a military plan, and 2 percent were covered by other types of plans.

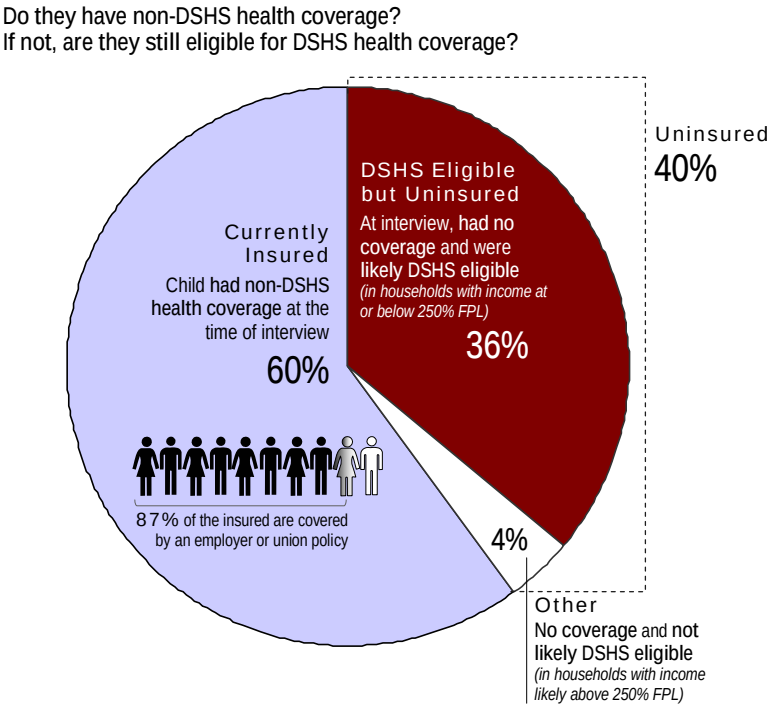
Of the Children's Medical "leavers," 40 percent were uninsured at the time of the interview. **Almost all children who were uninsured at the time of the interview were likely eligible for DSHS coverage.**[7] Specifically, 90 percent of uninsured children were estimated to be eligible for DSHS medical coverage, with 77 percent estimated to be eligible for Medicaid (at or below 200 percent FPL) and 13 percent estimated to be eligible for SCHIP (above 200 percent FPL but at or below 250 percent FPL).

The next set of exhibits compares the circumstances of **DSHS eligible but uninsured** children with the circumstances of children who were **currently insured** at the time of the interview.

FIGURE 5

What happened to the children who left DSHS coverage?

SOURCE: Children's Medical Leavers Survey



[7] Survey respondents were asked about their household size and gross monthly household income. Households with income at or below 250 percent FPL were determined to be likely DSHS eligible. That is, we defined DSHS-eligibility to include eligibility for *either* the Children's Medical (up to 200 percent FPL) program or the SCHIP (200-250 percent FPL) program. This determination is approximate and does not take into account earned income or child care cost disregards or the presence of potentially disqualifying non-DSHS coverage among children who might otherwise qualify for SCHIP. We are more likely to understate (rather than overstate) the proportion of children who are DSHS-eligible. In addition, 9 percent of respondents did not answer the household income question. As shown in Figure 13, there is a strong correlation between household income and the likelihood that a child had non-DSHS health coverage at interview. Children whose parents did not respond to the household income question had higher rates of current non-DSHS coverage (88 percent) than children whose parents reported household income above 250 percent of FPL (84 percent). Based on this finding, we assessed children whose parents did not report income as not likely to be eligible for DSHS medical coverage.

Most DSHS Eligible but Uninsured "Leavers" Say It Was Not Their Decision to Leave Medicaid

Why did your child leave Medicaid? Parents of DSHS eligible but uninsured children reported very different reasons for leaving Medicaid, compared to parents of children with health coverage at the time of the interview. We first asked parents whether it was their decision to leave Medicaid, or whether DSHS made that decision (Figure 6). Most parents of children who were likely DSHS eligible but uninsured when interviewed reported that DSHS made the decision (85 percent), while most parents of children with insurance when interviewed reported it was their decision to leave Medicaid (62 percent).

We then asked parents about the underlying reason why their child left Medicaid (Figure 7). We identified a set of responses that raise potential concerns about the additional administrative burden imposed by the eligibility policy changes, including:

- I didn't complete the eligibility review.
- I didn't or couldn't verify income.
- I reapplied, but never heard back from DSHS.
- It was too much hassle to reapply.

About half (48 percent) of parents of DSHS eligible but uninsured children cited a reason of potential concern – the most common reason being "I didn't complete the eligibility review." Few of these parents cited increased earnings (14 percent) or access to non-DSHS medical coverage (4 percent) as the underlying reason for leaving Medicaid. In contrast, most parents of children with health insurance when interviewed reported they left Medicaid either because they had other medical coverage (43 percent) or because the family had increased earned income (26 percent).

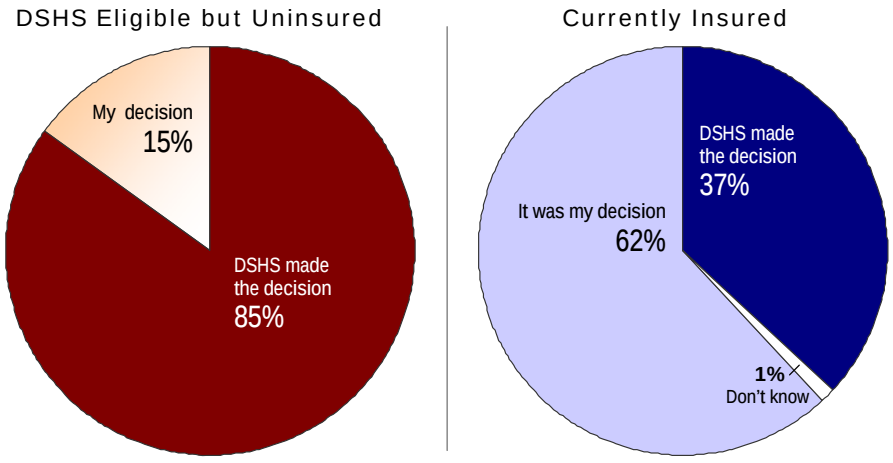
Do you plan to reapply for Medicaid? Most parents of DSHS eligible but uninsured children (88 percent) reported they planned to reapply or had already started to reapply for Medicaid (Figure 8). As expected, fewer parents of insured "leavers" (24 percent) reported they planned to reapply. However, a large proportion of these parents (59 percent) indicated they might reapply in the future if circumstances warranted.

Given the ability of parents of DSHS eligible but uninsured children to obtain "retroactive" Medicaid coverage if a significant medical event were to occur, the fact that many of these parents plan to reapply for Medicaid may temper our view of the impact of loss of coverage for these children. We return to this issue when we look at use of emergency room and physician or clinic care on page 9.

FIGURE 6

Was it your decision to leave Medicaid?

SOURCE: Children's Medical Leavers Survey

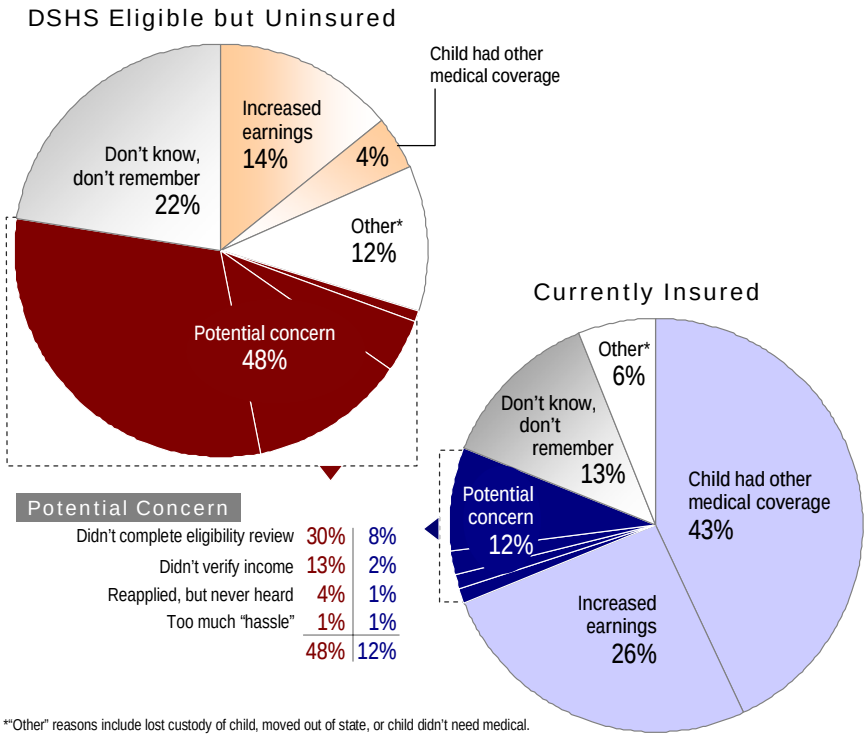


Most Insured "Leavers" Cite Availability of Other Coverage or Increased Earnings as Reason for Exit

FIGURE 7

Why did your child leave Medicaid?

SOURCE: Children's Medical Leavers Survey



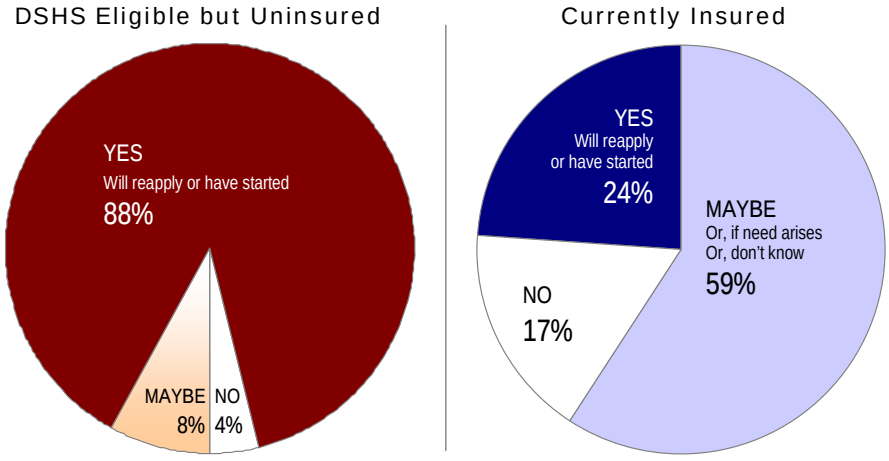
*"Other" reasons include lost custody of child, moved out of state, or child didn't need medical.

Most DSHS Eligible but Uninsured "Leavers" Say They Plan to Reapply for Medicaid

FIGURE 8

Do you plan to reapply for Medicaid?

SOURCE: Children's Medical Leavers Survey



Comparison of Survey and Administrative Exit Reasons

We were interested in parents' views of why their children left the Children's Medical program (Figure 7), and we were concerned about the degree to which administrative data may create mistaken impressions of those reasons. For example, administrative data show that the increase in exits that occurred following the eligibility policy changes was exclusively due to an increase in exits related to income verification or an incomplete eligibility review, perhaps creating an impression that administrative barriers were the prime driver of increased exits.

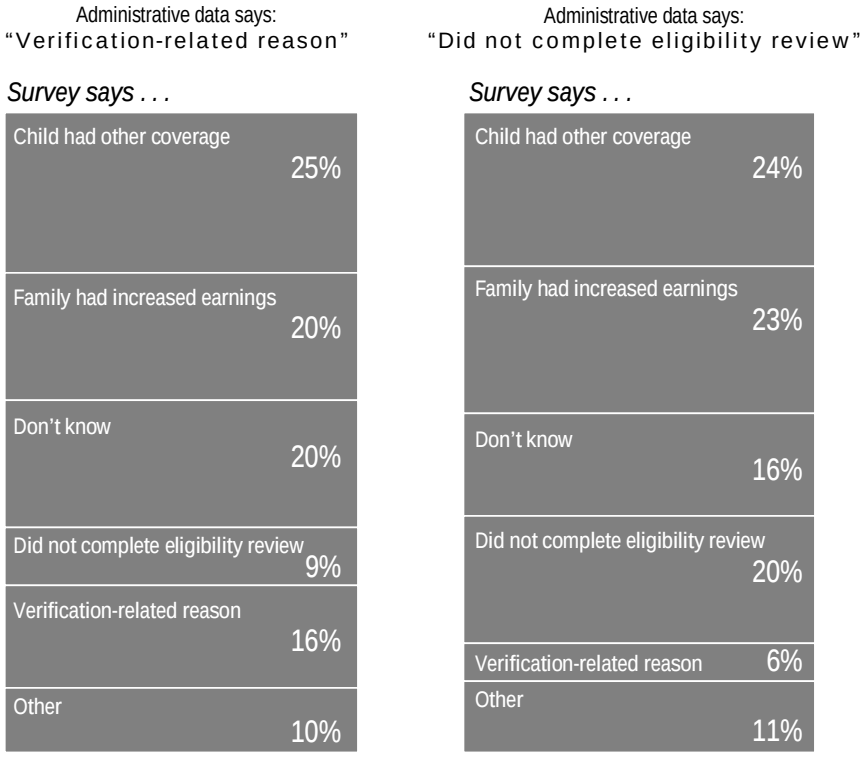
However, a comparison of administrative and self-reported reasons for exit (Figure 9) tells a different story. That is, for children whose administrative exit reason was recorded as "did not complete eligibility review," nearly one-half left for reasons completely unrelated to the eligibility policy changes – because of increased earnings (23 percent) or the availability of other coverage (24 percent). The story is similar for children whose administrative exit reason was recorded as "verification related" – 25 percent of these parents said they left Medicaid because their child had other coverage and another 20 percent said they left due to increased earnings.

We raise this issue not to argue pro or con the impact that the administrative changes may have had for maintaining enrollment for eligible children; rather as simply a caution not to "over interpret" the administrative reasons for exit. Refinements to the process of recording reasons for exit may help to better identify children's exit reasons in administrative data.

FIGURE 9

How do self-reported reasons for exit compare to reasons recorded in administrative data?

SOURCE: ACES Exit Reason and Children's Medical Leavers Survey



A Look at Health Status and Use of Medical Services

To facilitate comparisons between Children's Medical "leavers" and children staying on Medicaid, our survey included items from the Consumer Assessment of Health Plans Survey (CAHPS) regarding health conditions, emergency room use, and physician or clinic visits.[8] The CAHPS surveyed children continuously enrolled in Medicaid ("stayers") and was fielded in 2004. We found Children's Medical "leavers" to be less likely than CAHPS "stayers" to have a persistent medical, behavioral, or other health condition lasting three months or more (Figure 10). Only 8 percent of currently insured "leavers" and 12 percent of DSHS eligible but uninsured "leavers" were reported to have a persistent health condition, compared to 24 percent of CAHPS "stayers."

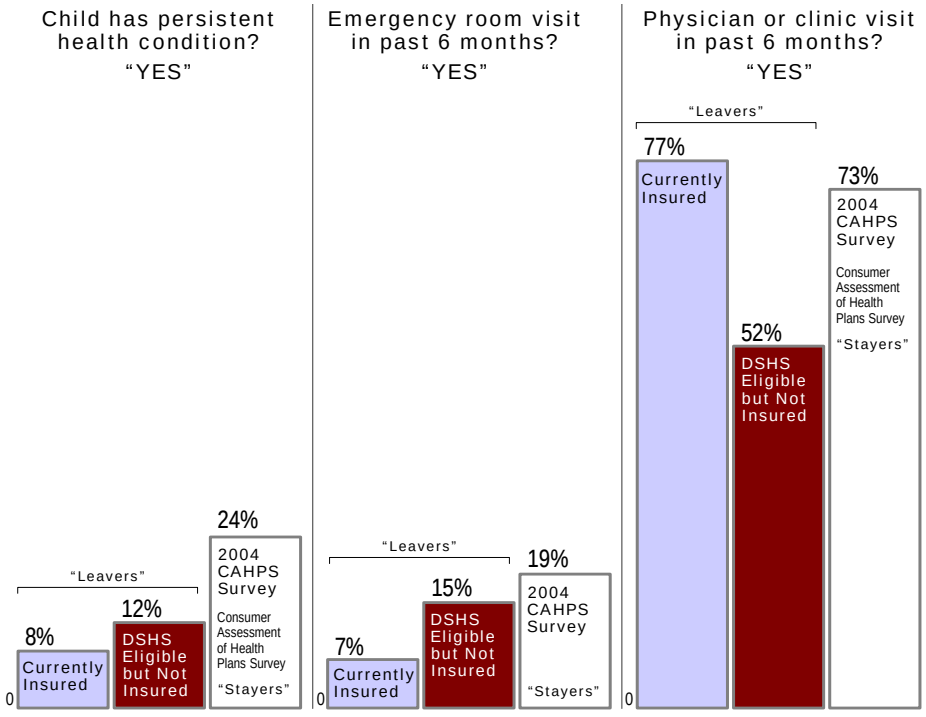
A likely consequence of the relatively low prevalence of persistent health conditions among our "leavers" is a low rate of emergency room use, compared to CAHPS "stayers." Among "leavers," 7 percent of the currently insured and 15 percent of the DSHS eligible but uninsured had an emergency room visit in the previous six months, compared to 19 percent of CAHPS "stayers."

Earlier we noted that a high proportion (88 percent) of parents of DSHS eligible but uninsured children planned to return to Medicaid, and raised the question of how concerned we should be about lack of current coverage for these children who could be covered (retroactively if necessary) by Medicaid if a significant medical event should occur. However, survey data on emergency room visits and physician or clinic visits suggest reason for concern. DSHS eligible but uninsured "leavers" were less likely than currently insured "leavers" to have had a physician or clinic visit in the previous six months (52 percent vs. 77 percent), but were twice as likely to use the emergency room in that period (15 percent vs. 7 percent). Although merely suggestive, these findings are consistent with the notion that DSHS eligible but uninsured "leavers" may not be getting the routine care they need, which could result in more potentially avoidable emergency room visits for these children.

FIGURE 10

"Leavers" less likely than "stayers" to have a persistent health condition or use the emergency room

SOURCE: Children's Medical Leavers Survey



[8] Our survey also included a CAHPS item asking the parent to assess their child's health status. Similar proportions of Children's Medical "leavers" and CAHPS "stayers" were reported to be in very good or excellent health (about 80 percent of children in each group). See the Technical Note on page 16 for more about the CAHPS survey.

Demographic Differences

Among children leaving the Children's Medical caseload, Hispanic children were overrepresented in the DSHS eligible but uninsured group. Specifically, 24 percent of the DSHS eligible but uninsured children were Hispanic, compared to only 11 percent of "leavers" who had coverage at the time of the interview (Figure 11).

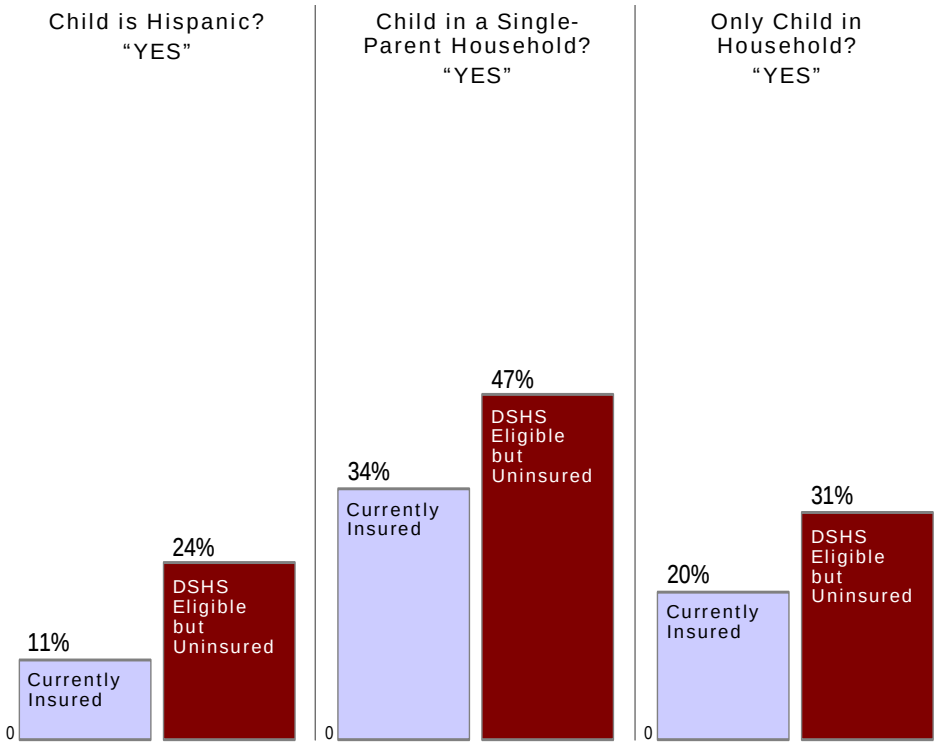
It is interesting to compare this result to the Phase I finding that children leaving Medicaid following the eligibility policy changes were *less likely* to be Hispanic than children staying on the Children's Medical caseload.[9] In other words, Hispanic children were less likely to leave the Children's Medical caseload following the eligibility policy changes, but the Hispanic children who did leave that caseload were disproportionately likely to end up uninsured.

DSHS eligible but uninsured "leavers" were also more likely than insured "leavers" (47 percent vs. 34 percent) to reside in a single-parent household (Figure 11). This probably reflects the greater likelihood that two-parent households will have access to employer-provided health insurance. DSHS eligible but uninsured "leavers" were also more likely to be an only child (31 percent vs. 20 percent).

FIGURE 11

DSHS eligible but uninsured "leavers" are more likely to be Hispanic, from single parent households, or an only child

SOURCE: Children's Medical Leavers Survey



[9] To see this, compare the Hispanic proportion of the "Leavers After" and "Stayers After" columns in Table 1 of the Phase I report.

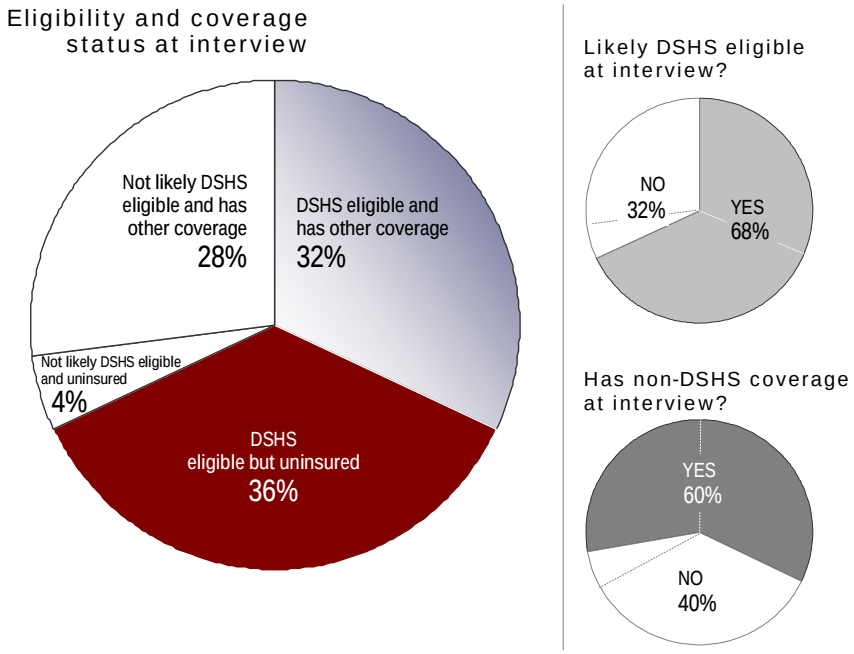
Policy Implications: Eligibility and Coverage Trade-offs

Findings from the survey help shed light on the trade-offs that decision makers face in setting program policy direction. Using Figure 12 we examined these trade-offs from the perspectives of eligibility[10] and coverage.

Eligibility – *How wide to cast the net?* There is a trade-off between serving *only* children for whom the program is intended (in which case some eligible children may be excluded) and serving *all* children for whom the program is intended (in which case some ineligible children may be included). Our survey results put some numbers to this trade-off, given that these are all children who left the program and yet under the "rules" of 12-month continuous eligibility could have stayed, generally for an additional six months. Taken *solely* from the perspective of eligibility, the trade-off between serving "*only versus all"* boils down to this question: *If 12-month continuous coverage were in place, would it have been worth covering up to 32 percent ineligible children to ensure that the 68 percent eligible children remained enrolled?* To make the trade-off more challenging, consider that 4 of the 32 percentage points of ineligible children would also become uninsured if they lost their public coverage. And to raise the ante even more, consider that most children who *left but were still likely to be eligible* were *uninsured* at interview.

Coverage – *Balancing the private side?* A second trade-off raised by the findings in Figure 12 relates to the unexpectedly high proportion of children who had other coverage, primarily employer/union based. This trade-off comes in the form of "*opportunity gained versus opportunity lost"* to capitalize on other sources of coverage. Again, under the rules of 12-month continuous coverage all of these "exited" children could likely have stayed in the program beyond the time they left. At risk, under less frequent (i.e., 12-month) compared to more frequent (i.e., 6-month) reviews, is the opportunity to identify children with employer-based coverage and to make use of that information.[11] Again, our survey puts some numbers to this potential opportunity.

FIGURE 12
Two of three "leavers" were likely DSHS-eligible
SOURCE: Children's Medical Leavers Survey



[10] Our approach to estimating eligibility is described in footnote 7.

[11] Experience indicates that parents are more likely to engage in "passive disenrollment" rather than "active disenrollment." If parents obtain other coverage for their children they simply quit using the public coverage and when recertification comes around they do not respond. (If most children were enrolled in fee-for-service, rather than managed care, the cost implication of this would be much less. However, under managed care the state continues to pay a monthly premium for the child whether or not services are used.)

Policy Implications: More on Eligibility and Coverage

Ineligible children with private coverage. First, Figure 12 shows that in the presence of 6-month reviews, 32 percent of the surveyed group left the program and likely were not eligible. *However,* seven out of eight of these "exited" children had other coverage (primarily employer/union based) at the time their parents were interviewed and *thus were not at risk of being uninsured* if their DSHS coverage were discontinued.[12]

Eligible children with private coverage. For those children who continue to be eligible for medical assistance, there also may be an opportunity to capitalize on the existence of other coverage – *close to half of the children who remained DSHS eligible also had other coverage*. Six-month reviews present an opportunity to identify the "covered" children sooner rather than later and open the door to earlier coordination of benefits and/or the possibility of "buying the child into" employer-based coverage.[13] The Medical Assistance Administration (MAA) currently does significant work in the area of coordinating benefits and is piloting an "employer buy-in" initiative which, if cost-effective, covers the premium needed to enroll a child in employer coverage. Survey results provide support for both efforts to continue and be enhanced where they are cost effective.

Balancing public eligibility and private coverage. In the end, it is important that public program integrity be maintained and that resources are directed to those children most in need. At the same time, one must ask: *Where is the integrity in creating barriers that make it less easy for parents of eligible children to sustain their child's coverage or that contribute to the ranks of uninsured children (at interview, four of 10 children were uninsured, the majority of whom continued to be eligible)?* Given our findings, *perhaps the most reasonable compromise* is to maintain 12-month continuous enrollment while ensuring a robust network for linking to other state and local systems, such as Employment Security, to identify those children who are likely to have other coverage. Once identified, these children can be reviewed for eligibility – if ineligible their enrollment can be ended (without fear of them being uninsured[14]) and if eligible, then opportunities to link public dollars with private coverage, if cost effective, can be explored. MAA should be supported in its continued efforts to improve the linkages it makes with other state and local systems.[15] [16]

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[12] Clearly this statement does not address concerns regarding the quality and continuity of that other coverage, concerns not to be ignored. We are limited by the contents of the survey which asked only about the presence/absence and source of non-DSHS coverage, not about the specifics of the coverage. However, the findings reported in Figure 10 do not suggest that the children who left to private coverage have health coverage that limits access to care. Despite having a lower incidence of persistent health conditions, currently insured "leavers" were somewhat more likely than CAHPS "stayers" to have had a physician or clinic visit in the previous 6 months.

[13] In part, this gets to the issue of continuous versus non-continuous coverage (regardless of whether it's for 6 or 12 months). A requirement to report changes of circumstances that might impact eligibility (i.e., non-continuous eligibility) generally is enormously hard to police and often ineffective. Thus, shorter eligibility periods are sometimes considered in lieu of requiring "change" reporting.

[14] See footnote 12.

[15] This compromise aligns with the Governor's and Legislature's goal to cover all children by 2010 and hopefully would prevent premature additions to the ranks of Washington's uninsured children.

[16] It was not part of our study to look at the cost trade-offs associated with the recertification policy changes. However, we would be remiss in not reminding ourselves that part of the balancing equation involves other costs including, for example, financial costs of eligible but uninsured children on other parts of the system funded by public dollars; costs to the program, working parents, health plans, providers and community outreach programs of disenrolling and re-enrolling children; and, individual and system costs associated with discontinuous care.

Policy Implications: Other Issues

Beyond the implications of Figure 12, there are other policy issues we want to raise. The first concerns the income distribution of children who had non-DSHS coverage at the time of the interview, the second is a reminder of where the survey population of "leavers" fits in the context of the Children's Medical program as a whole, and the third addresses impacts of the eligibility policy changes on program cycling.

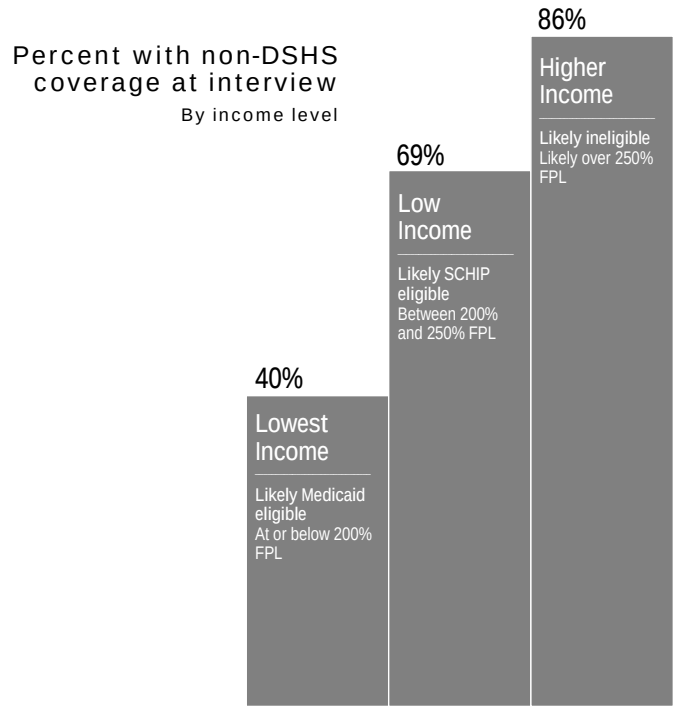
Lowest-income children disproportionately impacted. It is clear from Figure 13 that based on parents' reports of child's coverage status at interview, the lowest income children were much more likely to end up without coverage, either public or private, than were less-poor children, following their exit from the caseload. Specifically, higher income children (over 250 percent federal poverty) were more than twice as likely to have coverage (mostly employer or union based) as were the lowest income children (at or below 200 percent federal poverty). Thus, it appears that the very group for whom our public programs are designed is the group most disadvantaged by the recertification policy changes in that their earlier exit (earlier than if 12-month continuous eligibility were in place) added substantial numbers of them to the uninsured population.

Crowd-out concerns. Although we did not focus on crowd-out per se, Figure 13 provides some support for conventional wisdom. That is, as income eligibility levels for public programs increase the *potential* for public coverage to supplant private coverage rises, simply by virtue of the fact that greater numbers of children at higher income levels have private coverage options. Considered in a vacuum, crowd-out might seem to present a solid argument for lower income eligibility levels. That argument pales somewhat when one considers that many potentially excluded children are likely to end up uninsured. We are not arguing that concerns about crowd-out should be ignored, but perhaps dealt with in ways other than closing the doors on lower income children truly in need of a public coverage option.

FIGURE 13

Poorest "leavers" were least likely to have health coverage

SOURCE: Children's Medical Caseload Survey Responses



Policy Implications: Other Issues

Study Group in Broader Context. Finally, by design this analysis is about children who left the Children's Medical program following implementation of more stringent eligibility policies. Although we do not want to trivialize the impact of the administrative changes on an eligible child's ability to remain in the program, it is useful to note the small segment of the program represented by the study group, and remind the reader not to stretch the interpretation of results too far.

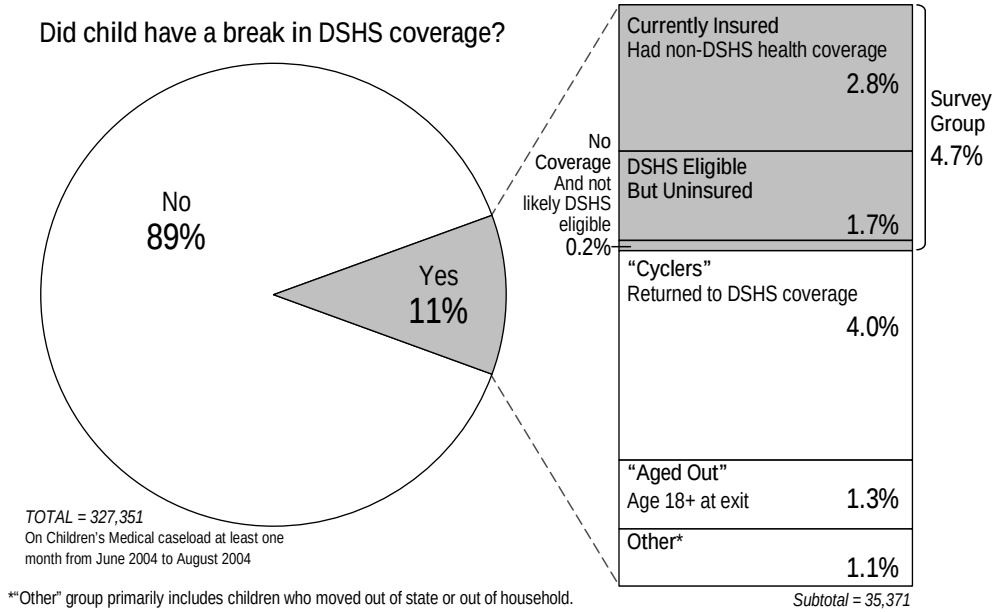
This group of "leavers" represents *slightly less than 5 percent* of the children enrolled during the 3-month sampling period (June through August 2004). Overall, 89 percent of the enrollment during this 3-month window stayed in the program, i.e., did not experience a gap in coverage. We should not lose sight of the fact that the Children's Medical program serves hundreds of thousands of children on a monthly basis.

Increased Cycling Merits Attention. Last but not least, what research paper can end without a suggestion for further research? There is another group of children that was not the focus of this survey but for whom the administrative changes also have had consequences – the 4 percent of children with a break in coverage who were identified as "cyclers" (Figure 14). These are children who left the program but subsequently returned. By itself, the 4 percent may not seem compelling. However, when combined with two other pieces of information we believe the issue rises to a level meriting concern. First is the finding in Part I of the study that increased cycling in the Children's Medical program accounted for 12 percent of the caseload decline that occurred after the eligibility policy changes. Second, there is the survey finding showing that a substantial portion of parents of DSHS eligible but uninsured children say they have already started the reapplication process for their "exited" child or are likely to do so (Figure 8). Thus, many of our DSHS eligible but uninsured "leavers" may become "cyclers" in the near future. Given the substantial amount of literature on the problems associated with non-continuous access to coverage and care, this is a consequence of the policy changes that warrants a closer look.[17]

FIGURE 14

Study group in broader context

SOURCE: OFM Eligibility File, Children's Medical Leavers Survey estimates



[17] Problems associated with non-continuous access include health and economic impacts on the children and families, as well as added costs to the system (public programs, health plans, providers, community programs) for disenrolling and re-enrolling the same child. See footnote 16.

What do other studies say?

Few studies perfectly share Washington's program context, often differing in one or more important respects. For example, they address dropout at different stages of enrollment (*prior to* versus *at* recertification); focus on different programs (SCHIP versus Medicaid) with varying income eligibility levels that aren't always clear and don't correspond to Washington cut-offs; and examine related but slightly different issues (e.g., benefits of staying in the program versus impact of policy decisions on drop-out). The distinctions are important but not always readily discernable. The following are selected references that speak specifically to disenrollment at recertification (reasons for, predictors of, impacts) and its relationship to more stringent review procedures, especially 12-month continuous eligibility compared to more frequent reviews.

Dick, A.W., R.A. Allison, S.G. Haber, C. Brach, and E. Shenkman. 2002. "Consequences of States' Policies for SCHIP Disenrollment." *Health Care Financing Review* 23 (3): 65-88.

Fairbrother, G. April 2005. *How Much Does Churning in Medi-Cal Cost?* Woodland Hills, CA: The California Endowment.

Gardner, M., T. Lew, and P. Lichiello. 2004. *The Costs of Enrollment Instability in Washington State's Medicaid Program*. Seattle, WA: Health Policy Analysis Program, University of Washington.

Hill, I., and A.W. Lutzky. 2003. *Is There a Hole in the Bucket? Understanding SCHIP Retention.* Assessing the New Federalism. Occasional Paper 67. Washington, DC: The Urban Institute.

Irvin, C., D. Peikes, C. Trenholm, and N. Khan. 2001. *Discontinuous Coverage in Medicaid and the Implications of 12-Month Continuous Coverage for Children.* Cambridge, MA: Mathematica Policy Research.

Kavoussi, R. and E. Burchfield. May 2004. *Stretching the Safety Net: The Rising Uninsured at Washington's Community Health Centers.* Seattle, WA: Community Health Network of Washington.

Kronebusch, K., and B. Elbel. 2004. "Simplifying Children's Medicaid and SCHIP." *Health Affairs* 23 (3): 233-246.

Lipson, K., E Fishman, P. Boozang, and D. Bachrach. August 2003. *Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs.* New York, NY: The Commonwealth Fund.

Mark-Wilson, P., J. Gallagher, and S.A. Mathis. 2004. *Findings and Recommendations: Focus Group and Interview Study of Washington Medicaid and CHIP Programs.* Washington, D.C.: Health Systems Research, Inc.

O'Brien, E., and C. Mann. 2003. *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*. Washington, DC: Health Policy Institute, Georgetown University.

Phillips, J.A., J.E. Miller, J.C. Cantor, and D. Gaboda. 2004. "Context or Composition: What Explains Variation in SCHIP Disenrollment." *Health Services Research* 39 (4): 865-885.

Riley, T., C. Pernice, S. Kannel, and M. Perry. May 2002. *Technical Report: Why Eligible Children Lose or Leave SCHIP: Findings from a Comprehensive Study of Retention and Disenrollment* Portland, ME: National Academy for State Health Policy.

Sommers, B. D. 2005. "From Medicaid to Uninsured: Drop-Out Among Children in Public Insurance Programs." *Health Services Research* 40 (1): 59-78.

Survey Design

The survey sample frame was developed using the December 2004 Office of Financial Management (OFM) Eligibility File. The sample was selected from children age 17 and under who left the Children's Medical caseload in June, July, or August 2004 and were not observed to return to any type of DSHS medical coverage by December 2004. We excluded children age 18 from the sample frame because most of these children "aged off" the caseload, and most of those who did not age off the caseload would have been age 19 (and therefore ineligible for the Children's Medical program) by the time of the interview. We sampled 800 heads of households of children who met these criteria. Many sampled parents had more than one "study eligible" child, and we randomly sampled a "reference child" for each parent, with a systematic structure to ensure balanced representation by child age and gender.

Data collection was conducted by the MAA Medical Eligibility Quality Control unit. During the "desk audit" phase of data collection, we excluded 196 children from the telephone interview phase who were observed to return to DSHS medical coverage after December 2004 (that is, they returned to DSHS coverage prior to the interview but too late to be excluded from the initial sample frame). We also excluded 87 children who were determined to have left the state. Thirty children were screened out of the telephone interview phase for other reasons (primarily because they left the sampled parent's household).

This left 487 children from the initial sample who screened through to the telephone interview stage. Of these children, 353 had an Automated Client Eligibility System (ACES) exit reason of "ER not complete," 78 had a verification-related exit reason, and 56 had other ACES exit reasons. We completed 301 interviews, for a response rate of 62 percent. Interviews were conducted from January to April 2005, six to ten months after exit from DSHS coverage.

Analysis weights were constructed to account for the number of exiting children associated with the sampled head of household. Weights were also adjusted for non-response using the inverse fitted probability of response (among the 487 children who screened through to the telephone interview stage) from a logistic regression model with the following control variables:

- Child's age, gender, and race/ethnicity;
- Household head's age and gender;
- Administrative reason for exit from ACES; and
- Estimated household income at exit (from the desk audit).

Weighted and unweighted survey estimates were generally very close to each other.

Comparisons with the CAHPS Healthy Options General Child Population

The 2004 CAHPS Healthy Options general child population sample frame included children age 17 and younger who were enrolled in a Medicaid Healthy Options plan from July 1, 2003 through December 31, 2003 with no more than a one-month break in Medicaid coverage during that period. The survey was fielded in 2004. The CAHPS sample frame includes lower income children enrolled in the Family Medical program, in addition to children enrolled in the Children's Medical program.

Additional copies of this report may be obtained from:

http://www1.dshs.wa.gov/RDA/

Olympia, Washington

Washington State Department of Social & Health Services

Research and Data Analysis Division
Report Number 9.74b

Children's Medical Caseload

This two-part report examines why the Children's Medical caseload declined following a series of eligibility policy changes implemented in April 2003. The changes included new signature and income verification requirements, a 6-month eligibility review cycle, and termination of 12-month continuous eligibility.

Part I of this study examined administrative data and found a **net decline of 39,085 children** on the Children's Medical caseload in the 18 months following the eligibility policy changes. **Most of the loss of coverage was attributable to increased exits**, as opposed to fewer new entries or increased cycling off and on the caseload.

Part II of this study used client survey data to better understand why children left the Children's Medical program after the policy changes. We found that **most "leavers" had non-DSHS coverage** (60 percent) at the time of the interview, but **almost all uninsured "leavers" were still eligible for DSHS coverage**.

Washington State
Department of Social & Health Services

RDA Research & Data
Analysis Division