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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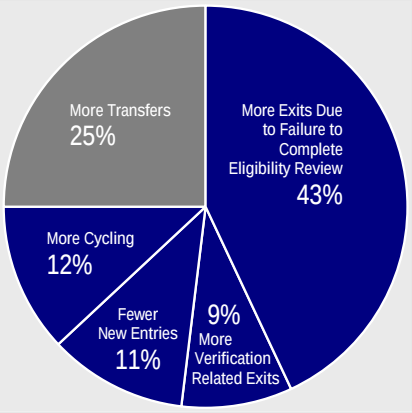
The Department of Social and Health Services (DSHS) implemented a series of eligibility policy changes beginning in April 2003 that resulted in a significant decline in the Children's Medical caseload. The policy changes included new signature and income verification requirements, adoption of a 6-month 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.

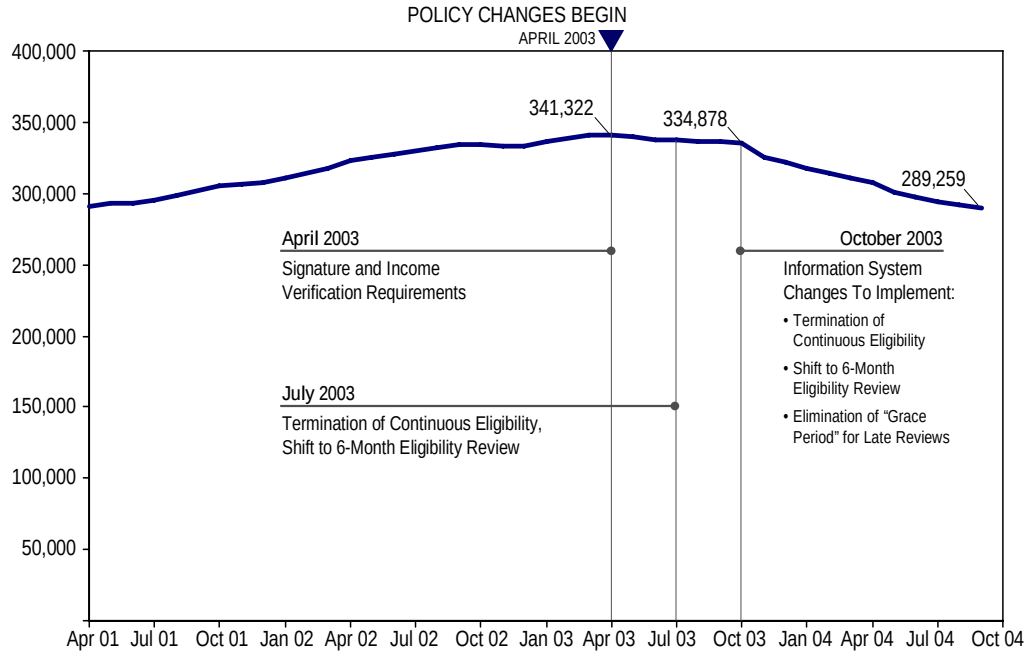
Caseload Decline Begins in April 2003 and Accelerates in November 2003

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 . . .

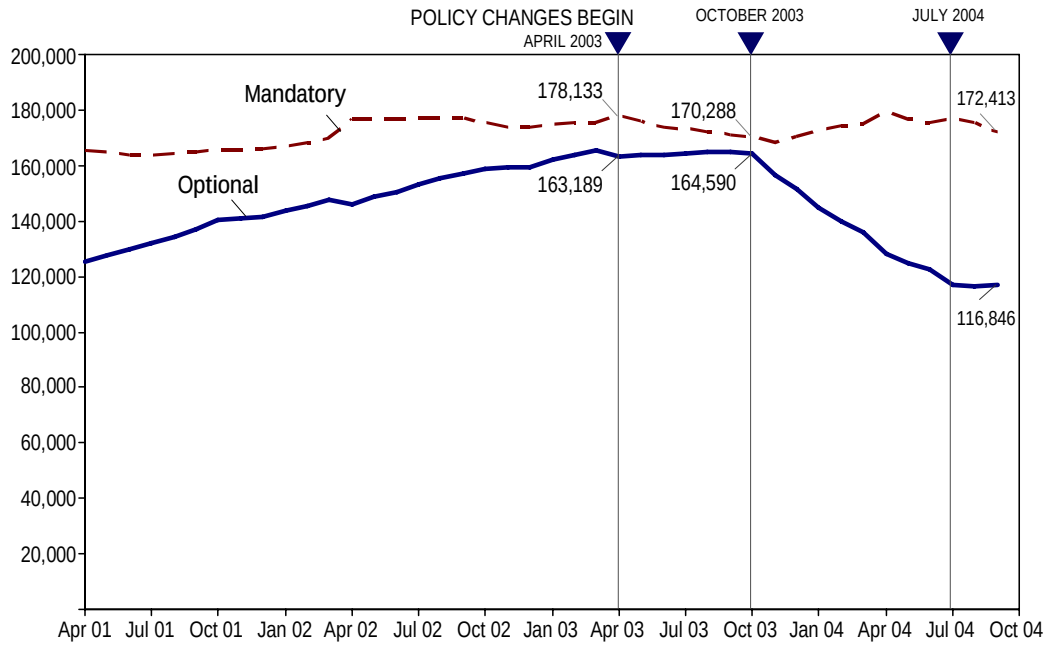
The Optional coverage group grew rapidly in the period leading up to the eligibility changes, increasing from 125,228 cases in April 2001 to 163,189 cases in April 2003 (Figure 3). The Mandatory coverage group generally remained stable over the same period – except for the annual increase in April caused 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.

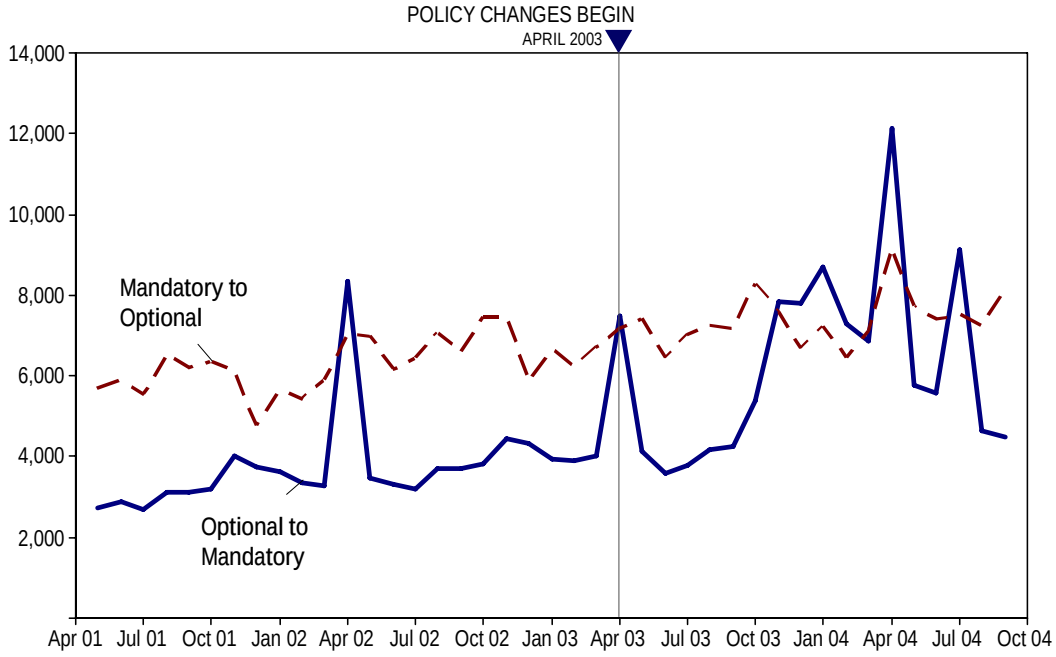
. . . Because Sneede-Kizer Shifted Children to Mandatory Coverage

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.

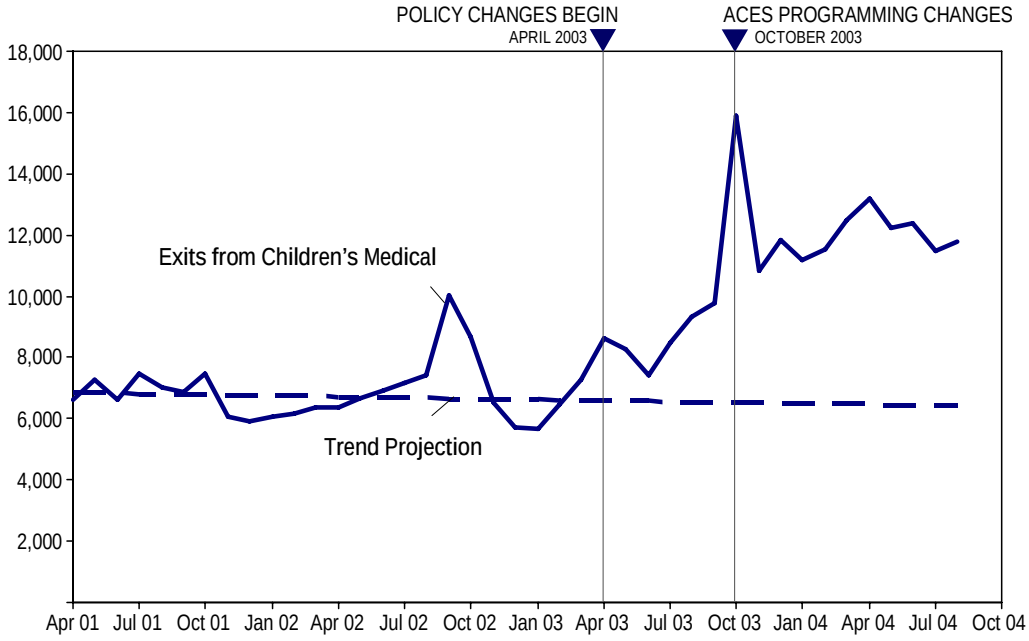
Policy Changes Increased Exits

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

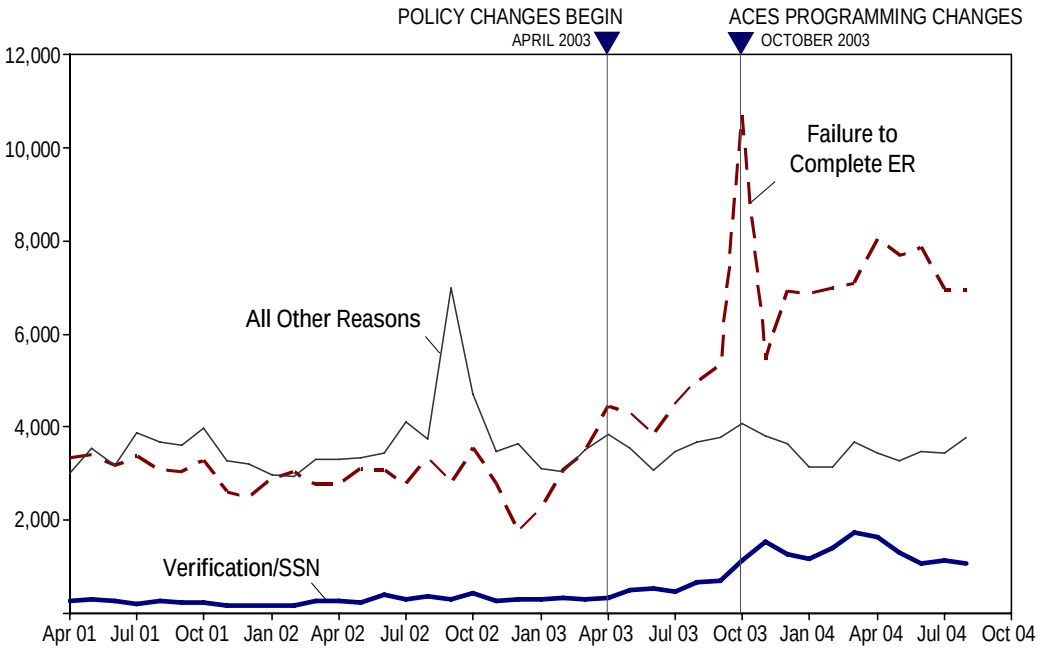
Administrative reasons for exit were extracted from the Automated Client Eligibility System (ACES) and grouped into three categories: (1) failure to complete an eligibility review[10], (2) failure to verify income or provide an SSN[11], (3) and all other exit reasons. Exits due to excess income are almost 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.

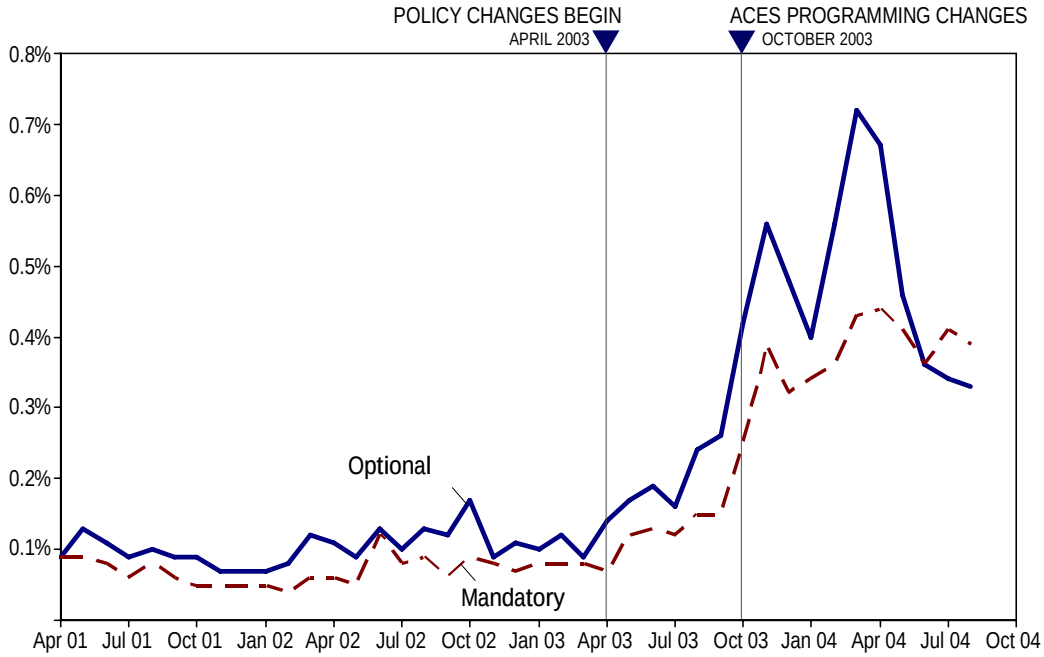
Mandatory Children Now More Likely to Have Verification-Related Exit

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:

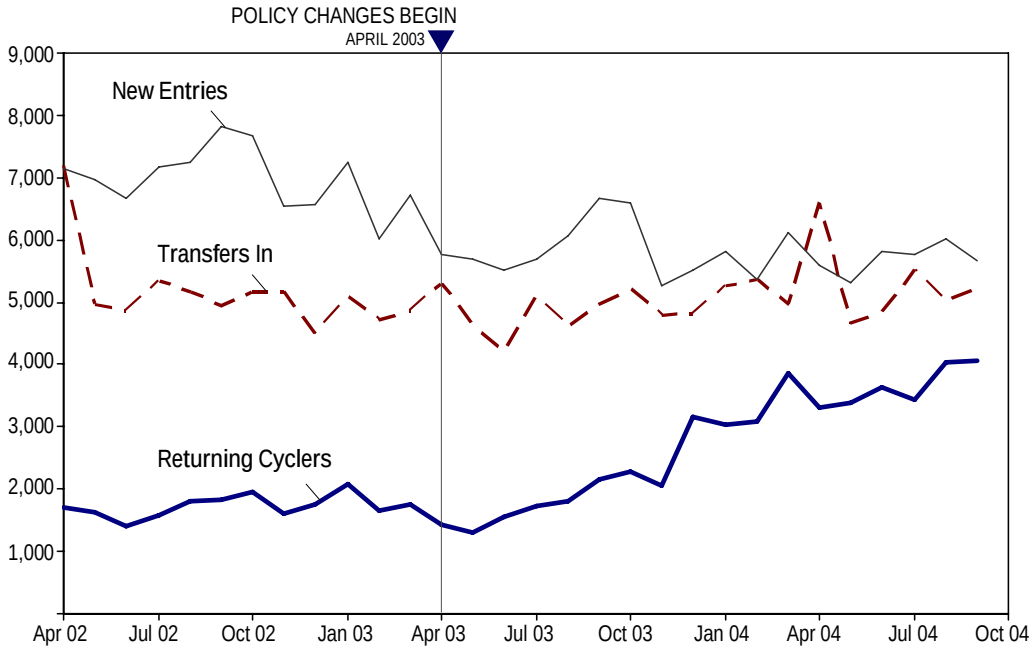
- **Returning Cyclers** – Children returning from a break in Children's Medical coverage of at least one month but not more than 12 months
- **New Entries** – Children who were not eligible for medical assistance in any eligibility category in the previous 12 months
- **Transfers In** – Children who 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.

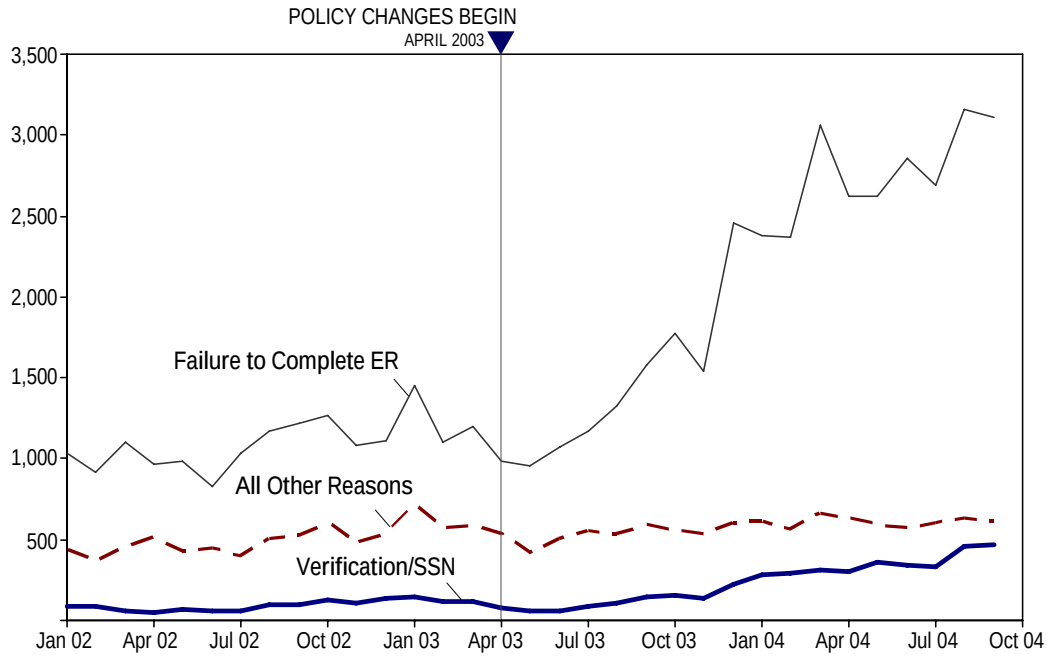
In the year prior to April 2003, 12 percent of exiting children returned to the Children's Medical caseload after a gap in coverage of three months or less. In the April 2003 to September 2003 period, 14 percent of exiting children returned to the Children's Medical caseload after a gap of three months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

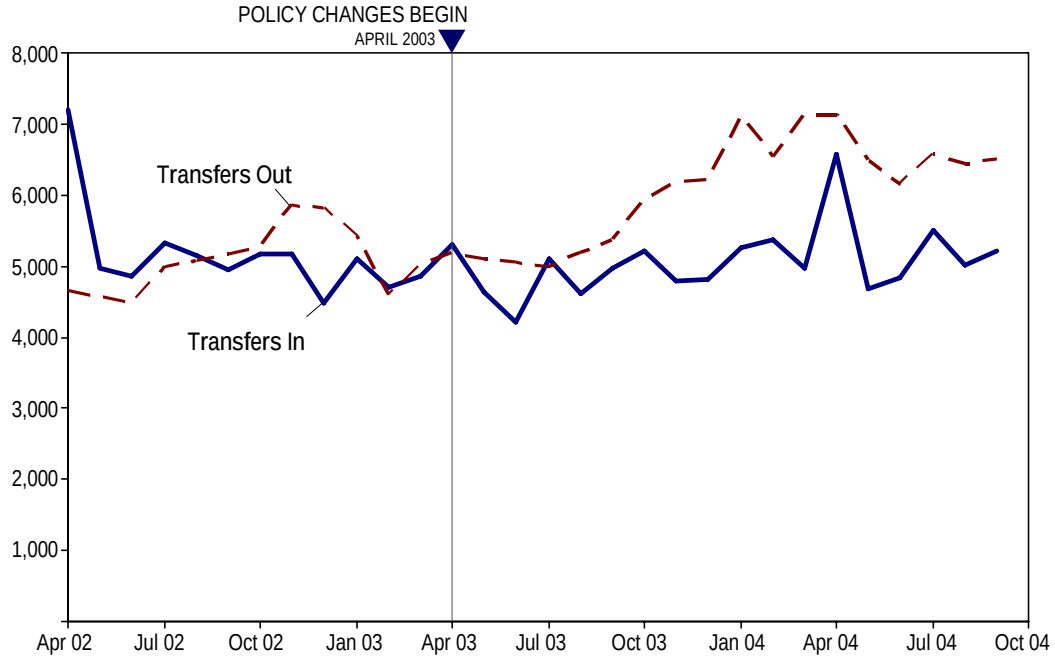
The eligibility policy changes increased the number of children transferring from the Children's Medical caseload to other DSHS medical assistance groups (Figure 10). "Transfers out" include children beginning a new Medicaid or SCHIP eligibility spell who were last eligible for medical assistance on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

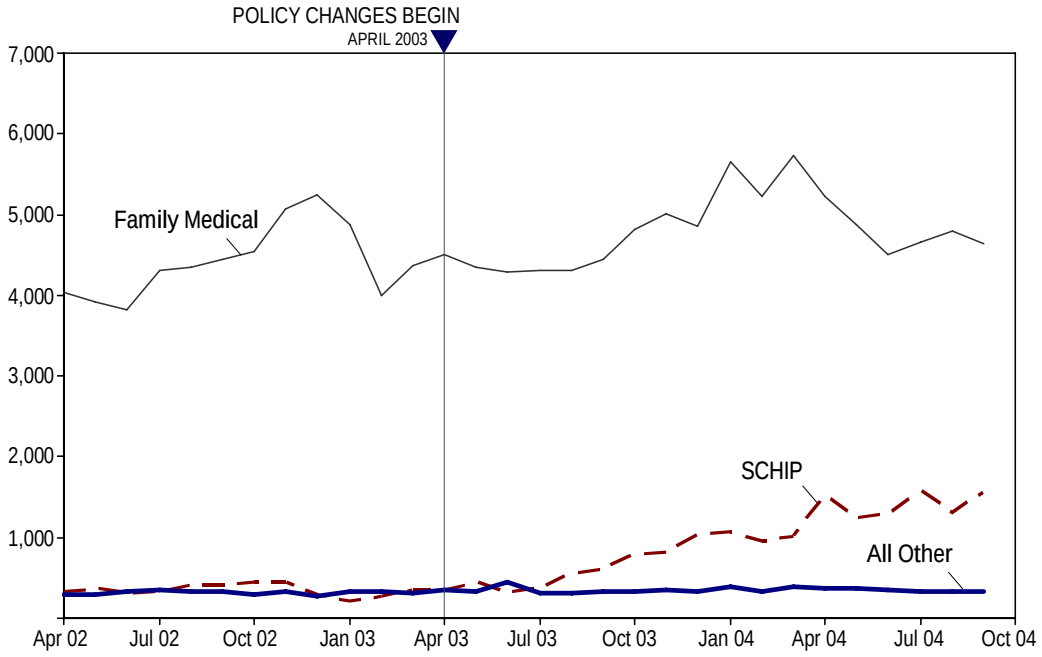
Policy Changes Increased Transfers to SCHIP, Family Medical

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.

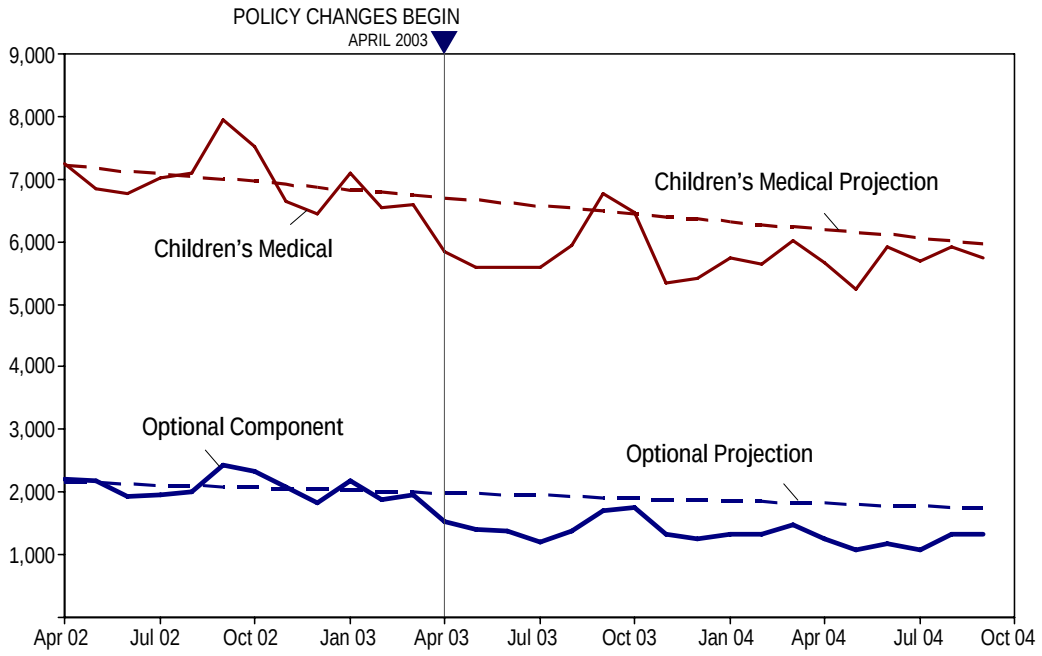
The downward drift in new entries predates the first set of eligibility changes in April 2003 and may be related to earlier reductions in enrollment outreach activities (Figure 12). However, comparing actual new entries to a trend forecast of new entries based on April 2002 to March 2003 data, we find 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



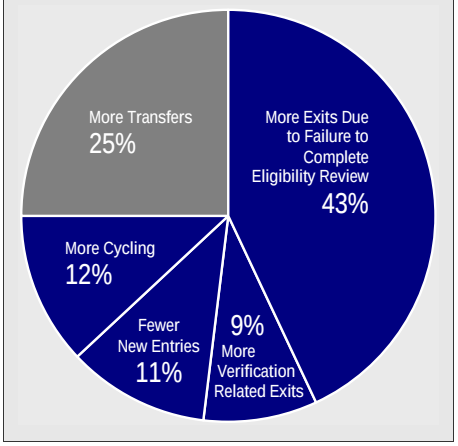
Accounting for the Caseload Decline

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

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