COVERING KIDS AND FAMILIES EVALUATION

Case Study of California: Exploring Medicaid and SCHIP Enrollment Trends and Their Links To Policy and Practice

Final Report

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I. INTRODUCTION

Covering Kids and Families (CKF) is a national initiative funded by the Robert Wood Johnson Foundation (RWJF) that works through state and local coalitions to increase enrollment in public health insurance for low-income children and adults who are otherwise uninsured. The program's strategies are to (1) conduct outreach to children and families without coverage, (2) simplify enrollment and renewal processes, and (3) coordinate existing health care coverage programs. Mathematica Policy Research, Inc., and its subcontractors, the Urban Institute and Health Management Associates, are evaluating the program.

This case study examines the trends in new Medicaid and SCHIP enrollment in California from 2000 through 2004. In particular, we are interested in examining the potential links between new enrollment trends and major outreach strategies or policy changes that took place in California at the state and local level, especially those associated with the CKF grants. Ideally, we would examine such links through a formal impacts analysis that estimates the effect of individual policy changes or outreach efforts on the number of children enrolling in Medicaid or SCHIP. This type of analysis is not possible, however, because many of the outreach efforts and policy changes occurred at the same time. In addition, no state or other geographic area is a defensible comparison group for a more rigorous analysis. The case study approach, which combines exploratory data analysis with in-depth key informant interviews, allowed us to assess the potential influence that major outreach efforts or policy changes have had on new enrollments.

The main source of data for the study is child-level enrollment files from the Medicaid Statistical Information System (MSIS), which we obtained from the Centers for Medicare & Medicaid Services. Using these data, we developed a measure indicating the number of Medicaid "new entries" during each month of the study period. Our definition of a Medicaid

new entry is any child who is newly enrolling in Medicaid who has not been enrolled in the program in the past 12 months. Thus it excludes any child who is reentering the program after a short time.[1] We focus on this new entries measure, rather than on a count of all new Medicaid enrollees or of overall Medicaid enrollees, because it should be particularly sensitive to the effects of major outreach efforts or policy changes associated with new enrollment.[2] The measure therefore provides an excellent basis for examining the role that CKF has played in enrolling children into Medicaid in the state. The measure does not provide an effective means to evaluate trends in overall Medicaid coverage, however, which are affected by children's retention in Medicaid not simply whether they enroll. Likewise, it does not provide a means to evaluate trends in children's health insurance coverage in the state, which are determined by many more factors than Medicaid entry.

With the data, the evaluation team assembled a timeline showing the number of new entries in Medicaid (and total new enrollees in SCHIP) for California from April 2000 through September 2004. This period covers nearly the entire period of RWJF's original Covering Kids (CK) grant to the state (awarded mid-1999) and the first 27 months of the subsequent CKF grant (awarded in July 2002). We also assembled a similar timeline for each local program and for each county the projects served.

[1] Unfortunately, the MSIS data for California do not include children enrolled in its SCHIP program. As a substitute, we have used enrollment data available from public files of the Managed Risk Medical Insurance Board (MRMIB). These public data do not allow us to create a measure of *new entries* to SCHIP, as we have for the Medicaid program. As a result, the trends presented in the report for SCHIP reflect a more traditional measure of *total new enrollment*, which includes not only children who are new entries to SCHIP but also children who transfer from Medicaid or who cycle back onto SCHIP after a short time (less than 12 months). Given this limitation, the findings we present on SCHIP trends are more limited than those for Medicaid.

[2] In addition, within the Medicaid program, we focus on new-entry children whose program eligibility is based on income. (For example, children in the poverty expansion eligibility group or one of the eligibility groups related to Temporary Assistance for Needy Families). Outreach efforts and enrollment simplification policies are more likely to affect these children than those enrolled for other reasons, such as disability or foster care status.

In June 2005, we discussed these data during detailed interviews conducted with the state CKF grantee, state officials, and selected local CKF projects. During these interviews, we asked informants to identify the key changes that occurred in state and local policies and outreach practices during the observation period and whether and how these might account for the trends seen in new entries. Other sources, including an earlier site visit to California conducted in June 2003, the CKF Online Reporting System, program documents, and demographic and economic data from the Bureau of Census and from the Bureau of Labor Statistics, provided additional insights.

II. STATE POLICY CONTEXT

During the study period, California experienced both major economic changes and changes related to public health insurance coverage for children (Table 1). Up until early 2001, California enjoyed a strong and growing economy and, with the support of Governor Gray Davis, the state enacted major expansions to children's health coverage and large investments in outreach and enrollment simplification under SCHIP and Medi-Cal for children. However, by mid-2001, the state began to experience an economic downturn, leading to an eventual loss in state revenues and pressure to reduce spending on public health coverage and other state-funded programs.

The first major programmatic changes took place in July 1998, when California enacted a combination SCHIP program with a Medicaid-expansion component and a new separate SCHIP component known as Healthy Families. The adoption of the Medicaid-expansion component accelerated the federally mandated expansion of Medi-Cal coverage to include children up to age 19 with family incomes at or below 100 percent of the federal poverty level (FPL) and eliminated the assets test for poverty-level coverage under Medi-Cal. The original Healthy Families program covered children with family incomes between 100 and 200 percent of FPL,

TABLE 1

KEY EVENTS IN CHILD HEALTH COVERAGE IN CALIFORNIA
(1997–2003)

1997	California submits Title XXI state plan: - Accelerates phase-in of federally mandated coverage of Medi-Cal to children up to age 19 with family incomes at or below 100 percent of FPL. - Eliminates the assets test for poverty-level coverage under Medi-Cal. - Expands Access for Infants and Mothers (AIM) to infants up to age 1with family incomes between 200 to 250 percent of FPL. - Introduces California's SCHIP program, Healthy Families, covering children ages 1 to 19 with family incomes from 100 to 200 percent of FPL. - Plan includes mass media campaign, outreach contracts with community organizations and schools, and a Certified Application Assistant program.
March 1998	Medicaid expansion implemented.
July 1998	Healthy Families program implemented.
January 1999	Governor Gray Davis takes office.
July 1999 – June 2002	Robert Wood Johnson Foundation's (RWJF's) Covering Kids Initiative (CK).
July 1999	SCHIP Amendment #3 expands income eligibility for Healthy Families up to 250 percent of FPL.
January 2002	Section 1115 Health Insurance Flexibility and Accountability (HIFA) waiver is approved to provide two months of interim coverage for children transitioning from Healthy Families to Medi-Cal and one additional month for children transitioning from Medi-Cal to Healthy Families.
July 2002 – June 2006	RWJF's Covering Kids and Families (CKF) Initiative: - Community Health Councils in Los Angeles is the lead agency for the state coalition. - Four local pilot projects are located in Fresno, Lake County, Riverside County, and Humboldt and Del Norte counties.
July 2002	Elimination of: - Mass media campaigns. - Outreach contracts to community organizations and schools.
January 2003	SCHIP Amendment #7: - Expands coverage to 300 percent of FPL for children in Alameda, San Francisco, San Mateo, and Santa Clara counties through the County Children's Health Insurance Program. - Expands coverage to children up to age 2 born to mothers enrolled in AIM with incomes up to 300 percent of FPL.
July 2003	SCHIP Amendment #9 allows the state to provide presumptive eligibility to children with family incomes from 100 to 200 percent of FPL through the Child Health and Disability Prevention (CHDP) program (CHDP Gateway). State introduces Express Lane Eligibility (ELE) pilot program to use information from the National School Lunch Program to facilitate Medi-Cal application. Elimination of $50 Certified Application Assistant fee incentive. Freeze on SCHIP reimbursement rates.
November 2003	Governor Arnold Schwarzenegger takes office.

Sources: Centers for Medicare and Medicaid Services website: www.cms.hhs.gov Accessed December 12, 2005; Hill, Ian, and Corinna Hawkes. "Congressionally Mandated Evaluation of SCHIP: Site Visit Report on The State of California's Healthy Families Program." Princeton, NJ: Mathematica Policy Research, Inc., November 2002.

but in July 1999 the state raised the income threshold to 250 percent of FPL through income disregards.

To encourage enrollment in these new programs, the state undertook aggressive outreach by enacting a major statewide media campaign to promote Medi-Cal and the new Healthy Families program and contracting with community-based organizations and schools to find and enroll eligible children in Medi-Cal and Healthy Families. It also began the Certified Application Assistant program, which provided $50 per successfully enrolled application as an incentive to community based organizations that offered application assistance to parents completing Medi-Cal and Healthy Families applications. In addition, the state began allowing health plan staff to receive Certified Application Assistant training, and some plans participated in outreach and application assistance.

In January 2002, the state gained approval for a Section 1115 HIFA waiver to provide two months of interim SCHIP coverage to children transitioning between Healthy Families and Medi-Cal and one month of interim coverage to children transitioning from Medi-Cal to Healthy Families when a child is no longer eligible for no cost, full scope Medi-Cal. In July 2002, budget shortfalls led the state to eliminate its state-sponsored mass media campaigns and outreach contracts to community-based organizations and schools. In January 2003, a SCHIP amendment expanded eligibility up to 300 percent of FPL for children in four counties and expanded eligibility from 250 to 300 percent of FPL for children up to age two in the Access for Infants and Mothers (AIM) program.[3]

In 2003, the state adopted a series of additional policy changes. The state enacted a major simplification policy in July 2003 by allowing presumptive eligibility through its Child Health

[3] AIM is a state-funded program providing coverage to pregnant women and their newborns up to age 2 living in families with incomes below 300 percent of FPL who are not eligible for Medi-Cal.

and Disability Prevention (CHDP) program (California's Early and Periodic Screening, Diagnostic, and Testing component of Medi-Cal). Prior to this policy change, uninsured children could receive preventive screening services through a state-supported program similar to CHDP. With the policy change, entitled CHDP Gateway, providers could review the family incomes of these uninsured children and, if appropriate, declare them presumptively eligible for either Medi-Cal or Healthy Families. Any care rendered to the child during the visit or during the current and future months is covered by federal and state Title XXI dollars. In addition, the state introduced Express Lane Eligibility (ELE), which allowed the use of a modified National School Lunch Program application to determine initial eligibility for the National School Lunch Program and Medi-Cal. To address the potential cost of these new policies, however, the state cut back further on its outreach by eliminating the $50 application assistance fee. The state also froze payment rates to contracted SCHIP health plans.

III. HISTORY OF COVERING KIDS (CK)/CKF PROGRAMS IN CALIFORNIA

Community Health Councils, Inc., the lead Covering Kids grantee from July 1999 through June 2002, is an advocacy organization dedicated to increasing health care access for uninsured and underinsured populations in Los Angeles County and throughout the state. The three local pilot projects under Covering Kids included a university (University of California at San Diego, Department of Pediatrics), an organization that provided training services for other community-based organizations (Health Access, based in Oakland), and a rural community services organization (Sutter Lakeside Community Services).

In September 2001, Community Health Councils submitted its application for CKF funding to extend the work begun under Covering Kids. RWJF awarded Community Health Councils a

$1.2 million grant that began in May 2002. Half of the grant was allocated to state-level activities and half to four local projects, two of which are included in this study:[4]

- ***The Multi-Cultural Community Alliance of Fresno*** is a coalition of 12 community groups, 2 media partners, the Fresno County Human Services System (the county TANF/Medicaid agency), and a local health plan. The coalition focuses on outreach and enrollment efforts to minority groups.
- ***Sutter Lakeside Community Services*** is a non-profit community services agency, located in Lakeport, that focuses on teen pregnancy, child abuse, rape crisis, domestic violence, and health insurance outreach. The organization began in 1995; before receiving the CKF grant in 2002, it was a CK grantee. In 2003, its coalition consisted of 12 community partners, including community-based family health and education organizations.

During the time that it served as the state CK grantee, Community Health Councils trained Certified Application Assistants and collaborated with the state Department of Health Services (DHS) and the Managed Risk Medical Insurance Board (MRMIB) on effective implementation of the Healthy Families program. More recently, as the state CKF grantee, Community Healthy Councils has focused on building capacity among the various outreach groups across the state (CKF and non-CKF) and on facilitating communication between the local outreach groups, state CKF coalition members, and state policy officials. For example, Community Health Councils convenes regular meetings in Sacramento between state Medi-Cal and Healthy Families officials and local outreach groups from around the state. Through participation in the meetings, the outreach groups have been able to share their experiences and challenges with state policymakers and with one another and to learn about new policies directly from the state agencies that create them. Late in 2002, as budget pressure mounted in the state and the opportunity to build

[4] We selected these two projects because of positive information we received about their activities during an initial site visit to the state in 2003. The other two local CKF projects, not included in this case study, are the Riverside County Department of Public Health and the North Coast Clinics Network in Humboldt and Del Norte counties.

outreach capacity declined, Community Health Councils shifted its emphasis to enrollment simplification and coalition-building at the state level.

IV. STATE-LEVEL FINDINGS

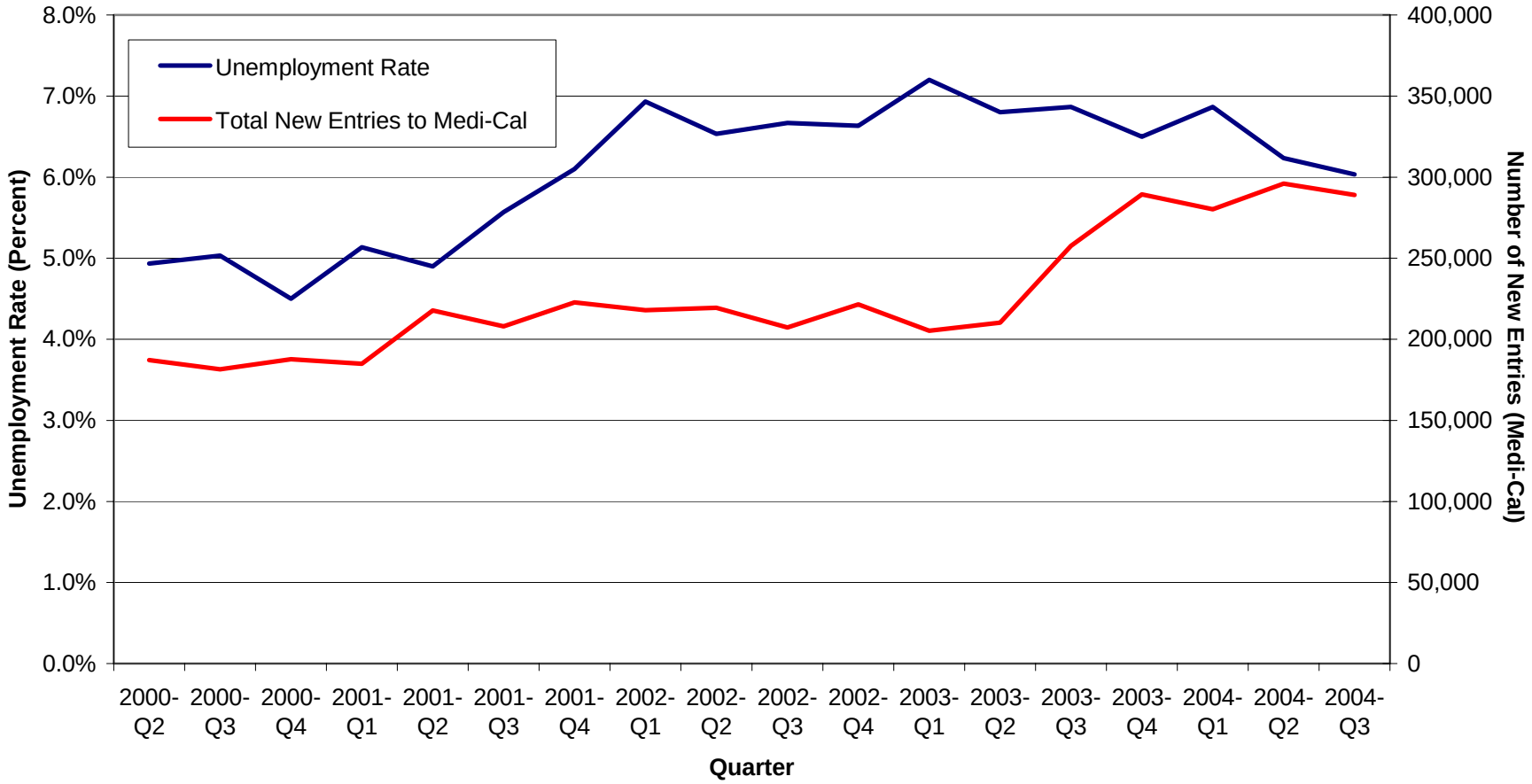
Economic Trends. The economy often has a major influence on public health insurance enrollment. Typically, as economies worsen, more families enroll their children in public coverage. However, as seen in Figure 1, there is no clear link evident between economic conditions and the numbers of children entering coverage in California.[5]

In early 2001, the state went into recession, and the unemployment rate rose sharply from four percent at the start of 2001 to seven percent by the start of 2002. For the next three years, from 2002 through 2004, the economy remained sluggish, and unemployment held constant at around seven percent. This economic downturn would be expected to increase the numbers of children newly *eligible* for Medicaid. However, during this three year period, the number of *new entries* to Medi-Cal did not increase. In fact, starting at the end of 2001, the number of new entries actually began a slow but steady decline—from about 200,000 new entries in the last quarter of 2001 to about 170,000 new entries in the third quarter of 2004.[6] This trend could suggest that the number of new entries in California is largely unrelated to economic conditions,

[5] Because we cannot measure the number of new entries in Healthy Families, Figure 1 focuses only on new entries in Medi-Cal. Figure 1 also does not include children in the "Other Child" Medicaid eligibility category. As discussed below, this eligibility group experienced a dramatic rise in new entries after the adoption of the state's CHDP-Gateway program in 2003. Previously, these children would have received screening and preventive services through a state funded program and so are not included in the totals for Figure 1.

[6] Despite the flat trend in new entries, estimates from the California Health Interview Survey (CHIS) indicate that the percentage of low-income children with Medicaid coverage rose from 2001 to 2003 and the percentage of low-income uninsured children fell. This suggests that while Medicaid was not adding more new children to the program after the economic downturn, it was retaining them at a higher rate. A future report will explore retention in the state's Medicaid program and their links to state policy and the activities of the CKF grantees.

Figure 1
Unemployment Rate and New Entries to Medi-Cal
April 2000 - September 2004



Source: Medicaid Statistical Information System and Bureau of Labor Statistics
Note: New entries are children enrolling in Medicaid for the first time in the past 12 months. The chart focuses only on children enrolling in Medicaid due to data limitations in estimating the number of new entries to Healthy Families (SCHIP).

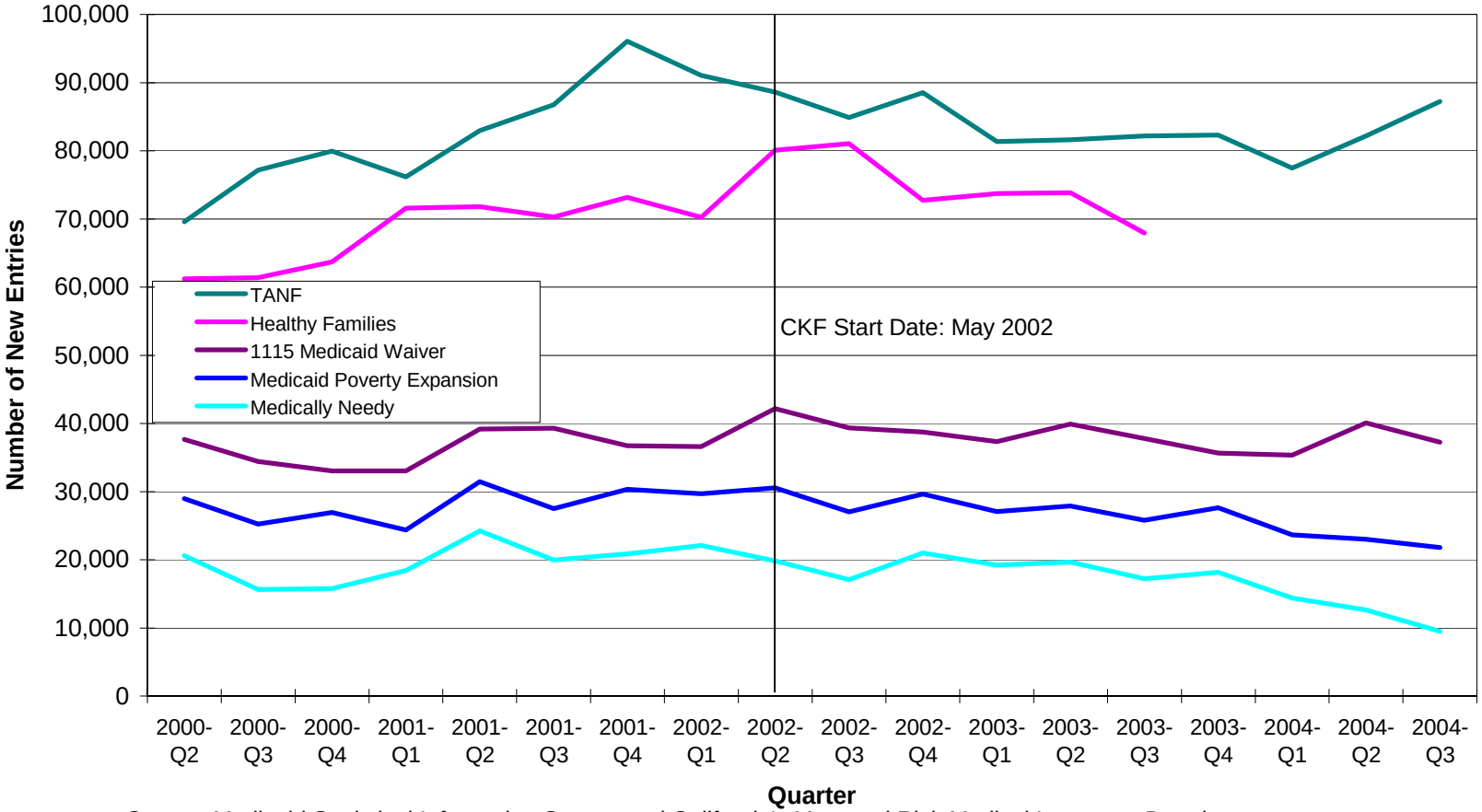
which seems unlikely, or that other factors led to a dampening in the number of new entries as the state's economy worsened.

Links Between Enrollment and State Policy Changes. Looking at the enrollment trends for selected eligibility groups, there is some evidence of a link between economic conditions and enrollment, but it is not consistent (Figure 2).[7] For example, for the TANF/1931(b) group within Medi-Cal, perhaps the most sensitive to economic conditions, the number of new entries rises as the economy worsens during 2001, but then it falls during 2002 despite persistence in the economic downturn. In fact, from 2002 onward, the number of new entries for each of the eligibility groups shown in Figure 2 either trends downward or remains unchanged, suggesting that factors other than the economy were influencing these trends.

One potential factor is the major cutbacks in outreach that took place in mid-2002, around the time that the number of new entries in all the eligibility groups begins to decline. Until this time, California had a well-funded outreach and information campaign. However, in 2002, the state cut its mass media campaign and eliminated all of its community- and school-based outreach contracts. Policymakers had aimed to avoid cutting eligibility for Medi-Cal and Healthy Families, and faced with a declining state budget, chose to adopt these cutbacks instead. The downward trends in Figure 2 suggest that these cutbacks slowed the numbers of children entering public coverage in the state. Indeed, in 2003, when the fee incentive for Certified Application Assistors was eliminated, we see a further decline in Healthy Families enrollment.

[7] As noted previously, due to data limitations, the trend shown for Healthy Families reflects all new enrollees. It thus includes not only new entries (children enrolling in Health Families who have not been enrolled for at least 12 months) but also the other types of new enrollees (namely, children transferring from Medi-Cal and children re-enrolling in SCHIP within 12 months). In addition, the trend shown Healthy Families covers only the period of available data, through the third quarter of 2003.

Figure 2
Public Health Coverage New Entries by Quarter
April 2000 - September 2004



Source: Medicaid Statistical Information System and California's Managed Risk Medical Insurance Board

Note: New entries are children enrolling in Medicaid for the first time in the past 12 months. Due to data limitations in estimating the number of new entries to Healthy Families (SCHIP), the numbers shown for Healthy Families reflect the trend in all new enrollment (not just new entries). The other groups shown include all the major eligibility categories within Medi-Cal except for the "Other Child" group, which is displayed separately in Figure 3.

CHDP Gateway Enrollment. The remaining Medi-Cal eligibility category, shown separately in Figure 3 because of its distinctive trend, is the "Other Medicaid—CHDP Gateway" group. Like other eligibility groups, the number of new entries in this group remains roughly unchanged from 2000 through 2002. However, starting in 2003, the number of new entries grows dramatically from just 20,000 in the second quarter of 2003 to more than 120,000 in the second quarter of 2004.

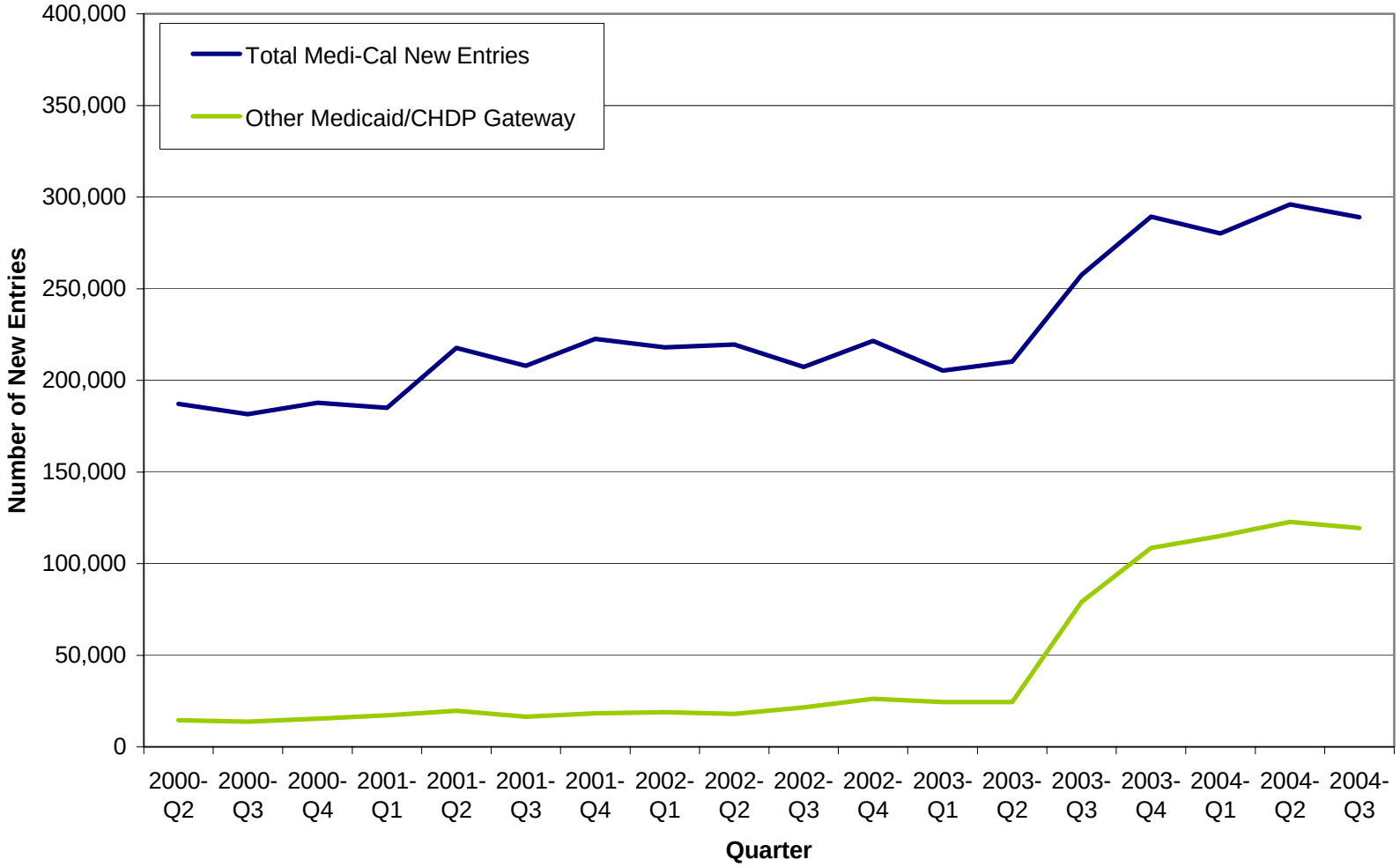
This sharp rise in new entries corresponds exactly with the state's adoption of the CHDP Gateway in July 2003, which offered two months of presumptive Medi-Cal eligibility to uninsured children seeking medical care. This rise would seem to indicate that the Gateway program has been very successful at increasing the number of publicly covered children in the state. However, additional analysis finds that fully two-thirds of these new entries were enrolled for four months or less (not shown), suggesting that the parents of many presumptively eligible children failed to complete an application for permanent Medi-Cal or Healthy Families coverage.[8] Thus, despite having some success, the program appears to be missing an opportunity to extend full coverage to a larger number of uninsured children.

V. LOCAL-AREA FINDINGS

The case study focused on local areas served by two of the four CKF local grantees—the Fresno Multi-Cultural Community Alliance and Sutter Lakeside Community Services. We also studied the area served by a non-CKF project in Sonoma County—the Sonoma County Health and Human Services Department. Sonoma had received funding from the California Health Care

[8] This eligibility category also includes children with undocumented immigration status, who receive a limited set of benefits under the state's Emergency Medi-Cal program. We do not know how many of the new entries who continued coverage beyond the four month period fall into this undocumented/limited benefit group. However, the number may be large, as only a small number of children transitioned from this "other child" code into an eligibility code (TANF, Medicaid-expansion, and so forth) that would typically be used for children with full-benefit coverage.

Figure 3
New Entries to Medi-Cal in the "Other Child-CHDP" Eligibility Group,
April 2000 - September 2004



Source: Medicaid Statistical Information System
Note: New entries are children enrolling in Medicaid for the first time in the past 12 months.

Foundation to conduct outreach and application assistance for the county and, using state funding, also employed Certified Application Assistants. Although its resources differ, the County's goals are similar to those of the local CKF projects.

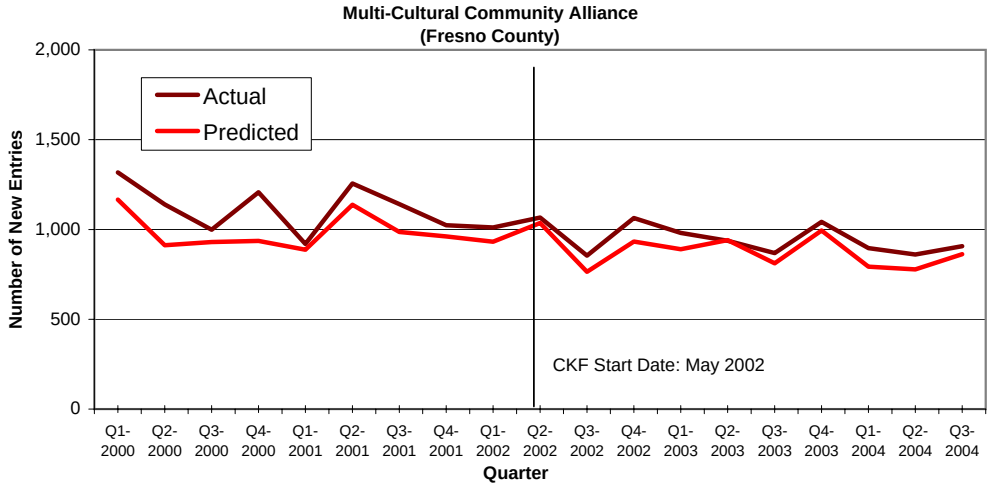
Links Between Enrollment and Local Projects. To explore the possibility that local outreach activities by the CKF and non-CKF projects may have had an effect on the number of children enrolling in public coverage, we compared the trend in new entries in each of the three local areas with the trends we would have expected based on those in other parts of the state.[9] If the actual trend in the three areas exceeded our expectations, it suggests that local outreach activities were relatively more successful than outreach activities elsewhere in the state.

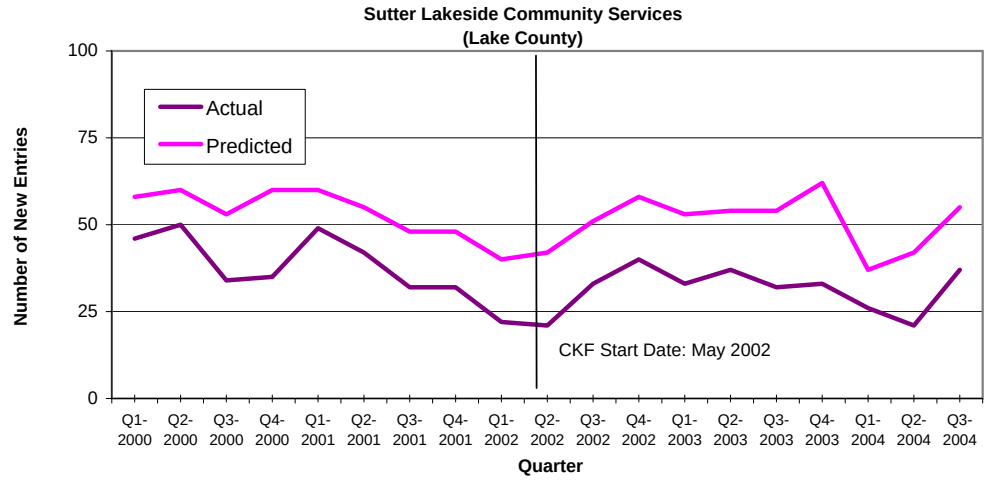
Findings from Fresno show that the number of new entries tended to exceed the number expected, though most differences were small and typically took place before the start of CKF funding (Figure 4, top). The largest difference, in fourth quarter of 2000, was about 19 percent, but the average difference was only about 5 percent. For Sutter Lakeside, the findings are the opposite, with the number of new entries consistently lower than expected (Figure 4, middle). Because the county is rural with a small population, the nominal difference between actual and expected new entries is modest, amounting to no more than 20 enrollees in a quarter.

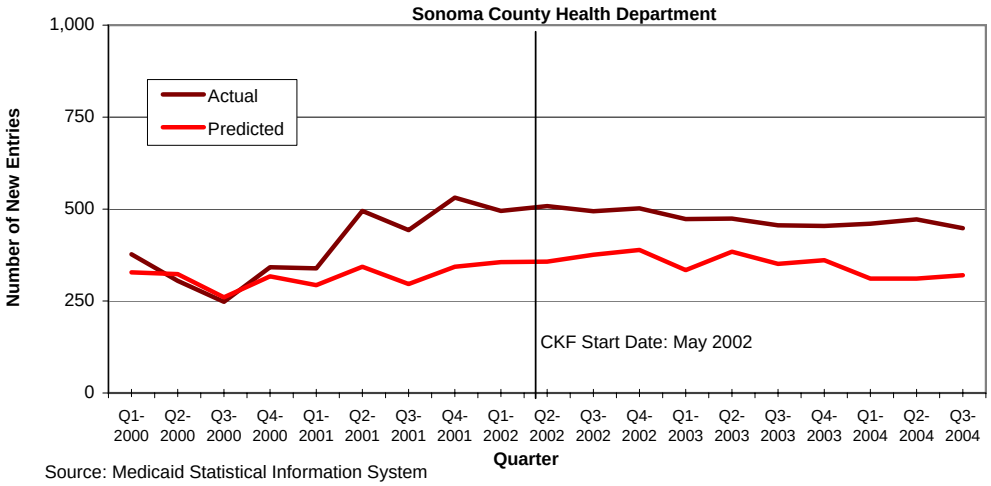
The third area that we examined, Sonoma County, though not a CKF grantee, does display a trend in new entries that is consistently higher than expected, suggesting relative success at enrolling children into coverage (Figure 4, bottom). From the fourth quarter of 2000 forward,

[9] Expected enrollment is based on a forecasting model that predicts, for each county and city in the state, the number of new entries in Medi-Cal in each quarter. Inputs to the model include the demographic characteristics of children and families in the county, most notably the number of children below 200 percent of FPL, and the population that has just moved into the county from out of state. All of these variables are obtained from Census data; some but not all are time varying (depending on whether Census updated them after 2000). The model also includes the local unemployment rate, obtained from Department of Labor statistics. In order to maximize the opportunity to detect successful outreach efforts, we focused on the two Medi-Cal eligibility groups, TANF and Medicaid-expansion, that we expect to be most responsive to them.

Figure 4
New Entries to Medi-Cal
Local Areas: Actual versus Predicted
January 2000 - September 2004







Source: Medicaid Statistical Information System
Note: New entries are children enrolling in Medicaid for the first time in the past 12 months.

the actual number of new entries exceeded the number expected by as much as 37 percent (in the fourth quarter of 2001) and averaged nearly 20 percent above expectation across the entire time period.

Differences Among Local Projects. In light of these findings, we sought to understand how the three local projects differed and whether the relatively favorable trend seen in Sonoma might be explained by any notable outreach efforts in the area. Interviews with stakeholders in each community suggest only modest differences in the various outreach strategies being implemented across the communities. However, there were differences in the staffing levels to support these strategies. Each project's outreach efforts are described below.

The Fresno Multi-Cultural Community Alliance has conducted a number of large-scale outreach events, most often focused around the state Back-to-School and Cover the Uninsured Week initiatives. The project has also worked on application simplification and on Express Lane Eligibility. Those we spoke to at the Alliance suggested that the loss of the state contract for outreach funding in 2002 was a significant setback. Their CKF proposal had assumed that state money would still be available, so when it became clear that this would not be the case, they conducted an internal self-assessment. Although they had less funding to support direct service staff, they still had their partnerships and an active infrastructure for referrals. Building on these strengths, the Alliance continued to work with its partners and remaining Certified Application Assistants to conduct outreach during tough budget times.

Sutter Lakeside Community Services is a local grantee that conducts outreach targeted to various low-income populations in Lake County. Its main outreach strategies have been to target schools, businesses that do not offer health insurance, doctors' offices, and community fairs; staff members also do "in-reach" with their existing clients who visit Sutter Lakeside for other reasons. In schools, they conduct on-site outreach and enrollment and have worked with school

nurses to identify children at high risk for being uninsured. For these children, a Sutter Lakeside worker follows up with parents to get children enrolled in public programs. A Certified Application Assistant makes rounds to all area businesses twice a year to post materials about Medi-Cal and Healthy Families and offers to give presentations on the programs. She also makes regular visits to the three casinos in the county to talk with employees about children's coverage. Other outreach strategies have included public service announcements in local newspapers, on the radio, and on television as well as mass mailings to area residents.

In Sonoma County, before the economic decline in 2001–2002, the Health and Human Services Department outstationed workers in all but one of the county's hospitals and in all its Community Health Centers. State outreach cutbacks in 2002 led to a 23 percent decline in funding, which in turn led to a departmental reorganization. The department reduced Certified Application Assistant hours and eventually also reduced the number of Certified Application Assistants working in the county. In need of more funding, the department sought and received a grant from the California Healthcare Foundation for a program called "First Things First." This funding allowed Sonoma to do additional outreach and enrollment work; in doing so, staff members realized that their Certified Application Assistants needed more training. This spurred yet another new project, "Project Reach Out," which supported a training program for Certified Application Assistants to help them better answer families' questions, complete applications correctly, maintain contact with families, and other skills. The findings above suggest that these new funding sources, and the additional programming that resulted, were effective at countering the loss of state funding; Sonoma County's Medi-Cal enrollment rate continued to grow at greater-than-expected levels throughout the study period.

Sonoma does not appear to have used markedly different strategies than the CKF grantees. However, it does appear to have implemented its strategies relatively well, in part because of its

success gaining new funding for its Certified Application Assistors. Sonoma has excellent, mutually supportive relationships between community clinics, the county social services agency (responsible for Medi-Cal eligibility), and the health department. Close communication between eligibility and outreach workers from Sonoma allows effective problem-solving when problematic eligibility issues arise. One person at the health department coordinates all the applications it receives from Certified Application Assistants, which promotes consistency. Sonoma has had most of its Certified Application Assistants since 1998, and this stability, plus training, has also helped them develop a high level of expertise over time. Thus, it appears that the County has been relatively successful at finding and enrolling eligible children for public programs largely because of strong relationships with other local stakeholders and operational expertise that improved over time.

VI. CONCLUSIONS

This case study suggests that changes in state policies related to state and local outreach had important effects on the numbers of children obtaining public health coverage in California. During a severe economic downturn when public program eligibility was expanded and simplified—events that should have spurred significant public program growth—new Medi-Cal and Healthy Families enrollment grew little. Reduced state funding for outreach and application assistance appears to be an important source for this stagnation. During the same period that the state's economy worsened, California ended financial support for conducting outreach and application assistance to schools and community-based organizations. Shortly thereafter the state eliminated its support for the Certified Application Assistant program. These cuts in application assistance, along with cutbacks in statewide media, seem to have blunted new enrollment growth, suggesting that, at the time they were funded, these activities played an important role in expanding coverage in the state.

The negative effects of these cutbacks might have been even more pronounced had it not been for the presence of local outreach projects, both CKF and non-CKF supported, as well as the work of the state grantee. Local projects are uniquely positioned to identify appropriate times and places for targeted outreach and to provide resources to the community that would otherwise not be available. These resources include both monetary and non-monetary resources, such as capable staff and strong relationships with other community stakeholders. Outreach workers from the Sonoma County Health Department, for example, developed a close relationship with the county clinics, providing them an effective means to reach and enroll eligible families.

The state grantee is credited with greatly facilitating communication between state and local health officials involved with outreach and enrollment, leading to improvements in available outreach programs. Community Health Councils' monthly meetings with state and local officials in Sacramento were cited as particularly useful in clarifying policy changes and their potential implications for localities. According to staff of the Fresno project, there is "standing room only" at the meetings with state Medi-Cal and Healthy Families officials. When leadership changed at Sutter Lakeside, the new program director found these meetings invaluable in helping her project transition to new roles under changing state policies.

Finally, our analysis of new enrollment trends illustrates both the potential and the limitations of the state's presumptive eligibility initiative, CHDP Gateway. The Gateway was created as a means of extending short-term, federally funded eligibility to children who receive preventive care from CHDP providers and are judged by those providers to likely be eligible for full-scope Medi-Cal or Healthy Families coverage. Our analysis shows how the adoption of presumptive eligibility can generate rapid enrollment among its target population.

Unfortunately, it also suggests that, without additional steps to facilitate the application process for full coverage, a high proportion of those enrolled in the program will quickly leave.