

Bridging the Gap: Continuity and Quality of Coverage in Medicaid

Leighton Ku, PhD, MPH, and Erika Steinmetz, MBA
Department of Health Policy
School of Public Health and Health Services
George Washington University

September 10, 2013



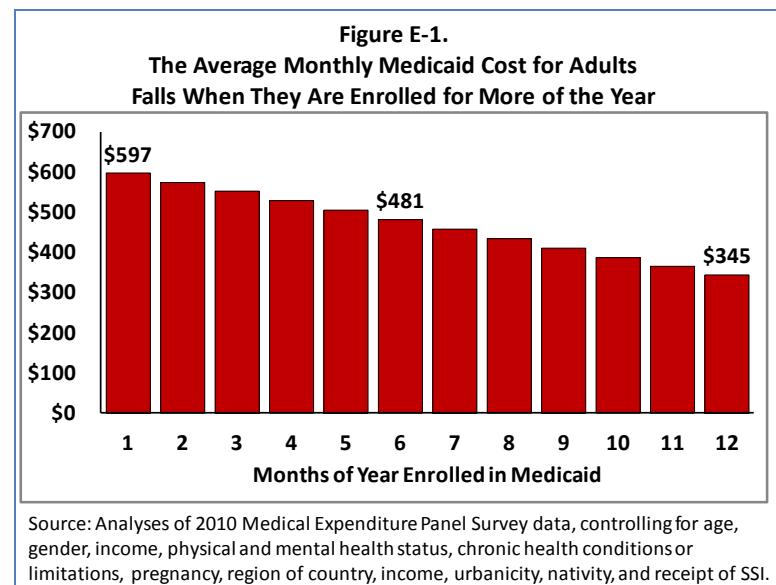
Executive Summary

Medicaid provides insurance coverage to help tens of millions of low-income children, adults, elderly and individuals with disabilities access affordable health services. The Affordable Care Act (ACA) establishes an array of improvements in Medicaid, including allowing states to expand coverage to millions of additional low-income adults beginning in 2014.¹ Nonetheless, Medicaid can be like a leaky sieve: every year millions of people enroll, only to subsequently lose their coverage, even though they are still eligible. Even if they reapply later, they may experience gaps without insurance coverage. The turnover of beneficiaries entering and exiting Medicaid is sometimes called “churning.”

On average, a typical Medicaid beneficiary is covered for four-fifths of the year and lacks Medicaid coverage for the remaining fifth of a year. Gaps are more common for non-elderly adults and less common for children, the elderly and those with disabilities. Interruptions can be caused by many factors including: minor fluctuations in income, failure to submit periodic reports to update records about income or other factors, or being unable to renew enrollment on a timely basis.

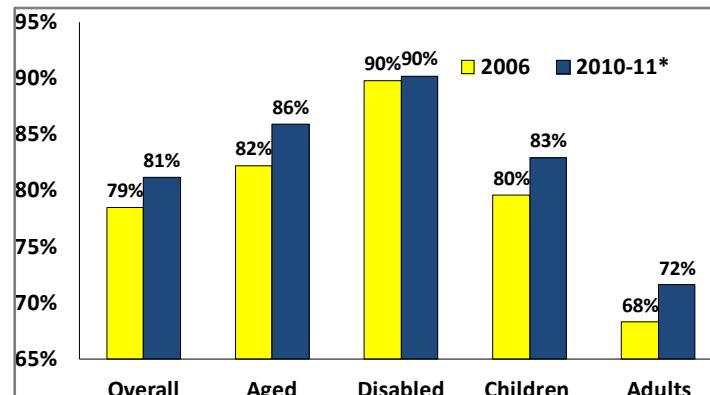
Interruptions in Medicaid coverage frustrate both patients and their health care providers and can compromise the continuity and effectiveness of care. Research has shown that churning and insurance gaps lead to higher use of emergency rooms and psychiatric facilities, greater onset of health problems (e.g., asthma, diabetes problems) that could have been managed with ambulatory care and lower rates of cancer screening and early detection. Moreover, when parents have insurance gaps, it is more likely that their children will also have gaps.

If low-income patients are unable to afford to see physicians or fill their prescriptions for even a month or two, they can become sicker and eventually require emergency room or hospital inpatient care. Doctors and hospitals are frustrated and may lose money if they are not paid because a patient’s Medicaid eligibility has lapsed for a brief period. There are cost-effective ways to provide more security to Medicaid beneficiaries and providers and to improve the effectiveness of the care they receive. New analyses of data from the Medical Expenditure Panel Survey demonstrate that when beneficiaries are enrolled in Medicaid for longer periods, the average monthly cost for their care declines. For example, the average monthly Medicaid cost for the care of an adult falls by 22 percent when the length of enrollment rises from six months of the year to 12 months (Figure E-1).



Medicaid continuity has improved slightly in recent years. In 2006, the overall level of continuity over the year was 78 percent, but grew to 81 percent by 2010-11 (Fig E-2). In part, this gain was due to operational changes made by some state Medicaid programs. For example, seven states adopted policies of 12 month continuous eligibility for children in Medicaid, spurred by the passage of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 and a recent study shows this led to significant increases in the continuity of coverage.² States have the option to guarantee 12 months of continuous eligibility to children in Medicaid. Unfortunately, no comparable option exists for adults.

Figure E-2.
**Changes in Medicaid Continuity Ratios,
2006 to 2010-11**



Note: Analyses of Medicaid Statistical Information System data. 2006 data are all from FY 2006, but 2010/11 data are a blend of data from FY 2009 to 2011.

Insurance gaps also have implications for Medicaid quality. Measurements of clinical quality – which assess the extent to which patients receive medically appropriate care -- are usually based on patients who are continuously enrolled for a year or more. Thus, lengthening enrollment strengthens the ability to monitor and improve quality of care in Medicaid.

Interest in improving continuity of coverage in Medicaid has been rising. The Medicaid and CHIP Payment and Access Commission has recommended that Congress give states an equivalent option to provide 12 month continuous eligibility for adults.³ The Centers for Medicare and Medicaid Services (CMS) has endorsed the use of 12 month continuous eligibility for adults using Section 1115 waivers.⁴ Legislation to adopt the use of 12 month continuous eligibility in Medicaid and CHIP for all adults and children in all states has been introduced in Congress.ⁱ

ⁱ The most recent example is the Stabilize Medicaid and CHIP Coverage Act (H.R. 1698), introduced by Congressmen Gene Green (D-TX) and Joe Barton (R-TX) in April 2013.

Continuity of Health Insurance Coverage Matters

While Medicaid can offer life-sustaining health insurance coverage to those who could not otherwise afford insurance, the process of applying and renewing Medicaid coverage can be arduous. In contrast, enrolling in Medicare—the federal insurance program for seniors—is largely automatic when people turn 65 and there is no need for periodic re-enrollment. Moreover, typically, it is easy for workers to enroll in job-based insurance at the workplace and they remain covered until they choose a different arrangement, leave that job or the employer drops coverage.

Enrolling in Medicaid often requires completing a complex application and then waiting up to 45 days while the Medicaid agency verifies eligibility. States may offer Medicaid certification periods of varying length, up to 12 months. After that, beneficiaries must reapply (or renew their coverage); their eligibility must be reevaluated at least annually and the renewal process is often burdensome too. Those who fail to reapply in time are dropped from coverage. They may reapply later, but it takes time to process the re-application. While they are enrolled, beneficiaries usually must report any changes in their income, family composition, residence or other circumstances and are often required to submit periodic (e.g., quarterly) reports. If they fail to submit the periodic reports properly, they may be dropped from Medicaid. Under the ACA, effective January 1, 2014, children and non-elderly adults enrolled under the new expansion eligibility option will have a 12 month certification period, but may still lose coverage during that period if their income or other factors change during the year or if they fail to report a change in circumstances.

When people are uninsured, it is harder for them to afford medical care and, thus, their health may be jeopardized.⁵ This also happens when people have even relatively brief gaps in their insurance coverage; they often have to skip or delay getting care or leave prescriptions unfilled because of the costs. Many with brief spells of uninsurance face serious financial consequences because they have to pay—or go into debt—for medical care needed while they are uninsured. They may be pursued by debt collection firms, deplete their savings, or be forced to borrow money from friends or family to pay their medical expenses.⁶

Skipped or delayed health care can lead to unnecessary illness or even death, as well as leading to inefficient and expensive use of emergency room or hospital care for preventable medical conditions like asthma or diabetes.⁷ A national study found that when Medicaid patients churn into or out of Medicaid, they use emergency departments and are admitted to hospitals more often, perhaps in part because are less able to afford their medications.⁸ These findings were corroborated by another study that found that those with greater churning in insurance coverage use emergency departments more than those with stable coverage.⁹ Another recent study found that when parents have insurance coverage gaps their children are also more likely to suffer disruptions, suggesting that improving Medicaid continuity for parents can help their children.¹⁰

Retention of health insurance coverage also helps build ongoing and continuous relationships between patients and their doctors, facilitating primary and preventive health care on a timely basis. An ongoing relationship between a patient and primary care provider is a fundamental characteristic of “patient-centered medical homes,”^{11, 12} which are being

increasingly emphasized across the nation. Those with gaps in insurance are less likely to have a usual source of health care.¹³ Continuity of care can improve quality because a regular ongoing physician is more aware of the patient's health history and the patient and caregiver can develop a more trusting relationship.

Health care providers are also affected by insurance gaps. Primary care physicians prefer to maintain ongoing, long-term relationships with their patients and know that an ever-changing panel of patients can make their work both harder and less effective. Moreover, Medicaid churning disrupts administrative and financial operations. Patients are often unaware of whether their Medicaid eligibility is still valid. The systems used to check on eligibility can be cumbersome and time-consuming. If a patient shows up at a medical appointment and it turns out that his or her Medicaid eligibility has lapsed, the physician (or clinic or hospital) faces a difficult choice of whether to care for the patient -- and risk not getting paid -- or refuse to serve the patient. Neither is a good choice. Assuring greater continuity of Medicaid coverage can reduce provider frustration and administrative red tape. Ultimately, administrative barriers like these reduce providers' willingness to serve Medicaid patients.

While research demonstrates that Medicaid is effective in improving access to health care¹⁴ and reducing mortality¹⁵, studies also reveal that gaps in Medicaid coverage may lead to serious health problems, while continuous Medicaid coverage can improve outcomes.

- A number of chronic health diseases, like diabetes, asthma, or chronic obstructive pulmonary disease, can be effectively treated with primary medical care, including regular use of medications for diabetes or hypertension or steroid inhalers for asthma. These "ambulatory-sensitive" conditions can be controlled through appropriate ambulatory (i.e., office-based) care. When these diseases are not well-controlled, they can lead to expensive emergency room visits or even hospitalizations. Research by Andrew Bindman and his colleagues has shown that, for both adults and children, interruptions in Medicaid coverage can lead to significant increases in hospitalizations for ambulatory sensitive conditions.^{16, 17} For adults, interruptions in Medicaid coverage led to a four-fold increase in such hospitalizations, compared to those with continuous Medicaid coverage.
- Continuous Medicaid coverage can contribute to improved cancer detection and outcomes. Women with continuous Medicaid enrollment were more likely to be screened for breast cancer.¹⁸ Breast and cervical cancer patients enrolled in Medicaid for longer periods of time had less severe cancers than those enrolled for shorter periods.¹⁹ A similar study found that cancer patients enrolled in Medicaid before their cancer diagnoses lived longer than those who enrolled only after diagnosis.²⁰
- People with diabetes whose Medicaid coverage has been interrupted have higher medical care costs than people with diabetes with continuous coverage, particularly because those with interrupted coverage are more likely to use the emergency room or be hospitalized.²¹
- Interruptions in Medicaid coverage are associated with greater use of expensive, inpatient psychiatric services and higher psychiatric care costs. Those with continuous coverage were less likely to be hospitalized in an inpatient psychiatric facility, were more likely to

have shorter stays when they were hospitalized,²² and had lower overall psychiatric care costs.²³ Further, complicated Medicaid renewal and monthly reporting requirements pose additional problems for persons with mental illness. .

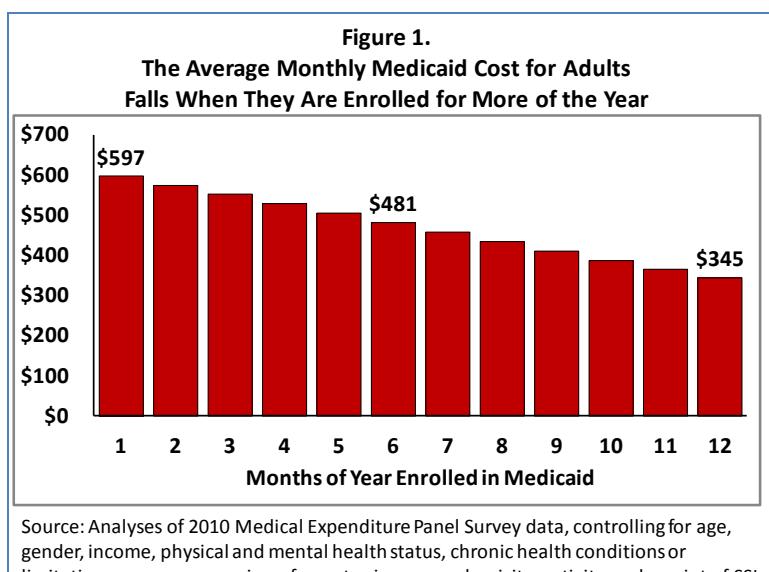
- Gaps in coverage can even affect care received at safety net providers, like community health centers that care for both Medicaid and uninsured patients. Diabetes patients with interrupted insurance coverage were less likely to have key preventive and primary care services, such as testing of blood sugar or cholesterol levels.²⁴

Continuity Reduces Monthly Medicaid Costs

A key policy barrier to extending Medicaid continuity of coverage is the inevitable concern about costs. It is intuitive to believe that if a person is enrolled for 12 months instead of six, then the annual costs of medical care must be twice as large. Thus, efforts to extend continuity could be very costly. But this is not true. We examined the cost issue in two ways. This section presents new research findings about how continuity of Medicaid coverage affects monthly medical costs. Another study examined what happened when a number of states adopted 12 month continuous eligibility after the passage of the CHIP Reauthorization Act in 2009 and is summarized in the next section.

Using data from the Medical Expenditure Panel Survey for 2010 (the most recent year available), we examined how monthly Medicaid costs change when people are enrolled for longer periods of time. Many things affect medical costs, including a person's age, gender and health status, so our analyses control for these to isolate the specific effect of changes in the continuity of Medicaid coverage. The methodology for this analysis is described in a box at the end of this section.

Figure 1 illustrates the findings for 19 to 64 year old adults. If an adult was enrolled for just one month in the year, the average estimated Medicaid health care cost is \$597 for that month. When people are enrolled for more of the year, the average monthly Medicaid cost declines. If an adult was enrolled for six months of the year, the average monthly cost dropped to \$481, a 23 percent reduction. If the person was enrolled for the full 12 months, the average monthly cost fell to \$345, 22 percent less than the amount for an adult enrolled six months or 45 percent less than the cost for an adult enrolled just one month.



Over the course of a year, total annual costs rise because people are enrolled for more months, but the increase is tempered because the average monthly costs decline. Thus, an adult enrolled for six months would incur estimated Medicaid medical expenditures or \$2,886 (\$481 per month times 6 months). But someone enrolled for all 12 months would have an expected annual cost of \$4,140 (\$345 per month times 12 months). The total Medicaid costs rises only 40 percent when the length of enrollment rises from 6 to 12 months.

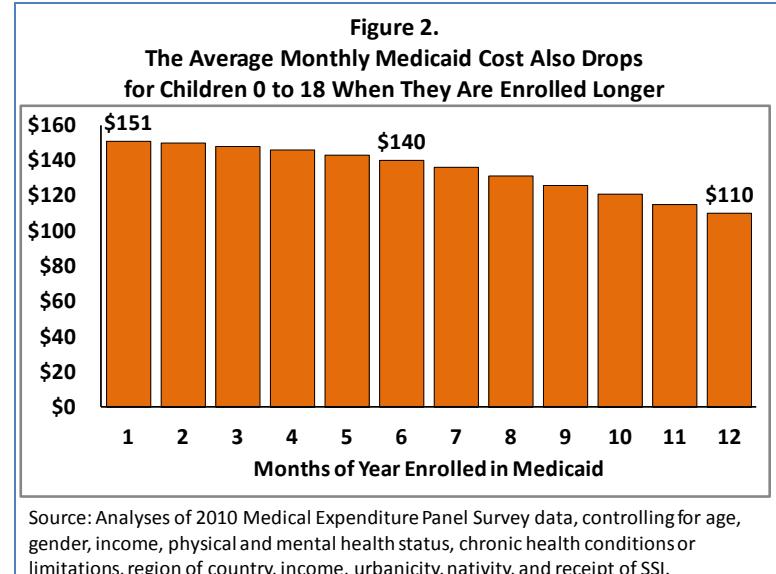
As seen in Figure 2, results are similar for children 18 or younger enrolled in Medicaid. Average monthly costs are lower because children are usually healthier than adults. The average monthly Medicaid benefit cost for a single month for a child was \$151. For six months of enrollment, the average monthly cost was \$140 per month and for 12 months it was \$110.

The costs in this analysis reflect the payments for the medical care received by the person, not the amount that might be paid by the state Medicaid agency. If, for example, the person receives care in a capitated managed care plan, the amount paid by the state is the monthly capitation fee established by the managed care contract, regardless of actual care costs. But, in the long run, even capitation fees should reflect the actual costs of care. Typically, states require managed care plans to report their costs periodically and rebase the capitation payments so that they better reflect actual costs. Thus, over time, actual medical savings should be realized in capitation fees, too.

The savings occur for two reasons. First, when people are enrolled for longer periods, they may get primary and preventive care to help keep them healthy and reduce the risk of needing more expensive specialty, emergency or inpatient care. Second, people often enroll in Medicaid when they are sick and therefore often have higher initial health care utilization just after enrollment. When they remain enrolled for longer periods, their health needs stabilize and less care is needed later in the year.

The results presented here are consistent with earlier analyses, which also found that monthly Medicaid costs fell with longer enrollment.^{25, 26, 27} The key differences between this analysis and the earlier ones is that the current analysis uses more recent data and more sophisticated analytical methods.

The analyses here only examine benefit costs in Medicaid, but churning also raises administrative costs. Administrative costs are incurred every time an application must be reprocessed; it is simpler and less costly to just extend a person's eligibility. Moreover, managed



care plans incur costs to provide new member services for those who had a gap in coverage. For example, in 2004 the administrative costs of enrolling a child in Medicaid or Child Health Plus program were about \$280 in New York.¹⁹ Churning these children in and out of the system clearly imposes substantial additional costs.²⁸ One study from 2005 found that Medi-Cal, California's Medicaid program, lost about 600,000 children over three years because of churning, but children were reenrolled after policies were changed to increase certification periods again. Processing their reenrollment cost \$120 million.²⁹ To the extent that continuous coverage increases Medicaid benefit costs somewhat, there may be offsetting savings in administrative costs.

Methodology

Data are from the 2010 Medical Expenditure Panel Survey, which is conducted by the Agency for Healthcare Research and Quality. Analyses were conducted for 2,736 adults 19 to 64 years old and 5,081 children 0 to 18 years old enrolled in Medicaid for at least one month. Costs for the elderly were not analyzed, since almost all of them are also covered by Medicare which covers the majority of their medical costs. Because of the skewed distribution of medical expenditures – many have no expenditures in a year and a few have very high expenditures – a two-part model was implemented. (1) A logit model estimated the probability that a person has any Medicaid expenditures in the year. (2) A generalized linear model using a gamma distribution with a log link estimated average monthly Medicaid expenditures among those who incurred any costs. Models were weighted to reflect the national population and adjusted for the complex sample design. Both sets of models assessed the effects of months enrolled in Medicaid, age, gender, race/ethnicity, income, self-reported physical and mental health status, chronic health conditions (e.g., diabetes, asthma) or limitations (e.g., blindness, mobility problems), pregnancy, region of residence, metropolitan status, nativity and receipt of Supplemental Security Income disability benefits. The months of Medicaid enrollment were statistically significant in all models. The Medicaid costs are based on the annual payments made for medical care (including office visits, hospital inpatient, outpatient and emergency department visits, dental care, prescription drug costs) divided by the number of months on Medicaid.

These models are used to predict probabilities (from the logit model) and expenditures (from the generalized linear model) for every Medicaid enrollee. Using the method of recycled predictions, we incrementally estimated the independent effect of being enrolled from 1 to 12 months. This approach estimates the independent effects of changes in the months on Medicaid, controlling for all other characteristics of the beneficiaries. The estimated probability of expenditures was multiplied by the estimated Medicaid expenditure (among those with any expenditures) to generate the overall estimated Medicaid monthly costs for each person, ranging between 1 to 12 months of enrollment.

References: Basu, A. "Modeling Healthcare Expenditures" Health Economics Resource Center Cyberseminar, June 16, 2010. Deb, P., Manning, W. and Norton, E. "Modeling Health Care Costs and Counts", American Society for Health Economics, Minneapolis, MN, 2012.

Effects of 12 Month Continuous Eligibility Policies

One of the most important ways that Medicaid enrollment can be stabilized is by adopting a policy of *12 month continuous eligibility*, during which a person is given 12 months of insurance coverage, regardless of minor fluctuations in income or other changes and without the need for periodic reports. This policy exists as a state option for children in Medicaid and there is a similar option to extend pregnant women's coverage until two months after her baby is born. It is also similar to the method of determining eligibility for low-income subsidies for Medicare prescription drug benefits, which are guaranteed for a year. But this option is not available for non-pregnant adults in Medicaid.

Findings of a study about the effectiveness of the 12 month continuous eligibility policy were recently published in *Health Affairs*.³⁰ The study examined changes in state continuity ratios for children between 2008 and 2010, after the enactment of the CHIP Reauthorization Act of 2009. During this period, seven states adopted 12 month continuous eligibility policies, which were encouraged by that law. The analysis revealed that the policy change led to a statistically significant increase in average length of Medicaid enrollment for children, even after controlling for changes in state income levels and other policy factors, such as whether states adopted 12 month certification periods or received enrollment/retention bonuses. The study design also controlled for other state-specific factors such as race or age distribution. The policy change was to increase the estimated length of children's enrollment by about two percentage points. Since the length of enrollment is directly related to the average annual cost; this change only increased the annual cost for children's coverage by 2 percent. The findings of this study suggest that a comparable policy extended to adults in Medicaid could improve the continuity of coverage at a modest cost.

Measuring Continuity of Medicaid Coverage

In 2009 we developed a method to compare Medicaid enrollment continuity using state enrollment data across states or over time.³¹ The Medicaid "continuity ratio" measures the average percentage of a fiscal year that beneficiaries are enrolled; it measures the average length of enrollment during the year. It is computed by dividing the average monthly number of Medicaid enrollees during a fiscal year by the total number of unduplicated people enrolled in Medicaid at any time over the year.

A score of 100 percent is perfect, meaning everyone was enrolled for the entire year. A score of 8.3 percent means that there was a 100 percent turnover in enrollees each month (so the total unduplicated number enrolled over the year is 12 times the number enrolled in any month). These data are based on administrative data reported by state Medicaid agencies in the Medicaid Statistical Information System (MSIS) data mart. The accuracy of these computations is limited by the accuracy and timeliness of MSIS data as reported by states and CMS. For example, if a state modified its computer systems, data may differ from one year to the next.

Figure 3 presents comparisons of continuity ratios in FY 2006 and FY 2010-11. The most recent period includes FY 2011 for 25 states, FY 2010 data for 21 states and FY 2009 data for 5 states, based on the data available as of March 2013. The FY 2006 data are complete for all states. (We classified enrollees as aged, blind or disabled, children or non-elderly adults. A small number have unknown status and are included in the overall counts, but not the categories.)

As seen in Figure 3, there were modest improvements in continuity between 2006 and 2010-11. The overall national average continuity ratio increased from 79 to 81 percent, which means that an average person enrolled in Medicaid was covered for about four-fifths of the year and lacked Medicaid for the remaining fifth. The continuity ratio is higher and remains unchanged (90 percent) for those who are blind or disabled. The aged and children are the next highest, with averages of 86 percent and 83 percent, respectively. The ratio for non-elderly, non-disabled adults (primarily low-income parents) is by far the lowest, at 72 percent. The problem

of interrupted coverage is most severe for the non-elderly adults, the group whose eligibility is being expanded under the Affordable Care Act.

Aged and blind/disabled enrollees have greater continuity because they are often living on fixed incomes and tend to have longer certification periods. Moreover, their Medicaid coverage is often linked to cash assistance under the Supplemental Security Income (SSI) program, so they can jointly renew coverage for both

Medicaid and SSI. While continuity ratios for these populations are greater, the impact of losing eligibility – even for a short period of time – is very significant, since these individuals are the most likely to have chronic illnesses and conditions which require ongoing treatment and monitoring. Children may have greater continuity because states have long been encouraged to simplify enrollment and renewal procedures in Medicaid, with increased emphasis under CHIPRA.

Table 1 presents state-level data on continuity of Medicaid coverage in the FY 2010-11 period. Two versions of an overall ratio are presented: the overall *unadjusted* ratio and the overall *standardized* ratio. Because continuity varies so much by eligibility category, a state's unadjusted ratio is strongly affected by the state caseload composition. A state with more disabled and fewer adult enrollees would naturally have a higher overall continuity ratio than a state with more adults and fewer disabled, even if they had the same enrollment policies. The standardized ratio attempts to adjust for these caseload differences by treating all states as if they had the same proportions of aged, disabled, children and adults, based on the national averages. The standardized ratio better reflects the policy component of a state's enrollment policies. Based on the standardized enrollment continuity ratios, the ten states with the highest continuity of coverage are Ohio, Tennessee, New York, Connecticut, New Mexico, Hawaii, Arizona, Rhode Island, Louisiana, and Illinois; ratios for these states range from 84.5 percent to 88.6 percent. The ten states with the lowest continuity of coverage are Utah, Texas, Colorado, Nevada, Idaho, Florida, Georgia, Kansas, Wyoming, and North Dakota, with ratios between 68.8 percent and 76.5 percent. (More detailed historical data are available in an earlier report.³²⁾

Table 1. Enrollment Continuity Ratios for State Medicaid Programs, FY2010/11

| | Overall Unadjusted Ratio ¹ | Aged | Children | Blind/Disabled | Non-elderly Adults | Overall Standardized Ratio ¹ |
|-----------------------|---------------------------------------|--------------|--------------|----------------|--------------------|---|
| United States | 81.2% | 85.9% | 82.9% | 90.2% | 71.6% | 81.2% |
| Alaska | 79.8% | 85.3% | 83.0% | 88.2% | 65.9% | 79.2% |
| Alabama | 85.5% | 88.1% | 85.7% | 90.3% | 77.1% | 84.2% |
| Arkansas | 86.1% | 87.3% | 88.1% | 89.1% | 73.6% | 84.2% |
| Arizona | 85.6% | 91.6% | 87.6% | 91.7% | 80.2% | 86.5% |
| California | 77.7% | 88.3% | 79.7% | 92.6% | 70.4% | 79.8% |
| Colorado** | 74.4% | 85.5% | 73.5% | 88.9% | 60.8% | 73.3% |
| Connecticut | 84.1% | 83.8% | 88.0% | 90.4% | 78.2% | 85.3% |
| District of Columbia* | 77.2% | 84.3% | 88.6% | 90.1% | 56.2% | 79.6% |
| Delaware | 81.8% | 86.4% | 84.7% | 90.4% | 76.3% | 83.4% |
| Florida | 76.4% | 85.1% | 79.7% | 87.2% | 55.0% | 74.5% |
| Georgia | 77.9% | 84.9% | 78.7% | 89.6% | 58.7% | 75.4% |
| Hawaii* | 85.6% | 86.6% | 89.7% | 89.6% | 78.9% | 86.4% |
| Iowa | 80.2% | 83.6% | 82.0% | 91.1% | 71.7% | 80.7% |
| Idaho** | 76.9% | 84.9% | 76.4% | 90.3% | 57.3% | 73.9% |
| Illinois | 88.7% | 86.8% | 90.5% | 93.3% | 83.3% | 88.6% |
| Indiana* | 82.0% | 82.5% | 84.7% | 88.5% | 70.2% | 81.1% |
| Kansas* | 78.4% | 82.6% | 79.2% | 87.5% | 60.2% | 75.5% |
| Kentucky | 82.0% | 85.1% | 82.3% | 90.4% | 64.2% | 78.7% |
| Louisiana* | 88.2% | 89.1% | 91.3% | 90.6% | 75.5% | 86.6% |
| Massachusetts* | 83.5% | 86.3% | 83.2% | 93.9% | 79.2% | 83.9% |
| Maryland* | 83.1% | 84.6% | 85.4% | 89.6% | 74.3% | 82.9% |
| Maine* | 80.7% | 84.5% | 88.4% | 65.7% | 83.4% | 83.2% |
| Michigan | 83.0% | 83.4% | 86.2% | 89.4% | 73.1% | 82.8% |
| Minnesota* | 78.0% | 71.2% | 80.8% | 89.5% | 69.9% | 78.3% |
| Missouri** | 80.7% | 80.6% | 83.4% | 84.5% | 67.4% | 78.9% |
| Mississippi | 83.0% | 85.5% | 82.0% | 91.8% | 71.6% | 80.9% |
| Montana | 79.1% | 83.1% | 80.1% | 86.9% | 64.9% | 77.2% |
| North Carolina* | 80.9% | 87.3% | 82.8% | 90.9% | 64.4% | 79.7% |
| North Dakota* | 77.0% | 82.0% | 79.0% | 87.7% | 62.3% | 76.5% |
| Nebraska | 79.9% | 72.4% | 83.1% | 88.6% | 62.7% | 77.4% |
| New Hampshire* | 80.0% | 81.9% | 82.0% | 84.7% | 64.7% | 77.6% |
| New Jersey* | 85.3% | 87.6% | 86.6% | 92.4% | 75.2% | 84.4% |
| New Mexico | 85.5% | 86.0% | 86.6% | 90.4% | 80.8% | 85.5% |
| Nevada* | 74.8% | 84.3% | 76.0% | 85.1% | 60.7% | 73.8% |
| New York* | 84.0% | 86.8% | 85.1% | 93.0% | 79.1% | 84.7% |
| Ohio* | 85.0% | 84.0% | 86.6% | 88.7% | 78.9% | 84.5% |
| Oklahoma* | 80.1% | 85.5% | 84.0% | 88.3% | 61.3% | 78.5% |
| Oregon | 80.1% | 84.8% | 79.7% | 90.3% | 74.3% | 80.2% |
| Pennsylvania* | 83.8% | 84.5% | 84.8% | 90.4% | 73.3% | 82.4% |
| Rhode Island | 86.9% | 88.3% | 87.4% | 93.2% | 81.0% | 86.6% |
| South Carolina | 84.6% | 86.7% | 86.5% | 91.3% | 74.1% | 83.8% |
| South Dakota | 80.5% | 83.0% | 82.6% | 89.1% | 63.5% | 78.4% |
| Tennessee | 85.7% | 84.1% | 88.0% | 90.7% | 75.6% | 84.7% |
| Texas* | 76.2% | 88.8% | 76.9% | 90.3% | 51.4% | 72.9% |
| Utah** | 68.0% | 79.4% | 68.5% | 84.4% | 57.8% | 68.8% |
| Virginia | 81.6% | 85.7% | 83.0% | 88.8% | 66.7% | 79.6% |
| Vermont* | 81.7% | 88.0% | 85.6% | 90.3% | 74.2% | 83.4% |
| Washington* | 81.2% | 84.0% | 85.0% | 86.6% | 66.8% | 80.1% |
| Wisconsin** | 79.4% | 86.3% | 80.2% | 92.0% | 70.8% | 79.9% |
| West Virginia | 80.8% | 84.5% | 81.0% | 89.1% | 62.0% | 77.2% |
| Wyoming | 77.3% | 82.4% | 78.2% | 86.6% | 63.2% | 75.7% |

Source: GW analysis of Medicaid Statistical Information System Data mart for FY2010/11, except where noted.

¹Excludes data for Unknowns and non-eligibles

*Data from 2010

**Data from 2009

The continuity ratio essentially measures the average level of enrollment during a fiscal year. It has limitations. The reference period is the federal fiscal year. A person who enrolls in April 2010 and remains covered for 12 months would have 50 percent continuity in FY 2010 and 50 percent in FY 2011. Similarly, a person who was enrolled October to March, then experienced a one-month gap and re-enrolled from April to September has 11 months of coverage, the same as someone continuously enrolled from October through August. Finally, as noted earlier, we do not know whether a person has other coverage or is uninsured during the months without Medicaid (although other research suggests they are often uninsured). These limitations are inherent in the nature of the MSIS data source. Finally, the accuracy of data is limited by the accuracy of MSIS data. For example, if a state modified its eligibility system, reports for one year might not be compatible with another year.

These findings can be compared with a report by John Czajka of Mathematica Policy Research, who examined Medicaid enrollment continuity over three years from 2005 to 2007.³³ He directly tabulated detailed Medicaid eligibility files for persons enrolled as of January 2005 and followed their status up through December 2007. Of those enrolled from the beginning of 2005 (with full benefits), slightly less than half (47percent) were still enrolled three years later, 31percent left Medicaid and did not return and 22percent exited and returned at least once. While the percent continuously covered is lower than the 81percent we report for the 2010-11 period, it is important to consider that we are measuring the average number of months enrolled in a single year, while the Mathematica report examines continuity over three years; as the period lengthens, the percent continuously enrolled inherently declines. As in our findings, non-elderly adults had the lowest continuity and the blind/disabled and aged had the highest, with children in the middle. The pattern of states with high and low levels of enrollment continuity was broadly similar in the two analyses, despite the studies' differences.

Other Strategies to Improve Medicaid's Continuity

While 12 month continuous eligibility is an effective way to improve continuity of coverage, other approaches are possible. Moreover, implementation of the Affordable Care Act (ACA) creates other considerations for extending insurance coverage. First, new health insurance marketplaces (HIMs, also known as exchanges) will begin enrollment in October 2013 for insurance coverage beginning in January 2014. Those who do not have access to affordable insurance may also be eligible for advance refundable tax credits – affordability credits – to help pay the premiums for plans offered in HIMs and may receive discounts in their out-of-pocket costs. In states that are expanding Medicaid, the tax credits will be available to those with incomes between 138 and 400 percent of the poverty line. In states that are not expanding Medicaid, they will be available between 100 and 400 percent of poverty.³⁴ To simplify coordination with HIM and tax credit eligibility, Medicaid income eligibility standards are converting to a Modified Adjusted Gross Income (MAGI) accounting system, which is similar to that used for computing federal income taxes.

The implications of these changes will begin as insurance expansions roll out. First, “churning” may occur between Medicaid and the HIMs. Benjamin Sommers and Sara Rosenbaum have found that, after the ACA is implemented, churning could occur in transitions between eligibility for Medicaid and for the health insurance exchanges and federal tax credits. About half of all adults with incomes under 200 percent of the poverty line – 28 million people –

will experience income changes that could require them to change coverage between Medicaid and the Exchanges within a one-year period.³⁵ While the ACA has policies that promote integrated “one-stop” enrollment and renewal procedures for Medicaid and the HIMs, delays in processing or misunderstandings could create insurance gaps if someone loses Medicaid but is not immediately enrolled in an exchange plan or vice versa. Moreover, even if insurance coverage is maintained, people may experience difficulties if they have to change insurance carriers or primary care physicians. Twelve month continuous eligibility in Medicaid could help reduce these problems by permitting a buffer period, during which people maintain Medicaid coverage until their exchange plan has been established. Since Medicaid is less costly than private insurance, this is also a cost-effective option.³⁶ The risks of churning between Medicaid, HIM coverage and uninsurance will be much higher in states that fail to expand Medicaid because there may be a large gap between the income limits at which adults are eligible for Medicaid and eligibility for health insurance exchanges if they fail to expand Medicaid.

Development of a Basic Health Program, a new option authorized under the ACA, could reduce churning. Under this option, states may establish managed care programs that essentially act as a bridge between Medicaid and the HIMs. Eligibility is for those who would otherwise be uninsured with incomes between the 138 percent (the Medicaid income limit) and 200 percent of poverty. (Legal immigrants ineligible for Medicaid may be eligible with lower incomes). The health coverage available under Basic Health Programs would have lower cost-sharing than available under the HIMs.^{37, 38} Analyses indicate that adoption of a Basic Health Program option could reduce churning by establishing a “buffer” income range between 138 and 200 percent of poverty, above which incomes are less volatile.³⁹ States would receive federal funding based on 95 percent of the amounts per member that would otherwise be available as federal tax credits and cost-sharing reductions in the HIMs. As of early September 2013, the Department of Health and Human Services was expected to release proposed regulations for the implementation of this option in the near future; a number of states have expressed interest.

The adoption of the new MAGI accounting rules (effective January 1, 2014) may create some technical complications for renewals of Medicaid coverage between October 1, 2013 and March 31, 2014. To mitigate these problems, CMS has suggested options for states to reduce these problems.⁴⁰ One suggested option was to grant adults 12 months of continuous eligibility, using a Section 1115 waiver. Other options include adopting the MAGI standards ahead of time or temporarily extending certification periods.

There are a variety of other procedural strategies that states could adopt to simplify Medicaid renewal procedures too, regardless of the ACA policy changes. These have been tried and tested by some state Medicaid or CHIP programs, particularly with renewals of children’s coverage, but they could be more widely used for adults as well. Some approaches include:

- Ensuring that there are readily available methods to make it easier for Medicaid beneficiaries to renew coverage by mail, telephone or the internet.
- Arranging for enrollment or renewal assistance at convenient locations, such as community health centers or hospitals.

- Simplifying application or renewal procedures by, for example, allowing people to self-attest to income and other circumstances. States may use other automated data sources to verify income without requiring people to find and bring in their paperwork.
- Pre-filling renewal forms with information already available to make them simpler to complete (i.e., listing address and family members in advance, although permitting the applicant to make changes as needed.)
- Permitting Medicaid renewals based on other updated information that is available to the state, such as data from Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp Program) certification.

Quality and Continuity of Coverage

Having health insurance coverage is a first step in getting quality health care. To be successful, a health insurance program must cover health benefits sufficient to meet the needs and budgets of the populations served, establish a health care provider network that assures adequate access to quality health care in a culturally appropriate manner, make payments sufficient to maintain an adequate set of quality providers, and address the quality of the health care delivered. For the consumer, this can lead to getting “the right care for every person every time.”⁴¹ Indeed, noted child health researcher Genevieve Kenney has observed that continuity of Medicaid and CHIP coverage may, in and of itself, be an important indicator of the quality of children’s health care.⁴²

Medicaid programs have developed a number of systems to monitor and improve the quality of care for beneficiaries. Federal rules require systems for quality monitoring and improvement for Medicaid capitated managed care organizations (MCOs, such as Health Maintenance Organizations and similar plans that are paid a fixed monthly fee per member that, in turn, arrange for payment of the health care providers). Capitated MCOs provide services to half of Medicaid enrollees, with levels varying from state to state.⁴³ States must develop quality assurance and improvement plans that includes access standards, including continuity of care and access to primary and specialty care services, and procedures to monitor the quality and appropriateness of care for MCO beneficiaries. Key elements of Medicaid quality monitoring systems include submission of data about the clinical quality of care (e.g., HEDIS reports or similar data), consumer satisfaction (e.g., Consumer Assessment of Health Plan Surveys, CAHPS) and additional reviews by External Quality Review Organizations.

However, there are no comparable federal requirements regarding quality monitoring or improvement for care delivered for the other half of Medicaid beneficiaries, those who receive care under state-administered fee-for-service (FFS) or Primary Care Case Management (PCCM) arrangements. (In FFS systems, the Medicaid agency or its contractor directly reimburses providers for services rendered. In PCCM, primary care physicians or other clinicians act as the main primary care providers and gatekeepers and receive a small monthly PCCM fee, but most services are reimbursed on an FFS basis.) As of June 2013, 34 states had laws requiring the use of either HEDIS or CAHPS data in Medicaid, but they generally apply to managed care plans and not to PCCM or FFS care.⁴⁴

When quality data are available, program administrators and health care providers can identify areas where improvements are needed and, in some cases, offer incentives to promote better quality. Most of the HEDIS measures of clinical quality (e.g., whether a person had a primary care visit or an immunization) are measured only for those who have been continuously enrolled for a year. Quality measurement experts recognize that it takes time for patients to get all the health services they need; for example, a person enrolled for just one month is less likely to be vaccinated than a person enrolled for a full year. The requirements for 12 months of continuous enrollment assure that all measurements are made on an equivalent basis.

However, as noted earlier in this report, there can be substantial churning in Medicaid enrollment. As a result, quality metrics miss the large number of Medicaid beneficiaries with gaps in coverage. Promoting more continuous Medicaid coverage, so that more beneficiaries have 12 months of continuous enrollment, would permit broader and more representative measurement of quality in Medicaid.

The other large gap in Medicaid quality reporting is the lack of comparable data for the half of beneficiaries who are served in FFS or PCCM systems. Few states have established quality reporting systems for FFS or PCCM care.⁴⁵

To assess the quality of care in Medicaid more broadly, CMS has recently developed and begun to examine measures for the assessment of pediatric and adult care quality.^{46, 47} The submission of these data by state Medicaid agencies is voluntary, however, and still in its early stages. Many of the core quality measures are based on HEDIS or CAHPS measures developed for MCOs. While the measures could, in theory, be applied to any type of care, since the quality reporting systems in states are primarily designed for capitated managed care, these are the sectors most likely to be reported by states and there may be substantial gaps in quality reporting for FFS or PCCM care (as well as for those enrolled in managed care plans for less than 12 months). CMS has created a framework for broader quality assessment in Medicaid, but there are still some important gaps in this system.

Conclusions and Recommendations

Unnecessary disruptions in Medicaid insurance coverage create challenges for both patients and health care providers. In both states that expand Medicaid eligibility under the ACA and those that do not, Medicaid beneficiaries, particularly non-elderly adults, are at substantial risk of experiencing gaps in coverage due to churning. Churning makes Medicaid less efficient and less effective. Analyses presented in this report demonstrate that increasing the continuity of Medicaid coverage can reduce monthly medical costs and that policies of 12 month continuous eligibility can be effective in improving continuity.

In light of the evidence, the Association for Community Affiliated Plans (ACAP) has made recommendations to improve the continuity, effectiveness, efficiency and quality of care for the tens of millions of people helped by Medicaid.ⁱⁱ The key recommendations are:

ⁱⁱ For more information about ACAP and its recommendations, see www.communityplans.net and <http://www.communityplans.net/portals/0/coverageyoucancounton/index.html>.

- Twelve month continuous eligibility should be established as a policy for all Medicaid beneficiaries.
- Quality monitoring and improvement systems should be developed to encompass all Medicaid beneficiaries, not just those in capitated managed care, in a systematic and standardized fashion.
- In addition, to encourage states to implement these policies, legislation could provide performance incentives akin to those which encourage children's enrollment under the CHIP Reauthorization Act.

There have been signs of policy interest in the past year. In March 2013, the Medicaid and CHIP Payment and Access Commission recommended changes to Congress that the Medicaid statute be modified to give states the option to offer adults 12 months of continuous eligibility.⁴⁸ In May CMS encouraged states to consider this as an option which could be implemented with Section 1115 waivers.⁴⁹ In April, legislation to adopt the use of 12 month continuous eligibility in Medicaid and CHIP for all adults and children in all states was introduced in Congress.⁵⁰ As noted earlier, CMS has already developed core measures of the quality of care for children and adults in Medicaid which could applied in managed care and fee-for-service settings.

Efforts to stabilize the continuity of Medicaid coverage – and, in the near future, efforts to reduce churning between Medicaid and the Health Insurance Marketplaces -- can reduce gaps and problems associated with the loss of insurance coverage. In turn, this could improve the efficiency of Medicaid and prompt improvements in access to and quality of care for millions of low-income Americans.

Endnotes

¹ As originally enacted in the Affordable Care Act, Medicaid coverage would be extended to non-elderly adults with incomes up to 138 percent of the poverty line in 2014. However, a Supreme Court decision in the summer of 2012 granted states the option to expand Medicaid. As of late August 2013, it appears that about half the states will not expand Medicaid, although a few are still making decisions.

² Ku, L., Steinmetz, E., Bruen, B. "Continuous eligibility policies stabilize Medicaid coverage for children and could be extended to adults with similar results," *Health Affairs*, 2013 Sept.; 32(9): 1576-1582.

³ Medicaid and CHIP Payment and Access Commission. "Report to the Congress on Medicaid and CHIP." Washington , DC: MACPAC; Chap. 2, p. 21–32. Mar. 2013.

⁴ Mann, C. State Health Official Letter #13-003: "Facilitating Medicaid and CHIP enrollment and renewal in 2014," Center for Medicare and Medicaid Services. May 17, 2013.

⁵ Institute of Medicine. *Insuring America's Health: Principles and Recommendations*. Washington, DC: National Academy Press. 2004.

⁶ Duchon, L. et al. "Security matters: how instability in health insurance puts U.S. workers at risk" New York: Commonwealth Fund, 2001.

⁷ Institute of Medicine. *Care Without Coverage: Too Little, Too Late*. Washington, DC: National Academy Press, 2002.

⁸ Banerjee, R., Ziegenfuss, J., Shah, J. "Impact of discontinuity in health insurance on resource utilization." *BMC Health Serv Res*. 2010; 10:195. doi:10.1186/1472-6963-10-195.

<http://www.biomedcentral.com/1472-6963/10/195>

⁹ Ginde, A., Lowe, R., Wilde, J. "Health insurance status change and emergency department use among US adults," *Ann Intern Med*. 2012;172(8):642-647.

¹⁰ Yamuchi, M., Carlson, M., Wright, B., et al. "Does health insurance continuity among low-income adults impact their children's insurance coverage?" *Matern Child Health J*. 2013, Feb.; 17(2): 248-255.

¹¹ American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, "Joint principles of the patient-centered medical home," 2007.

¹² Starfield, B. and Shi, L. "The medical home, access to care, and insurance: a review of evidence." *Pediatrics* 2004; 113 (5): 1493-1498.

¹³ Lavarreda, S., Gatchell, M., Ponce, N., Brown, E.R., Chia, Y.. "Switching health insurance and its effects on access to physician services." *Med Care*. 2008 Oct; 46(10):1055-63.

¹⁴ Baicker, K., Taubman, S., Allen, H., et al. "The Oregon experiment—effects of Medicaid on clinical outcomes." *N Engl J Med*. 2013;368(18):1713-22.

¹⁵ Sommers, B., Baicker, K., Epstein, A. "Mortality and access to care among adults after state Medicaid expansions." *N Engl J Med*. 2012; 367(11):1025-34.

¹⁶ Bindman, A., et al. "Medicaid re-enrollment policies and children's risk of hospitalizations for ambulatory care sensitive conditions." *Med Care*. 2008; 46(10):1049-54.

¹⁷ Bindman, A., et al. "Interruptions in Medicaid coverage and risk for hospitalization for ambulatory care-sensitive conditions." *Ann. Int. Med.* 2008; 149: 854-60.

¹⁸ Koroukian, S.M. "Screening mammography was used more, and more frequently, by longer than shorter term Medicaid enrollees." *J Clin Epidemiol*. 2004 Aug; 57 (8):824-31.

-
- ¹⁹ Koroukian, S.M. "Assessing the effectiveness of Medicaid in breast and cervical cancer prevention." *J Public Health Manag Pract.* 2003 Jul-Aug; 9 (4):306-14.
- ²⁰ Bradley, C.J., Gardiner, J., Given, C.W., Roberts, C. "Cancer, Medicaid enrollment, and survival disparities." *Cancer.* 2005 Apr 15; 103 (8):1712-8.
- ²¹ Hall, A.G., Harman, J.S., Zhang, J. "Lapses in Medicaid coverage: impact on cost and utilization among individuals with diabetes enrolled in Medicaid." *Med Care.* 2008 Dec;46(12):1219-25
- ²² Harman, J.S., Manning, W.G., Lurie, N., Christianson, J.B. "Association between interruptions in Medicaid coverage and use of inpatient psychiatric services." *Psychiatr Serv.* 2003 Jul;54 (7):999-1005.
- ²³ Harman, J.S., Hall, A.G., Zhang, J. Changes in health care use and costs after a break in Medicaid coverage among persons with depression. *Psychiatr Serv.* 2007 Jan;58(1):49-54.
- ²⁴ Gold, R., et al. "Insurance continuity and receipt of diabetes preventive care in a network of federally qualified health centers." *Med Care.* 2009 Apr; 47(4):431-9.
- ²⁵ Irvin, C. et al. "Discontinuous coverage in Medicaid and implications for 12-month continuous coverage," Cambridge, MA: Mathematica Policy Research. 2001.
- ²⁶ Ku, L. and Cohen Ross, D. "Staying covered: the importance of retaining health insurance coverage for low-income families," New York: Commonwealth Fund. December 2002.
- ²⁷ Ku L., MacTaggart P, Pervez F, Rosenbaum S. "Improving Medicaid's continuity and quality of care." Washington, DC: Association for Community Affiliated Plans, July 2009.
<http://www.communityplans.net/Portals/0/ACAP%20Docs/ACAP%20MCQA%20Report.pdf>
- ²⁸ Fairbrother, G., Dutton, M.J., Bachrach, D., Newell, K.A., Boozang, P., Cooper, R. "Costs of enrolling children in Medicaid and SCHIP." *Health Affairs.* 2004; 23(1):237-43.
- ²⁹ Fairbrother, G. "How much does churning in Medi-Cal cost?" Woodland Hills (CA): California Endowment. April 2005.
- ³⁰ Ku, L. Steinmetz, E., Bruen, B., *op cit.*
- ³¹ *Ibid.*
- ³² Ku, L., Steinmetz, E. "The continuity of Medicaid: an update." Washington, DC: Association for Community Affiliated Plans. April 2013. Available at
http://www.communityplans.net/portals/0/coverageyoucancounton/Continuity_of_Medicaid_Coverage_Update_4-2013.pdf
- ³³ Czajka, J. "Medicaid enrollment gaps, 2005 to 2007." Final Report to CMS. Washington, DC: Mathematica Policy Research. April 30, 2012.
- ³⁴ In principle, HIMs are open to those with incomes above the poverty line, but in states that expand Medicaid to 138 percent of poverty, HIM eligibility will begin just above the Medicaid eligibility level.
- ³⁵ Sommers B, Rosenbaum S. "Issues in health reform: how changes in eligibility may move millions back and forth between Medicaid and insurance exchanges." *Health Affairs* 2011 Feb; 30(2): 228-236.
- ³⁶ Ku L, Broaddus M. "Public and private health insurance: stacking up the costs," *Health Affairs*, 2008 Jun, 27(4):w318-327.
- ³⁷ Dorn, S., Buettgens, M., Carroll, C. "Using the Basic Health Program to make coverage more affordable to low-income households: a promising approach to many states." Washington, DC: Association for Community Affiliated Plans. Sept. 2011.

³⁸ American Medical Association. "Improving the health insurance marketplace: Basic Health Program." 2013. Available at www.ama-assn.org/resources/doc/market.../basic-health-program.pdf.

³⁹ Hwang, A., Rosenbaum, S., Sommers, B. "Creation of state Basic Health Programs would lead to 4 percent fewer people churning between Medicaid and exchanges." *Health Affairs*. 2012 June, 31(6): 1314-20.

⁴⁰ Mann, C. 2013, *op cit.*

⁴¹ See www.cms.hhs.gov/MedicaidCHIPQualPrac.

⁴² Kenney, G., Pelletier, J. "Monitoring duration of coverage in Medicaid and CHIP to assess program performance and quality." *Acad Pediatr*. 2011;11:S34-S41

⁴³ Medicaid and CHIP Payment and Access Commission. "Report to the Congress on Medicaid and CHIP." Washington , DC: MACPAC. Table 15, p. 108. June 2013.

⁴⁴ NCQA. "State laws requiring the use of HEDIS/CAHPS for Medicaid managed care plans." June. 2013.

⁴⁵ Schneider, E.C., et. al. "Quality oversight in Medicaid primary care case management programs." *Health Affairs* 2005; 23(6):235-42.

⁴⁶ The CMS intial core pediatric quality measures are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>. The CMS initial adult quality measures can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93PM-Adult-Health-Care-Quality-Measures.html>.

⁴⁷ U.S. Department of Health and Human Services. " 2012 Annual Report on the Quality of Care for Children in Medicaid and CHIP. " Dec. 2012

⁴⁸ Medicaid and CHIP Payment and Access Commission. May 2013, *op cit.*

⁴⁹ Mann, C., *op cit.*

⁵⁰ The Stabilize Medicaid and CHIP Coverage Act of 2013 (H.R. 1698), introduced by Reps. Gene Green, Joe Barton and others.