

IMPROVING MEDICAID'S CONTINUITY OF COVERAGE AND QUALITY OF CARE

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Executive Summary

Medicaid provides health insurance coverage to tens of millions of low-income children, parents, seniors and people with disabilities. Unfortunately, Medicaid enrollment is like a leaky sieve; every year millions of people enroll, only to subsequently lose their coverage, despite still being eligible, because of inefficient and cumbersome paperwork requirements. The interruptions in coverage affect the continuity and effectiveness of health care received. Interruptions also impair quality monitoring and improvement activities because many Medicaid enrollees were not enrolled long enough to assess the quality of their care. The presumption is that people who have been enrolled for less than a year have not been exposed to enough care to measure quality or to experience health-promoting quality effects. Improving retention in Medicaid is a cost-effective way to reduce the number of uninsured people, make their health insurance coverage more secure, improve the measurement of health care quality, and ultimately improve people's health.

Data show that the typical enrollee receives Medicaid coverage for about three-quarters (78 percent) of the year. Coverage periods are lower for non-elderly, non-disabled adults (68 percent), but somewhat higher for those with disabilities, seniors and children. Research has shown that even brief gaps in insurance coverage can have harmful consequences for people, because they have poorer access to care and to prescription drugs during the time they are uninsured and because it interrupts the continuity of medical care. Studies show that Medicaid enrollees with coverage interruptions are more likely to be hospitalized for illnesses like asthma, diabetes, or cardiovascular disease that can be effectively managed through ongoing primary medical care and medication, are less likely to be screened for breast cancer and may have poorer cancer outcomes. Thus, interruptions in insurance coverage can impair the receipt of effective primary care and lead to expensive hospitalizations or emergency room visits.

Continuous Medicaid enrollment is more efficient, both medically and administratively. New analyses show that longer Medicaid coverage lowers average monthly medical costs. The average monthly medical expenditure for an adult enrolled in Medicaid for 12 months is about two-thirds the level of a person enrolled for just six months and half the level of a person enrolled for just one month. When people enroll, then disenroll, and then enroll again, they incur much higher administrative costs associated with enrollment procedures and processing for new enrollees. The administrative cost burdens may be borne by state and local eligibility agencies, Medicaid health plans and primary care providers, all of whom may spend time helping the Medicaid enrollees.

Another important goal of health reform is to measure and improve the quality of health care received. Federal law already requires various quality monitoring and improvement processes for capitated managed care organizations in Medicaid, which serve just under half of all enrollees. However, for the majority of Medicaid enrollees, who are served by Primary Care Case Management (PCCM) or fee-for-service arrangements, including many of those with the most severe health needs, there are no federal requirements for comparable quality monitoring or

improvement. Additionally, no structured oversight exists for Medicaid enrollees when they move between fee-for-service and capitated managed care plans.

The Association of Community Affiliated Plans (ACAP) is a trade association for 42 not-for-profit safety net health plans in 23 states serving over 6 million Medicaid members. ACAP believes it is possible to improve the continuity of coverage and the quality of care for all Medicaid enrollees, taking steps that are similar in nature to some of those recently enacted for children in the Children's Health Insurance Program Reauthorization Act (CHIPRA, Public Law 111-3).

The Medicaid Continuous Quality Act proposal would make 12-month continuous eligibility standard for most Medicaid enrollees. Currently, this is an option for children, but not for adult aged, and blind and disabled populations in Medicaid. It would also call for analyses of the effect of this change and recommendations on how to further improve continuity of coverage. The proposal would also direct the Secretary of Health and Human Services to develop procedures to ensure that quality monitoring is conducted in Medicaid PCCM and fee-for-service arrangements, just as it is now for Medicaid managed care, in order to make fair assessments across all modes of care.

This proposal would support bipartisan goals for national health reform. It will lower the number of people who lack health insurance coverage and improve the security, continuity and quality of care they receive. It will ensure more efficient and cost-effective care, both from the perspective of medical and administrative expenses. And by making efforts to measure quality of care in Medicaid more comprehensive, it will ultimately help program administrators improve the quality of services delivered in Medicaid and improve the value of care received.

Introduction

Each year, millions of people enroll in Medicaid, and then lose coverage, even though they remain eligible, because of inefficient administrative practices and cumbersome paperwork requirements. These interruptions in coverage may compromise their medical care, because a person may lack access to affordable care during the time they are uninsured, and make it difficult to assess whether they are receiving quality medical care. Medicaid, the nation's primary health coverage program for low-income people who would otherwise be uninsured, is a leaky sieve.

According to the Congressional Budget Office, although Medicaid will provide health insurance coverage to 68 million people over the course of fiscal year 2009, the number enrolled in a typical month will be about one-fifth lower, 55 million.¹ Therefore, there is a 13 million person gap between the number of people who are ever covered in the year and the number covered at a given time. Those who experience gaps in Medicaid coverage are uninsured for a portion of the year, as they typically have no other source of coverage. If we could help low-income people to retain their Medicaid coverage for all periods in which they are eligible, the number of uninsured Americans would be much lower. One study estimated that if every low-income person with public or private health insurance coverage at the beginning of a year retained coverage over the next 12 months, the number of low-income children who are uninsured could be decreased by two-fifths and the number of low-income adults who are uninsured could be lowered by one-quarter.²

Congress and the Administration are now considering national health reform plans to substantially reduce the number of uninsured people in this country. Developing better mechanisms to help low-income people to *retain* coverage in Medicaid is a critical and cost-effective component of efforts to reduce the ranks of the uninsured. Retention is a powerful and simple complement to outreach efforts: outreach seeks to help eligible people who have not yet enrolled, while retention efforts "reach in" to help those who already enrolled maintain their coverage.

In private employer-sponsored coverage, the norm is that once workers enroll in an insurance plan, they remain covered by default, unless they make active decisions to change coverage or leave the job. Unless employees make a decision to change during their annual open enrollment period or employers decide to switch insurers, employees generally remain enrolled in the same insurance plan they had the year before. Such is not the case in Medicaid. Based on a welfare-type model of repetitive application and enrollment, people must periodically prove that they are eligible for Medicaid. If they are unable to submit the right paperwork on time, their coverage is dropped, even if they still meet the eligibility criteria. Because of the complex administrative processes, families often do not know when their Medicaid certification periods expire, may be dropped without knowing it, and do not know why they lost coverage. Those who have been disenrolled typically say they wanted to retain their insurance coverage, but did not know how to do so.³ If a person is enrolled for a six-month certification period, but is unable to complete the renewal package at the end of that time, they will lose coverage. Even if he or she is certified for 12 months, but is required to report their income or residency every month or every quarter, his or her enrollment can be terminated prematurely for failing to submit the

paperwork on time. This person could join again later, but would be uninsured in the interim. This on-and-off-and-on pattern, often called “churning,” is common in Medicaid

Another critical goal of health reform is to assess and improve the value of medical care. Having health insurance coverage is simply the first step. For health care reform to be successful, it must cover health benefits sufficient to meet the needs of the populations served, offer 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 network of quality providers, and address the quality and financial oversight of the health care delivered and the delivery of the health care. For the consumer, this means the right care at the right time from the right place.⁴ (The Centers for Medicare and Medicaid Services (CMS) also defines quality as “the right care for every person every time.”⁵) It also means continuity of care, which is dependent on continuity of providers and continuity of services.

It is imperative to measure, monitor and improve the quality of care and care delivery provided under Medicaid. Federal law requires that there be procedures for quality monitoring and improvement for capitated managed care organizations (MCOs – that is, Health Maintenance Organizations and similar plans that are paid a fixed monthly fee per member), but there are no comparable requirements for those served under state-run fee-for-service or Primary Care Case Management (PCCM) arrangements. But fewer than half of Medicaid enrollees (46 percent in 2007) are served by managed care plans; the majority are served under fee-for-service or PCCM arrangements.⁶ Thus, information about the quality of care provided under Medicaid is available for a minority of those enrolled, and it is not possible to get an overall perspective of the quality of care in Medicaid.

Additional structural and process quality measures are required when states contract with capitated MCOs. These measures include verification of provider capacity to serve the expected enrollment; development and implementation of a quality assessment and improvement strategy (QAPI) that addresses timely access, quality of care and quality of care delivery; and an annual external independent review of the quality outcomes, and timeliness of and access to services provided. Thus, states use structural measures for pre-enrollment (such as network capacity), process measures for ongoing oversight, and outcome measures for health impact. The various options within structural, process, and outcomes are numerous, but provide states with the ability to hold the MCOs and their providers accountable for meeting the standards.

The recently enacted Children’s Health Improvement Program Reauthorization Act of 2009 (CHIPRA) established new opportunities for states to simplify enrollment and retention of children and offered financial incentives to attain higher participation levels of low-income children. It also called for the development and implementation of improved methods of monitoring the quality of care for children. The same opportunities are not available for low-income adults in Medicaid, who have much poorer retention rates than children. Moreover, the majority of Medicaid enrollees are not covered under the current quality monitoring requirements.

This report discusses why comparable changes are warranted for adults covered by Medicaid and how such improvement can be accomplished. It also addresses why continuity of

insurance coverage is important for patients and health care providers, how improved continuity of insurance can improve efficiency, value and quality of services, ways to improve retention of Medicaid coverage, why quality reporting is important, and how it can be broadened to provide a better system of total quality measurement for Medicaid.

This report was commissioned by the Association of Community-Affiliated Plans (ACAP). ACAP is a national trade association representing 42 nonprofit safety net health plans in 23 states. ACAP's mission is to represent and strengthen not-for-profit, safety net health plans as they work in their communities to improve the health and well being of vulnerable populations. Collectively, ACAP plans serve over 6 million enrollees, comprising over 50 percent of individuals enrolled in Medicaid-focused health plans.

Why Continuity of Health Insurance Coverage Matters For Access and Quality of Care

When people are uninsured, they have less access to medical care and, thus, their health may be jeopardized.⁷ This also happens when people have even relatively brief gaps in their insurance coverage. People with interruptions in coverage often have to skip or delay getting care or leave prescriptions unfilled because they cannot afford care. Many with brief spells of uninsurance face serious financial consequences because they had to pay – or go into debt – for medical care needed while they were uninsured. They are pursued by debt collection firms, deplete their savings, or are forced to borrow money from friends or family to pay their medical expenses.⁸ 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.⁹

Retention of health insurance coverage is also important because it permits ongoing and continuous relationships between patients and their health care providers, making it easier for a person to obtain primary and preventive health services on a timely basis. A continuous relationship between a patient and primary care provider is a fundamental characteristic of “patient-centered medical homes.”^{10 11} Those who switch plans or have gaps in insurance are less likely to have a usual source of health care.¹² Continuous coverage can improve the quality of care, because a regular physician is more aware of the patient's health problems and the efficacy of treatments the patient has already received, and because the patient knows who to turn to for medical care and advice.

Disruptions in health insurance may also have repercussions for future insurance coverage. Under the Health Insurance Portability and Accountability Act (HIPAA), a person who is uninsured for more than two months may be denied coverage for preexisting conditions, even after they subsequently gain private health coverage. For example, a patient with diabetes who has been uninsured for a few months, but eventually secures private insurance coverage, may find the new plan will not pay for diabetes or illnesses caused by diabetes because these are considered preexisting conditions.

Medical research has indicated that gaps in Medicaid coverage may lead to serious health problems, while continuous Medicaid coverage is related to better health:

- Many chronic health diseases, such as diabetes, asthma, or chronic obstructive pulmonary disease, can be effectively treated with primary medical care, including regular use of appropriate medications such as oral diabetes drugs or steroid inhalers for asthma. Such diseases are considered “ambulatory-sensitive” conditions because they can be controlled through appropriate ambulatory (i.e., office-based) primary care. When these diseases are not well-controlled, they can lead to expensive emergency room visits or even hospitalizations. Research has shown that, for both adults and children, interruptions in Medicaid coverage can lead to significant increases in hospitalizations for ambulatory sensitive conditions.^{13 14} 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 earlier cancer identification and improved outcomes. One study found that women with continuous Medicaid enrollment were more likely to be screened for breast cancer.¹⁵ Another study found that female breast and cervical cancer patients enrolled in Medicaid for longer periods of time had less severe cancers than those enrolled for shorter periods.¹⁶ A similar study found that cancer patients enrolled in Medicaid before their cancer diagnoses lived longer than those who enrolled only after diagnosis.¹⁷
- 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.¹⁸
- 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,¹⁹ and had lower overall psychiatric care costs.²⁰ Further, complicated Medicaid renewal and monthly reporting requirements pose additional problems for persons with mental illness. .
- Continuity of coverage matters, even for care at safety net providers such as community health centers, which provide care to both insured and uninsured patients. A new study shows that 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.²¹

The importance of continuity in health care has been well understood for some time. For example, in standard quality reporting systems such as HEDIS® (the Healthcare Effectiveness Data and Information System), clinical measures are only collected for persons who have been continuously enrolled in a health plan for 12 months or more. The presumption is that people who have been enrolled for less than a year have not been exposed to enough care to measure quality or to experience health-promoting quality effects. Health care providers expect continuity of coverage to be the norm, not the exception.

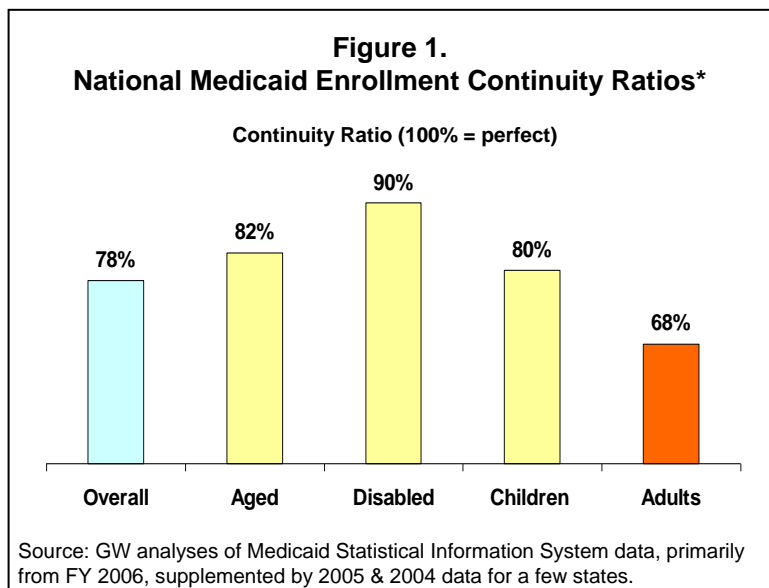
Churning in Medicaid

Outdated Medicaid administrative procedures contribute to unnecessary interruptions in Medicaid coverage. Because of Medicaid's historical linkage to welfare programs, there is an underlying philosophy that enrollees must persistently prove that they are still eligible or their coverage will be terminated. While Medicaid enrollment policies for children have become more modernized as policy officials have recognized the importance of continuous, uninterrupted periods of health insurance coverage for children, enrollment policies for adults remain more antiquated. For example, federal Medicaid legislation lets states grant children 12 months of continuous Medicaid enrollment without needing to repeatedly prove eligibility, but this option is not generally available for adults, including the mothers of these children. State options for continuous eligibility also exist for pregnant women (through 60 days postpartum), and for some managed care enrollees (for six months of managed care benefits). Although most states use a 12-month certification period to enroll children, far fewer do so for parents.²² (Note: "12-month continuous eligibility" and "12-month certification periods" are not synonymous. A 12-month certification period means a person need not reapply until 12 months have passed, but the state may still require periodic reporting of income, residency or other data, so the person may lose coverage after, say, three months if she fails to submit a periodic report in time. Under 12-month continuous eligibility, a person is guaranteed 12 months of enrollment in Medicaid without requirements for periodic reporting.)

These problems can be compounded by unnecessarily complicated renewal procedures. For example, although most states permit Medicaid renewals by mail, over the telephone, or through the internet, one state requires in-person renewals, so that a working parent must take time off from work and bring all the appropriate paperwork to the eligibility office in order to keep Medicaid.²³ Because it often takes more than one visit to deliver all the paperwork, the parent might be forced to miss two or three days of work. Many states require that those renewing their Medicaid coverage also submit additional documentation of income, assets or residency, making renewal more complex. Many low-income people enrolled in Medicaid have difficulties meeting these requirements and renewing coverage, because they don't receive renewal notices on time due to their unstable addresses, have unstable employment, have limited literacy or English comprehension, or have limited transportation or phone service.

Analysis of Medicaid administrative data provides insight into the problems of churning and interrupted coverage. Figure 1 presents data about a Medicaid enrollment "continuity ratio," which we compute 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 would mean the average monthly enrollment and total annual unduplicated enrollment are the same, indicating that everyone was enrolled for the entire year. The lower the ratio, the lower the level of continuity of enrollment. These data are based on administrative data reported by states in the Medicaid Statistical Information System (MSIS). As such, the accuracy of these computations is limited by the accuracy and timeliness of MSIS data as reported by states and CMS. (As of June 2009, MSIS data for 2007 was available only for 32 states; we present data here for 2006, which is more complete.)

As seen in Figure 1, the overall national average continuity ratio is 78 percent, which means that an average person enrolled in Medicaid was covered for about three-quarters of the year and lacked Medicaid for the remaining quarter. The continuity ratio is higher (90 percent) for those who are blind or disabled. The aged and children are the next highest, with averages of 82 percent and 80 percent, respectively. The ratio for non-elderly, non-disabled adults (primarily low-income parents) is by far the lowest, at 68 percent.



This indicates that the problems of interrupted coverage are most severe for the non-elderly adults, such as parents, on Medicaid.

The likely explanation for greater continuity among the aged and disabled enrollees is that, because seniors and the disabled are primarily living on fixed incomes, they tend to be enrolled for longer certification periods. Moreover, their Medicaid coverage is often linked to cash assistance under the supplemental security income (SSI), so they can jointly renew coverage for both Medicaid and SSI. Children may have greater continuity because, as noted above, states often have adopted policies that give them longer eligibility periods and simplified renewal. For example, 18 states provide 12-month continuous eligibility for children, while this option is not available for non-elderly adults.²⁴ Even with simplified renewal procedures for children, however, there can be problems if these same procedures do not apply for their parents, making it more difficult for a whole family to renew coverage at the same time.

Table 1 presents state-level data on continuity of Medicaid coverage. Most of the data are for fiscal year 2006, but because MSIS data for 2006 was missing for seven states, we present data for 2004 or 2005 for those states. We present two versions of an overall ratio: one is the overall *unadjusted* ratio and one is the overall *standardized* ratio. Because the ratios vary so much by eligibility category, the unadjusted ratio is strongly affected by the state caseload composition. That is, a state with a high percentage of disabled and a low percentage of adults would naturally have a higher overall continuity ratio than a state which has the same enrollment policies but more adults and fewer disabled. 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, thus, better reflects the policy component of a state's enrollment policies. Based on the standardized enrollment continuity ratios, the ten states with the best continuity of coverage are Arkansas, Connecticut, District of Columbia, Hawaii, Louisiana, Maine, Massachusetts, New Jersey, New York and Tennessee; ratios for these states range from 82.2 percent to 85.6 percent. The ten states with the lowest continuity of coverage are Florida, Georgia, Kansas, Montana, Nevada, North Dakota, Oregon, Texas, Utah and Wyoming, with ratios between 68.1 percent and 74.8 percent.

While the enrollment continuity ratio broadly measures the continuity of enrollment, it is not an optimal or completely accurate measure of retention. For example, if a pregnant woman's eligibility expires upon the birth of her baby, her 60 days of postpartum coverage ends, and she does not qualify for another group, the continuity ratio would fall even though there was no way she could have retained coverage. If a person gains coverage midway through the year, that could also contribute to reducing the continuity ratio. While the enrollment continuity ratio is a measure that can be calculated using the types of Medicaid data that are now available at the national level, states should be able to more directly report the percent of people whose coverage is retained at the end of a certification period.

Continuous Coverage Is More Efficient

In many cases, states hesitate to adopt policies to improve Medicaid continuity and retention because of budgetary concerns. But data show that continuous coverage is an efficient and cost-effective use of financial resources. Earlier analyses have indicated that when people are enrolled in Medicaid for longer periods, their average monthly Medicaid medical expenses are lower.^{25 26}

Table 1.
Enrollment Continuity Ratios for State Medicaid Programs

Based on Medicaid Statistical Information System Datamart for FY 2006, except as noted.

	Overall Unadjusted Ratio	Aged	Blind/ Disabled	Children	Non-elderly Adults	Overall Standardized Ratio
United States	78.5%	82.2%	89.9%	79.6%	68.3%	78.5%
Alaska	75.8%	86.8%	89.6%	77.9%	60.2%	75.9%
Alabama	81.0%	87.6%	89.7%	80.1%	71.0%	79.9%
Arizona*	75.0%	79.7%	89.0%	76.9%	68.9%	76.9%
Arkansas	83.0%	86.0%	86.4%	85.8%	72.8%	82.5%
California	75.7%	87.1%	92.0%	76.8%	68.6%	77.9%
Colorado	76.1%	85.2%	88.6%	75.5%	63.4%	75.2%
Connecticut	83.5%	86.3%	89.7%	83.6%	78.1%	83.4%
Delaware	79.0%	86.3%	90.0%	80.3%	72.9%	80.4%
Dist Columbia*	85.7%	84.4%	87.3%	87.9%	80.6%	85.6%
Florida	74.1%	83.3%	87.8%	75.1%	53.0%	72.0%
Georgia	74.6%	84.2%	88.4%	74.7%	57.6%	73.2%
Hawaii	83.9%	85.8%	87.2%	88.4%	75.5%	84.7%
Idaho	78.8%	83.5%	88.9%	80.4%	59.5%	76.5%
Illinois	77.9%	50.2%	90.7%	84.4%	70.2%	78.6%
Indiana	79.1%	81.8%	88.5%	80.8%	65.2%	78.0%
Iowa	75.8%	83.2%	91.0%	77.2%	61.9%	75.9%
Kansas	76.0%	81.9%	87.6%	76.6%	59.4%	74.3%
Kentucky*	81.3%	84.4%	91.1%	81.1%	63.4%	78.3%
Louisiana	86.1%	87.3%	87.6%	89.0%	69.5%	83.6%
Maine**	83.5%	85.3%	91.8%	85.4%	76.8%	84.1%
Maryland	81.1%	78.5%	88.3%	82.7%	72.4%	80.5%
Massachusetts*	82.8%	85.8%	92.3%	81.8%	76.4%	82.4%
Michigan	80.1%	83.4%	90.2%	83.5%	65.0%	79.7%
Minnesota	76.0%	72.3%	89.0%	77.8%	66.1%	76.0%
Mississippi	80.8%	89.6%	91.3%	76.6%	74.6%	79.5%
Missouri	79.7%	81.3%	83.5%	82.5%	68.0%	78.8%
Montana	74.0%	73.9%	81.9%	75.1%	64.5%	73.3%
Nebraska	78.4%	83.8%	89.3%	79.2%	63.9%	77.2%
Nevada*	68.8%	79.9%	81.1%	69.1%	54.5%	68.1%
New Hampshire	78.0%	80.9%	85.0%	78.9%	64.5%	76.3%
New Jersey	83.5%	86.9%	92.5%	84.3%	70.4%	82.2%
New Mexico	78.5%	85.1%	90.2%	78.8%	70.5%	79.0%
New York	81.4%	84.0%	91.6%	82.1%	76.0%	82.2%
North Carolina	78.3%	86.7%	89.2%	79.1%	61.3%	76.7%
North Dakota	71.8%	80.5%	85.8%	70.3%	60.9%	71.2%
Ohio*	81.2%	81.5%	86.4%	83.9%	71.2%	80.8%
Oklahoma	77.2%	84.5%	87.7%	78.8%	59.1%	75.6%
Oregon	74.9%	83.7%	88.1%	72.1%	69.0%	74.8%
Pennsylvania	82.1%	84.1%	89.7%	81.9%	72.1%	80.7%
Rhode Island	84.6%	84.6%	93.2%	83.7%	79.6%	84.1%
South Carolina	81.0%	64.6%	91.9%	83.7%	77.2%	81.5%
South Dakota	80.3%	84.7%	90.2%	81.3%	65.4%	78.8%
Tennessee	84.8%	82.2%	94.0%	85.4%	73.9%	83.5%
Texas	73.5%	89.0%	89.8%	73.7%	45.4%	70.2%
Utah	68.0%	79.6%	85.2%	68.3%	58.3%	69.3%
Vermont	79.1%	84.5%	89.4%	82.7%	68.3%	80.1%
Virginia	82.0%	86.1%	90.3%	81.9%	70.1%	80.5%
Washington	79.4%	82.9%	86.7%	82.6%	68.3%	79.5%
West Virginia	80.1%	81.8%	89.3%	80.9%	59.6%	76.7%
Wisconsin	80.5%	84.5%	91.0%	80.2%	73.7%	80.5%
Wyoming	75.5%	82.0%	87.0%	76.3%	60.5%	74.4%

* data from 2005

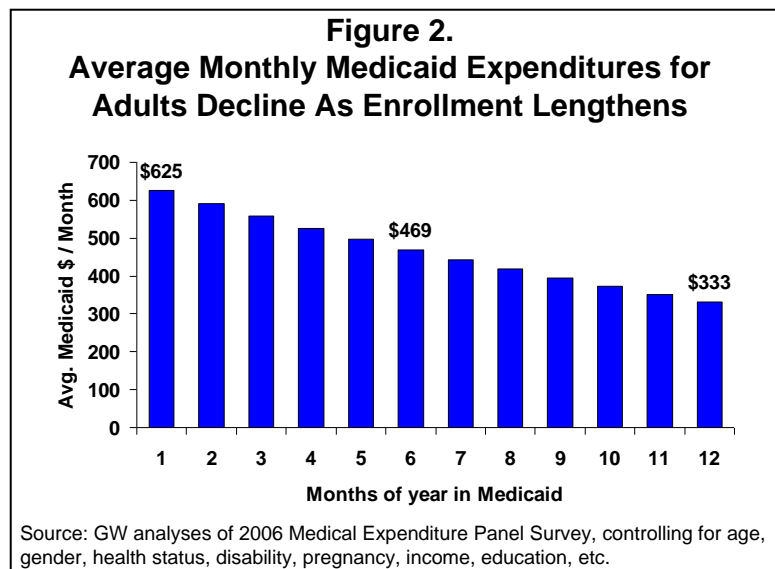
** data from 2004

For this project, GW researchers conducted new analyses about how Medicaid expenditures are affected the level of Medicaid enrollment during a year, using the 2006 Medical Expenditure Panel Survey (MEPS), a nationally representative survey conducted by the Agency for Healthcare Research and Quality. The expenditures measured are the actual medical expenditures paid by Medicaid or an MCO for medical care; they are not the same as capitation payments paid by a state Medicaid program to an MCO or insurer for a month of coverage. We examined how the number of months that a person was enrolled in Medicaid (from a minimum of one month to a maximum of 12 months during the year) affected the likelihood that a person received any Medicaid services during the year, as well as the average monthly Medicaid medical expenses, the average monthly amount paid by Medicaid for physician, hospital or other medical care, prescription drugs, and so on, during the year.

Because medical expenditures are affected by many factors, we statistically controlled for differences attributable to a broad array of factors, including health status, mental health status, presence of a chronic disease, pregnancy, functional limitations, age, race/ethnicity, gender, income, educational attainment, marital status, region of country, urban/rural status, and receipt of supplemental security income.

We ran separate analyses for children, non-elderly adults, and seniors. For all the groups, longer enrollment in Medicaid was associated with increases in the likelihood that a person used medical benefits covered by Medicaid. It is not surprising that longer Medicaid enrollment is associated with greater access to medical care and benefits.

For children and non-elderly adults who used any services, the longer people were enrolled in Medicaid, the lower their average monthly Medicaid expenditures were. This is illustrated in Figure 2 for non-elderly adults. An adult enrolled for just one month in 2006 had an estimated average expenditure of \$625, while an adult enrolled for six months would have average expenditures of \$469 per month



and an adult enrolled for 12 months would have average expenditures of \$333 per month. Therefore, contrary to an intuitive belief that the cost of Medicaid services for a person enrolled 12 months would be *twice* as high as a person enrolled six months, these analyses show that the cost of 12 months of coverage (\$3,006) is only 42 percent more than the cost for six months (\$2,814).²⁷

We found similar reductions for children with more continuous coverage. Our analyses suggested similar reductions may exist for seniors, but the results were not statistically significant. It is plausible that the effects for senior citizens are harder to measure because

Medicare serves as their primary insurer, as almost all Medicaid seniors are dually enrolled in Medicare, and because they tend to have relatively steady enrollment in Medicaid.

There appear to be two reasons why average costs decline when people are enrolled for longer periods. First, as indicated by the research cited above, when Medicaid beneficiaries have more continuous coverage, they receive more preventive and primary medical care, which improves their health and reduces the likelihood of costly emergency room visits or inpatient hospital admissions for ambulatory-sensitive conditions or for mental illness. Thus, continuous coverage can lead to more cost-effective and medically appropriate care. Second, sometimes uninsured people join Medicaid at a time when they need medical care, such as when they become ill or when a woman becomes pregnant. Because of “pent-up demand” for services they did not receive when they were uninsured, they may have higher expenses at the beginning of their period of enrollment in Medicaid, but their medical care needs become less acute after those initial needs are addressed.

Continuous eligibility not only reduces average monthly medical expenses; it also reduces administrative expenses related to disenrollment re-enrollment and new member processing that occur when a person must lose and regains enrollment in Medicaid. For example, in New York, the administrative costs of enrolling a child in Medicaid or that state’s Child Health Plus program were about \$280. Churning these children in and out of the system clearly imposes significant additional costs.²⁸ One study found that California had lost about 600,000 children over three years due to churning, but they were re-enrolled when policies were changed again. The reprocessing of their enrollment cost \$120 million.²⁹ When Washington State shifted children’s certification periods from 12 to six months, administrative costs rose by \$5 million.³⁰ These higher costs accrue to both state and local eligibility offices and to health plans and primary care providers, due to the time and effort it takes to collect the documentation needed, to conduct necessary computer operations, to initiate member processing and education efforts, and so on. Simplification of renewal procedures can reduce paperwork burdens for enrollees, eligibility workers, health plans and providers.

Enrollment Procedures Make a Difference

State Medicaid (and Children’s Health Insurance Program or CHIP) agencies have a variety of tools and options available to them to help improve renewal and retention rates. These have been most often applied for children’s coverage but many can be used for adult populations as well. They include:

- **Twelve-month Medicaid continuous eligibility.** This is already a state option available for children, but not other Medicaid enrollees. Under 12-month continuous eligibility, the state may assure that, once certified, a child retains coverage for the next 12 months and there are no requirements for interim reporting and the attendant risks of disenrollment. As of January 2009, 18 states provided 12-month continuous eligibility for children in Medicaid, although 30 did so in CHIP.³¹ Pregnant women may be granted continuous eligibility in Medicaid that lasts up to two months after the end of pregnancy. In Medicare, dual eligibles (low-income people enrolled in both Medicare and Medicaid)

can be determined eligible for low-income subsidies for Medicare prescription drugs in the next calendar year if they are enrolled in Medicaid as of October of this year. That is, year-long enrollment is assured based on eligibility in the previous October. Because 12-month continuous eligibility for Medicaid is only available to children, a federal legislative change would be required to extend it to other populations.

- **Elimination of an assets test.** For most types of Medicaid eligibility, states have the option to not impose an assets test. Because there are so many types of assets (bank accounts, cars, homes, personal property, and equity in insurance policies), and because low-income people typically have few such assets, assets tests are cumbersome and inefficient to administer. In addition, imposing an assets test discourages low-income people from saving money for important purposes, such as paying for education or buying a car needed to get to work. Assets tests are particularly problematic for those who have recently lost their jobs and exhausted their unemployment benefits; although they have no or low-incomes, they may be unable to get health insurance because they own a car, truck or other asset purchased when they were still working.
- **Simplifying renewal methods.** Rather than requiring an in-person interview, states may use more convenient methods, such as telephone, mail-in, or internet renewal procedures which do not force a person to miss work to reapply. Making a renewal form brief, containing just a few items rather than pages of information, also simplifies and expedites renewal. A host of simple operational changes can also make renewal simpler. For example, in Arkansas, outreach staff place telephone reminder calls to let people know it is time to renew.³² Former enrollees have cited this as one of the most convenient ways to get reminders.³³ When forms are required, the simpler they are, the greater the chance they will be completed. Forms can be prepopulated with key pieces of information already contained in state data, such as name, social security number, address, telephone number and birth date; individuals renewing their coverage can simply note that such information is correct or can make needed changes.
- **Self-declaration of income and residency and paperless renewal.** The more documentation that a person is required to provide in renewal, the more complicated the process becomes. Paperwork documentation is particularly difficult with telephone or internet-based renewals. States already have the option to permit self-declaration of income, assets or residency in Medicaid. Although states may have been concerned that self-declaration can lead to the risks of errors being determined by the Medicaid Payment Error Rate Measurement system, CHIPRA recently amended the rules, granting leeway for states.* If a state permits self-declaration of income, even if the review process detects an inconsistency in actual income, an error is not counted as long as the eligibility office properly followed state procedures when the person was enrolled.

* Under § 601(c)(2) of CHIPRA “the payment error rate for a State shall not take into account payment errors resulting from the State’s verification of an applicant’s self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant’s self-declaration or self-certification satisfies the requirements for such process applicable under regulations promulgated by the Secretary or otherwise approved under the Secretary.”

- **Paperless renewals using automated data.** Rather than ask for documentation of wages, a state may conduct automated wage matches with Employment Security data to check on income or check income data collected as eligibility verification for other programs, such as the Supplemental Nutrition Assistance Program (SNAP, formerly called the Food Stamp Program).³⁴ Ohio conducted a two-year pilot project to test paperless verification and found that approval rates climbed from 65 percent to 85 percent, retention rates also climbed, and the time needed to process enrollment was cut in half.³⁵ Paperless renewals, coupling automated reviews with self-declaration of income and assets, were associated with error rates of three percent or below.³⁶ For many states, a barrier to the use of automated data is the lack of data sharing across programs, or the incompatibility of computer systems. Improved data sharing and matching capability with state Employment Security, SNAP and TANF (Temporary Assistance to Needy Families) programs and with federal Social Security Administration programs could simplify the renewal process. In some cases, these programs also collect income data. In other cases, benefits provided by programs such as unemployment, TANF or Social Security may be counted as income for Medicaid eligibility purposes.
- **Administrative or default renewals.** As noted earlier, in employment-based private insurance, a common approach to renewal is default renewal: at open enrollment if a person does not change his or her insurance policy, it is automatically renewed. States could use a similar approach for Medicaid as well. Florida utilized such an approach to renew coverage for children in its CHIP program, but eliminated it for budgetary reasons. The University of Florida found that after default renewals ended, the rate of disenrollment climbed ten-fold.³⁷
- ***Ex parte* reviews and pending status.** Under federal policy, before a person's Medicaid coverage is terminated, the eligibility office should review whether the person would qualify under other eligibility categories. For example, a woman who had been eligible as a pregnant woman may still be eligible under Section 1931 (low-income) criteria. A person who had been eligible under Section 1931 but whose income increased may be eligible under transitional Medicaid. Unfortunately, these reviews are not always conducted, and a person's coverage is not continued under a pending status until such time as the reviews are completed. Proper application of such policies could substantially reduce churning.
- **Default re-enrollment into managed care organizations.** When Medicaid enrollment is interrupted, people are not always re-enrolled into the same MCOs they had before. If an enrollee does not select a MCO, the enrollee will be automatically enrolled through a random process or plan incentive program into one of the contracted MCOs. If there is no provision to re-enroll the enrollee into his/her previous MCO, the enrollee may be placed in a new MCO. While this does not affect continuity of eligibility for Medicaid benefits *per se*, it can affect continuity of care, because it increases the risk that an eligible individual will be forced to choose a different primary care physician after joining the new MCO. It also creates problems for health care providers, who might have to treat patients without being familiar with them or their medical histories. While many

states use reenrollment into a person's previous MCO as the default option, there are no federal requirements or incentives for such policies.

A study explored the effect of churning in measuring childhood immunization coverage rates under the current system. Data were collected from administrative databases at the CMS and 12 states with high Medicaid managed care penetration. In these states, on average, only 39 percent of the children enrolled in one specific managed care plan met the continuous enrollment requirement. However, CMS data showed that 78 percent of children were enrolled in Medicaid (but not the same MCO) continuously for 12 months.³⁸

Other factors also affect retention. Using longer (12-month) certification periods and not requiring or simplifying the use of periodic income reporting also improve retention rates. Although federal law prohibits charging monthly premiums to most Medicaid recipients, in some states premiums are required for certain enrollees (for example, those with incomes above the federal poverty line). (Premiums are more common in CHIP.) When premiums are required, nonpayment can be another cause of disenrollment, if cash-strapped enrollees are unable to make payments on time for a couple of months. Moreover, in some cases those who do not pay premiums on time may be "locked out" of reenrolling for some period of time, such as six months. Eliminating or reducing premiums can aid retention. Simplifying premium payment rules, expanding grace periods, permitting payroll deduction of Medicaid co-premiums or permitting discounted advance payment (e.g., instead of paying \$10 every month for a year, a person can make a one-time payment of \$60 for the year) can reduce disenrollment associated with premiums.

Language barriers can be another problem. If forms sent out are only in English or if eligibility staff only speak English, those who are not English-proficient will have difficulty completing renewal. Multilingual forms, multilingual staff, interpreters and the use of community groups as facilitators can ease these problems. CHIPRA provides stronger incentives for states to arrange for language translation and interpretation services to enroll or retain those with limited English proficiency by providing a higher (75 percent) match rate for Medicaid and by increasing the applicable CHIP matching rate.

Medicaid income limits also affect continuity of coverage. If a state's Medicaid program has a very low income limit, such as \$500 per month for a person in a family of three (about 33 percent of the federal poverty line), then slight fluctuations in income, due to a minor increase in work hours or pay rate, could trigger to a loss of eligibility. Higher income limits improve continuity of coverage because people are more likely to retain eligibility even when their incomes fluctuate somewhat, as is common among low-income individuals.

CHIPRA emphasized the importance of employing methods for simplifying enrollment and renewal processes for children. Under CHIPRA, states may earn additional federal Medicaid payments for medical benefits as a performance bonus for enrolling more children in Medicaid if they have adopted five of eight policies that simplify enrollment or renewal for children:³⁹

- 12-month continuous eligibility
- No asset test (or simplified asset verification)
- No face-to-face interview requirement
- Joint application and verification processes for Medicaid and CHIP
- Administrative or *ex parte* renewals
- Presumptive eligibility
- Express Lane eligibility
- Premium assistance option

There is substantial overlap between these CHIPRA policies and the policies we discussed above, although the CHIPRA policies are focused exclusively on children. The level of the Medicaid performance bonus is based on applying a higher federal match rate for the number of children who are enrolled in a year above state-specific target levels. For these higher-than-target children, the federal bonus essentially covers 15 percent to 62.5 percent of the state costs of enrolling these children.

Monitoring and Improving Health Care Quality in Medicaid

Continuity in insurance coverage and the resulting reduction of churning are only the first steps in assuring continuity of care, coordination of care, and better health outcomes. Enrollment into Medicaid is of questionable value if we do not know whether those “covered” are able to access quality health care services. Quality, which the Institute of Medicine defines as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge,”⁴⁰ results from getting the “right care to the right patient at the right time, and getting it right the first time⁴¹.” It represents one of the three “legs” of health care (access, cost, and outcomes), encompasses access to both insurance and benefits, and affects long-term costs. Because Medicaid covers more people than any other form of insurance, including Medicare, Medicaid’s impact on the health care delivery system is significant.

Quality monitoring and quality improvement have become central aspects of modern health care delivery. Medicaid statute (§1932) requires that if a state contracts with managed care organizations (MCOs), it must provide comparative information to the extent available on quality and performance indicators for the benefits offered by the MCO. Moreover, the state must develop a “quality assurance and improvement strategy” 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 the populations covered by the MCOs. The state’s strategy must include the utilization of quality information, using standards established by HHS and states. In order for states to implement the quality assessment and improvement strategy effectively, enhanced federal funding is available for external quality review organizations (EQROs) that conduct independent reviews of MCO activities.

However, fewer than half (46%) of Medicaid enrollees are covered under MCOs that are required to meet these criteria; the majority are served under fee-for-service (FFS) or Primary Care Case Management (PCCM) arrangements. PCCM is a basic form of managed care in which enrollees are assigned to primary care physicians (or, in some cases, nurse practitioners)

who provide primary care services and serve as gatekeepers for specialty care. Typically, the primary care physician is paid a small monthly fee (often about \$3) to serve in this role, but individual health care services are reimbursed by Medicaid on a fee-for-service basis. Because there are no federal requirements for quality monitoring or improvement activities among fee-for-service or PCCM clients, information about the quality of Medicaid services is available for only half of those enrolled.

In a time of great concern about creating and maintaining transparency and accountability, the role of quality performance measurement for purposes of improvement and oversight cannot be understated. All stakeholders in the health system are concerned with how quality measurement is going to be used. Consumers want states to provide the results of quality measurement in order to make informed choices and, for that purpose, it is imperative that the measures be fair, replicable, and accurate. Providers seek feedback on their quality results in order to help themselves improve the care they deliver. Thus, providing benchmarks and comparison results is useful. Purchasers such as state Medicaid programs use the information to evaluate the performance of their contractors in order to manage their health care plans, whether through incentives or sanctions. In addition, states – as both policymakers and regulators – have oversight responsibility related to access, utilization, fraud, abuse, consumer experience and health care outcomes, and must use the quality measurements to monitor health system performance.

Current Approaches to Quality Monitoring in Medicaid MCOs

Many states that contract with MCOs use national performance measures, including HEDIS® and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). HEDIS® is a measurement system developed by the National Committee for Quality Assurance (NCQA) and used by more than 90 percent of America's health plans to measure performance on important dimensions of clinical care and service. HEDIS® measures include provider performance on certain clinical indicators, such as the percent of patients who received adequate prenatal care, diabetic care or asthma care, breast, cervical or colon cancer screening. CAHPS is a survey system developed for the Agency for Healthcare Research and Quality; CAHPS surveys ask patients about their experiences and satisfaction with ambulatory or facility-specific care.

Some states have chosen to collect and report “HEDIS-like” measures. Such measures usually have the same numerator and denominator specifications as a HEDIS® measure but, recognizing the higher likelihood of churning among Medicaid and CHIP recipients, exclude the continuous enrollment requirement. Similarly, the CAHPS survey has made an accommodation for the Medicaid population’s length of enrollment by asking commercial and Medicare plan enrollees to rate their experiences in the past 12 months and asking Medicaid and CHIP plan enrollees to rate their experiences in the past 6 months.

States have also chosen various approaches to monitor and determine quality improvement using HEDIS® and HEDIS-like measures, including comparing the performance of a Medicaid MCO over time, comparing the performance among Medicaid MCOs in the same geographic location, comparing Medicaid and commercial MCOs in the same geographic location, and comparing the MCOs to a state and/or national benchmark. With the support of

the Commonwealth Fund and technical assistance provided through the NCQA, a National Medicaid HEDIS® Database/Benchmark Project was established with 1997 data as the base year.⁴² At the end of the first year of the project, the database contained nine performance measures from 110 MCOs representing approximately one-third of all the plans that had Medicaid contracts in 1997, as well as two state-operated primary care case management (PCCM) systems (Colorado and Massachusetts). Even though there are significant limitations to any reporting based on first year data, this study provided some of the first pieces of information related to quality of care and quality of delivery through Medicaid MCOs. In 1999, a single published study examined Medicaid quality of care requirements and found that, of 39 Medicaid agencies, childhood immunizations, use of prenatal care in the first trimester, and satisfaction with care were the quality performance requirements most commonly adopted by states.⁴³ The study also found that states used Healthcare Effectiveness Data and Information Set (HEDIS®) and non-HEDIS measures, but relied on HEDIS® specification as the basis for their own performance measures.

By 2001, the database incorporated HEDIS® data from 168 individual Medicaid MCOs (although the data were unaudited for 29 plans).⁴⁴ Although this original database is no longer funded, NCQA collects Medicaid HEDIS® data voluntarily reported by MCOs and for MCOs who have obtained NCQA accreditation for Medicaid. NCQA's report for 2008 for Medicaid provided information on 52 measures of clinical quality.⁴⁵

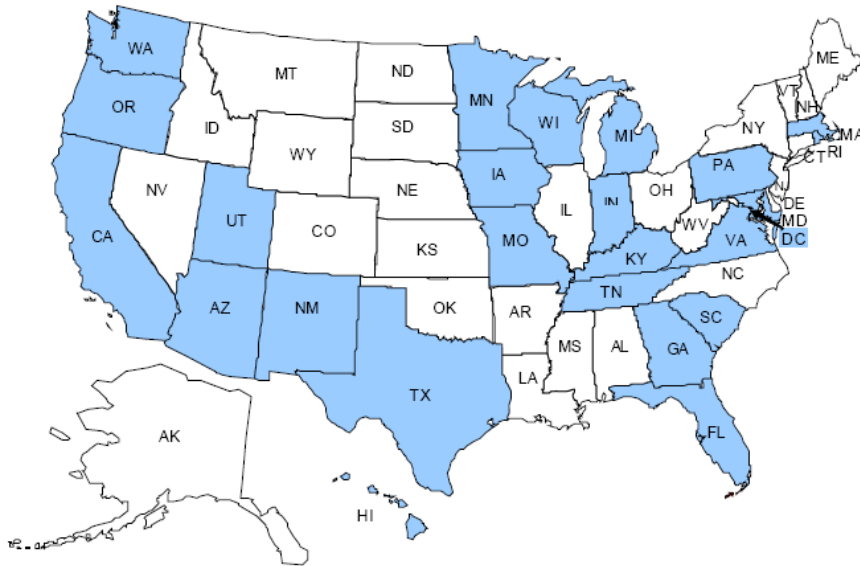
CMS has recently reinitiated a Medicaid modernization and quality measurement analysis project, which is being undertaken by NCQA. The purpose of the project is to provide CMS, state Medicaid agencies, EQROs, and other stakeholders with HEDIS® results from as many Medicaid managed care plans as possible. This data will then provide a set of benchmarks and analysis to support Medicaid managed care quality improvement. NCQA will augment the existing Quality Compass HEDIS® Database with supplemental Medicaid managed care performance data from plans that otherwise would not be included in Quality Compass.

States have also chosen various ways to use the performance measurement data. Some states have used the information to provide feedback to the individual MCOs for purposes of quality improvement. Other states have used the information for public reporting, and some have initiated performance incentives and penalties based on the results. Increasingly, consistent with private purchaser approaches, states have recognized the value of a combination of all three approaches. A recent report stated that “33 of the 37 States required their MCOs to make changes based on EQRO reports, 22 used EQRO reports to share knowledge across plans, and 16 States took other actions, such as setting new performance standards.”⁴⁶ With the passage of the Balanced Budget Act of 1997 (BBA), the Government Accountability Office investigated Medicaid MCO requirements and found that the access and quality requirements specifically addressed the needs of managed care “enrollees who are low income or have special cultural or health care needs, to an equal or greater extent than requirements applicable to Medicare and private sector MCOs.”⁴⁷ A recent NCQA survey indicated that about half the states incorporate NCQA accreditation into their quality oversight strategies for Medicaid (see the map on the next page.)

States are continuing to evolve in their oversight and requirements for Medicaid MCOs. For instance, Michigan releases an annual report on their HEDIS® results by MCO.⁴⁸

Wisconsin's Medicaid program sets incremental goals on selected targets for each MCO and also developed one of the first performance measure systems to include systematic performance improvement mechanisms.⁴⁹

25 Medicaid Programs Use or Require NCQA Accreditation as of March 2009



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Quality Monitoring Outside of MCOs

Quality measurement and improvement processes have traditionally emphasized MCOs for two reasons. First, because capitated managed care plans have capped revenues and typically seek to limit (or manage) certain types of care, there is a theoretical risk of underservice by such plans. Second, as business entities, MCOs can be and should be held accountable for the quality of care, including access to care, provided to patients under their oversight. Thus, quality monitoring systems are used to check that MCOs are providing adequate services, and to develop quality improvement plans.

The same logic should be applied to Medicaid FFS and PCCM arrangements as well. Although FFS and PCCM do not have capped payments, the fact that Medicaid reimbursement rates are often low and that some health care providers may limit care for Medicaid patients means that there is a risk of underservice in FFS or PCCM Medicaid. The extent of quality measurement in Medicaid PCCM and FFS systems is unknown. However, there are limited examples of states comparing and reporting quality across all delivery systems. Both the federal government and individual states have an interest in assessing quality and accountability, regardless of the delivery system.

In a 2006 report, the New York State Department of Health compared rates of performance across standardized measures of quality (i.e, childhood immunization, well-child visits, prenatal care in the first trimester, cervical cancer screening, use of appropriate medications for people with asthma, and comprehensive diabetes care) for New York's Medicaid MCOs and its fee-for-service system. For all but one measure, well child and preventive health

visits age 15 months, quality of care was statistically better under Medicaid managed care than under Medicaid FFS arrangements.⁵⁰ (See Tables 2 and 3 below.)

Some other states have also compared the results of their CAHPS surveys to enrollees of their MCOs and enrollees who receive their care through fee-for-service. In early 2009, Washington released the results of its CAHPS 2008 surveys.⁵¹ For the most part, the differences between managed care and FFS enrollees' responses were not statistically significant. However, two significant differences emerged: (1) managed care enrollees were more satisfied with customer service than were FFS clients, stating that office staff usually or always treated them with courtesy and respect; (2) managed care enrollees were less satisfied than FFS clients with how doctors communicated and explained things in an understandable way.

Table 2
Comparison Between Medicaid Managed Care and Medicaid Fee-for-Service Administrative Measures

Measure	Managed Care		Fee-for-Service		P Value
	Rate	N	Rate	N	
Well-child and preventive health visits age 15 months	55	14 957	62	35 531	<.0001
Well-child and preventive health visits ages 3-6 years	77	75 654	71	118 974	<.0001
Adolescent well care and preventive care visit	64	88 249	47	208 690	<.0001
Prenatal care in the first trimester	63	23 953	59	50 504	<.0001
Use of appropriate medications for persons with asthma					
Ages 5-17	53	9115	51	23 866	.0006
Ages 18-56	62	7094	60	38 381	.0008
Total	60	16 209	55	62 247	<.0001

Table 3
Comparison Between Medicaid Managed Care and Medicaid Fee-for-Service Hybrid Measures

Measure	Managed Care		Fee-for-Service		P Value
	Rate	N	Rate	N	
Childhood immunization					
4-3-1-2-3 Combination	64	9345	50	446	<.0001
4 DTP/DaP	78	9345	64	446	<.0001
3 IPV/OPV	83	9345	71	446	<.0001
1 MMR	88	9345	76	446	<.0001
2 Hib	79	9345	66	446	<.0001
3 HepB	80	9345	68	446	<.0001
Cervical cancer screening	71	11 033	39	687	<.0001
Comprehensive diabetes care					
Hemoglobin (HbA1c) testing	76	7204	32	600	<.0001
Hemoglobin level (HbA1c) in control (low rate is desirable)	53	7204	84	600	<.0001
Eye exam	49	7204	51	600	.1732
Cholesterol test	68	7204	25	600	<.0001
Cholesterol level in control	38	7204	15	600	<.0001
Nephropathy screening	45	7204	18	600	<.0001

DTP/DaP = diphtheria, tetanus, and pertussis; IPV/OPV = polio vaccinations; MMR = measles, mumps, and rubella; Hib = H influenza type b; HebB = hepatitis B.

Tables 2 and 3 are reproduced from Roohan, et al. 2006.

Patients under PCCM arrangements are also at potential risk of underservice because of low Medicaid reimbursement rates, because primary care providers may deny access to

appropriate specialty care or because patients find it burdensome to get approval from their primary care clinicians in advance for other types of care. And, although there are not the same types of business entities involved, it is reasonable to believe that the state Medicaid agency and primary care physicians ought to be accountable for the quality of care provided under their oversight.

A survey of Medicaid agency directors of 46 states and the District of Columbia determined that agencies were less likely to collect performance data in PCCM programs than in MCO programs. Of the 38 agencies with MCO programs and the 25 with PCCM programs surveyed, no states with PCCMs report quality information on mental health/substance use, while a third of the MCO-only states reported mental health/substance use data. Clinical quality and access performance data were collected by less than five states using PCCM programs, while more than half of the MCO-only states collected these measures. Only a few PCCM programs also reported performance results to the public or providers, and where they did report, the results were utilization-based, rather than quality measures.⁵²

EXHIBIT 2
Comparison Of State Medicaid Agencies' Collection Of Performance Data On Quality, By Type Of State And Type Of Program, 2002

Quality domain and indicator	PCCM only (n = 9)		PCCM and HMO (n = 16)				HMO only (n = 22)	
	PCCM		PCCM		HMO		HMO	
	N	%	N	%	N	%	N	%
Satisfaction								
Satisfaction with care	6	67	10	63	15	94	19	86
Access								
Translators	2	22	4	25	5	31	14	64
Kept waiting in office	1	11	3	19	7	44	11	50
Clinical quality								
Early prenatal care	1	11	1	6	13	81	18	82
Cervical cancer screening	2	22	1	6	10	63	14	64
Diabetic glycohemoglobin	2	22	0	0	10	63	12	55
Child immunizations	3	33	1	6	12	75	20	91
Appropriate medications for asthma	2	22	0	0	9	56	10	45
Mental health/substance abuse (MH/SA)								
Proportion of MH/SA admissions who receive a follow-up visit within 30 days	0	0	0	0	4	25	8	36
Proportion with new episode of depression who receive an antidepressant medication	0	0	0	0	3	19	7	32

SOURCE: Survey of Medicaid State Agencies, 2002.

NOTES: PCCM is primary care case management. HMO is health maintenance organization. Performance data were collected in 25 agencies with PCCM programs and 38 agencies with HMO programs.

Reproduced from Schneider, et al. 2005.

Although there is no federal requirement for quality monitoring in PCCM arrangements, some state Medicaid programs have developed their own initiatives. Oklahoma and North Carolina developed quality measurement approaches for their PCCM programs, including the use of HEDIS® measures. These state programs could serve as models for other states, so that both managed care and FFS/PCCM Medicaid programs may have comparable quality measures.

Oklahoma's SoonerCare Choice PCCM program utilizes a variety of HEDIS® measures to assess the quality of its PCCM program. Measures reported include dental access; breast cancer screening; cervical cancer screening; percentage of children who had their annual child checkup under Early Periodic Screening, Diagnosis and Treatment standards in the past calendar year; percentage of children who had at least one primary care provider visit in the past calendar year; percentage of adults accessing preventive or ambulatory services in the past calendar year; care for members with diabetes; and care for members with asthma. SoonerCare Choice also conducts two annual surveys to assess patient satisfaction. One is CAHPS and the other is the Experience of Care and Health Outcomes (ECHO), which addresses behavioral health services.

In North Carolina, both Carolina ACCESS and Community Care of North Carolina PCCM programs report HEDIS® measures to indicate quality of care. The following are the HEDIS® measures for which the PCCM programs collect data: effectiveness of care measures, including breast, cervical and colon cancer screening, diabetes and asthma care, children's and adolescents' vaccinations, and mental health follow-up after hospital discharge; availability of care measures, including children's access to primary care, adults' access to preventive ambulatory services, and prenatal care; use of service measures, including well-child visits, ambulatory care and inpatient utilization; and frequently selected procedures.

States face the same concerns as MCOs on how to balance the cost of collecting quality performance data with the cost of not collecting this information. In order to effectively and efficiently maximize data that is readily available, without medical chart audit burdens, states have tended to focus on HEDIS® measures that can be collected through administrative data for their PCCM programs. Because states have the claims data already in their Medicaid Management Information System claims databases, no additional effort is required on the part of the PCCM provider. States have also chosen to use the CAHPS survey for Medicaid fee-for-service, which allows the state to have comparable experience information, albeit through a survey tool designed for a fee-for-service delivery system model. CAHPS has been developed to assure consistency between approaches used for enrollees in MCOs, as well as enrollees in PCCMs. For instance, in the guidance for implementation of the CAHPS it states that Medicaid managed care enrollees must be enrolled at least 6 months, with a break in enrollment of no more than 30 days, to be part of a CAHPS survey. Those using CAHPS with a PCCM or FFS program have generally applied the same enrollment requirements in the survey methodology.⁵³

The Breadth and Comparability of Quality Measurement

If quality measurement is to be extended beyond Medicaid MCOs to FFS and PCCM systems, there will need to be a core of common, standardized measures, so that comparisons across systems can be fairly drawn. This would require time, effort, and consultation with a

variety of organizations to develop and implement such common measures. Insofar as quality measurement in Medicaid is now primarily oriented to MCOs, and Medicaid MCOs primarily enroll non-disabled families and children, these are the populations for which most quality monitoring standards now apply. Quality standards for children are often rudimentary and CHIPRA has called for developing better measures for child health (discussed more below). While many of those served in FFS and PCCM are also non-disabled families and children, many are aged or disabled Medicaid enrollees who are also enrolled in Medicare. There are gaps in quality standards for some of the relevant health care issues for individuals who have multiple chronic diseases or are aged, whether they are receiving their care through a MCO, PCCM or traditional fee-for-service non-system, which will need to be addressed.

For many years, CMS and state Medicaid agencies have been working together to develop Medicaid quality measures through, for example, the Quality Assurance Reform Initiative (QARI) and the Quality Improvement System for Managed Care (QISMC), both developed in the late 1990s.^{54 55} More recently, CMS and the states have been developing, in cooperation with many other national organizations, a National Medicaid Quality Framework, whose underlying theme of “the right care for every person, every time”⁵⁶ has already been referenced. The National Medicaid Quality Framework does not develop technical quality standards, but provides some key strategies across many domains of care in Medicaid, including preventive care, episodic acute care, chronic medical care, long-term care and end-of-life care. For example, the Framework includes consensus goals, such as every beneficiary having a medical home for primary care, full immunization following CDC standards, avoidance of medical errors, and so on.

Development of a common set of standardized performance measures is feasible, but would require time for development, transition and implementation of these measures across systems. Some of the specific improvements that could be implemented include:

- Expansion of current quality measurement efforts for children and adults to develop and implement a mandatory collection process of nationally recognized performance measures, endorsed by an organization like the National Quality Forum initially for PCCMs and Medicaid MCOs. If comparable measures can be developed, these efforts should be expanded to measure the quality of care for those in the FFS non-system. As electronic medical records and systems become more widely established (as is being encouraged by the health information technology provisions of the American Recovery and Reinvestment Act⁵⁷), it will be easier to measure the quality of care for those in FFS care systems.
- Expansion of quality improvement and oversight efforts under QISMC and standardization of reporting on quality structures, processes and outcomes through consultation with an advisory committee to determine populations, services and measures to be addressed; the role of public reporting; and the aligning of incentives across payment and service delivery approaches, including PCCM and FFS models of delivery.

To help states pay for these quality monitoring and improvement activities, states could use existing enhanced federal match provisions that are already available for EQROs and for “skilled medical professionals”.

New Child Health Quality Measures

The importance of strengthening quality measurement systems in Medicaid was recognized in recent legislation. Section 401 of CHIPRA provided \$225 million over five years for a variety of new child health quality initiatives. These include: developing and implementing a core set of evidence-based health quality measures for children enrolled in Medicaid and CHIP; improving state reporting of quality data for child health programs; initiating demonstration programs to improve quality; and establishing a program to encourage the creation and dissemination of model electronic health record format for children. CHIPRA specifically addresses measurement of availability and effectiveness of health care in ambulatory and inpatient settings. CHIPRA does not dictate a specific structure or format for quality monitoring and improvement for child health, but calls for the development of a standardized reporting format, and encourages states to voluntarily report on the quality of pediatric care, as well as calling upon the Institute of Medicine to study child health measurement systems and to provide a report to Congress.

Unlike the preexisting quality monitoring and improvement provisions of the Medicaid act, which are confined to MCOs, the CHIPRA provisions appear to apply more broadly to state Medicaid and CHIP programs, even when they are not operated as managed care programs. However, they are targeted to services for children, and would not apply to adult populations served by Medicaid.

Recommendations: The Medicaid Continuous Quality Act

Because of concerns about poor continuity of coverage and limited quality monitoring and improvement activities in Medicaid, ACAP is developing a legislative proposal, entitled the Medicaid Continuous Quality Act (MCQA). The proposal has two primary goals: (1) to improve the continuity of coverage for Medicaid enrollees, and (2) to strengthen quality monitoring and improvement procedures in Medicaid. Taken together, these provisions should reduce the number of uninsured low-income Americans and assure them greater security of coverage which in turn should ultimately lead to better quality care.

The MCQA is designed to complement provisions that were included in the recently-enacted Children's Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA extends performance bonuses to states that adopt policies to simplify or improve children's enrollment or retention and whose child enrollment levels exceed certain state-specific targets. The MCQA makes similar performance bonuses available to states that adopt policies to improve retention of coverage for adult populations, including the aged, the blind or disabled, and non-elderly, non-disabled adults such as parents or caretaker relatives. CHIPRA also included processes to help design and improve the measurement of the quality of health care for children. The MCQA seeks to make quality monitoring efforts in Medicaid more comprehensive, to include not only capitated managed care programs, but also PCCM or fee-for-service delivery systems.

The MCQA is also designed to complement efforts that will be considered as part of national health reform this year. Three key objectives of health reform are to decrease the number of uninsured people in the United States, to make health care more efficient, and to improve the quality of health care delivered. By improving retention of coverage for low-income adults in Medicaid, ACAP's legislative proposal will reduce the level of uninsurance and improve the quality and continuity of care for low-income adults in Medicaid. Moreover, as indicated earlier in this paper, improving the continuity of coverage will make care more efficient and cost-effective, both from the perspective of medical and administrative costs. Third, upgrading quality measurement systems in Medicaid will ultimately enable state and federal administrators to better assess the quality of care in Medicaid and to use an approach of continuous quality improvement. These efforts, in combination with improved continuity of coverage, should improve the quality of care received by Medicaid enrollees.

Two specific ideas for improving continuity of coverage appear to already be under consideration by Congress. Recent Congressional proposals for health reform include expanding Medicaid eligibility nationally to individuals with incomes ranging up to 100 or 150 percent of the federal poverty level for pregnant women, children and non-elderly adults. The Senate Finance Committee report also discussed simplifying enrollment and retention options by requiring states to implement 12-month continuous eligibility.⁵⁸ Expanding income eligibility would improve continuity of coverage by broadening the range of permissible incomes, so that a person would be less likely to lose eligibility because of slight changes in income. Requiring 12-month continuous eligibility would further improve continuity. We recognize that these changes could increase state costs for Medicaid and assume that federal health reform legislation would include methods to defray these costs for states.

Key elements of the MCQA proposal are described below.

Improving Retention and Continuity of Enrollment

1. Require 12-Month Continuous Eligibility. States would be required to provide 12-month continuous eligibility to most child, adult, aged, blind and disabled enrollees. This option would not apply to certain enrollment groups: those enrolled in Medicaid because they receive Supplemental Security Income (SSI) benefits, those whose Medicaid coverage is based on medically needy spend-down provisions, and pregnant women – whose coverage would be guaranteed through pregnancy and 60 days postpartum. SSI beneficiaries are not included because their eligibility is linked to SSI participation and is set by the Social Security Administration. Medically needy enrollees have much more complex enrollment patterns because of Medicaid spend-down provisions. States would have the option to begin implementation upon enactment of the law and must implement it for all persons enrolled or renewed after September 30, 2010.
2. Performance-based Bonus Payments. This component would provide additional federal funding to states that both adopt procedures designed to enhance retention of coverage and increase the level of measured continuity of enrollment beginning in FY 2013 for: (a) the aged, (b) the blind or disabled, and (c) other non-elderly, non-disabled adults, including parents and caretaker relatives. These would help simplify renewal of coverage after the 12-

month period. Because CHIPRA already included similar bonuses to increase children's enrollment, the proposal would not modify performance bonuses for children.

- a. Qualifying Procedures. To qualify, a state must adopt at least three of the following five policies (all these options are already permissible in Medicaid) by the beginning of the fiscal year:
 - i. Elimination of the requirement for in-person interviews
 - ii. Use of administrative renewals, which minimize paperwork requirements for those who are renewing coverage
 - iii. Enhanced electronic data-sharing between the Medicaid eligibility and other agencies, such as the Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp Program), other programs permitted under Express Lane enrollment, state employment security agencies, and the Social Security Administration, for the purpose of determining or renewing eligibility
 - iv. Eligibility based on pending status, before a person's renewal status has been determined and before alternative eligibility categories have been ruled out
 - v. Default re-enrollment into individuals' previous managed care organization for those who have been disenrolled for less than six months, with an exception for those who voluntarily choose to enroll in a different health plan than they had before.
 - b. Improved Enrollment Reporting. HHS will collect data about continuity of enrollment and retention in each state and must publish annual reports beginning September 2012, which include performance data for each state. The Secretary will, at a minimum, compute Medicaid enrollment continuity ratios using Medicaid Statistical Information System data and may collect and report other measures of retention.
 - c. Performance Based Bonuses to States. For FY 2013 and subsequent years, the Secretary will provide federal bonus payments to states that meet the three-of-five requirement in (a), and that improve the continuity of enrollment by aged, disabled and adult populations, compared to a baseline of state performance in FY 2012, based on regulations developed by the Secretary. These payments must be paid to states within 12 months of the end of the fiscal year being measured. A new fund of \$500 million per year will be made available to the Secretary and will be used for the payment of state performance bonuses.
3. Enhanced Matching for Electronic Data Sharing. The federal matching rate for administrative expenditures to develop data sharing systems for improved enrollment or retention will be increased to 90 percent, in addition to the current 75 percent matching rate that applies to the operation of such systems.

Expanding the Scope of Medicaid Quality Monitoring

4. Expansion of Scope. Within 2 years, HHS should develop a system and process to be used by states to report on the quality of care delivered by managed care organizations, PCCMs or providers engaged in fee-for-service care. The system would be designed to permit comparisons of quality measurements across systems nationally or by state.

- a. In developing this system, HHS will consult an advisory group whose members represent diverse interests, including state agency officials, Medicaid-focused health plans, health care providers, consumers, representatives of national organizations with expertise in health care quality and performance measurement and public reporting, and representatives of voluntary consensus standard- setting organizations and other organizations involved in the advancement of evidence-based measures of health care.
- b. Where feasible, the system shall permit a direct comparison of different types of managed care entities, including managed care organizations, PCCMs, and fee-for-service care. The measures used will be reviewed and approved by the National Quality Forum.
- c. Following consultation with the aforementioned advisory group and development of such a quality measurement program, HHS will introduce its description into the Federal Register. Initial reporting of quality will begin within two years of enactment of the Act.
- d. The system will, at a minimum, include measures such as: the duration of health insurance coverage over a 12-month time period; the availability and effectiveness of preventive services; treatments and follow-up care for acute conditions; treatment and management of chronic physical and behavioral health conditions; availability of care in both ambulatory and inpatient health care settings; and other measures relevant to measuring the quality of health care for Medicaid enrollees to allow for comparability across health care delivery approaches.

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