

Enrollment and Disenrollment in MassHealth and Commonwealth Care

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About the Massachusetts Medicaid Policy Institute

The Massachusetts Medicaid Policy Institute is an independent and nonpartisan source for information and analysis about the Massachusetts Medicaid program (often referred to as “MassHealth”). MMPI seeks broader understanding of MassHealth and a rigorous and thoughtful public discussion of the program’s successes and challenges ahead.

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Executive Summary

Massachusetts has made great strides in making health insurance attainable for nearly all of its residents, and the state's main public coverage programs — MassHealth and Commonwealth Care — have been a significant component of this achievement. Beyond getting coverage, though, it is necessary to *maintain* coverage, because continuity of coverage is an important element of access to care, particularly among those with frequent medical needs.

Evidence from MassHealth and CommCare, and from Medicaid and CHIP programs in other states, suggests that a sizable number of people are unable to maintain their coverage over a period of time, despite remaining eligible for the program. There are a number of reasons for this enrollment volatility, including:

- an enrollee's income has increased or they have gained access to employer-sponsored insurance;
- an enrollee does not want to or is unable to pay required premium contributions; or
- an enrollee fails to return paperwork or provide other necessary documentation of their eligibility, in some cases because MassHealth does not have a current address for them.

Of those who are disenrolled, some will come back to the program at a future date and requalify for benefits, while others will transition to another public program, private coverage or uninsured status. If an individual returns to the program after a short time, it is often because the initial disenrollment was due to a failure to return paperwork, provide adequate documentation of income or employment status, or some other reason unrelated to conditions of financial eligibility. These administrative closings followed by swift reopenings — sometimes called “churning” — can disrupt people's access to health care.

Not all movement on and off of programs is churning: some enrollment and disenrollment is a natural and legitimate consequence of a program where eligibility is based on income and employment circumstances that are subject to frequent change. Federal requirements and the desire for good fiscal management impel states to remove from program rolls individuals who are not eligible. In tight budget times, states also often use administrative requirements such as more frequent eligibility redeterminations as a means of managing program growth. Nevertheless, good public policy should reduce unnecessary churning to the extent possible, because continuity of coverage means better health care and also reduces the administrative costs of repeated cycles of disenrollment and re-enrollment.

This report explores the extent of churning in Massachusetts coverage programs, possible consequences, and possible remedies for unnecessary enrollment volatility. The key findings include:

- **The consequences for those who encounter even a temporary loss of their health insurance coverage are extensive, significant, and often detrimental.** Recent studies have also shown that the simple transition from one insurance program to another, even if there is no gap in coverage, still “affects access to care at a very basic level.”¹ This finding is relevant to the structure of health insurance in Massachusetts, which features multiple public programs with separate though sometimes overlapping eligibility standards and provider networks.
- **People who experience a coverage gap of any length face substantial barriers to accessing affordable, quality care.**² In general, people who experience a disruption of coverage tend to underuse preventive care.³ Demographically, individuals with a gap in coverage are more likely to be less educated, poor, and have private non-group insurance.⁴ Beyond the clinical consequences of volatile coverage, there are financial ones, both in terms of increased health care use after a coverage gap and increased administrative costs when programs enroll and re-enroll the same person.
- **Massachusetts compares favorably with available national data and data from selected states on enrollment volatility.** When comparing the “continuity ratio,” a measure of the amount of continuity in coverage for Medicaid enrollees, analysis of Massachusetts data from 2006 estimated the state’s ratio at 82%, among the highest in the nation (a higher ratio means better continuity of coverage). The overall national rate was 78%. Compared with five other states in a study of gaps in coverage for children in Medicaid, Massachusetts was in the middle of the pack. 28% of MassHealth enrollees experienced at least one gap in coverage during a three-year period, while rates for other states ranged from 16% in Pennsylvania to 41% in Oregon (a lower rate means there were fewer gaps).
- **Analysis of data from 2008 and 2009 shows that, in an average month, more than 12,000 individuals who were disenrolled for an administrative reason within the preceding 90 days were re-enrolled in either Commonwealth Care or MassHealth.** This amounts to nearly a quarter of all individuals disenrolled from the two programs for administrative reasons. This pattern suggests that many individuals probably remained financially eligible despite losing coverage for administrative reasons. The administrative costs associated with each enrollment are estimated to be about \$200 per enrollee, per enrollment cycle, so there is some savings to be realized if this type of disenrollment could be reduced.
- **Transitions between programs also present possibilities for gaps in coverage.** Among the three programs for which MassHealth determines eligibility (MassHealth, CommCare and Health Safety Net), an average of 9,800 people per month moved onto MassHealth from the other two programs from January 2008 through April 2009, and 9,400 per month moved onto CommCare from MassHealth and the HSN. This represents over a quarter (27%) of all MassHealth case openings and two-thirds (67%) of all CommCare openings,

and brings considerable administrative expense and increased risk of gaps in coverage or access to care. Though most transitioned without a gap in coverage, a significant number did experience a gap: 17% in MassHealth and 16% in CommCare. In addition, most transitions to Commonwealth Care involve at least a small gap, because CommCare coverage does not begin until the first of the month following eligibility determination, regardless of when previous coverage ends. (CommCare members are enrolled in the Health Safety Net during this period.)

Table ES1 provides a summary of the Massachusetts data and points of comparison included in this report.

Table ES1. Summary of findings about enrollment volatility in MassHealth and Commonwealth Care

Indicator	Source	Population (Year)	Major Finding
Continuity Ratio: portion of the year the average MassHealth member is continuously enrolled	Ku et al. (2009)	Mass Health (2006)	MA better than national average
Gaps in Coverage among children for any reason and any length of time over a 3-year period	Fairbrother et al. (2007) and MassHealth data	MassHealth children (2001-03)	Compared with 5 other states, MA children have an average likelihood of experiencing any gap, and they have a high number of gaps of relatively short duration.
Frequency of and reasons for openings, closings and reopenings in MassHealth and CommCare	MassHealth data	MassHealth/CommCare (2008-09)	In MassHealth, almost a third of monthly reopenings had been closed within past 90 days, three-quarters of them for administrative reasons; in CommCare, 12% of reopenings had been closed within 90 days, 81% for administrative reasons (based on number eligible, not necessarily enrolled).
Transitions between programs	MassHealth data	MassHealth/CommCare/HSN (2008-09)	Transitions from other programs comprise a significant share of case openings in MassHealth and CommCare, and about one in six transitions includes a coverage gap.

Some states, including Massachusetts, have adopted a combination of simplification and retention strategies in their Medicaid and CHIP programs⁵ to increase program retention. These include longer enrollment periods before redetermination, allowance for renewals over the phone, and the use of administrative data systems (rather than documentation such as pay stubs) to verify eligibility.

Massachusetts has recently begun to focus on how to improve its administrative processes to promote retention, as a grantee of the Robert Wood Johnson Foundation’s “Maximizing Enrollment for Kids” program. An independent diagnostic assessment⁶ of Massachusetts done for that program found churning among children to be an area for potential improvement. The state has responded with an action plan that aims to increase retention, improve data use and capacity, and improve customer service. A key step for the retention goal is to evaluate a number of innovations for possible adoption by MassHealth, including:

- Administrative renewal: pre-printed forms that only require a reponse if circumstances have changed;
- Ex-parte renewal using Food Stamp eligibility data to verify continued MassHealth eligibility;
- Ex-parte renewal using Department of Revenue’s quarterly wage match;
- 12-month continuous eligibility; and
- Centralized electronic document management.

A parallel program to smooth transitions and reduce the occurrence of gaps across programs would be equally fruitful. But Massachusetts must consider its efforts to streamline administrative processes and reduce churning through a prism of program integrity. The challenge to program administrators designing solutions is to effect these improvements while always remaining conscious of the need to minimize fraud and overpayments, and to comply with related federal requirements. While improvements in efficiency and fairness clearly are possible, state program officials remain ever-conscious of the policy imperatives of payment accuracy and financial responsibility.

Background

This policy brief examines enrollment volatility in Massachusetts’ two main public health insurance programs, MassHealth and Commonwealth Care. Cycling on, off and between programs can disrupt a person’s access to care, so minimizing volatility can benefit enrollees, as well as reduce administrative burdens on the programs. Some volatility is unavoidable and justified, reflecting the role of these programs as a safety net that provides coverage to low-income people only when they have no other options. There is much avoidable volatility as well, though; identifying why it occurs and designing policy innovations to reduce it can improve the experience of both program enrollees and administrators.

Massachusetts has used expanded eligibility for Medicaid and CHIP (MassHealth) as a key policy tool to provide coverage to uninsured adults and children in the Commonwealth. In 2006, the state created the Commonwealth Care (CommCare) program, which provides subsidized health insurance to certain low-income individuals who enroll in managed care organizations and are not eligible for MassHealth. The state also has enacted a requirement that all adults have health insurance, though some residents may be exempted from that mandate if affordable coverage is not available to them. MassHealth and CommCare coverage are integral to providing high quality health care to about 1.4 million residents of the state and to making progress toward the state's goal of coverage for all. The state also continues to operate the Health Safety Net (formerly the Uncompensated Care Pool) to cover medical expenses of individuals who do not qualify for MassHealth or CommCare and are exempted from the state's health insurance mandate. Eligibility for all programs is based in part on one's income.

To maintain program integrity and to comply with federal law, MassHealth administrators determine eligibility for all three programs — MassHealth, Commonwealth Care and the Health Safety Net — through an integrated process meant to approve individuals only for the program for which they qualify on the basis of income and other characteristics.* MassHealth also regularly redetermines the eligibility of MassHealth and CommCare members. This involves verifying such factors as income, employment status, and availability of employer-sponsored health insurance. Both programs redetermine eligibility for their members annually, on a rolling basis. Both have rules about the length of time allowed for an enrollee to respond to information requests before they are disenrolled.

Massachusetts, like other states, also uses redetermination as a tool to control overall program enrollment during economic downturns. States' ability to use this tool is curtailed during the the current recession, though, by the American Recovery and Reinvestment Act (ARRA) of 2009, which requires state "maintenance of effort" in order to qualify for additional federal Medicaid funds.

The redetermination process results in termination of eligibility for a significant number of MassHealth and CommCare enrollees each month. Terminations may result from either unavoidable or avoidable circumstances. An unavoidable termination occurs, for example, because an enrollee's income has increased or she has gained access to employer-sponsored insurance. Some CommCare members disenroll because they do not want to or are unable to pay required premium contributions. These transitions are a natural and legitimate consequence of a program where eligibility and cost sharing requirements are based on

* Though the Connector Authority administers Commonwealth Care, including enrolling members into managed care plans after they are found eligible, MassHealth is responsible for eligibility determination, because Commonwealth Care is authorized under the state's federal Medicaid waiver.

income and employment circumstances that are subject to frequent change. In contrast, avoidable terminations are caused by administrative lapses such as the failure to return paperwork or provide other necessary documentation of eligibility. In some of these cases, people are disenrolled because MassHealth does not have a current address for them and redetermination forms do not reach the enrollees.

Of those who are disenrolled, some number will come back to the program at a future date and requalify for benefits. If an individual returns to the program after a short time, it is often because the initial disenrollment was due to an administrative failure unrelated to conditions of financial eligibility. These administrative closings followed by swift reopenings — sometimes called “churning” — are prime examples of avoidable volatility *within* programs that can be reduced in order to improve people’s access to health care and relieve unnecessary administrative burdens. In addition, Massachusetts’ complex structure of multiple programs contributes to unnecessary coverage gaps that result from moving *across* programs. Table 1 gives examples of both of these types of avoidable volatility.

Table 1. Examples of administrative causes of coverage gaps in MassHealth and Commonwealth Care

Scope of Issue	Precipitating Event	Consequences	Affected Programs
Volatility within programs	<ul style="list-style-type: none"> Member does not submit redetermination information or fails to respond to Job Update Form Member does not receive redetermination letters or other requests for information, or letters are returned “whereabouts unknown” Completed redetermination information does not reach MassHealth 	Termination of coverage; may be reinstated when information is provided and received, if member is still financially eligible	MassHealth, Commonwealth Care, Health Safety Net
Volatility when transitioning across programs <i>[also see Appendix]</i>	When moving from MassHealth to CommCare because of income or other eligibility change, MassHealth coverage may end at any point in a month, but Commonwealth Care coverage only starts on the first of the month, provided timely payment has been made during the previous month.	Gap in coverage due to mismatch between MassHealth and CommCare timing. People lose MassHealth eligibility based on MH time lines. Retroactive coverage is not available in Commonwealth Care.	Commonwealth Care

Good public policy would reduce unnecessary coverage gaps to the extent possible, as there is evidence that continuity of coverage increases the likelihood that insured individuals will

obtain preventive care and aids in the management of chronic conditions.⁷ More generally, gaps in coverage have been shown to add to the administrative costs of public programs and to undermine continuity and quality of care for enrollees.⁸ On the other hand, good fiscal management requires that we enroll in public programs only those who are eligible.

This report explores the extent of enrollment volatility in Massachusetts programs, potential consequences of that volatility, and possible remedies for unnecessary volatility. It begins with a review of the research on the consequences of discontinuous coverage and of the evidence from the literature on its extent nationally and in other states, as a basis for comparison to Massachusetts. It then presents recent enrollment and disenrollment data from Massachusetts. Next, the brief discusses federal rules regarding enrollment, redetermination, and program integrity that might limit state action to reduce churning, and some of the strategies that states have adopted. Finally, it examines the Massachusetts situation in more depth: the ways in which eligible people may become disenrolled, and what the state is doing now to reduce volatility while ensuring program integrity.

The consequences of enrollment volatility: a review of the literature

The benefits of continuous health insurance coverage are well documented in the research literature.⁹ The consequences for those who encounter even a temporary loss of their health insurance coverage are extensive, significant, and often detrimental. Recent studies have also shown that the simple transition from one insurance program to another, even if there is no gap in coverage, still “affects access to care at a very basic level.”¹⁰ This finding is relevant to the structure of health insurance in Massachusetts, which features multiple public programs with separate though sometimes overlapping eligibility standards and provider networks.

People who experience a coverage gap of any length face substantial barriers to accessing affordable, quality care.¹¹ Continuity of coverage, more than the type of coverage, is the key to access.¹² Much of the research in this area has looked particularly at children in Medicaid and the Children’s Health Insurance Program (CHIP). For example, discontinuous coverage limits access for children in similar ways to being consistently uninsured.¹³ Children with interrupted coverage are more likely than those who are continuously insured to report having experienced a delay in care, a missed appointment,¹⁴ an unmet medical care need, or an unfilled prescription.¹⁵ Families that experience even marginal disruptions in coverage are also more likely than the continuously insured to report less access to a medical home, an inability to obtain necessary prescriptions, and are less likely to seek regular or preventive care

for their children.¹⁶ Indeed, children with gaps in coverage receive levels of well-child care below the levels recommended by the American Academy of Pediatrics, which in turn may lead to long term “decrements” in utilization.¹⁷ Naturally, children with greater need for more frequent care, such as those with disabilities, chronic illness, and birth defects, are particularly vulnerable to gaps in coverage.

A smaller body of research has studied the consequences of discontinuous coverage for adults, finding similar consequences as for children. Adults with gaps in coverage typically use less ambulatory care and more emergency room services, face increased costs, and experience poorer health outcomes.¹⁸ According to a 2006 survey, adults who encountered gaps in coverage were twice as likely to use the emergency room or spend the night in a hospital, and were more likely to report not understanding a diagnosis or treatment following a medical appointment.¹⁹

In general, people of any age who experience a disruption of coverage tend to underuse preventive care.²⁰ Demographically, individuals with a gap in coverage are more likely to be less educated, poor, and have private non-group insurance.²¹

Beyond clinical consequences of volatile coverage, there are also financial consequences. Patients and their families who spend any time uninsured are at heightened risk of catastrophic medical bills.²² Costs are also borne by safety net providers, state governments, and health plans that must reestablish eligibility and reenroll those who return to the system. According to a study of California’s Healthy Family (CHIP) Program, costs averaged \$5.9 million per month for children in the 6 months prior to a 3-month gap in coverage, but increased to approximately \$13.5 million in the first month following the gap and averaged over \$10 million per month for the ensuing 6 months.²³ Further, the study showed that the longer the gap in coverage, the higher the cost following the gap. For instance, after gaps of three, six, and twelve months, total costs increased 1.7, 1.9, and 2.1 times (respectively) the costs observed in the period prior to the gap.²⁴ Administrative costs can also be significant. Various studies have found costs of enrolling people into public programs to range from \$180 per person, per enrollment in California²⁵ to \$280 per person, per enrollment in New York.²⁶ Massachusetts estimates the comparable cost to be \$198.²⁷ These costs multiply every time an eligible recipient loses coverage and must be re-enrolled.

State and national statistics on enrollment volatility

There is no standard definition of “churning” — avoidable disenrollment and reenrollment — nor are there standard reports of churning to allow state comparisons of the extent of

enrollment volatility and the contribution of state policies — positive and negative — to churning rates. Much of what is available can only be distilled from discrete pieces of policy research, conducted independently and using a number of different methodologies. Some studies look at involuntary disenrollment that occurs, in spite of continuing financial eligibility, as a result of administrative processes. Others look at the frequency and length of gaps in coverage that Medicaid and CHIP enrollees face, regardless of the reason for the gap. Still others look at the absence of volatility — that is, the average length of time that coverage continues without a disruption. Results that use these different methods are not directly comparable. They address different policy questions and may suggest different solutions. Nevertheless, they are all concerned with breaks in coverage that can upset the continuity of health care, and they provide a context for examining the extent of volatility in Massachusetts.

Following is a summary of selected state and national studies, most of which focus on children. Churning likely affects adults to a greater degree because many existing retention efforts (such as 12-month continuous eligibility) target only children.²⁸

National data

One study found that, over a 3-year period, 84.8 million people under age 65 in the U.S. — 38 percent of the population — experienced at least one month uninsured, a third of whom (28.2 million) were repeatedly uninsured. The repeatedly uninsured included 8 million children and 9.1 million adults with incomes below 200 percent of the federal poverty level (FPL), most of whom were covered by Medicaid at some point.²⁹ Other research found that, among children who have their CHIP coverage terminated following redetermination, nearly a quarter are subsequently reenrolled.³⁰

A recent study presents a “continuity ratio” as a way to measure the extent to which Medicaid recipients are continuously enrolled and for evaluating the effectiveness of enrollment policies within a state. The continuity ratio for a Medicaid program is

$$\frac{\text{Average monthly number of Medicaid enrollees over one year}}{\text{Total unduplicated enrollment during year}}$$

The average continuity ratio in the U.S. is 78%, meaning the average Medicaid recipient is enrolled for 78% of the year, implying some degree of discontinuity. (The optimal continuity ratio is something less than 100% because some people leave Medicaid for legitimate reasons — they are no longer eligible for benefits — and because some administrative friction is inevitable in trying to keep eligible people enrolled while maintaining program integrity.) Continuity ratios vary by type of Medicaid enrollee and by state. Analysis of data from 2006 estimated the Massachusetts ratio at 82%, among the highest in the nation (a higher

ratio means better continuity of coverage). The disabled and elderly had the greatest rates of continuity. Children had greater continuity than non-disabled and non-elderly adults, most likely due in part to existing efforts to simplify the redetermination process and the adoption of continuous eligibility policies for children.³¹ Public programs also usually have broader eligibility ranges for children, making transitions between programs less likely for children than adults.

**Table 2. Standardized* continuity ratios for U.S. and MA
(A higher ratio means better continuity of coverage)**

	National	MA
Overall	78%	82%
Blind/disabled	90%	92%
Aged	82%	86%
Children	80%	82%
Adults	68%	76%

*In state to state comparisons, the continuity ratio was adjusted for differences in age and disability.

[Source: Ku et al. (2009)]

State data

California

An analysis of California’s Medicaid program (Medi-Cal) demonstrated that the frequency of gaps in coverage (for any reason) varied by eligibility category. The percentage of recipients with at least one gap in coverage over a 3-year period was highest (28-31%) for children whose eligibility was based on their income rather than receipt of public assistance, and lowest for those receiving SSI (3%).³² The median gap in enrollment was 3 months and the mean number of gaps over three years was between 1.1 and 1.3 depending on the eligibility category.³³ Most children experienced only a single break in coverage; a quarter of these children were reenrolled within 6 months and upwards of one half were reenrolled within 3 years.³⁴ In any given year, 10% of Medi-Cal children leave the rolls and subsequently reenroll and, over three years, almost 20% experience at least one gap in coverage.³⁵

New York

As in other states, many children in New York are disenrolled during the annual eligibility review process. In a published study, approximately one-half of the children due for recertification each month in New York’s CHIP program failed to complete the process

and more than 85 percent of Medicaid beneficiaries (who also receive public assistance) failed to complete recertification in a typical month. Of all families that failed to complete recertification, three-quarters remained financially eligible. The families that failed to complete the redetermination process, on average, had lower household incomes than families that successfully completed the process. Twelve Medicaid managed care organizations in NY reported losing 4 percent of their membership each month to involuntary disenrollment.³⁶

Multiple states

An evaluation of the State Childrens’ Health Insurance Program includes a review of four studies that measured re-enrollment following periods of disenrollment between 3 and 12 months. The studies spanned 16 states and found a range of re-enrollment rates — from 3 to 26 percent of disenrolled children re-enrolled within three months, and 10 to 46 percent re-enrolled within 12 months.³⁷

Another study of enrollment gaps and continuity over three years in five states provides a rare comparison of volatility across states using a single methodology.³⁸ The five states differ somewhat in their administrative processes for enrollment and redetermination, so this treatment allows us to consider how certain policy changes may affect churning rates. MassHealth has produced data, using the published methodology from this multi-state study, to compare Massachusetts’ experience with these states.

Table 3. Patterns of enrollment for Medicaid children in 6 states from January 2001 – December 2003

	PA	CA	OH	MI	OR	MA
At least 1 gap* in 3-yr period	16%	18%	23%	40%	41%	28%
<i>(a lower value means better continuity of coverage)</i>						
Mean # of gaps	1.09	1.14	1.14	1.30	1.32	1.31
Mean length of gap (months)	5.11	5.43	5.61	4.49	6.13	3.89
Median length of gap (months)	3	3	3	2	4	1.55
% continuously enrolled during 3-year period for						
All 3 years (a higher % is better)	54%	52%	48%	34%	31%	52%
At least 1 year	81	79	80	69	62	74
Less than 1 year	19	21	20	31	38	26

Source: PA, CA, OH, MI, OR: Fairbrother et al. (2007); MA: Office of Medicaid

Data for CA, OH, MI, OR and MA are for children age 3-17; PA age 5-17.

* A gap is any length of time disenrolled with a subsequent return to rolls.

Massachusetts data

An examination of the dynamics of the MassHealth and Commonwealth Care caseloads, by looking at aggregate data on case openings and closings, also yields some insight into potentially avoidable gaps in coverage within and across programs. Though these data do not track individual members, they do provide a basic picture of what drives caseload volatility.

From January 2008 through April 2009, MassHealth closed an average of about 34,000 cases every month, roughly 3 percent of its total caseload. Over half of these closings were for administrative reasons such as failure to complete or return information (45%) or for not providing required verification (8%). During the same period, MassHealth opened nearly 37,000 cases per month. Almost 11,000 of those (29%) had been active cases — mainly MassHealth, but also Commonwealth Care and Health Safety Net — within the previous 90 days. Nearly three-quarters of these reopenings had been closed for administrative reasons: failure to complete or return information (59%) and not providing required verification (14%) (Figure 1). The relatively short duration of the gap in coverage suggests that many of these individuals probably remained financially eligible despite losing coverage for administrative reasons.

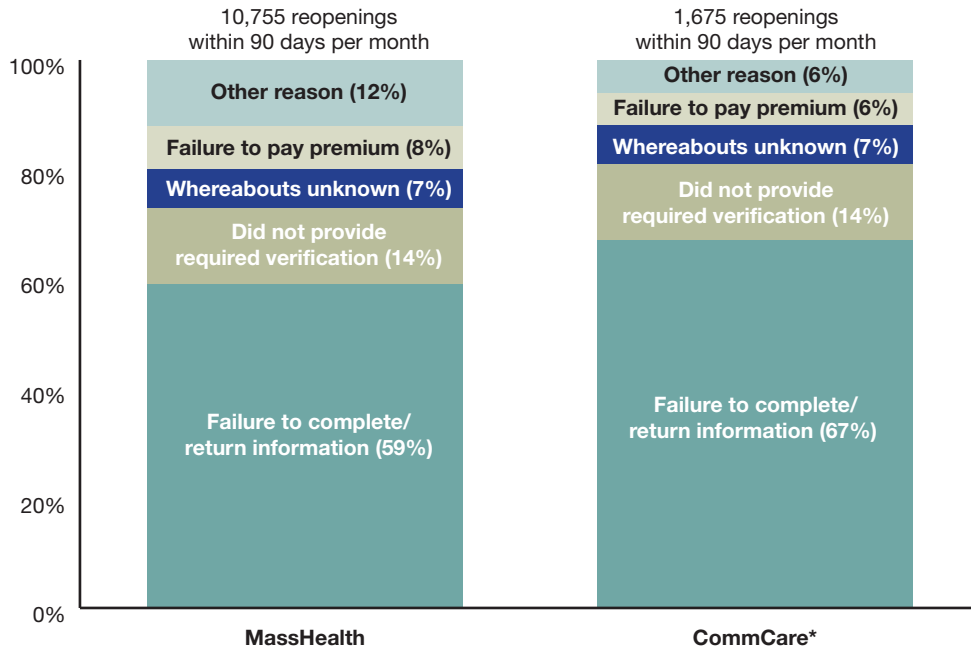
The pattern in Commonwealth Care was similar. There were about 12,000 Commonwealth Care cases closed per month from January 2008 through April 2009, which represented about 4 percent of the CommCare eligible caseload. More than three in five were closed for not returning information or providing needed verification. About 12,000 cases per month were opened, about 4 percent of caseload.* Only about 12 percent of those openings were cases that had been closed within the past 90 days. Most CommCare openings during this period were people being transferred from MassHealth or the Health Safety Net. Among the reopened cases that had been closed for less than 90 days, fully four-fifths (81%) had been closed for administrative reasons.†

Figure 1 shows the frequency of the most common reasons for closing among MassHealth and Commonwealth Care cases that were reopened within 90 days.

* These closing and opening figures exclude members who simply move from one CommCare plan type to another, usually because of a change in income. Eligibility data record these shifts as a closing, with a corresponding opening.

† The percentage of administrative closings is based on CommCare eligible individuals, and does not necessarily reflect the percentage of for members who are actually enrolled in a CommCare health plan.

**Figure 1 Reasons for last closing, for cases reopened within 90 days
January 2008 – April 2009**



*CommCare percentages based on CommCare eligibles, not necessarily enrolled.

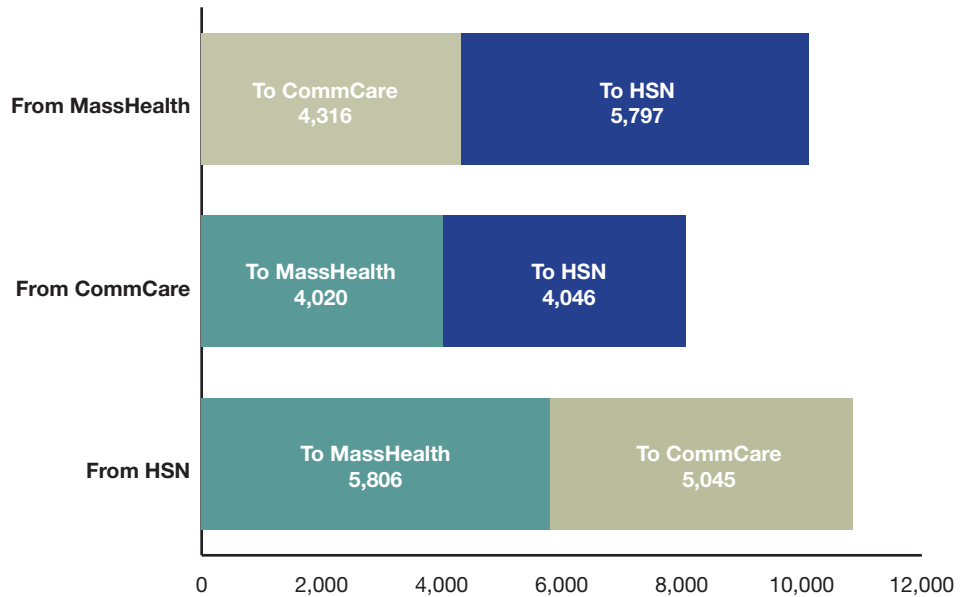
Source: Office of Medicaid

Transitions between programs also present possibilities for gaps in coverage. Among the three programs for which MassHealth determines eligibility (MassHealth, CommCare and Health Safety Net), an average of 9,800 people per month moved onto MassHealth from the other two programs from January 2008 through April 2009, and 9,400 per month moved onto CommCare from MassHealth and the HSN (Figure 2). This represents over a quarter (27%) of all MassHealth case openings and two-thirds (67%) of all CommCare openings (though the monthly trend for CommCare was slightly downward during this period), as well as considerable administrative expense and increased risk of gaps in coverage or access to care. Though most transitioned without a gap in coverage, a significant minority did experience a gap: 17 percent in MassHealth and 16 percent in CommCare. In addition, most transitions to Commonwealth Care involve at least a small gap, not apparent in the data, because CommCare coverage does not begin until the first of the month following eligibility determination, regardless of when previous coverage ends. (CommCare members are enrolled in the Health Safety Net during this interim period.)* Figure 2 illustrates the dynamics of

* The Commonwealth Care design does not allow for partial month capitation payments or fee-for-service payments to cover services received between eligibility determination and the start of the month following enrollment in a managed care organization (MCO). By contrast, the MassHealth MCO program is able to make partial, pro-rated capitation payments to MCOs based on the number of days in a month that a person is enrolled in the plan and therefore can begin coverage immediately, retroactive to 10 calendar days before MassHealth received the application.

enrollment across MassHealth, Commonwealth Care and the Health Safety Net, and Table 4 breaks down the lengths of the gaps in coverage resulting from transitions.*

Figure 2 Transitions across programs
Monthly average, Jan 2008 - April 2009



Source: Office of Medicaid

Table 4. Length of gaps resulting from transitions between programs, January 2008-April 2009

	From MassHealth					From CommCare					From HSN				
	No Gap	2-30 days	31-90 days	91+ days	Total	No Gap	2-30 days	31-90 days	91+ days	Total	No Gap	2-30 days	31-90 days	91+ days	Total
To MassHealth						82%	5%	5%	8%	100%	84%	3%	3%	10%	100%
To CommCare	77%	6%	5%	12%	100%						90%	2%	2%	7%	100%
To HSN	71%	7%	5%	17%	100%	77%	7%	6%	10%	100%					

Source: Office of Medicaid

The Appendix presents a simplified diagram that shows all of the points at which a gap in coverage might occur as someone transitions from MassHealth to Commonwealth Care.

Not all of this volatility is due to churning. Even when a case is closed for an administrative reason, it is possible that a financial (or other aspect of eligibility) reason underlies it; someone who has obtained insurance through a job, for example, might simply not bother

* The data presented here show gaps between termination from one program and determination of eligibility for another. Commonwealth Care requires an additional step — enrollment in a health plan — before coverage begins at the start of the following month. Eligibility data do not capture this gap.

sending a redetermination form back to MassHealth. Targeted efforts to reduce churning might consider developing ways to understand more precisely why a form is not returned or documentation not provided.

To summarize, about 3 percent of the MassHealth caseload and 4 percent of the CommCare caseload opened each month (with nearly an equal number closing) between January 2008 and April 2009. Many of those cases had been closed for administrative reasons not long before; a sizable portion of them were probably avoidable. Table 5 summarizes what we know about coverage transitions in Massachusetts from research studies and direct analysis of MassHealth data.

Table 5. Summary of findings about enrollment volatility in MassHealth and Commonwealth Care

Indicator	Source	Population (Year)	Major Finding
Continuity Ratio: portion of the year the average MassHealth member is continuously enrolled	Ku et al. (2009)	Mass Health (2006)	MA better than national average
Gaps in Coverage among children for any reason and any length of time over a 3-year period	Fairbrother et al. (2007) and MassHealth data	MassHealth children (2001-03)	Compared with 5 other states, MA children have an average likelihood of experiencing any gap, and they have a high number of gaps of relatively short duration.
Frequency of and reasons for openings, closings and reopenings in MassHealth and CommCare	MassHealth data	MassHealth/CommCare (2008-09)	In MassHealth, almost a third of monthly reopenings had been closed within past 90 days, three-quarters of them for administrative reasons; in CommCare, 12% of reopenings had been closed within 90 days, 81% for administrative reasons (based on number eligible, not necessarily enrolled).
Transitions between programs	MassHealth data	MassHealth/CommCare/HSN (2008-09)	Transitions from other programs comprise a significant share of case openings in MassHealth and CommCare, and about one in six transitions includes a coverage gap.

Federal rules and state practices

Explicit federal rules directing states how to conduct redeterminations are minimal. States are required simply to redetermine eligibility for Medicaid and CHIP at least every 12 months, and must have procedures for members to report any changes that may affect their eligibility.³⁹ There are no specific requirements regarding documentation, except in the verification of citizenship or immigration status.⁴⁰

States have flexibility in how they conduct eligibility redeterminations. Many states take advantage of this flexibility and institute policies that attempt to minimize administrative disenrollment of otherwise eligible people. The evaluation of the first 10 years of the CHIP program found that 12-month continuous coverage policies, renewal simplifications, and passive renewal were important factors in promoting retention in the program.⁴¹

Most states, including Massachusetts, have adopted at least some of the simplification and retention strategies listed in Table 6 in their Medicaid and CHIP programs.⁴²

Table 6. Simplification and retention strategies in Medicaid and CHIP programs

Strategy	Used in Massachusetts?
12-month eligibility period before redetermination	Yes
12-month continuous eligibility for children: guarantees enrollment for 12 months, regardless of changes in circumstances	No
No face-to-face interview for redetermination	Yes
Administrative verification: gather information from other state data sources to verify income, rather than requiring a member to supply pay stubs	DOR match used for some verifications
“Ex parte” renewal: gather information from other state data sources and only send renewal forms to those from whom more information is needed	No
Passive renewal: assume continued eligibility unless member returns a renewal form with information about a change in circumstances	No
Mail prepopulated renewal forms with known information and ask member only to correct or update	Not MassHealth; some CommCare
Self-declaration of income	No
Phone renewals, with follow-up only if information is incomplete	No
Off-cycle renewals: allow renewals at a site of care, such as a community health center, before renewal deadline and then reschedule next renewal for 12 months hence	CommCare; MassHealth when job update form is returned following wage match
Mail renewal reminder notices	No
Outreach worker follow-up with families that have not responded or that are on a termination list	Outreach workers and MCOs notified about upcoming renewal

Source: Wachino and Weiss (2009); Ross and Marks (2009); Southern Institute on Children and Families (2009); MA Office of Medicaid

Massachusetts has recently begun to focus on how to improve its administrative processes to promote retention, as a grantee of the Robert Wood Johnson Foundation’s “Maximizing Enrollment for Kids” program. An independent diagnostic assessment⁴³ of Massachusetts done for that program found churning among children to be an area for improvement. The state has responded with an action plan that aims to increase retention, improve data use and capacity, and improve customer service. A key step for the retention goal is to evaluate a number of innovations for possible adoption by MassHealth, including:

- Administrative renewal: pre-printed forms that only require a reponse if circumstances have changed;
- Ex-parte renewal using Food Stamp eligibility data to verify continued MassHealth eligibility;
- Ex-parte renewal using Department of Revenue’s quarterly wage match;
- 12-month continuous eligibility; and
- Centralized electronic document management to better distribute workflow, improve processing time, and reduce the chance of losing documents.

Because Medicaid and CHIP are administered as a single program — MassHealth — the benefits of sharing best practices with the other seven state grantees extend beyond reducing enrollment volatility among children. In fact, MassHealth officials are now looking at other populations whose circumstances are unlikely to change for testing the viability of administrative renewal. MassHealth members living in nursing homes are the first such group.

In opposition to the general trend of states simplifying application and renewal processes is the pull to use these processes to slow the growth in program enrollment in times of budget shortfalls. Because Medicaid is an entitlement, states have little control over the size of the caseload, which tends to grow faster during difficult economic times when state budgets are most strained. So states have used administrative tools within their discretion — more documentation requirements, greater frequency of redeterminations, suspension of 12-month continuous eligibility, for example — as a means to exert some control over the size of their programs. During the economic downturn in the early 2000s, many states made changes to these requirements, which immediately slowed caseload growth. The changes were often reversed when economic circumstances improved.⁴⁴ During the recent recession, Massachusetts reduced the time allowed for returning a redetermination form to 45 days from 60 in December 2007, then reversed a later decision to reduce it further to 30 days because of the “maintenance of effort” requirement associated with the enhanced federal Medicaid funds made available through the American Recovery and Reinvestment Act of 2009 (ARRA).⁴⁵

Payment error rate monitoring

Procedures for determining and redetermining eligibility reflect a state’s interest in limiting Medicaid and CHIP program payments made in error — that is, payments on behalf of people who are not actually eligible for them. Churning is, in a sense, a side effect of efforts to limit payment errors. These efforts are motivated by the damage overpayments can cause to states’ budgets, and by federal requirements to monitor accuracy in paying benefits, which are tied to financial penalties. The administrative expense of carrying out these reviews, as well as the potential loss of federal dollars for excessive error rates, create a tension between the

intent of these initiatives to safeguard the integrity of public expenditures on the one hand and states' desires to reduce barriers to public coverage on the other.⁴⁶ The federal payment accuracy rules are more likely to restrict state efforts to reduce churning than those that directly govern redetermination.

The Department of Health and Human Services (HHS) introduced the Payment Error Rate Measurement (PERM) program into Medicaid and CHIP in 2002, to meet the requirements of a federal law that requires federal agencies to review programs at risk for "significant erroneous payments."⁴⁷ There was concern among state officials as PERM was introduced that eligibility reviews would be based on documentation in case files and would impel states to restore documentation requirements they had removed to reduce enrollment volatility. Regulations proposed in 2009 clarify that a state cannot be penalized for overpayments that are a result of the state allowing self-declaration of eligibility. This protects at least one simplification strategy that some states have adopted. The regulation makes clear, however, that questionable payments will be assumed to be erroneous unless documentation is present to show otherwise.⁴⁸ This could have a significant effect on states' reforming their eligibility processes with methods that rely on information from other sources, which may not be explicitly documented in a case file.

The Medicaid Integrity Program (MIP), begun in 2006, is another mechanism for federal oversight of state benefit payments, focusing specifically on fraud, waste and abuse in the Medicaid program. CMS uses MIP's \$75 million annual appropriation to support 100 full-time staff and contract auditors to work closely with states to "promote the proper expenditure of Medicaid program funds."⁴⁹

CMS sees the Medicaid Integrity Program as an opportunity to "more directly ensure the accuracy of Medicaid payments" and to "prevent, identify and recover inappropriate Medicaid payments."⁵⁰ Massachusetts' experience with MIP is that it is a serious effort, and that CMS oversight is evident. While MIP can give the state support in detecting and preventing fraud, abuse and overpayments, the state is also subject to greater scrutiny, which can result in penalties for excessive payment errors.

Massachusetts therefore must consider its efforts to streamline administrative processes and reduce churning through a prism of program integrity. While improvements in efficiency and fairness clearly are possible, state program officials remain ever conscious of the policy imperatives of payment accuracy and financial responsibility.

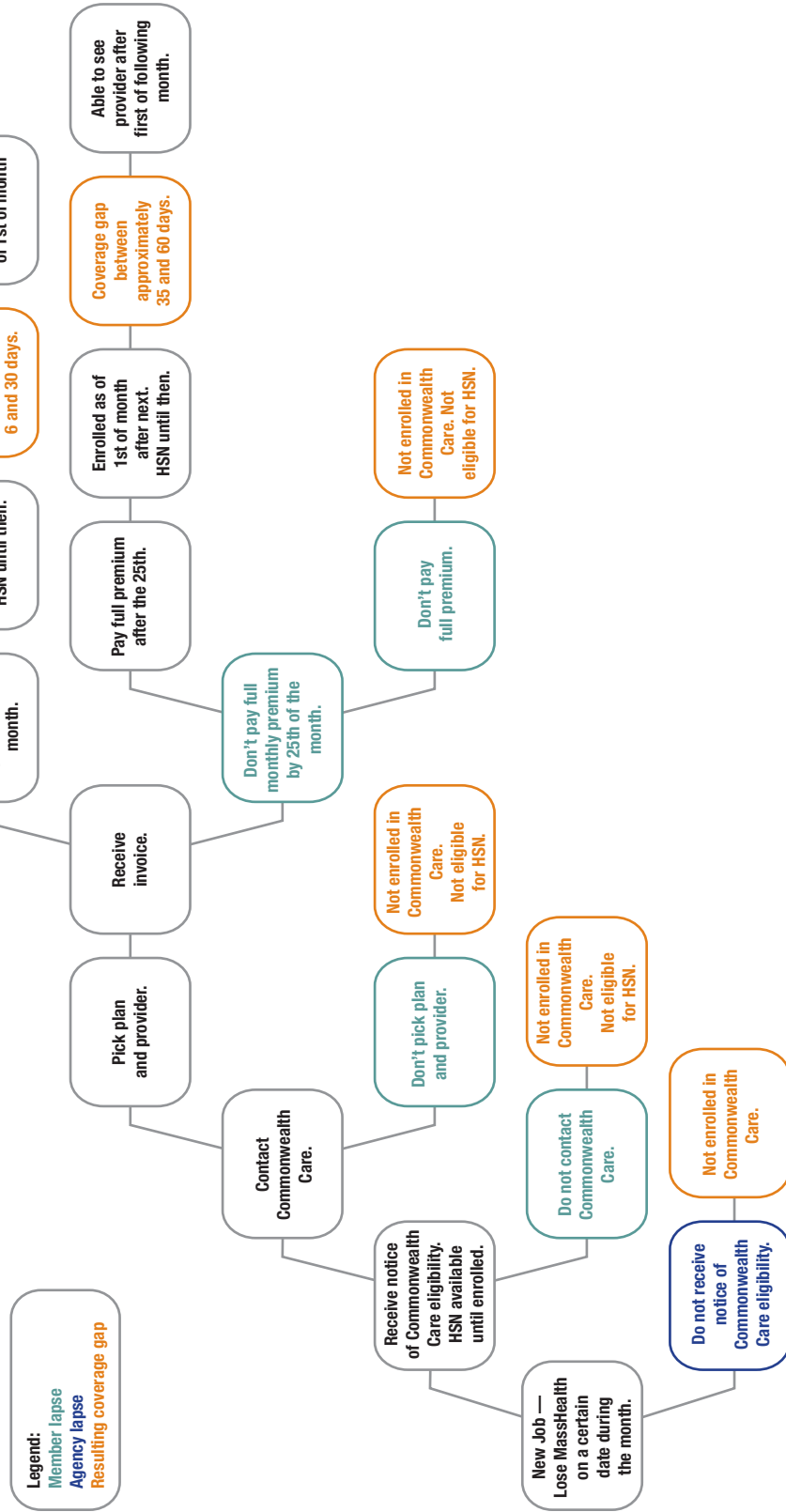
Conclusion

Massachusetts has made great strides in making health insurance attainable for nearly all of its residents, and the main public coverage programs — MassHealth and Commonwealth Care — have been a significant component of this achievement. Beyond getting coverage, though, it is necessary to *maintain* coverage, because continuity of coverage is an important element of access to care, particularly among those with frequent medical needs. There is evidence of some volatility in enrollment within MassHealth and CommCare, as there is in other states' programs, suggesting that a number of people are unable to maintain their coverage over a period of time, despite remaining eligible for the program. Data showing the high frequency of closings for administrative reasons among cases reopening within 90 days suggest the potential for operational improvements that would increase program retention. Massachusetts is embarked on a project now to consider simplifications that would be expected to reduce volatility within programs. A parallel program to smooth transitions and reduce the occurrence of gaps across programs would be equally fruitful. The challenge to program administrators designing solutions is to effect these improvements while always remaining conscious of the need to minimize fraud and overpayments and maintain program integrity.

Appendix

Potential Pathways to Gaps in Coverage When Moving from MassHealth to Commonwealth Care

This example shows the path of eligibility and enrollment that could result in coverage gaps for someone moving from MassHealth to Commonwealth Care under a Commonwealth Care plan requiring a premium payment. Pathways would be slightly different for people in different circumstances.



Source: Commonwealth Care Program Guide

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