

# **The Costs of Enrollment Instability In Washington State's Medicaid Program**

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**TABLE OF CONTENTS**

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**I. INTRODUCTION, METHODS, AND MAJOR FINDINGS ..... 2**

**II. FINDINGS FROM THE LITERATURE ..... 6**

**III. POLICY CHANGES AFFECTING RETENTION—CHANGES AND EFFECTS ..... 12**

**IV. COSTS TO PROVIDERS, HEALTH PLANS, AND THE STATE..... 24**

**V. CONCLUSION ..... 35**

## I. INTRODUCTION, METHODS, AND MAJOR FINDINGS

### Introduction

In the mid- to late-1990s, substantial debate and research were devoted to examining options for increasing access to health insurance. Much of this activity was driven by high and rising national uninsured rates. In part in response to the rise in the number of uninsured, many states chose to expand access to publicly-financed health insurance programs, especially the joint state-federal Medicaid program. Congress also created a new program, the State Children's Health Insurance Program (SCHIP), that states could participate in, either as a stand-alone program or as an expansion of Medicaid. As a result of the expansion of eligibility for Medicaid and the creation of SCHIP programs, the publicly insured proportion of the population began to rise nationwide, helping to reduce the total rate of uninsured. Similar trends occurred in Washington, lowering the uninsured rate for the under-65 population from 13.1 percent in 1993 to 9.2 percent in 2000.<sup>1</sup>

In conjunction with these program expansions, states were also motivated to reduce barriers to enrollment among those eligible for public programs. These changes were prompted by numerous studies showing that many who were eligible for public insurance were not enrolled. Many studies showed that barriers to enrollment, not substantive ineligibility, as well as lack of knowledge about the availability of insurance and program rules, were responsible for some of this under-enrollment.<sup>2</sup> As a result, many states simplified their enrollment processes and undertook a number of outreach and enrollment assistance projects to increase enrollment among those eligible to enroll.

In an effort to consolidate gains in enrollment, recent research and policy emphasis has shifted to retention: making sure that those enrolled in public programs and who remain eligible are able to remain enrolled. A number of studies, reviewed below, found that barriers to enrollment renewal, not ineligibility, are the main cause of disenrollment from Medicaid and SCHIP. Much of the literature focuses on the causes of low rates of enrollment retention at the time of eligibility renewal, as well as on the related problem of low-income families cycling in and out of Medicaid eligibility. In an effort to increase retention after initial enrollment, many states have reduced the frequency of eligibility reviews and adopted other measures to simplify the enrollment process. Washington was among those states that adopted a substantial number of measures to increase enrollment and retention.

Some studies have focused on the costs to enrollees of the disruption in continuity of care. A much smaller group of recent studies have described the costs imposed on different parts of the health care system from low rates of retention and high rates of cycling. Issues identified include the costs of "pent up demand" for services immediately after re-enrollment and the costs imposed on agencies or health plans when re-enrolling and treating re-enrollees.

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<sup>1</sup> Health Policy Analysis Program. *Targeting the Uninsured in Washington State*. Submitted to the Washington State Planning Grant on Access to Health Insurance, April 2002. p. 15. <http://www.ofm.wa.gov/accesshealth/research/31targetingcombined.pdf>

<sup>2</sup> See, for example, Marilyn Ellwood, *The Medicaid Eligibility Maze: Coverage Expands, But Enrollment Problems Persist*, Urban Institute, Assessing the New Federalism, Occasional Paper Number 30, December 1999; Genevieve M. Kenney, Jennifer M. Haley, Frank Ullman, *Most Uninsured Children Are in Families Served by Government Programs*, The Urban Institute, Series B, No. B-4, December 1999.

This paper contributes to this research by focusing on the costs to the various components of the health care system of low retention and cycling within Washington State's Medicaid population. Costs include the direct costs to the state of re-enrolling individuals after they lose coverage, as well as costs to managed care health plans and medical providers when clients cycle on and off Medicaid. This study also identifies the changes to Medicaid eligibility and re-enrollment procedures that appear to be associated with changes in the rate of retention and cycling. We also briefly review some of the early effects of recent changes adopted by the state that increase the number of eligibility reviews and documentation requirements within the Medicaid program.

### **Study Overview and Methods**

In order to identify costs associated with enrollment instability, this report relies on agency data, budget documents, a literature review, and a series of interviews with knowledgeable people at state agencies, health plans, and provider organizations. In Section II we review a number of recent national studies documenting the factors influencing retention rates and cycling. A small subset of this literature discusses some of the costs placed on various parts of the health care system as retention drops and cycling increases. Many of these studies include case studies of specific states or reviews of the situation across a number of states. The literature shows that factors that increase or reduce retention have some common features, although the specific effects within states vary according to state or even local (e.g., county) conditions.

Section III provides a brief history of changes in policies affecting retention in Washington drawn from agency documents, Web sites, and interviews with state officials. This section also reviews available quantitative data derived from agency administrative eligibility and enrollment systems to document changes in relevant measures such as retention rates in Medicaid and patterns of return to enrollment after people leave the caseload. We focus on evidence drawn from the larger non-welfare Medicaid programs for children and adults, since enrollment in SCHIP in Washington State remains quite small and retention patterns in the welfare-related programs tend to be dominated by changes in welfare policy. Revisions in Medicaid renewal policies cannot always explain all observed changes in retention since other changes affecting the program often occur simultaneously. However, patterns of people remaining on or leaving Medicaid change in expected ways as enrollment renewal procedures change.

Section IV documents the costs to state agencies, health plans, and providers of low rates of retention and of patients who cycle in and out of Medicaid coverage. Information in this chapter is drawn from interviews with agency, health plan, and provider personnel who described the specifics of costs placed on the various parts of the health care delivery system. Because time and resource constraints prohibited an extensive collection of data and information from a large sample of providers and health plans, we are unable to extrapolate these findings to describe the full costs distributed to these various components of the health system. However, we view the results of this report as producing a qualitative inventory of the types of costs imposed on various parts of the system. Although we cannot describe the statewide magnitude of these costs, we are confident that the issues identified here are real and worthy of further examination.

## A Brief Summary of Findings

### Findings from literature

- Most failures of Medicaid enrollees to renew eligibility are due to procedural barriers, not substantive ineligibility.
- State policies have substantial effects on Medicaid renewal rates.
- Movement of individuals on and off Medicaid contributes substantially to total uninsured rates.
- Reducing average enrollment through increased barriers to retention is an inefficient way to save state dollars because such policies add to administrative costs and lead to higher health care expenditures after individuals return to Medicaid.

### Findings on the effects of Washington State renewal procedures

- By 2002, Washington State had adopted most of the procedures identified in the literature as improving retention and reducing cycling. The cumulative effect of these changes was to increase retention and reduce cycling. For example, average monthly disenrollment in the Children's Medicaid program dropped from 3 percent to 2 percent after the review process was streamlined and the frequency of reviews decreased. Even when exit rates are relatively low, however, many of those leaving the program returned to the rolls a short period after disenrollment.
- More recently, the state has increased the frequency of eligibility reviews and added documentation requirements. These changes are increasing exits from the Medicaid program and have contributed to a substantial enrollment reduction of more than 20,000 between April 2003 and December 2003.<sup>3</sup> While we do not yet have data on return rates, it is likely that these changes will increase cycling in the caseload.

### Findings about costs to medical practices, hospitals, health plans, and state programs

- Costs borne by medical practices and clinics vary by clinic policies regarding care for disenrolled Medicaid patients, or patients for whom they cannot confirm enrollment. Some medical practices reduce their exposure by verifying enrollment and do not treat patients who are not enrolled. This can result in an uninsured patient going to another clinic or hospital emergency department for treatment, thereby shifting costs to another part of the health system.
- Financial costs borne by medical practices and hospitals as a consequence of disenrollment and cycling include delayed payment and denied claims, which become charity care. Administrative costs include increased time spent both verifying enrollment at the time the patient presents and troubleshooting enrollment after services have been provided to ensure that payment is received.

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<sup>3</sup> Washington State Office of the Forecast Council, Categorically Needy Adults and Children, Forecast Details Report, [http://www.cfc.wa.gov/Monitoring/MAA-Categorically\\_Needy\\_Frames.html](http://www.cfc.wa.gov/Monitoring/MAA-Categorically_Needy_Frames.html)

- Health plans must work with their network or contract providers to ascertain who is responsible for the cost of care for temporarily disenrolled clients: the provider or the health plan. Plans experience payment gaps for temporarily disenrolled clients.
- All providers incur administrative costs to troubleshoot payment, eligibility, and enrollment issues. We are unable to quantify these effects on individual practices or statewide due to lack of available data at present.
- The main costs to the state relate to substantially increased workload on medical assistance enrollment staff. State budget estimates put additional staff needed for this purpose at 90 FTEs during the 2003-2005 biennium. Although the legislature allocated 90 additional FTEs for this purpose, this increase was more than offset by a reduction of 250 FTEs elsewhere in the budget.

### Policy implications

- **Medicaid disenrollment and cycling increases the number of uninsured, who represent higher costs to the health system overall.** Many people who lose Medicaid coverage because of procedural issues return to the Medicaid rolls, but most do not. As more people move off the caseload for procedural reasons, the state's uninsured rate goes up. The uninsured represent the highest cost to the provider system and also tax other funding sources, such as the limited federal or state funds available to offset the costs of charity care.
- **Policies that increase Medicaid disenrollment and cycling simply shift costs to other parts of the health care system.** Costs shifted to health plans and providers can be substantial, further burdening the health care delivery system for publicly funded enrollees and threatening its availability. Some of the cost shifting is borne by the state itself as it increases staffing to handle additional eligibility reviews, and provides more money to offset charity care at both clinics and hospitals.
- **A broader framework for cost analysis would contribute to more effective policies that address Medicaid retention.** Given all the costs incurred throughout the system as Medicaid enrollment becomes more unstable and the number of uninsured increases, the state might consider performing a broader cost analysis before adopting procedural changes that affect retention. Policy makers are pressed to resolve immediate budget crises with short-term solutions, but calculating net savings only as they affect single agencies biases the analysis toward any change that results in savings in a particular budget line item. A broader analysis would also consider savings and costs to other DSHS subagencies and to other state programs, often in other departments, that subsidize charity care. Such an analysis would also consider the costs to the broader health care delivery system—health plans, medical practices, and hospitals. In addition, the loss of federal match dollars to the state from Medicaid disenrollment, and consequent effects on local health systems, should be considered when the state assesses options that have the effect of reducing retention and increasing the number of uninsured.

## II. FINDINGS FROM THE LITERATURE

### Introduction

Extensive recent research has documented the costs of uninsurance to society and individuals<sup>4</sup> and has also documented many of the reasons people remain uninsured despite eligibility for public programs.<sup>5</sup> Attention has recently turned to an examination of reasons why people who are enrolled in public insurance do not retain coverage over time. A number of recent studies have looked at the effect of program characteristics on rates of retention and on patterns of cycling in and out of coverage. In general, these studies find that program design affects enrollment continuity. More eligibility reviews, more documentation requirements, and the presence of, or increases in, cost sharing increases rates of disenrollment and cycling among income-eligible people. These studies also show that the majority of those leaving Medicaid or SCHIP programs remained eligible for enrollment, and that many returned to the caseload one or more times.

Other recent studies, reviewed below, also show that reducing enrollment by increasing procedures and requirements designed to reduce retention is not a very efficient way to reduce program expenditures. Although reducing the average number of people with insurance coverage can reduce overall state spending, costs do not always respond as expected. Because those disenrolled for procedural, not eligibility, reasons often come back on the rolls when they are sick, they tend to have higher expenditures immediately after reenrollment, reducing the net savings from lower average enrollments. Also, administrative costs within welfare and other public program agencies increase as the total number of reapplications goes up and the complexities of program administration increase. Greater enrollment instability also shifts costs to other parts of the system such as health plans and providers.

This section reviews recent findings from the academic and policy literature on the effects of state policies on enrollment and retention.

### The Consequences of Coverage Gaps

Coverage gaps have a number of negative consequences for individuals. As has been well documented in a number of recent studies, lack of coverage reduces health care access and increases the intensity of illness among the uninsured.<sup>6</sup> For example, a recent study that compared Medicaid enrollees to those eligible but not enrolled in Medicaid found that parents of eligible but uninsured children were more likely to postpone health care needed for their child (41 percent vs. 16 percent for Medicaid enrolled) and to leave a prescription unfilled because they could not afford it (26 percent vs. 13 percent for Medicaid enrolled).<sup>7</sup>

Even those who are uninsured for relatively short periods of time, such as those who cycle on and off public programs, experience reduced access. A 2001 Commonwealth

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<sup>4</sup> See the following publications by the Institute of Medicine: *Coverage Matters*, September 2001; *Care without Coverage: Too Little, Too Late*, May 2002; and *A Shared Destiny: Community Effects of Uninsurance*, March 2003.

<sup>5</sup> Perry M, Kannel S. *Medicaid and Children: Overcoming Barriers to Enrollment*. Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2000.

<sup>6</sup> Institute of Medicine. *Coverage Matters*, and *Care without Coverage*.

<sup>7</sup> Perry M, Kannel S. *Medicaid and Children: Overcoming Barriers to Enrollment*. Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2000. pp. 4-5.

Fund study showed that even short gaps in coverage result in delayed or foregone medical care and lead to other access issues such as unfilled prescriptions.<sup>8</sup> Gaps in public coverage may also lead to problems with pre-existing condition requirements for those who eventually do qualify for private insurance.<sup>9</sup> In addition, enrollees with complex medical conditions who drop in and out of Medicaid do not benefit from the disease management programs many health plans have developed,<sup>10</sup> and the plans have little incentive to invest in preventive care for these individuals or even for healthy individuals who may be here today but gone tomorrow.<sup>11</sup>

Lack of enrollment continuity also contributes to high total uninsured rates. Nationally, the number of low-income uninsured children would drop by almost 40 percent, and adults by more than 25 percent, if persons with public or private coverage at the beginning of a year remained continuously enrolled for 12 months.<sup>12</sup> Even among low-income people, those who are privately insured retain insurance at a higher rate than those on Medicaid: about one-fifth of those in Medicaid lose coverage over the course of a year, compared to one-tenth of those in private coverage.<sup>13</sup>

Moving in and out of coverage contributes to a larger proportion of the population being uninsured over time than would be apparent from surveys that look only at insurance status at a particular moment in time. For example, a recent analysis by Families USA showed that 30 percent of the U.S. population under age 65 was uninsured at least once during 2001 or 2002, far higher than the point-in-time uninsured rate. Children cycling on and off Medicaid and SCHIP were a major contributor to this high uninsured rate.<sup>14</sup> Another study showed that 38 percent of the population under 65 and 71 percent of those living below the poverty line were uninsured at least some time between 1996 and 1999. Among those with incomes below the federal poverty level (FPL), 41 percent were uninsured more than once during this period and half of those cycled back onto Medicaid or SCHIP at least once.<sup>15</sup> For the Medicaid and SCHIP populations, two-thirds (65 percent) of those who lost coverage at any particular time became uninsured.<sup>16</sup>

### **Effects of procedural barriers on enrollment**

Given existing eligibility rules in public programs, factors expected to influence the likelihood of staying enrolled include changes in employment, family structure, age of children, and income.<sup>17</sup> However, factors other than categorical eligibility rules and income eligibility limits are a major or even dominant cause of disenrollment. A number of administrative, language, and cost barriers contribute to those who are eligible

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<sup>8</sup> Duchon L, Schoen C, and Doy, M. *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk*. The Commonwealth Fund. 2001. pp. 8-9.

<sup>9</sup> Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*, Commonwealth Fund. December 2002. pp. 7,8.

<sup>10</sup> Birnbaum M, Holahan D. *Renewing Coverage in New York's Child Health Plus B Program: Retention Rates and Enrollee Experiences*. United Hospital Fund, 2003. p.2.

<sup>11</sup> *Retaining Eligible Children and Families in Medicaid and SCHIP: What We Know So Far*. Lake, Snell, Perry & Associates. June 2003. p. 14.

<sup>12</sup> Leighton Ku and Donna Cohen Ross, *Staying Covered*. pp. 1,6.

<sup>13</sup> Leighton Ku and Donna Cohen Ross, *Staying Covered*. p. 2.

<sup>14</sup> Families USA, *Going Without Health Insurance: Nearly One in Three Non-elderly Americans*, March 2003. p. 1.

<sup>15</sup> Pamela Farley Short, Deborah Graefe, and Cathy Schoen, *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem*, The Commonwealth Fund, November 2003. pp.1, 5-7.

<sup>16</sup> Pamela Farley Short, Deborah Graefe, and Cathy Schoen, *Churn, Churn, Churn*. p. 7.

<sup>17</sup> Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*, Commonwealth Fund. December 2002. p. 1.

becoming uninsured, and numerous studies have shown that changes in Medicaid coverage among individuals are only minimally correlated with changes in income or family status. For example, one study using longitudinal data showed that about 14 percent of low-income children enrolled in Medicaid still lost insurance over the course of a year even though their families remained below the federal poverty level for the entire year.<sup>18</sup> Another study by the Urban Institute found that most Medicaid enrollees do not experience changes in family structure or income that would result in loss of eligibility. For example, only one percent of children renewing New York's Child Health Program (CHP) coverage were denied eligibility because they did not meet income or other eligibility criteria.<sup>19</sup>

Put another way, these studies show that low-income families generally do not experience enough upward mobility or changes in family structure over the various time periods studied to lose eligibility. Instead, most of the enrollment losses occur at the time of recertification of eligibility for continued enrollment in Medicaid or SCHIP. For example, a study looking at New York's Medicaid program found that income and family size vary little from year to year and that rates of successful recertification were directly related to family income—families with higher incomes had significantly higher rates of completion than those with lower incomes. According to the authors, administrative barriers, most notably a long and cumbersome application process, were likely causes of most of the disenrollments.<sup>20</sup>

A recent report by the Urban Institute based on a survey of eight states indicated that, on average, less than 50 percent of children appear to be retaining eligibility at renewal within SCHIP.<sup>21</sup> Approval rates for recertifications ranged from 26 percent to 65 percent in the five states with detailed data available to the study, with denials ranging from 35 percent to 51 percent and referrals to Medicaid for potentially qualified applications from 9 percent to 32 percent.

In the Urban Institute study, denials were grouped in three broad categories: ineligibility, noncompliance with renewal procedures, and lost-to-follow-up. As reported in previous studies, the percentage of children losing eligibility because they no longer met eligibility criteria was minimal. Barriers to retention included reliance on a mail-based renewal system, which yields worse results than telephone-based or in-person systems, as well as the “hassle factor” of requirements to resubmit income and residency documentation. Many families also appeared to be confused over recertification requirements. In many states the SCHIP/Medicaid interface also is still quite inconsistent, causing problems when families move from one program to another.<sup>22</sup>

The Urban Institute also found that the largest proportion of denials were for children who were “lost” at recertification. Families may have left the state, qualified for employer-based insurance, decided to stop paying for coverage, or been unable to afford the premiums, and the researchers lamented their inability to discern specifics from the

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<sup>18</sup> Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*, Commonwealth Fund. December 2002. p. 4.

<sup>19</sup> Hill I, Lutzky A. *Is There a Hole in the Bucket?: Understanding SCHIP Retention*. Urban Institute, May 2003. p. 13.

<sup>20</sup> Lipson K, Fishman E, Boozang P, Bachrach D. *Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs*. Commonwealth Fund. 2003. p. 7.

<sup>21</sup> Hill I, Lutzky AW. *Is There a Hole in the Bucket?* p. 18.

<sup>22</sup> Hill I, Lutzky AW. *Is There a Hole in the Bucket?* pp. 8-10.

available administrative data.<sup>23</sup> The researchers also noted that trying to link state-to-state variations in renewal policies to levels of cycling or disenrollment was difficult: although policies were often similar in the five states examined, where enrollment rates differed they sometimes moved in a direction opposite to that expected.<sup>24</sup> This finding points out the need to review the specific sets of policies—and their interactions—within particular states. For example, New York has reduced the frequency of its reviews to once a year, but the state also has complicated administrative processes at renewal that work to increase disenrollment and cycling.<sup>25</sup>

Another study showed that New York's Medicaid, Child Health Plus, and Family Health Plus programs have persistently high rates of involuntary disenrollment each month. Approximately half the CHP enrollees due to recertify each month fail to complete the process, and Medicaid disenrollment rates may be even higher. After reviewing records and speaking with more than 100 families that did not successfully re-enroll, Commonwealth Fund researchers found that the vast majority remained eligible for coverage and that administrative requirements were the major barrier.<sup>26</sup>

A similar report by the New York United Hospital Fund found that retention rates varied dramatically by county, and by health plans within a single county. Demographic differences among enrollees, as well as the performance of local providers and community-based organizations offering enrollment assistance, may be responsible for the disparities. Because health plans play a key role in New York's CHP enrollment, poor retention rates are especially costly in both missed capitation payments and expenses for application and renewal assistance.<sup>27</sup>

A study by Mathematica in four states with frequent eligibility reviews demonstrated that inaccurate disenrollment was limited since some populations are exempt from more stringent eligibility reviews. For example, states typically exclude SSI-linked children, refugees, illegal immigrants and those who are enrolled in 100 percent state-funded programs from frequent reviews. In part because of these exemptions, the researchers found that relatively few children (less than ten percent) enrolled in public health insurance programs in the study states had gaps in coverage for two months or more. However, some groups of children were at particular risk for gaps in coverage, including adolescents (ages 15-19), Hispanics, and children who qualify for Medicaid under poverty criteria. Although children who spent at least part of the year in the states' medically needy programs were also exempt from more frequent reviews, their risk of disenrollment was higher than average, as well. These groups have limited access to health care already and are often those who likely need it the most.<sup>28</sup>

Many of the people who are disenrolled cycle back onto the rolls after they resolve procedural issues or because health problems prompt them to get re-enrolled. The United Hospital Fund discovered that 66 percent of children who dropped off New York's CHP

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<sup>23</sup> Hill I, Lutzky AW. *Is There a Hole in the Bucket?* pp. 19.

<sup>24</sup> Hill I, Lutzky AW. *Is There a Hole in the Bucket?* p. 11.

<sup>25</sup> Lipson K, Fishman E, Boozang P, Bachrach D. *Rethinking Recertification*. p. v.

<sup>26</sup> Lipson K, Fishman E, Boozang P, Bachrach D. *Rethinking Recertification*. pp. 6-7.

<sup>27</sup> Birnbaum M, Holahan D. *Renewing Coverage in New York's Child Health Plus B Program: Retention Rates and Enrollee Experiences*. pp. 2,5.

<sup>28</sup> Irvin C, Peikes D, Trenholm C, Khan N. *Discontinuous Coverage in Medicaid*. p. ix.

program during summer 2001 were back on the rolls by summer 2002.<sup>29</sup> A national study supported by the federal Agency for Healthcare Research and Quality found that nearly a quarter of children who drop off the SCHIP rolls at recertification are back within three months.<sup>30</sup>

**Changes in procedures lead to reductions in disenrollment and cycling.** Although states with policies that appear similar may have different re-enrollment rates for reasons that relate to idiosyncrasies of each state and to interactions of the various policies in place in each state, changes within particular states to reduce barriers or costs generally lead to increases in retention and a reduction in cycling. Various studies show that procedural changes can increase continuity of enrollment. For example, Florida's "passive renewal" program, wherein families are automatically renewed unless they return a pre-completed form with any changes noted, led to doubling in the number of children enrolled for two years or longer. Louisiana reduced case closures for procedural reasons from about 25 percent to less than 10 percent after adopting automated verification and a simplified renewal form. In Massachusetts, a process of "express renewal," which allows a family or person to renew coverage at community clinics or other agencies regardless of formal renewal deadlines, appears to be working well to maintain continued enrollment.<sup>31</sup>

All states typically send initial and repeat reminder notices and many have been working to simplify (and in some cases, pre-complete) the renewal form itself. Several states have reduced documentation requirements for renewal, although only one of the study states in a recent survey of renewal practices conducts passive renewal.<sup>32</sup>

Current federal law limits states' ability to make procedural changes to improve retention. For example, federal law does not allow 12-month continuous eligibility without review for adults, although it does allow this for children.<sup>33</sup> Also, federal law requires that only state or county employees can make Medicaid eligibility determinations. States have much more flexibility with their SCHIP programs. Many states have expanded the organizations authorized to perform eligibility determinations for SCHIP and the circumstances under which a child may be enrolled or recertified. Organizations now assisting in eligibility and enrollment include community nonprofit agencies and private firms, participating health plans, county social service administrators, and a state employees insurance board. To comply with federal requirements, joint SCHIP/Medicaid applications that appear to be eligible for Medicaid are typically referred to local government caseworkers for follow-up.<sup>34</sup>

**Administrative barriers are an inefficient way to cut expenditures.** Although administrative barriers and frequent eligibility reviews reduce average enrollment, they do not lead to proportionate reductions in costs to a state. One reason for this is that average monthly costs per enrollee drop the longer people are enrolled in Medicaid. Enrollees who cycle in and out of coverage often come back on the rolls when they have medical care needs. One recent study showed that the average monthly cost per enrollee

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<sup>29</sup> Birnbaum M, Holahan D. *Renewing Coverage in New York's Child Health Plus B Program: Retention Rates and Enrollee Experiences*. p.8.

<sup>30</sup> Dick AW, et al. *Consequences of States' Policies for SCHIP Disenrollment*. Health Care Financing Review 2002; 23(3):65-88.

<sup>31</sup> Leighton Ku and Donna Cohen Ross, *Staying Covered*. pp. 12,14.

<sup>32</sup> Hill I, Lutzky AW. *Is There a Hole in the Bucket?* p. 8.

<sup>33</sup> Leighton Ku and Donna Cohen Ross, *Staying Covered*. p. 11.

<sup>34</sup> Hill I, Lutzky AW. *Getting in, Not Getting In, and Why*. p. 5

drops by 30 percent in the second six months of enrollment. Therefore, policies that increase disenrollment rates may save less than expected since high cost episodes occur when patients come back on the rolls for treatment of illnesses or emergent needs.<sup>35</sup>

Frequent cycling also increases administrative costs by increasing workloads and requiring additional eligibility workers to re-enroll those who have temporarily left the rolls. In New York, for example, it costs about \$70 per enrollee for each recertification, including the costs of the enrollment process, handbooks and ID cards, and the selection of primary care providers.<sup>36</sup> A survey of a number of states by Mathematica showed that costs linked with redetermination, disenrollment, and re-enrollment accounted for between 2 and 12 percent of overall Medicaid administrative costs within these states' Medicaid agencies.<sup>37</sup> Policies that reduce disenrollment reduce these costs. For example, policy changes that decreased the frequency of redetermination to 12 months instead of 6 cut in half the number of children who dropped off and returned to the Medicaid rolls, with corresponding administrative savings. The study showed that enrollment costs would increase about 9-15 percent in the study states as the average number of enrollees increased, but this enrollment increase is partially offset by reduced administrative costs as a result of fewer redeterminations.<sup>38</sup>

### Some caveats

A number of studies have focused on states' SCHIP retention experience, often extrapolating their results to the larger Medicaid population, but few have examined the latter in detail. Unfortunately, significant differences between the programs may make any conclusions suspect. State Medicaid programs generally have at most minimal cost-sharing, in contrast to SCHIP with its premiums and co-payments. As such, premium and cost-sharing issues as factors in Medicaid retention are minimal. Medicaid also serves an extraordinarily broad population, while SCHIP is focused on children, many of whom are of higher income than average Medicaid populations.<sup>39</sup>

Differences in data collection among states are another barrier to meaningful retention analyses. States with too few reporting categories might group together families that do not re-enroll for very different reasons, and important information may be lost simply because there is no place to record it. In addition, when families fail to complete some activity that is part of the renewal process, the reason recorded in state records may not always precisely measure the real reason for non-renewal. For example, a family unable to pay SCHIP premiums may fail instead to complete the paperwork process and thus be shown as not having provided sufficient documentation, when the real problem may be affordability. Similarly a family that became ineligible for another reason (e.g., income gains) may fail to respond to a renewal notice rather than report a change in circumstance. Because of these data issues, it is important that state administrative records be supplemented with other information (e.g., from surveys or interviews) to create a more complete and accurate picture.<sup>40</sup>

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<sup>35</sup> Leighton Ku and Donna Cohen Ross, *Staying Covered*. pp. 8,9.

<sup>36</sup> Lipson K, Fishman E, Boozang P, Bachrach D. *Rethinking Recertification*. p. vi

<sup>37</sup> Irvin C, et al. *Discontinuous Coverage in Medicaid and the Implications of 12-Month Continuous Coverage for Children*. Cambridge MA: Mathematica Policy Research, Inc. October 2001. p. 38

<sup>38</sup> Irvin C, Peikes D, Trenholm C, Khan N. *Discontinuous Coverage in Medicaid*. p. 40

<sup>39</sup> *Retaining Eligible Children and Families in Medicaid and SCHIP: What We Know So Far*. p. 45.

<sup>40</sup> *Retaining Eligible Children and Families in Medicaid and SCHIP: What We Know So Far*. p. 16-18.

### III. POLICY CHANGES AFFECTING RETENTION—CHANGES AND EFFECTS

#### Re-Enrollment Policies – A Brief Overview

##### Introduction

Washington, along with many other states, steadily reduced barriers to Medicaid enrollment, and eligibility redetermination, through much of the decade of the 1990s. In the early- to mid-1990s, these changes occurred along with expansions in eligibility, so resulting increases in enrollment are the sum of eligibility expansions plus reductions in disenrollment rates as a result of changes in renewal policies. Later, rules for initial eligibility remained the same, but barriers to enrollment and re-enrollment were reduced further. Beginning in spring 2003, renewal requirements increased.

Changes to reduce disenrollment and cycling can be grouped broadly into the following categories: elimination of requirements for asset tests; elimination of the programmatic connection between welfare and Medicaid; changes in the length of the period within which enrollees have to re-establish eligibility; and changes in documentation requirements and income verification. In Washington, most of the changes the state adopted were designed to enhance retention and reduce cycling. Of the procedures allowed by federal law to increase retention, Washington had adopted all of them by the year 2002 except passive renewal.

By early 2003 the state began to reverse these innovations designed to support continuing enrollment. These reversals include no longer accepting client declarations of income and requiring employer verification instead; a switch from a 12-month to a 6-month renewal period for children; and the elimination of continuous enrollment for children, who can now be disenrolled whenever family or income circumstances change.

This section reviews the specifics of changes in renewal policies. Section B reviews available data to examine which changes in observed rates of retention might be the results of these policy changes.

##### Asset tests

Historically, most states adopted asset tests to set upward limits on the amount of liquid or other assets families could have and still qualify for public assistance. These asset limits are distinct from income limits. Although asset limits had the intent of ensuring that recipients of cash assistance and medical coverage were “truly needy,” they also had the effect of penalizing savings and forcing families to be virtually destitute to qualify for, and in some cases maintain, benefits.

At the beginning of the 1990s in Washington, total family assets exceeding \$1,000 disqualified an individual from eligibility. However, in spring 1992, asset limits for children to enroll or remain enrolled in Medicaid were eliminated. In spring 2000, the asset test for recertifying adults was eliminated as well—as long as a family's case remains open, asset limits do not apply. However, adults are still subject to an asset test of \$1,000 at their initial enrollment and again if their eligibility lapses long enough for their case to be closed. The aged/blind/disabled have always been subject to an asset test

at intake and renewal—single applicants are allowed \$2,000 in assets, and couples are allowed \$3,000; each additional dependant is allowed \$50.<sup>41</sup>

### **Welfare and Medicaid**

In August 1997, following federal law, Washington State acted to eliminate the formal connection between Medicaid and Temporary Assistance to Needy Families (TANF) (cash assistance) payments. Thus, a person could be enrolled in Medicaid after meeting various eligibility requirements even though they were not receiving any cash assistance payments. However, inertia in the system, most notably in the failure of the state to effectively de-link the two programs in its computer system, continued to result in Medicaid disenrollments as people left cash assistance, even though they remained eligible for Medicaid. As a result, thousands of people lost their insurance after leaving TANF.<sup>42</sup> Some of these clients were reinstated, at east temporarily, through an outreach program. The eligibility system has since been updated to automatically renew medical coverage with TANF benefits and to automatically continue coverage (when appropriate) if the family's TANF case is closed.

### **Eligibility periods and continuous eligibility**

Eligibility periods refer to the time period after enrollment, or recertification, that an individual can remain enrolled before being required to undergo a full eligibility review. Continuous eligibility refers to a provision, regulated by the federal government but adopted at state discretion, allowing a person to remain enrolled during an eligibility period even if income or other factors change that would otherwise cause that person become ineligible. In the 1990s, Washington State increased the length of eligibility periods for children and adults, and adopted continuous eligibility for children. More recently, the state has rescinded these changes.

In October 1994, Washington adopted continuous eligibility for the six month period for which children were then eligible. In 1997, the federal Balanced Budget Act first gave states the option of 12-month continuous Medicaid eligibility for children. In April 1999, Washington extended continuous Medicaid coverage for children after each eligibility determination from 6 to 12 months. Thus, after each determination of eligibility, a child could remain covered for an entire year regardless of whether the child experienced changes in other eligibility criteria, with the exception of moving out of state, dying, or losing contact with the state's Medicaid agency, the Medical Assistance Administration (MAA). The state also began to certify adult eligibility for 12 months for medical-only programs, although this 12-month eligibility was not continuous: a change in circumstances at any time during the 12 months could possibly lead to disenrollment.

In July 2003, the Washington legislature mandated a return to 6-month eligibility verification periods for individuals enrolled in the State's children's and family medical programs. Also in July 2003, continuous eligibility for children was rescinded, meaning that increases in income above the income limit at any time result in loss of eligibility. Now, both children and adults with changes in circumstances, such as income increases, may lose eligibility at that time.

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<sup>41</sup> Interviews with Medical Assistance Administration staff.

<sup>42</sup> Mark Gardner, *kids.health.2001 and the Washington State Campaign for Kids: An Evaluation of Outreach, Systems Change, and Communication*, Health Policy Analysis Program, May 2002.

The 6-month eligibility periods went into effect for clients who became eligible or renewed eligibility in July 2003. But computer automation of the 6-month eligibility certifications was not implemented until October 2003, requiring CSO case workers to manually set new eligibility periods before that time. Because of this lag in changes in the state's computer eligibility system, the full effect of the shift to 6-month eligibility may not be known until July 2004. According to assumptions used in the 2003-2005 state budget, by the end of 2005 these changes are predicted to cause a net disenrollment of approximately 19,000 people who would otherwise have remained enrolled.<sup>43</sup>

### **The renewal process and verification procedures**

Enrollees receive renewal notices in the mail approximately six weeks prior to their actual termination date. Face-to-face interviews are not required for Medicaid enrollment or recertification, eliminating a significant coverage barrier for many families. In February 2003, the state adopted the use of a pre-printed form with enrollees' names and their last known incomes. Enrollees are asked to note any changes and return the forms along with verification of current income. Enrollees who do not return the renewal form are sent warning letters, and those who still fail to comply after the final notice are disenrolled after ten days have elapsed.<sup>44</sup> According to Medical Assistance Administration staff, it is not clear that this new form is helping continuity, and may even be hurting it. Some clients do not recognize the pre-printed form as a review form. Many just submit it with no changes and do not attempt to provide the additional information or documentation required.<sup>45</sup>

In April 2003, the department began to require written documentation of income for children and pregnant women to remain eligible. Previously, the department accepted a client self-declaration of income for initial eligibility and redetermination. (Applicants for family medical coverage—mostly adults in families with children—have always had to show proof of qualifying income.)<sup>46</sup>

The state has adopted certain automated verification procedures to assist or automate some of these verification processes. For example, the state verifies income using a number of methods, including computer cross-matches with income information from Food Stamp data, child support records, and the like. In addition, medical coverage is automatically renewed when families renew their TANF or food assistance eligibility. When these matches indicate continued income eligibility, the period of enrollment is set forward for the allotted number of months as specified in policy. For example, eligibility for enrollment for children receiving Food Stamps is verified every three months. When the state allowed 12-month continuous Medicaid enrollment for children, each Food Stamp verification initiated another 12-month window of eligibility for any child also enrolled in Medicaid. Now, with a change to a 6-month eligibility period, enrollment would be extended 6 additional months after each Food Stamp verification.

Staff with the Washington State Department of Social and Health Services (DSHS) also use other sources to verify income, such as checking employment income against records

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<sup>42</sup> Legislative Evaluation and Accountability Committee, 2003 Washington State Budget Notes, Part IV, Agency Detail, Department of Social and Health Services, <http://leap.leg.wa.gov/leap/budget/lbns/2003dshs.pdf>

<sup>44</sup> Interviews with Medical Assistance Administration staff.

<sup>45</sup> Interviews with Medical Assistance Administration staff.

<sup>46</sup> Interviews with Medical Assistance Administration staff.

in the state's Unemployment Insurance (UI) file. A new resource in use since July 2003 is a privately operated employment/income verification system called The Work Number. The system, run by the TALX Corporation, contains payroll information from a number of large employers and allows DSHS staff to verify wage income immediately without needing to wait for pay stubs or other paper documentation. Some of the limitations as well as the benefits of these electronic verification methods are discussed in Section IV, below.

Since a number of studies have shown that the majority of those disenrolled at renewal time are actually eligible, automated renewal processes could have an effect of extending enrollment, reducing disenrollment, and reducing cycling. On the other hand, such automatic verification procedures could flag possible income increases not caught by other methods, possibly resulting in disenrollment. We were not able to obtain data to verify the net impact of these conflicting effects.

### **Income disregards**

Another factor that may extend enrollment periods is the use of "income disregards"—formulas for reducing the amount of earned income countable against eligibility limits. For example, TANF/family medical recipients were only eligible for transitional medical coverage before April 2002 if their earned income remained below TANF limits for three of the previous six months. Recognizing that this situation was actually a disincentive to work, the federal Center for Medicaid and Medicare Services (CMS) approved MAA's request to ignore excess income for the months necessary to meet the three-month standard. Other things being equal, income disregards ought to stabilize enrollment for those having regular but minor fluctuations in earned income.

### **Premiums**

The federal government has traditionally restricted states' ability to charge premiums or impose other cost-sharing methods on their Medicaid populations. States continue to use the federal Medicaid waiver process, however, to introduce various forms of Medicaid cost sharing. In April 2002, for example, the Washington State legislature imposed premiums on Medicaid enrollees who have recently left TANF cash assistance and are in the second half of their allowed 12 months of continued transitional coverage.

In November 2001, DSHS requested a federal Section 1115 waiver to charge premiums for a number of Medicaid recipient groups and to make a variety of other eligibility and benefit changes. Staff with CMS rejected this initial waiver request. The state's third revision, however—which included premiums but dropped the proposed state budget-linked enrollment cap, prescription copayments, and charges for non-emergency visits to hospital emergency rooms—has recently been approved, although not yet implemented.<sup>47</sup>

Premiums have the effect of substantially decreasing enrollment, both through higher attrition and failure to enroll by those who cannot afford the premiums. Washington State's 2003-2005 budget assumes that 24,000 individuals will lose eligibility as a consequence of the imposition of premiums.<sup>48</sup>

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<sup>47</sup> Letter from Tommy G. Thompson, Secretary of Health and Human Services, to Gary Locke, February 3, 2004.

<sup>48</sup> Rebecca Kavoussi and Erin Burchfield, *Will the Health Care Safety Net Be There if we Need it?*, Community Health Network of Washington, January 2004.

Table 1 summarizes some of the major changes in eligibility and re-enrollment procedures. The next section assembles available data to shed light on the effects of these changes on retention or cycling.

TABLE 1: Major Changes in Eligibility and Re-enrollment Requirements in Washington
<ul style="list-style-type: none"> <li>• <b>April 1, 1992</b> – The state eliminated the <b>asset test</b> when determining the eligibility of a child under age 19 for a medical program. (The asset test was previously \$1,000.)</li> </ul>
<ul style="list-style-type: none"> <li>• <b>August 1, 1997</b> – Under welfare reform, <b>Medicaid was de-linked</b> from Temporary Assistance to Needy Families (TANF) financial assistance.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>April 1, 1999</b> – The state began to provide Medicaid coverage for children for <b>twelve continuous months</b> unless the child moves out of state, dies, or DSHS is unable to locate the child.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>April 1, 2000</b> – The state eliminated the <b>asset test</b> for adults in families when determining continuing eligibility. The asset limit for an adult initially applying for Medicaid remains at \$1,000.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>April 2002</b> – The state implemented an “income disregard” for section 1931 (transitioning off TANF cash assistance) families during the second and third month of eligibility. Premiums were also implemented during the second six months of medical extension benefits (MEB) for families who began receiving MEB on or after February 2002.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>April 2003</b> – The state began to <b>verify income</b> for children and pregnant women. Previously, like many states, Washington allowed families to self-declare their income.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>July 1, 2003</b> – The state began to immediately <b>terminate children’s coverage if a family’s income increased above the income standard</b>. In the past, children received uninterrupted medical coverage for 12 months.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>July 1, 2003</b> – The state <b>reduced the coverage period from 12 to 6 months for children and adults</b>. To maintain coverage, enrollees need to complete and return a review form every six months.</li> </ul>
<p>Source: Medical Assistance Administration, “Historical Eligibility Changes,” undated, and Medical Assistance Administration Web site.</p>

**Data on Retention and Cycling in Washington**

This section provides a review of available data on patterns of Medicaid retention and cycling. Where possible, we draw connections between changes in policy and changes in retention. We also review data that illuminates the factors associated with exiting the Medicaid caseload. And, we review data on how many, when, and which former enrollees come back on the caseload. Because patterns of Medicaid retention and cycling may be heavily influenced by changes in other public programs—in particular, for individuals who are enrolled simultaneously on Medicaid and TANF—we focus here on those children and adults in families not currently receiving TANF cash grants in order to isolate the effects of policies that affect retention and cycling. We also focus on periods after major program expansions occurred, since these expansions would be likely to strongly affect retention and cycling.

Because of data limitations, the information presented below provides only a broad overview of patterns of retention and cycling and any effects of state policies on these patterns. For example, average lengths of stay in Medicaid might decrease or increase as policies reduce or increase retention rates, but no Washington State data are available at present to measure this. More importantly, there are no data describing overall rates of recertification at times of renewal and how these have changed over time, although rates of exits from the caseload may serve as a proxy for such measures. In addition, many recent policy changes are too new for substantial evidence to have accumulated on their effects. Despite these limitations, this section provides a snapshot of retention patterns and a baseline from which to monitor future effects of recent major policy changes.

**Policy changes and effects on retention**

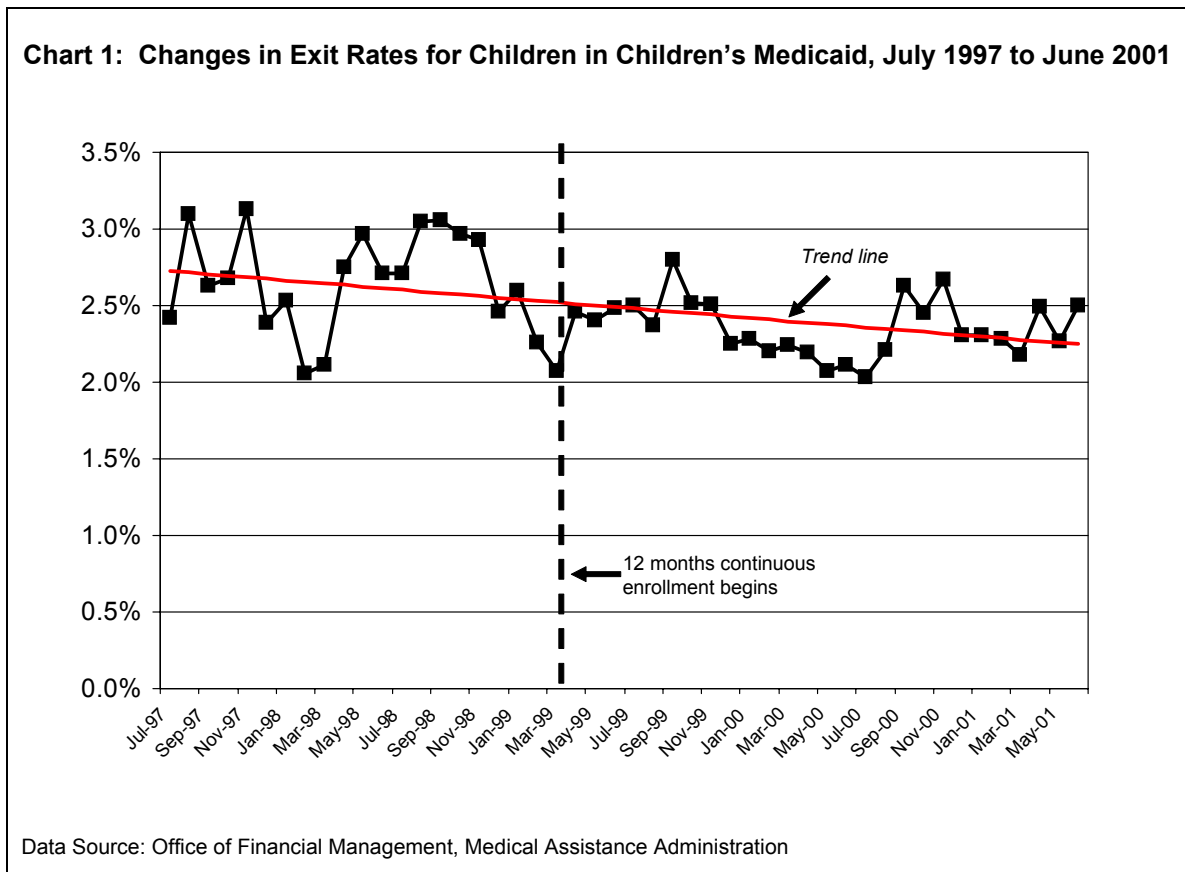
Enrollment data for Washington reveal some evidence that changes in policies and procedures are associated with increases or reductions in retention. As the state adopted a number of changes to streamline the re-enrollment process, there was a decline in the rates of individuals leaving Medicaid enrollment. As requirements were increased, retention rates declined.

The data presented here do not paint a simple picture, however. Changes in retention must take into account background rates of attrition given that some people will always become ineligible each month because they moved out of state, died, or no longer met age or family structure requirements. In addition, factors not directly related to the re-enrollment process may affect retention. For example, outreach campaigns, to the extent they also increase resources available to assist in retention, should reduce both exits and cycling. And, an ongoing decline in the Food Stamp rolls, a program that facilitates enrollment verification for Medicaid, could also contribute to higher exit rates.

Despite the complexity of these interactions, and the inability to isolate the specific effects of these various factors, the data suggest that retention generally increased in Washington as various changes were made to ease both enrollment and renewal processes. And, more recently, the data show an upsurge in exits and reduced retention as the state began to implement changes that increased the frequency of eligibility redeterminations and income verification requirements.

Major program changes are associated with changes in rates of disenrollment and cycling. An evaluation of the Healthy Options Medicaid managed care program for the

1993-1994 period showed that about 3 percent of all Medicaid enrollees left the program each month.<sup>49</sup> As is illustrated in Chart 1, more recent data from the Children's Medicaid program, for children whose families are not enrolled in TANF cash assistance, show that exit rates oscillated between 2.5 percent and 3 percent through mid-1999. After the policy of 12 months of continuous eligibility was implemented in the period beginning April 1999, the exit rate dropped steadily downward, hovering around 2 percent and 2.5 percent through mid-2001. Because the data already account for people leaving Medicaid for other public programs, they control for other programmatic causes of the changes in exit rates to some degree. However, because many Medicaid outreach campaigns began during this period, some of the increased retention could have resulted from those efforts.

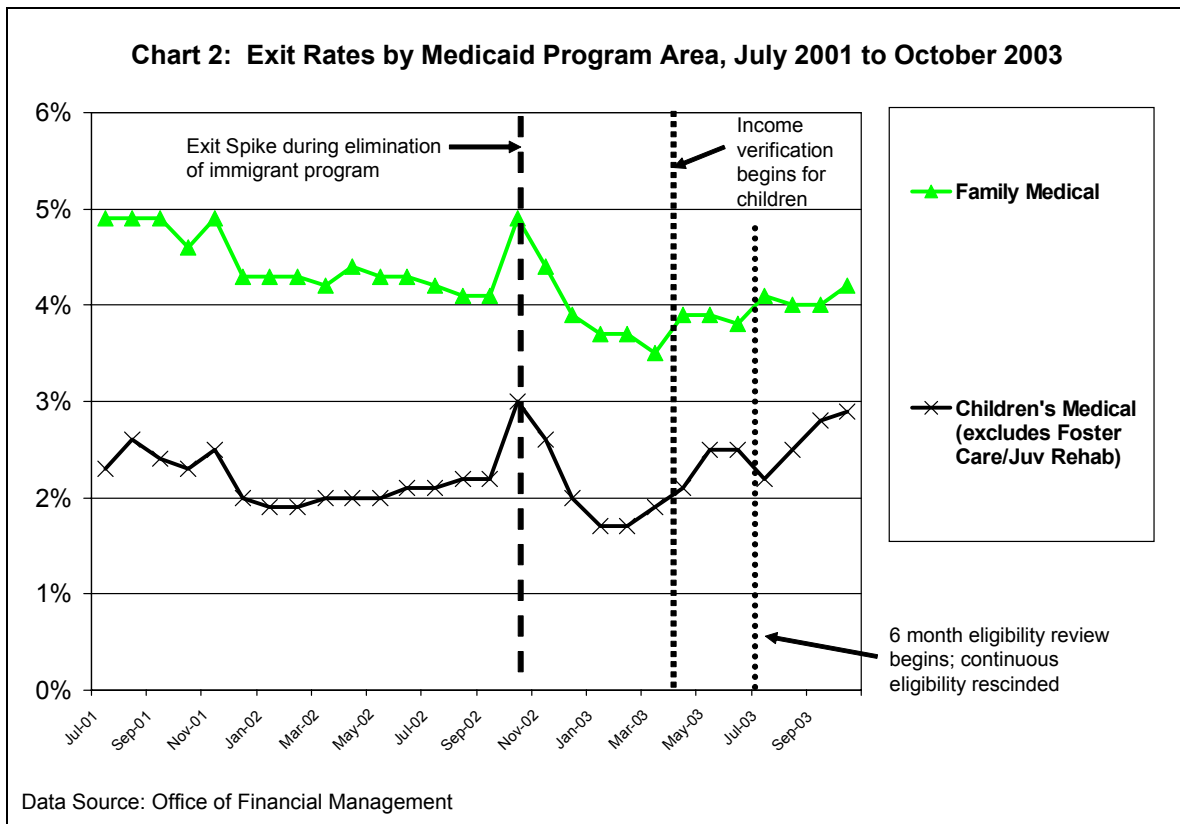


The view that changes in enrollment and retention policies made a difference is strengthened by an examination of more recent data. Chart 2 shows a continuation of the downward pattern in Children's Medicaid, with exit rates hovering steadily around 2 percent for most of 2002. After that, the data show a spike in exits starting October 2002. This is likely a side effect of the elimination of three programs for immigrants, which affected a portion of the enrollment groups measured here, and also caused substantial workload backups for Medicaid eligibility staff. By January 2003 the consequences of

<sup>49</sup> Health Policy Analysis Program, University of Washington. *Healthy Options Statewide Evaluation*. May 31, 1995.

this spike had resolved, with exits declining to less than 2 percent. After that, exit rates began to climb upwards, likely an effect of more recent changes in re-enrollment policies.

Similarly, Family Medical, consisting mostly of adults within the lowest income ranges, also saw a substantial decline in exit rates during the 2001-2002 period, save for a similar spike at the same time as the elimination of the immigrant programs.<sup>50</sup> Exit rates for this program are now creeping upward, in part due to new procedures and also possibly as a side effect of increased workload from more frequent eligibility reviews, which may result in backlogs in recertification (see Section IV, below). Since the procedural changes for adults are more limited than those for children, logic would suggest that changes in exit rates will be less dramatic, as well. (Since income eligibility cutoffs for the Family Medical program are quite low, obtaining even a low paying job may result in ineligibility. This explains an exit rate for this program that is on average substantially higher than for the Children's Medicaid program.)

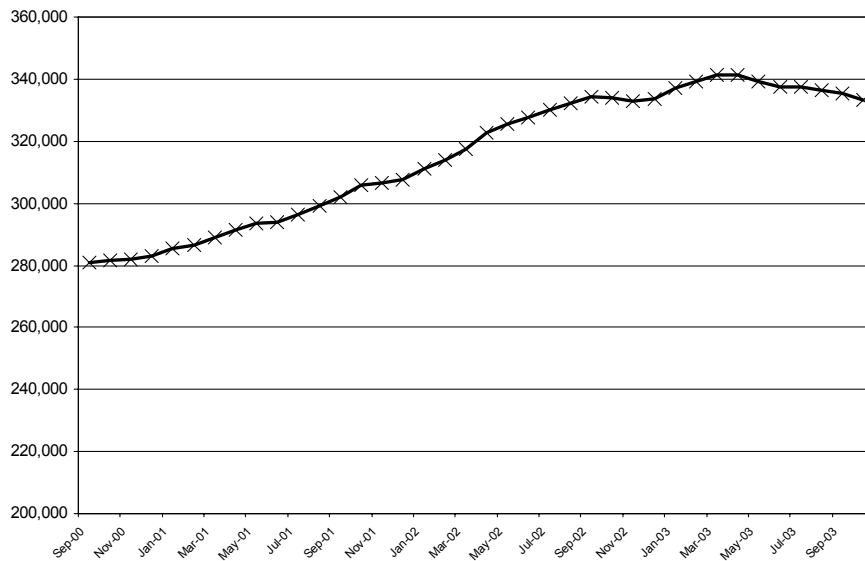


As Charts 3 and 4 show, these changes in exit rates in turn affect overall enrollment. Because exits affect only a small proportion of the caseload at any time, total enrollment in these programs is much more stable than exit data. The rate of new entries, as well as ongoing enrollment, determines enrollment in any particular month. Consequently, exit data alone cannot explain all enrollment trends. In addition, people may transfer from one Medicaid program to another, although these transfers remained steady during this

<sup>50</sup> We exclude from analysis those programs where enrollment is directly related to TANF, since eligibility policy for cash assistance is the major determinant of exit rates and enrollment in those programs.

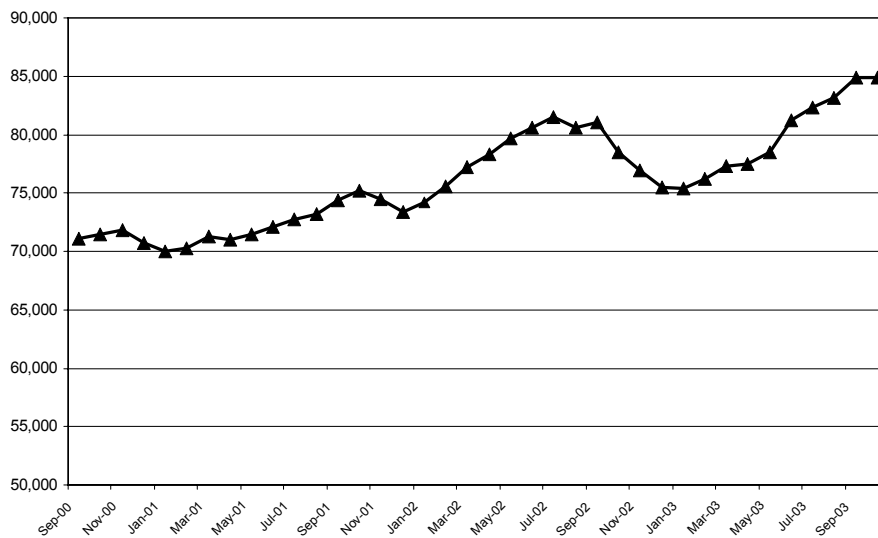
period: that is, the ratio of those transferring in and out remained roughly the same over the entire period. Entry rates also trended downward during this period, although the trend toward increased exits is more marked. Consequently, recent increases in exit rates are contributing to recent reductions in enrollment, especially for children.

**Chart 3: Enrollment in Children's Medicaid, July 2001 to October 2003**



Data Source: Office of Financial Management

**Chart 4: Enrollment in Family Medicaid (Adults and Children), July 2001 to October 2003**



Data Source: Office of Financial Management

**Reasons for exits, and who returns?** Available Medicaid data also illuminate some of the reasons that people leave the caseload, who returns, and when they return. Chart 5 groups all those who exited the caseload in one month—September 2000—by broad categories of reasons for exiting. The largest category—here labeled “failed at recertification”—encompasses three related “reason codes” available from the medical eligibility system. These are *failed to recertify*, signifying lack of enrollee response to requests to reverify; *eligibility review not received*, signifying lack of paperwork received by the agency; and *failed to provide verification*, where a client did not provide proof of the information required for continued enrollment, most likely income.

Just over half (51 percent) of those who did not remain enrolled fell into the *failed to recertify* category. One in five (21 percent) were ineligible due to age, family status, or other eligibility criteria. Consistent with the national literature, almost none of these were ineligible because of income. Nearly 80 percent were due to not meeting age or residency requirements. The remaining one-third of exits fell into the following categories: *requested disenrollment* (11 percent), *whereabouts unknown* (9 percent), and *other* (7 percent).

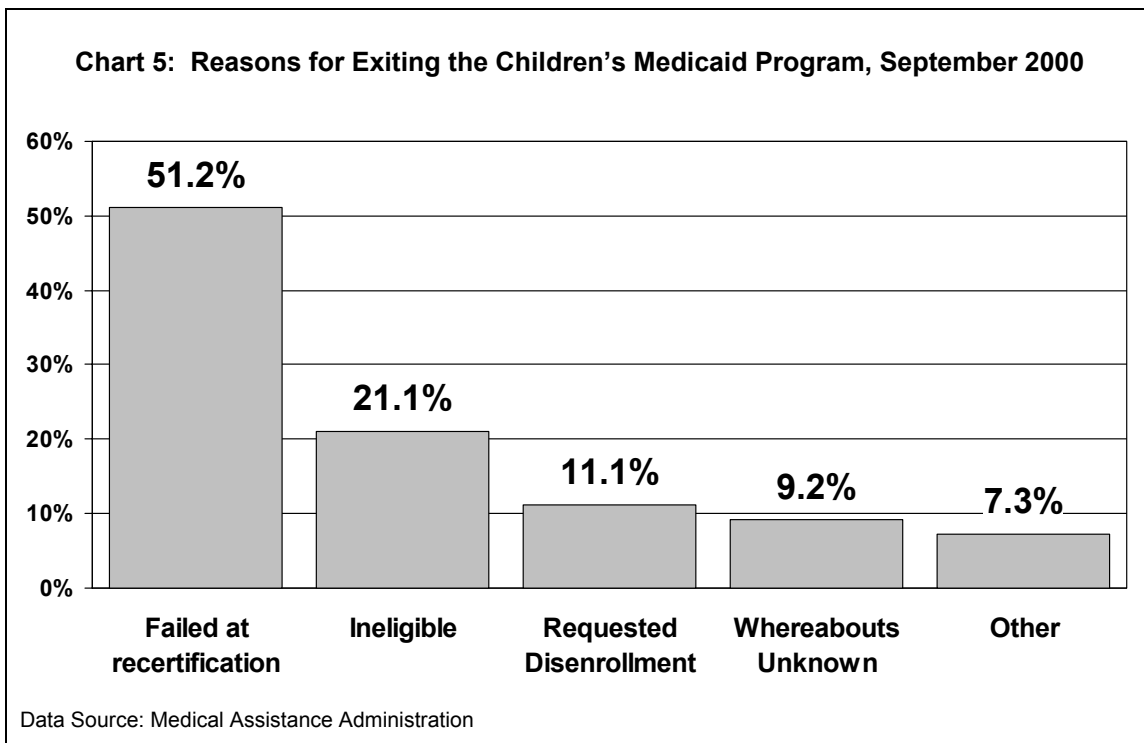
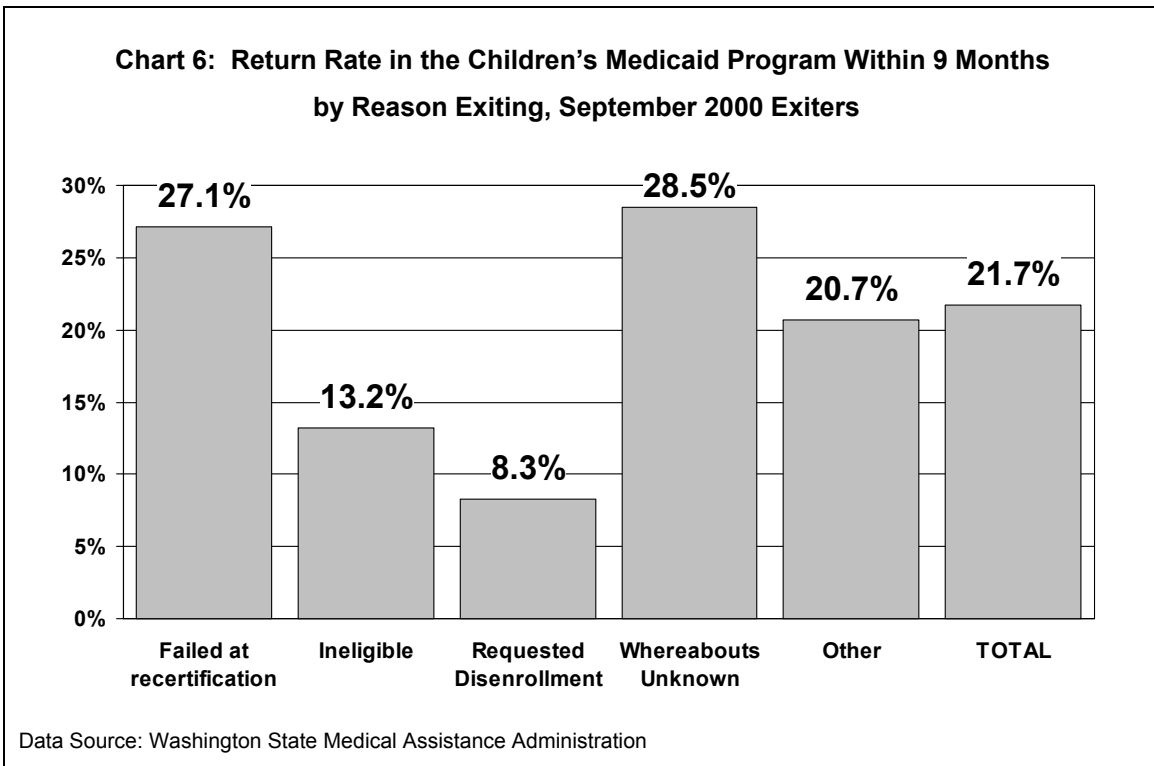


Chart 6 examines return rates for the various categories. With an exit defined as being enrolled in September 2000 and off the caseload at least one month beginning October 2000, the data show that more than one in five of all those who left (22 percent) returned within nine months after exiting. Return rates vary according to reason for leaving. *Failed at recertification* and *whereabouts unknown* returned at high rates (27 and 29 percent, respectively). Not surprisingly, those who were ineligible, and those who requested disenrollment, returned at much lower rates (13 and 8 percent, respectively).

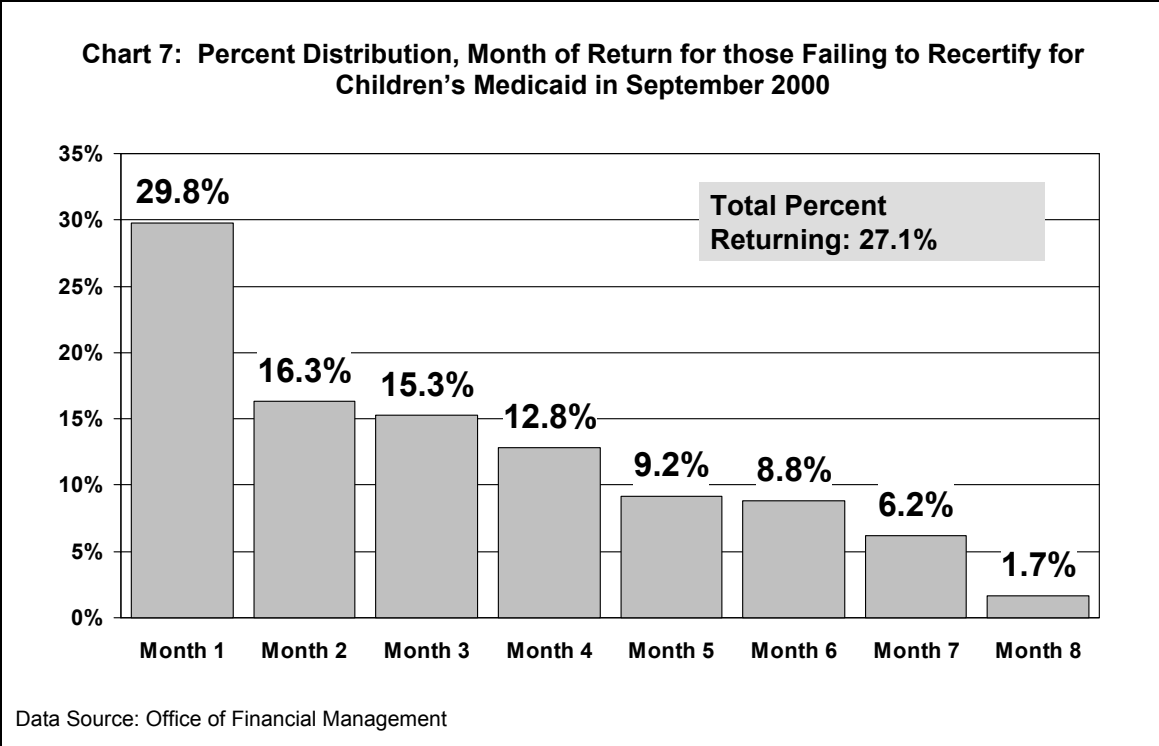
The relatively high return rates for *whereabouts unknown* likely indicate that these families temporarily lost contact with the agency (or vice versa) but were still interested in, and



eligible for, enrollment. Once contact was made, many of these families successfully re-enrolled.

Chart 7 shows the patterns of return for those in the category of *failed at recertification* who then re-enrolled during the first nine months after exit. Thirty percent returned after just one month off the caseload. By month four, three-quarters of those who returned in the first nine months after exiting have done so. From this, it seems that exits followed by relatively quick returns is the dominant pattern. The pattern of relatively quick returns is also found for those who leave for other reasons and then return (data not shown).

Although these data tell us something about those who return, we do not know how many of those who did not return from these various categories were truly ineligible. Some may have returned at a month later than those captured by this particular data source. If national data apply to Washington, many, or most, of those who exited but did not return will have become uninsured. Therefore, although these data do shed light on some of the patterns of leaving and returning from Medicaid, they do not capture the entire dynamics of exits and cycling and their effects on insured or uninsured status.



#### IV. COSTS TO PROVIDERS, HEALTH PLANS, AND THE STATE: KEY INFORMANT INTERVIEWS

##### Introduction

The literature reveals that there are health status and financial consequences connected with low retention and frequent program cycling among Medicaid enrollees. Published research indicates that enrollees experience postponed health care and unfilled prescriptions; inconsistent and interrupted care for complex and chronic conditions; reduced access to preventive care; and increased paperwork and process burden associated with renewal requirements. Providers and health plans experience missed Medicaid payments; increased costs associated with enrollees with delayed, and thus higher, health care needs; and increased administrative costs for providing application and renewal assistance. State program administrators experience increased workload from more frequent applications and renewals, and the state itself incurs higher health care expenditures resulting from enrollees with delayed health care needs.

Anecdotal reports suggest that health care providers, health plans, and state administrators experience costs in addition to those identified in the literature as a consequence of low retention and high cycling. To verify the literature findings for Washington State and to expand the breadth of our research findings for these three stakeholder groups, we conducted confidential<sup>51</sup> interviews with a small selection of key informants in the state, including:

- Three medical groups and three hospitals in eastern Washington.
- A health plan that offers Healthy Options in both rural and urban areas of the state.
- A DSHS Community Services Office (CSO) located in the greater Seattle area.

Resources for this working paper limited the number of interviews we could conduct. Consequently, the interview findings do not describe concerns common to a region or consistent across the state, and they do not describe any sort of consensus among any of the stakeholder groups. They do point out areas of concern that merit further examination to ascertain whether these issues do hold true for a significant number of stakeholders either within regions or market areas, or statewide.

##### Key informant interview questions

We asked the medical groups, hospitals, and the health plan a set of questions designed to discover what costs, if any, these stakeholders bear as a consequence of disenrollment and cycling of their Medicaid clients. Our questions addressed three main areas:

1. **Cost implications of disenrollment and cycling.** For medical groups and hospitals, implications could include:
  - Does the provider verify Medicaid enrollment status at the time the patient presents, and does the provider offer care to disenrolled patients?
  - Costs incurred as a consequence of temporary disenrollment, such as:

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<sup>51</sup> The findings from confidential interviews do not identify the names of the organizations or the people interviewed.

- o Delays in payment
  - o More troubleshooting required to receive payment
  - o Staffing impacts (increased workload or need for more staff)
  - o Increased use of the emergency department
  - o Problems when clients arrive with backlog of unmet health care needs
  - o Any other costs or issues that arise
- For health plans, implications could include:
  - Costs of exit and re-entry (short and longer term)
  - Payment reconciliation issues and retroactive eligibility
  - Continuity of care and preventive care
  - Specific costs of re-enrollment
  - Staffing impacts (increased workload or need for more staff)
  - Problems when clients arrive with backlog of unmet health care needs
  - Any other costs or issues that arise
2. **Cost increases in the past six months.** Have medical group and hospital providers noticed any increase in these costs as the State has begun to implement various procedural changes for continuing Medicaid enrollment, including 6-month eligibility periods and income verification?
3. **Distribution of the costs of disenrollment and cycling.** For medical groups, does the overall practice or do individual doctors bear the costs? For hospitals, how are the costs distributed between the hospital and the physicians who provide services to patients through the hospital?

We also asked whether these stakeholders had any data that would help us understand or document the costs of Medicaid disenrollment and cycling.

### Effects on Medical Group Providers

We spoke with three medical groups practicing in rural northeastern Washington. None of the groups was able to provide data within the time frame of our research to support their observations. For ease in reporting the findings, the groups are identified as Medical Groups A, B, and C. Their general characteristics are:

- **Medical Group A** is a small clinic with a service area of about 45 miles in each direction. The clinic has four full-time physicians.
- **Medical Group B** is a larger clinic with a service area of about 45 miles in each direction. The clinic has 23 full-time health care providers who serve about 30,000 patients a year, of which 18-20 percent are Medicaid. About half of the Medicaid recipients are enrolled in Healthy Options.
- **Medical Group C** has a number of satellite clinics that together have received designation from the federal government as a federally-qualified health center

(FQHC).<sup>52</sup> The clinics are geographically scattered and their service areas in some cases overlap those of Medical Groups A and B. The clinics together have nine full-time health care providers who serve 10,000-12,000 patients a year, 20-25 percent of whom are Medicaid recipients.

### **Cost implications of cycling**

The three clinics operate quite differently with regard to serving Medicaid recipients who are disenrolled or for whom enrollment cannot be verified. These differences reveal that the costs incurred from disenrollment and enrollment cycling can flow in several directions.

Medical Group A tries to verify the enrollment status of Medicaid patients who present without their health plan card or coupon, but will provide health care services to these patients at the time they present regardless of their status. As a consequence of serving disenrolled patients, the clinic experiences delays in Medicaid payments. Some of the care ends up being written off as charity care, if eligibility and enrollment status at the time of service could not be resolved retroactively. Since implementation of Healthy Options in the mid-1990s, the clinic has increased its administrative staff to accommodate the increased demands of participating in this program.

Medical Group B is aggressive at verifying that Medicaid patients are currently enrolled before it provides services. Patients whose enrollment cannot be confirmed are handled in three ways: 1) they are told to return later that day, after they have retrieved their health plan card or coupon from home; 2) they are scheduled to return later in the month, once their card or coupon has arrived in the mail; or 3) they are sent to the nearest hospital emergency department. Only rarely does the clinic provide services to patients whose enrollment cannot be confirmed. As a consequence, the clinic has few Medicaid claims denied. Although it has experienced some Medicaid payment delays, the impact on the clinic from disenrollment and cycling has been minimal. The clinic has incurred costs associated with increased staff time spent troubleshooting enrollment problems.

Medical Group C tries to verify Medicaid enrollment status prior to service, but each of the clinics provides care at the time the patient presents, regardless of this status. Our interviewee asserted that the consequences of providing such care, in the form of delayed payment or charity care, are at least partially offset by the clinics' FQHC status. Reimbursement for FQHCs is calculated prospectively by the State for the "reasonable costs of providing Medicaid-covered services."<sup>53</sup> This rate incorporates average costs incurred in a base year (fiscal years 1999 and 2000) adjusted each subsequent year by a federal index. The rate also is adjusted annually to account for changes in the scope of services provided.<sup>54</sup> Although the rate theoretically reflects the cost of care, there is concern that its initial basis was too low and its annual index is insufficient to account for

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<sup>52</sup> FQHCs are community health clinics that meet specific federal requirements, including being located in a federally designated "medically underserved area" or serving a "medically underserved population."

<sup>53</sup> Centers for Medicare & Medicaid Services (CMS). July 19, 2001. Letter to State Medical Directors. [www.cms.hhs.gov/states/letters/smd119a1.asp](http://www.cms.hhs.gov/states/letters/smd119a1.asp)

<sup>54</sup> The prospective payment calculation is designed to allow providers to bill for services at a rate closer to actual cost; it is not actually paid prospectively.

medical inflation.<sup>55</sup> Our interviewee for Medical Group C also noted that the calculation places a cap on administrative and marketing costs. Still, over the course of a year, for Medical Group C this payment mechanism helps to offset some of the costs incurred by the clinics for providing care to temporarily disenrolled Medicaid patients.

**Who bears the health care services costs?** All three clinics acknowledge that Medicaid patients who are temporarily disenrolled result in financial costs—delayed payments and charity care—to whomever offers them health care services. For Medical Group A, which provides care regardless of Medicaid enrollment status, these costs are borne by the clinic. For Medical Group B, which does not provide care to patients for whom enrollment cannot be confirmed, these costs are shifted to the local hospital emergency department (or, potentially, to another clinic). For Medical Group C, which provides care regardless of Medicaid enrollment status, some portion of these costs are offset by its FQHC reimbursement.

The interviews for this working paper were designed to be at an appropriate level of detail to offer a snapshot of the perspectives of medical groups on the costs they incur from Medicaid disenrollment and cycling. To develop a substantive understanding of the direction of Medicaid process-induced cost shifts and get a sense of the amount of dollars involved would require, however, a deeper and more thorough analysis that includes the alternate sources of funding available to providers who serve Medicaid recipients (as well as patients who are underinsured or who have no insurance at all). For example, the state's Community Health Services program offers funding to not-for-profit community clinics that treat those who are at or below 200 percent of the federal poverty level and have no other form of health care coverage, including Medicaid.

**Who bears the administrative costs?** Each of the clinics we interviewed bears the cost of increased Medicaid administrative procedures, especially time spent trying to verify enrollment and trying to get payment for patients retroactively re-enrolled by the State. These administrative costs are borne within the clinics—they are not shifted to any other entity. Some anecdotes illustrate the daily nature of such administrative costs:

- About 10 percent of Medical Group B's monthly patients present without Medicaid documentation. Enrollment verification, which includes using an on-line verification system that is not easily navigated, takes about 10 minutes per patient. This additional time, while not unreasonable on an individual patient basis, results in cumulatively significant delays for other patients as staff work to verify Medicaid enrollment for the patient(s) ahead of them. To address this issue, Medical Group B tries to avoid scheduling Medicaid patients early in the month to allow time for their health plan card or medical coupon to arrive.
- Not all of the clinic locations in Medical Group C have Internet access for on-line Medicaid enrollment verification, so they often cannot verify Medicaid status at the time the patient presents. Unlike health care costs, FQHC reimbursement rates do not account for the additional administrative troubleshooting time incurred to retro-actively discover the patient's Medicaid status or dispute claims denied by the State.

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<sup>55</sup> This information was offered in February 2004 in a confidential conversation with a community health center researcher.

**Cost increases in the past six months**

None of the three medical groups has noticed an increase in enrollment issues in the past six months—such as an increase in the number of patients presenting without appropriate Medicaid enrollment documentation, or an increase in the number of patients cycling on and off the program. None has noticed an increase in Medicaid payment concerns and administrative troubleshooting. As one interviewee observed, “For us, people going on and off Medicaid is nothing new.” Another offered, “It’s hard to keep up with Medicaid patients. We try, but it’s nigh onto impossible.” As a consequence of the state’s delayed implementation of the new recertification requirements, however, the full effects of these eligibility changes may not become known until July 2004 (see Section III.A).

**Distribution of the costs of disenrollment and cycling**

For each of the medical groups we interviewed, the clinic bears whatever delayed payment, charity care, and administrative costs it incurs related to Medicaid disenrollment issues—these are not passed on to staff providers. Additional time spent troubleshooting enrollment status is not tracked or quantified in any way by these providers but is absorbed as a general cost of doing business.

**Effects on Hospital Providers**

We spoke with three hospitals practicing in south central and southeast Washington. None of the hospitals was able to provide data within the time frame of our research to support their observations. For ease in reporting the findings, the hospitals are identified as Hospitals A, B, and C. Their general characteristics are:

- **Hospital A** has around 230 beds and is located within an urban area. The hospital serves about 275,000 people. Medicaid accounts for 24 percent of its revenues, a proportion that has been increasing in recent years and is expected to continue to do so.
- **Hospital B** is a 50 bed hospital located in a small city in a rural, largely agricultural area of the state. The hospital’s service area encompasses about 20,000 people. Medicaid accounts for about 15 percent of its annual charges.
- **Hospital C** is a 70 bed hospital located in a small city in an area of the state with both urban and rural characteristics. Medicaid accounts for about 23 percent of the hospital’s receivables, but a good proportion of these patients are from out of state and their receivables are not tracked separately.

**Cost implications of cycling**

Hospital A verifies Medicaid enrollment status for planned admissions at the time the patient registers, but provides care regardless of insurance status to both planned admissions and to those who arrive through the emergency department. The presence of two strong community clinics nearby has helped keep patients in care and out of the emergency department. Still, the number of disenrolled Medicaid patients that present at the hospital appears to be increasing, especially among those eligible for both Medicaid and Medicare (“dual-eligibles”).

As with the medical groups, Hospital A has experienced delays in Medicaid reimbursements and increased charity care as a consequence of serving disenrolled

Medicaid patients. The hospital's charity care has increased by roughly 100 percent over the past two years. The hospital attributes this rise to Medicaid eligibility changes as well as the recent elimination of the state's Medically Indigent (MI) program.<sup>56</sup> State grants designed to offset hospitals' lost MI program revenue have replaced only about a third of the dollars this hospital used to receive. In addition, the hospital's administrative troubleshooting for Medicaid patients has increased: "We spend a lot of time trying to establish eligibility for people."

Hospital B's planned admissions are referred primarily by a local medical provider group that verifies Medicaid enrollment status prior to referring patients. The hospital does screen patients seen in or admitted through the emergency department for Medicaid enrollment status, but provides care regardless of this status. As with Hospital A, serving disenrolled Medicaid patients results in delays in Medicaid reimbursements and, possibly, increased charity care. The hospital's charity care has increased by roughly 100 percent in the past year, and is expected to continue to increase in 2004. The hospital attributes this rise less to people cycling on and off of the Medicaid program than to people simply not having health insurance of any sort. Hospital B also observes that troubleshooting for Medicaid patients has increased its administrative workload.

Hospital C verifies Medicaid enrollment status for planned admissions and patients who present through the emergency department, but provides care regardless of Medicaid status. Hospital C also experiences delays in Medicaid reimbursements, and its charity care, currently at about \$30,000 per month, has been increasing. The hospital cannot attribute causes to all of this increase, but has seen a substantial increase in the number of charity write-offs that are ultimately due to Medicaid ineligibility. The hospital also has found that it has insufficient staff to handle the amount of Medicaid eligibility and payment troubleshooting currently necessary. Between 60 and 90 days can elapse before the hospital receives an initial response on its Medicaid claims. Sorting out eligibility problems adds several more days. And resubmitted claims take another 60 to 90 days for resolution. This has placed a substantial financial and administrative burden on the hospital.

**Who bears the health care costs?** All three hospitals provide services to Medicaid recipients regardless of their enrollment status. The costs incurred from Medicaid disenrollment and enrollment cycling are partially offset by federal funds—for example, disproportionate share hospital, or DSH funds, which some hospitals receive for serving a disproportionate share of Medicaid and low-income patients—and state grants. But the hospitals we interviewed bear the balance, and perhaps the larger portion, of these costs.

**Who bears the administrative costs?** Each of the hospitals observed that Medicaid enrollment verification at admission and during billing is a substantial administrative burden. These administrative costs are borne within each of the three hospitals—they are not shifted to any other entity. A few anecdotes illustrate the nature of these costs:

- For several years Hospital A had the services of an out-stationed Medicaid worker. The state recalled the position last year, however, observing that the hospital's contribution to the position salary was insufficient. Losing this person

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<sup>56</sup> The MI program was eliminated in the 2003 legislative session, effective July 1, 2003.

contributed to the hospital's increased Medicaid enrollment administrative time and effort. Because the hospital receives additional DSH funds, this outstationed Medicaid position is required by federal statute. The state recently reinstated the position but provided an untrained person to fill it. The hospital expects that once this person becomes trained, the additional Medicaid administrative burden on hospital staff will be reduced.

- Hospital C has two parallel online verification systems it uses for patients who present without proof of Medicaid enrollment. Occasionally, the systems produce different answers. In addition, when using the online systems to recheck patient eligibility after receiving claim denials, hospital billing staff often find information for the time of service that is different from that provided at the time of service: "A lot of time you really can't get a good answer. Even though the coupon says they're eligible, they're not."

#### **Cost increases in the past six months**

Hospitals A and C observed an increase in temporary Medicaid disenrollments in the past six months. Hospital C began to notice this increase in November 2003, although our interviewee suspects that the increase might have begun earlier. The hospital has experienced a "big increase" in Medicaid cycling, particularly for one-month periods. This "missing month" has become more frequent (up to one or two patients with enrollment gaps per week): "First they're on, and then you go back and the system has been updated and it says they're not eligible. So you have them sign a financial agreement, and a month later they bring back a coupon that says they really were eligible during that time."

#### **Distribution of the costs of disenrollment and cycling**

Because the costs of delayed payment, charity care, and administrative troubleshooting are imbedded in the hospitals' accounting records, such as increases in the length of the hospital's revenue cycle, they are not directly passed on to staff or contract providers. These costs might be passed on indirectly when hospitals develop provider reimbursement calculations, but this was not part of the research for this working paper.

#### **Effects on Health Plans**

We spoke with one health plan that offers Healthy Options in both rural and urban areas of the state.

#### **Cost implications of cycling**

For our study health plan, the cost implications of managing frequent disenrollment and cycling in large part mirror those identified by our medical group and hospital providers:

- The health plan must manage one-month cycling. The plan may bear the costs of paying claims for the period when a Medicaid recipient was not enrolled, and experiences "constant" interactions with providers regarding who is responsible for the costs of care for the period of disenrollment.
- The plan experiences payment gaps as a consequence of the 6-month recertification process. The process not only is twice as frequent as it used to be, it now also requires Medicaid recipients to take a more proactive role. The State

does reimburse health care expenses for Medicaid recipients who are re-enrolled retroactively, but the payment is fee-for-service and goes to the provider. As a result, the health plan loses the capitation payment.

- The plan loses its ability to manage Medicaid recipients' health care when they cycle on and off the program. This is important for recipients with, for example, chronic illnesses or high-risk pregnancies, and for children with asthma or other special health care needs. The health status of disenrolled patients is compromised if their care is discontinuous and they lack access to preventive care. For the health plan and its provider network, this translates into higher health care costs if the patient becomes re-enrolled and returns to care.

To maintain continuity of care and ensure access to preventive care, the plan's network providers often will provide care to disenrolled patients. The costs of (and potentially, delayed reimbursement for) this care are shifted from the plan to the network provider. When network providers are not federally-subsidized clinics, they may choose not to treat a patient. If a disenrolled patient goes to a non-network provider, such as a hospital emergency department, both the plan and its network provider lose contact with the patient, and continuity of care and preventive care are compromised. Costs (and reimbursements) are shifted to the non-network providers.

Whether as a consequence of disenrollment or for other reasons, when Medicaid recipients delay receiving health care and thereby have higher health care needs, this health plan bears higher health care costs.

- The plan bears some additional administrative costs as a consequence of repeatedly re-enrolling Medicaid recipients as members, but these costs are not substantial when compared to the other costs incurred from disenrollment and cycling.

#### **Cost increases in the past six months and distribution of these costs**

The new Medicaid enrollment requirements have already resulted in the loss of about 20,000 Medicaid recipients statewide. Drops in enrollment affect the financial planning of the plan and its providers—e.g., the latter must budget for increased charity care. Large drops in Medicaid clients affect contracting between plans and providers. The plan has not experienced any changes in administrative staffing needs as a consequence of changes in Medicaid enrollment procedures, as of yet.

#### **Effects on State Program Administrators**

We spoke with four staff members of a DSHS CSO located in the greater Seattle area to discover what costs, if any, might accrue to administration of the program as a consequence of enrollment process changes. Since we spoke with representatives from only one office, the findings cannot be extrapolated to all CSO offices or to the Medical Assistance Administration, which administers the State's Medicaid program, as a whole. The findings point out areas of concern that merit further examination to ascertain whether these issues hold true across CSO offices and whether their level of intensity has implications for policy makers.

**Key informant interview questions**

We began our interview with several questions designed to help us understand the procedures CSO staff use to process applications and renewals. Our subsequent questions were designed to address the disenrollment and cycling concerns of this working paper. They included:

**1. Effectiveness of renewal procedures in preventing disenrollment.**

- How long has MAA been sending out pre-filled recertification forms? Has this increased retention at all?

**2. Reasons for disenrollment and cycling.**

- Are most terminations due to eligibility changes (e.g., enrollee gets a job and income is too high to qualify) or administrative issues (e.g., not returning paperwork in time)?
- Have you noticed any common characteristics (demographics, family size, income, etc.) of those who cycle on and off versus those who remain continuously enrolled?

**3. Changes in the past six months.**

- Have the last year's eligibility changes (6-month certifications, stricter income verifications, etc.) affected enrollment or recertification figures?
- How many enrollees terminate but re-enroll within the retroactive eligibility window? How many do so after the window closes? What reasons do they give for doing so?

**Effectiveness of renewal procedures in preventing disenrollment**

Our interviewees observed that for them, the Medicaid enrollment renewal process is less time consuming than establishing initial eligibility. And for both initial enrollment and renewal, it is quicker for a family to come into the CSO or mail in an application form than for the applicant to use an online form DSHS has created. The online form is substantially longer than the written form, and must still be printed out and signed by the client in order for a client to be eligible. However, this signature requirement in the recertification process may be rescinded in the near future since federal law does not require it.

DSHS's online linkages with other assistance programs are only marginally useful for the CSO staff we interviewed, because there is lag time in important information being entered into it. For example, the State Employment Security Department enters employment data quarterly. But the low-income population changes jobs frequently, so quarterly employment data may not be accurate. Employment Security Department data also will often include information for more than one job per person or for only part of a month. Hence, CSO staff often must ask for documentation from the client or an employer in order to verify employment status and pay.

**Reasons for disenrollment and cycling**

These CSO staff noted that Medicaid enrollees for whom English is not their first language and enrollees with low literacy are more likely to "drop off" when they are due to renew. Enrollees who are self-employed also are more likely to drop off.

From the perspective of these CSO staff, providers who do not verify Medicaid enrollment prior to treating patients leave the patients assuming they are still enrolled. This can lead to patients not completing the renewal process.

Our interviewees also observed that many Medicaid-eligible residents enroll and disenroll for convenience. For example, they let their eligibility end when they think they don't need coverage, and then re-apply just before they need to see a health care provider.

#### **Changes in the past six months**

The recertification form now instructs Medicaid enrollees that they need to submit income documentation. Our CSO interviewees asserted that income verification is the most difficult part of the renewal process. They observed that people do not like to verify income, especially since it is a new requirement. In their estimation, two-to-three out of ten initial or renewal applications have missing information, usually income information. Many applications also are missing Social Security numbers—in particular, those of the many undocumented people who apply to the program. Our interviewees noted that the new system does discover people that have become ineligible because they are over the Medicaid income thresholds.

In this CSO, the average medical eligibility worker processes 40-50 initial applications or recertifications per day. Since the 6-month recertification requirement was implemented, along with the new renewal documentation requirements, the proportion of their time that staff spend on renewals has increased from about 25-30 percent to 50 percent. The workload increase has created backlogs of initial applications and renewals. CSO staff are confident that the processing of these applications will occur and, if they meet eligibility criteria, the applicants will be enrolled in the program with retroactive eligibility. They assert that retroactive eligibility means that provider claims ultimately will be settled. They noted that this scenario is an acceptable, if not ideal, outcome to a CSO eligibility worker, but probably causes problems for providers.

CSO staff feel that the increased workload from the new 6-month certification period is starting to, or has already, stabilized. The initial delay in implementing the 6-month certification period, however—which resulted in many applicants continuing to receive 12-month eligibility—could translate into a “real flood” of renewal applications in the coming months.

<b>TABLE 2: Summary of Costs to the Health Care System</b>		
<b>Part of System</b>	<b>Description of Costs</b>	<b>Data Sources</b>
<b>Medical Practices/Clinics</b>	<ul style="list-style-type: none"> <li>• Charity care</li> <li>• Cost of deferred care</li> <li>• Delayed payment/gaps in payment</li> <li>• Referral costs</li> <li>• Increased staffing costs</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews</li> </ul>
<b>Hospitals</b>	<ul style="list-style-type: none"> <li>• Charity care, increased ED use</li> <li>• Delayed payment/gaps in payment</li> <li>• Costs of enrollment staff (if applicable)</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews</li> </ul>
<b>Health Plans</b>	<ul style="list-style-type: none"> <li>• Costs of re-enrollment, doctor reselection, etc.</li> <li>• Cost of deferred care/inability to manage patient care</li> <li>• Costs of lost capitation payments</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews</li> <li>• Cost data for activities associated with re-enrollment</li> </ul>
<b>State Agencies (MAA/ESA)</b>	<ul style="list-style-type: none"> <li>• Administrative costs of re-enrollment: letters, phone calls, in-person work, etc.</li> <li>• Costs of increased enrollment staff</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews</li> <li>• Cost estimates as derived from budget documents, etc.</li> </ul>

## V. CONCLUSION

### A Recap of Findings

This study examined the issue of the costs of retention through a review of national literature; a review of policy changes in Washington and associated changes in patterns of retention; and a series of qualitative interviews with providers, state workers, and a health plan to gather information on how the costs of low retention and cycling are distributed throughout the state's health system.

The literature consistently showed that most failures to renew are due to procedural, not eligibility issues. Low Medicaid retention is also a significant contributor to uninsured rates. A smaller set of studies showed that the costs associated with low retention rates make efforts to shrink Medicaid enrollment through procedural barriers an inefficient way to save state dollars. Patients who come back on to the caseload often have unmet health care needs, preventive care is often neglected, and the administrative resources expended in re-enrollment can be substantial for state agencies. Health plans lose capitation payments and are less able to realize savings from disease management and other care management programs.

A review of policy showed that Washington had implemented most of the measures identified as increasing retention by the late 1990s. After these measures were adopted, Medicaid enrollees left the caseload at reduced rates. More recent data show that new state renewal policies that increase the frequency of eligibility reviews and require more income documentation at renewal are increasing exit rates and reducing average caseloads. This is consistent with assumptions used in the state's 2003-2005 budget regarding the effects of these policies. Thus far, enrollment losses from these procedural changes are exceeding original estimates.<sup>57</sup>

An analysis of data for Washington showed that one in five of those who exit Medicaid in a particular month come back on the caseload within nine months. Most of these returns occurred quite quickly after exit, consistent with the views expressed by many of our key informants. Because we did not have longitudinal data to illustrate long-term return patterns, we cannot say whether others exiting Medicaid re-enroll after health issues cause them to seek insurance.

A limited examination of the costs of low Medicaid retention and cycling to various parts of the health system suggests that costs are shifted to providers—clinics and hospitals—and to health plans. These costs are the consequence of establishing Medicaid enrollment status at the time of intake and service provision, seeking retroactive reimbursement for such care, and writing off care for which the State will not pay. Providers also bear the cost of treating rising numbers of uninsured. For providers, costs varied according to whether a provider had a high Medicaid caseload; had capacity to review eligibility before providing treatment and whether it provided treatment regardless of enrollment status; whether the provider participated in various federal or state funding schemes to increase or supplement reimbursement; and whether non-enrolled patients could be referred to other providers (e.g., hospital emergency rooms) for care. All providers

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<sup>57</sup> Washington State Caseload Forecast Council, "Medical Assistance Administration, Categorically Needy Adult and Children's Programs," November 12, 2003. [www.cfc.wa.gov/Forecast/Current/MA-Cat\\_Needly.htm](http://www.cfc.wa.gov/Forecast/Current/MA-Cat_Needly.htm)

experienced increased costs due to the staff required to verify enrollment and troubleshoot payment issues. We were unable to quantify this effect, however, as providers do not track the specific effects of Medicaid clients on staffing levels and staff time expended. Health plans lost capitation payments when individuals were disenrolled, and lost the ability to manage client care when people disappeared from enrollment. Interviews with CSO staff indicated increased workloads and a growing backlog of applications and renewals. Although we do not have direct information on the statewide impacts of increased staffing needs, the state budget for the 2003-2005 biennium estimates that an additional \$8 million will be expended for additional staff (90 FTEs) needed to conduct more frequent eligibility reviews.<sup>58</sup> However, this number was offset with a 250 FTE cut at the same time, resulting in a net decrease of 160 FTEs.

This review of evidence regarding the costs of cycling points to a need for additional analysis and continued monitoring. Only some of the issues identified in the national studies could be examined using available Washington State data, and some of the evidence is murky given that many program elements change simultaneously in Medicaid, making isolating the effects of specific retention policies difficult. Useful research would include additional analysis of trends over time in retention, cycling, average length of enrollment, and trends in overall recertification rates, and a focus on the effects of recent policy changes on retention and cycling. An expanded analysis of the effects of cost-shifting throughout the health system would generate useful insight for policy makers, as would an examination of the costs shifted within state agencies as increased eligibility reviews and re-enrollments consume increased staff time.

### **Policy implications**

Although recent policy changes may increase assurance that only the “truly needy” receive benefits, there are negative side effects of such policies. It is likely that most of the disenrolled individuals actually are eligible to remain enrolled and only go off the rolls because of procedural and verification requirements. This reality, and the attendant costs of enrollment instability within the Medicaid program, highlight a number of implications for policy makers as they consider policies that affect eligibility redetermination. These are:

- 1. Medicaid disenrollment and cycling increases the number of uninsured, who represent higher costs to the health system overall.** Although policies that increase cycling generate costs that are distributed throughout the health system, perhaps the largest result is a general increase in the number of uninsured. Many people return to the Medicaid rolls, but most do not, and as more people move off the caseload for procedural reasons, the state's uninsured rate goes up. The uninsured represent the highest cost to the provider system and also tax other funding sources, such as the limited federal or state funds available to offset the costs of charity care.
- 2. Policies that increase Medicaid disenrollment and cycling shift costs to other parts of the health care system.** Some of the cost increases are borne by the state itself as it increases staffing to handle additional eligibility reviews, and provides more money to offset charity care at both clinics and hospitals. Equally important, when

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<sup>58</sup> Legislative Evaluation and Accountability Committee, 2003 Washington State Budget Notes, Part IV, Agency Detail, Department of Social and Health Services, <http://leap.leg.wa.gov/leap/budget/lbns/2003dshs.pdf>

people become uninsured the state loses federal match dollars that help subsidize local health systems and maintain the health of the state's population. Although the state still nets substantial savings from reduced average Medicaid enrollment, this is offset by a dollar-for-dollar loss of federal Medicaid match money. Some costs may eventually be borne by other state agencies as pressures to reimburse for charity care increase. And the costs that are shifted to health plans and providers may be substantial, further burdening the health care delivery system for publicly-funded enrollees.

- 3. A broader framework for cost analysis would contribute to more effective policies that address Medicaid retention.** Given all the costs incurred throughout the system as Medicaid enrollment becomes more unstable and the number of uninsured increases, the state might consider performing a broader cost analysis before adopting procedural changes that affect retention. Policy makers are pressed to resolve immediate budget crises with short-term solutions, but calculating net savings only as they affect single agencies biases the analysis toward any change that results in savings in a particular budget line item. A broader analysis would also consider savings and costs to other DSHS subagencies and to other state programs, often in other departments, that subsidize charity care. Such an analysis would also consider the costs to the broader health care delivery system—health plans, medical practices, and hospitals. In addition, the loss of federal match dollars to the state from Medicaid disenrollment, and consequent effects on local health systems, should be considered when the state assesses options that have the effect of reducing retention and increasing the number of uninsured.