Medicaid 'churning' leads to increased acute care use for patients with major depression

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For adult Medicaid beneficiaries with major depression, disruptions in coverage are followed by increases in emergency department (ED) visits and longer hospital stays after the person goes back on Medicaid, reports a study in the August issue of *Medical Care*.

Disruptions in Medicaid coverage—sometimes called "churning"—are less frequent in states with streamlined Medicaid re-enrollment procedures (ie, requiring only yearly recertification versus every six months or more frequently). According to the report by Xu Ji, MSPH, and colleagues of Rollins School of Public Health, Emory University, "Maintenance of continuous Medicaid coverage may help prevent acute episodes requiring high-cost interventions" for those with mental health problems.

Disruptions in Medicaid Coverage Linked to Increases in Acute Care Use

The study used Medicaid data on nearly 140,000 adults treated for major depression during 2003-04. The researchers looked at how disruptions in Medicaid coverage affected healthcare use—focusing on acute care services such as ED visits and hospital stays.

The results show the high rate of Medicaid "churning" among low-income adults with major depression, and suggests that these disruptions lead to increased use of costly ED and hospital inpatient services among

this vulnerable population after they re-enroll in Medicaid. Twenty-nine percent of patients had disruptions in Medicaid coverage lasting at least one month; the average duration was eight months. About one-fourth of patients with interrupted coverage re-enrolled in Medicaid later during the study period.

Medicaid beneficiaries with depression that had interrupted coverage experienced increased use of acute care services. Emergency department visits were about 40 percent higher and hospital stays were about 67 percent longer for those with disruptions in coverage than for those without disruptions. The data used in this study did not include any information on care use or costs during the periods when patients lost Medicaid coverage.

For patients with coverage disruptions, acute care costs increased by $650 per patient per Medicaid-covered month, compared to those without disruption. The increase in acute care costs contributed to an overall increase in costs for all adult patients with major depression: by $310 per person per Medicaid-covered month.

The sharpest rise in acute care costs occurred during the first two months after re-enrolling in Medicaid. The longer the disruption in coverage, the more intensive the use of acute care after re-enrollment.

Disruption in coverage was related to state policies regarding Medicaid re-enrollment. The disruption rate was 25.8 percent among beneficiaries living in states with more streamlined policies (requiring re-enrollment yearly) versus 37.5 percent among those living in states with more frequent re-enrollment (every six months or more frequently).

Ms. Ji and coauthors write, "State policies related to Medicaid re-enrollment have implications for coverage continuity." They add that, "The lack of a constant source of coverage may cause patients to miss

visits with their providers until their depression symptoms and complications worsen to the degree that emergency visits are required. For some individuals, acute care may serve as "an entry point for returning to treatment" and "trigger their re-enrollment in Medicaid."

The authors note some significant limitations of their study—particularly the use of older Medicaid data. But they believe the findings still have important implications amid the current debate over Medicaid and the possible repeal of the Affordable Care Act.

The Affordable Care Act streamlines Medicaid re-enrollment policies by requiring states to recertify eligibility no more frequently than annually for beneficiaries who qualify based on income. Proposals currently debated in Congress would give states more autonomy in administrating their Medicaid programs. Some proposals include the option of re-determining eligibility every six months or more frequently. The findings of this study suggest that the proposed policies could exacerbate disruptions in Medicaid coverage for those with mental health needs, which can increase the use of costly services delivered in hospital acute care settings. As policymakers continue to debate the future of Medicaid, it will be important to consider "strategies that improve the continuity of Medicaid coverage and ensure adequate access to care for vulnerable populations."

More information: Xu Ji et al. Discontinuity of Medicaid Coverage, *Medical Care* (2017). DOI: 10.1097/MLR.0000000000000751

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