Resource Paper

Policies and Practices that Lead to Short Tenures in Medicaid Managed Care

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INTRODUCTION

Short tenures in Medicaid have long been recognized as a problem for both adults and children, as has the related problem of churning. There is recent evidence that short tenures in Medicaid managed care may be an even more significant problem than short tenures in Medicaid itself. A recent study reported that only about 40 percent of two-year-olds in 12 states with high Medicaid managed care enrollment had been enrolled in the same health plan continuously for 12 months. In contrast, almost 80 percent of the two-year-olds had been in Medicaid for the same amount of time. An older study, undertaken by the Work Group developing performance measures in HEDIS (Health Plan Employer Data Information Set) for Medicaid, examined tenures for all Medicaid managed care members (adults and children) in relatively stable health plans in eight states. This investigation reported similar findings for tenures in health plans: approximately 50 percent of the Medicaid enrollees had been with the same health plan for one year, 27 percent for two years, and 17 percent for three years. In contrast, commercial health plan members have far longer tenures.

Managed care is now Medicaid’s dominant form of service delivery. In 2000, 49 states either mandated or encouraged managed care for their Medicaid population. By 2002, 57 percent of all Medicaid enrollees nationwide were in some form of managed care, up from 9 percent in 1990. Managed care is seen not only as a vehicle for controlling costs in Medicaid, but also as a way to improve quality of care for recipients and to hold health plans accountable for delivery of services. However, serious questions need to be raised about how well health plans can manage care and improve health outcomes of the Medicaid population as a whole if most individual Medicaid recipients are health plan members for less than a year. With respect to accountability, health plans report performance on, and are held accountable in the HEDIS system, for members who have been enrolled for 12 months continuously, allowing for only one break. Thus, short tenures mean that health plans are reporting on a fraction of their Medicaid population. Health plans have argued that members need to be enrolled for at least a year before the plan can have an impact on the quality of care delivered to that member. By that standard, the findings that fewer than half of the members are in a given health plan for a year raises concerns. The additional finding that members may be in Medicaid, although not in the same managed care plan for 12 months, raises still other concerns and questions.

The purpose of this study is to explore reasons for differences in tenures in Medicaid and in health plans. We do this by conducting case studies in five states, focusing especially on children in Medicaid because recent policies have targeted children. The paper offers recommendations for addressing the issue of short tenures in Medicaid managed care, including options for measuring performance and monitoring quality.
METHODS

We selected five states to offer variation in tenure in Medicaid managed care, as well as to afford geographical variation, experience with managed care, and variation in state Medicaid and SCHIP programs. The five states are: Arizona, Michigan, New York, Oregon, and Pennsylvania. In the prior study, Pennsylvania had the highest percentage of two-year-old children continuously enrolled, Oregon had the lowest percentage, while Arizona, Michigan, and New York were in the middle. Table 1 shows state characteristics.

In each state, we conducted on-site interviews with Medicaid and managed care offices, including medical directors, eligibility and enrollment specialists, client service representatives, and quality monitoring offices. In addition, we conducted interviews were held with Medicaid managed care enrollment brokers as well as medical services offices and quality monitoring offices in health plans. Follow-up interviews and interviews with those who were not available were conducted by phone. We focused our inquiry on children in Medicaid, but because SCHIP and Medicaid policies are often related, and because children can move from one program to the other, we also collected information on the state’s SCHIP policies.

- Arizona
  Arizona started its Medicaid program later than most states, but since its inception in 1982, it has been a Medicaid managed care program. The program provides care to more than 800,000 enrollees and 92 percent of these enrollees are in managed care. Arizona’s long history of managed care has resulted in a stable plan market with few plans leaving or entering the system.

- Michigan
  Michigan’s Medicaid managed care program, implemented in 1997, provides coverage to 1.2 million enrollees with 75 percent of the enrollees receiving coverage through managed care. Michigan’s Medicaid program for children is known as Healthy Kids. Currently, the state contracts with 17 health plans all of which are required to be accredited by NCQA or JACHO.

- New York
  New York’s Medicaid managed care program was implemented in 1997 through a phase-in process. The phase in occurred more quickly for upstate than the New York City area and is planned to reach completion this year. Twenty-eight plans participate in New York’s Medicaid managed care program, the majority of them providing care to individuals in the New York City area (22 plans). The program provides coverage for about 3.4 million people, approximately 45 percent which are in managed care.
• Oregon
Oregon’s Medicaid program was implemented in 1994 and is the smallest of our study states. The Oregon Health Plan provides coverage to about 400,000 enrollees, of which 87 percent are enrolled in managed care. The Oregon managed care market has seen volatility in the past five years, with six plans leaving 22 of Oregon’s 36 counties during that period. As a consequence, approximately 11 percent of Medicaid enrollees switched plans, primarily in rural areas.

• Pennsylvania
Pennsylvania’s Medicaid managed care program, also known as HealthChoices, provides coverage to 1.5 million enrollees. The program has been phased in by regions and is currently mandatory in 25 counties and voluntary in 26 counties (Pennsylvania has a total of 68 counties). The phase-in began in regions with large populations and, 79 percent of Medicaid enrollees currently are in managed care. The state expects that once it has completed the phase-in process, 90 percent of the Medicaid enrollees will be in managed care.
### Table 1
Characteristics of States and Their Medicaid Programs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of State (2003)</td>
<td>5,456,453</td>
<td>10,050,446</td>
<td>19,157,532</td>
<td>3,521,515</td>
<td>12,335,091</td>
</tr>
<tr>
<td>Number of Medicaid Health Plans</td>
<td>9</td>
<td>17</td>
<td>28</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>Commercial Plans or Medicaid Only Plans</td>
<td>Medicaid only</td>
<td>Mostly Medicaid only</td>
<td>Mostly Medicaid only</td>
<td>Mostly Medicaid only</td>
<td>Mostly Medicaid only</td>
</tr>
<tr>
<td>Payment to Plan</td>
<td>Capitated</td>
<td>Capitated</td>
<td>Capitated</td>
<td>Capitated</td>
<td>Capitated</td>
</tr>
<tr>
<td>SCHIP Separate, Medicaid Expansion, or Both</td>
<td>Separate</td>
<td>Both</td>
<td>Both</td>
<td>Separate</td>
<td>Separate</td>
</tr>
</tbody>
</table>

### Medicaid Program Characteristics

<table>
<thead>
<tr>
<th>Medicaid Income Eligibility Threshold</th>
<th>Arizona</th>
<th>Michigan</th>
<th>New York</th>
<th>Oregon</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 0-1</td>
<td>140% FPL</td>
<td>185% FPL</td>
<td>185% FPL</td>
<td>133% FPL</td>
<td>185% FPL</td>
</tr>
<tr>
<td>Ages 1-6</td>
<td>133% FPL</td>
<td>150% FPL</td>
<td>133% FPL</td>
<td>133% FPL</td>
<td>133% FPL</td>
</tr>
<tr>
<td>Ages 6-18</td>
<td>100% FPL</td>
<td>150% FPL</td>
<td>133% FPL</td>
<td>100% FPL</td>
<td>100% FPL</td>
</tr>
<tr>
<td>Total Medicaid Enrollees</td>
<td>821,748</td>
<td>1,191,456</td>
<td>3,388,931</td>
<td>427,547</td>
<td>1,458,694</td>
</tr>
<tr>
<td>Percent in Medicaid Managed Care</td>
<td>92%</td>
<td>75%</td>
<td>45%</td>
<td>87%</td>
<td>79%</td>
</tr>
</tbody>
</table>

### SCHIP Program Characteristics

<table>
<thead>
<tr>
<th>SCHIP Income Eligibility Threshold</th>
<th>Arizona</th>
<th>Michigan</th>
<th>New York</th>
<th>Oregon</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 0-19</td>
<td>200% FPL</td>
<td>200% FPL</td>
<td>250% FPL</td>
<td>185% FPL</td>
<td>200% FPL</td>
</tr>
<tr>
<td>Total SCHIP Enrollees</td>
<td>49,985</td>
<td>47,244</td>
<td>459,011</td>
<td>19,748</td>
<td>125,424</td>
</tr>
<tr>
<td>Percent in Managed Care</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>78%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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*Population data is from Census Bureau State Population Estimates, July 1, 2002.

* Oregon’s separate SCHIP program is a Medicaid look-alike program.

* Data from Medicaid Managed Care Enrollment as of December 31, 2002, Centers for Medicare and Medicaid Services.

* Oregon’s SCHIP income threshold changed to 185 percent in 2003.


* Estimated based on 1st of the month enrollment report for December 1, 2001.
RESULTS

Two factors emerged from our interviews and examination of reports and data in the five states as the major contributors to short tenures in Medicaid managed care. These factors are: (1) the gap between the time Medicaid coverage begins and enrollment in a health plan; and (2) the frequency and ease of re-determination for Medicaid. In addition to these two factors, health plan market instability also may play a role in churning. When the market is not stable, the withdrawal of plans from service areas or from the Medicaid program entirely has a large impact on the number of enrollees that are forced to change plans resulting in short tenures in any given plan. Only one of our five study states was affected by an unstable health plan market.

Before we present our findings about major contributing factors to short tenures in health plans, we offer an unexpected finding. We had expected that plan switching would be a major factor in the difference in tenures in Medicaid and Medicaid managed care. However, we did not find this to be the case. Four of our states had performed studies to determine how many members change health plans and why. They found generally low levels of plan switching – Pennsylvania found that fewer than 1 percent of its members switched plans, approximately 3 percent switched in Michigan and Arizona and approximately 11 percent switched in Oregon within a given year. The main reason for switching was not dissatisfaction with the health plan itself, but rather switching to enable a member to go to a provider of choice.

These findings from our states are consistent with other studies of Medicaid managed care enrollment and dis-enrollment. Studies in California and a national study by the National Academy for State Health Policy in Iowa, Minnesota, Rhode Island, and Utah found that about 10 percent of the enrollees switched plans. The latter study also underscored the importance of providers in the decision to stay with or leave a health plan. If plans have the same provider networks, then enrollees often do not have a preference for a specified health plan.

The following sections present discussion of the factors that we identified as being major contributors of short tenures in Medicaid managed care.

Gap between the Time Medicaid Coverage Begins and Enrollment in a Health Plan

One of the major reasons for the difference in the length of enrollment tenures in Medicaid itself and in a health plan is the gap between the time an applicant receives Medicaid coverage and the time that same applicant is enrolled in a health plan. In all states, including the five in this study, Medicaid eligibility needs to be established before the child is enrolled in a health plan. The two processes are separate and sequential: first, the Medicaid application is evaluated to determine if the child meets requirements for Medicaid coverage, and then the process begins to enroll those with Medicaid coverage in a health plan.

The gap arises because the start date for Medicaid is retroactive to a time before eligibility has been determined, while enrollment in a health plan is prospective and only occurs after Medicaid eligibility has been established.
Determining Medicaid Eligibility and Time Medicaid Coverage Begins

The broad outline of the Medicaid eligibility determination process is similar in all five states, as shown in Table 2, although some of the specific details vary. Broadly speaking, applicants fill out an application form and submit this with supporting documentation to prove eligibility. The documentation is evaluated, in a process that can take up to 45 days, and those children determined eligible receive Medicaid coverage. The coverage begins — not forward from the time the applicant was deemed eligible — but rather, retroactively to the time of application. In three of the states, Medicaid coverage is retroactive to the date of the application, while in the remaining two it is further retroactive to the first of the month in which the application was filed (Medicaid coverage can begin at an earlier point, if there are outstanding medical bills, coverage can be retroactive for an additional three months before application, if the applicant is subsequently deemed eligible).

Medicaid insurance cards are mailed to applicants after their eligibility is determined.¹ Medical bills incurred between time of application and time the applicant receives the card are covered. However, because the applicant does not have a card (and, in fact, does not know whether he/she will be eligible and actually receive coverage), applying clients may not behave as if they were insured during the limbo period between application and successful eligibility determination. They may not, for example, seek preventive services or well-child care during the period before they learn that they are eligible.

Enrollment in a Health Plan

Enrollment in a health plan, in contrast, is a separate process that begins after the child has been determined eligible for Medicaid. States vary more in the timing of enrollment in a health plan than they do in the start date for Medicaid coverage, as shown in Table 2. In four of the five states, applicants can pick a health plan at the time they apply for Medicaid, while in the fifth state (Michigan) the process of choosing a health plan begins after Medicaid eligibility has been determined.

The type of assistance also varies in the states. In Pennsylvania, enrollment broker personnel are stationed in County Assistance Centers and assist in plan selection at the same time the Medicaid staff is helping with the Medicaid application. In Oregon and Arizona, state field staff assists with both; while in New York, health plans, specially designated community-based organizations, and the enrollment broker can assist clients. In these four states, assistance is available at the time the Medicaid application form is filled out. In Michigan, the enrollment broker sends out enrollment packets to children after determination of eligibility for Medicaid. In all states, telephone assistance is available to help applicants select a health plan, as well as on-site assistance.

¹ New York is an exception. Children who enroll through health plans are temporarily placed in the health plan’s SCHIP program, if they appear to be eligible for Medicaid. After the determination is made, they are placed in Medicaid. These children have an insurance card (for SCHIP) in the period between time of application and Medicaid eligibility determination.
In four of the states, enrollment in the health plan occurs as soon as the paperwork can be processed and the health plan notified, which takes from one to 45 days after Medicaid eligibility is determined, depending on the state and the timing of the plan notification. In these states the per-member/per-month capitated payments to health plans for a given member begin after the time of notification. Health care costs incurred before this time are paid through fee-for-service reimbursement. In Arizona, enrollment in a health plan is retroactive to the date of Medicaid eligibility. Health plans in Arizona receive payment for this retroactive period based on actuarial costs for that period.

If a health plan is picked (and thus the child does not need to be auto-assigned) the gap between the time Medicaid coverage begins and enrollment in a health plan is approximately 45 to 80 days. If the child is auto-assigned, the process can be even longer.

**Auto-Assignment**

If the applicant does not pick a health plan within a specified time period, which varies by state as shown in Table 2, the applicant is auto-assigned to a health plan. Michigan and New York give the applicant 60 days after Medicaid eligibility has been determined to pick a health plan, while Pennsylvania gives four to five weeks. In Arizona, if a client has not chosen a plan by the time eligibility is determined then the client is auto-assigned to a plan. Oregon immediately auto-assigns children to a plan if one is not designated on the application. Michigan is planning to shorten the 60-day period to 30 days, because it found that 80 percent of the applicants who do pick a health plan, do so within two weeks. Giving extra time to select a health plan does not appreciably add to the number of applicants who pick a plan, but it does make a longer gap.

Applicants who do not pick a health plan are auto-assigned, through a formula that varies from state to state, and can reward the higher quality health plans, the lower bidding plans, or smaller and newer plans. Sometimes, auto-assignment is based on closest provider to the address of the auto-assigned child. Auto-assigned applicants are given from 16 days (Arizona) to 90 days (Michigan) of “free-look” time to decide whether they want to stay with the auto-assigned health plan or change. In Pennsylvania, applicants can change health plans at any time, but other states have restrictions on changing after the free-look period. After this free-look period, children are “locked in” to a plan for 12 months in Arizona, Michigan, and New York and six months in Oregon. After that time, applicants can switch plans at only specified times (see Table 2) without a cause. Pennsylvania is the only study state that allows its clients to change plans at any time, for any reason, but all states permit changing for “good cause,” such as to be with a specified provider.

**Gaps between Beginning of Medicaid Coverage and Enrollment in the Health Plan of Choice**

The size of the gap between the beginning of Medicaid coverage and enrollment in a health plan can vary greatly, depending on state rules and depending on whether a health plan was designated or the child was auto-assigned. The smallest gap occurs if the health plan is chosen at the earliest possible opportunity, which means that the plan was chosen on the application for Arizona, New York, Oregon, and Pennsylvania and immediately after notification by the
enrollment broker in Michigan. Under these best case conditions, the gap can be from 45 days to three months. If the health plan is not chosen, and the child needs to be auto-assigned, the gap can be much longer.

Examples from three states serve to illustrate the gap that would occur under the best of circumstances in those states; namely, when timing is optimal and there is no auto-assignment. Arizona and Pennsylvania have systems that result in short gaps. In both of these states, if the child chooses a health plan when he or she applies for Medicaid, the child’s health plan is notified as soon as Medicaid eligibility has been determined. Electronic lists go out to health plans daily in Arizona and twice a month in Pennsylvania. Thus, the child will be on the health plan’s rolls within a day of Medicaid eligibility determination in Arizona and within two weeks of Medicaid eligibility determination in Pennsylvania.

Michigan offers an example of a longer gap, even under the best of circumstances. In Michigan, if a child applied on the 20th of a month, and if eligibility determination took 45 days, then the first part of the gap would be 65 days, because coverage is retroactive to the first of the month of application. Then, the enrollment broker would need time to send out the health plan enrollment package, and the applicant would need time to make a decision (possibly after calling the enrollment broker for assistance) and mail the forms back. This process could add another month or more and result in a gap of two to four months between the time Medicaid coverage begins and enrollment in a health plan.

All three of the above examples represent best case scenarios for those states. In a worst case scenario, the applicant child does not choose a health plan, and instead is auto-assigned at the end of the allotted time period. Then, to continue the worst case scenario, the applicant may change plans, but wait until the end of the free-look period to do that.

As an extreme example of the gap that can occur, in Michigan an applicant could fail to select a health plan in the 60 days allotted, be auto-assigned, and switch out of the auto-assigned plan at the very end of the 90 day free-look period. This would give a seven month gap (65 days for determination activities, plus 60 days to select a health plan, plus 90 days for free look). This is an extreme example, but gaps of two or four months are not unusual.

**Policies Grew From Early Days of Managed Care**

The historical context for some of these polices needs to be acknowledged. Freedom in choice of provider has been part of Medicaid policies from the beginning, and indeed, states need to secure a waiver to require participation in managed care because that would restrict freedom of choice. In the early days of managed care, overly aggressive marketing on the part of some

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2 In Arizona, the client’s enrollment is retroactive to the date of Medicaid eligibility. The maximum gap would be one to two months, based on the amount of time it takes to determine eligibility (up to 45 days). The only additional time added if a client is auto-assigned is 16 days because auto-assignment happens immediately after Medicaid eligibility determination. Applicants are given 16 days to switch if they are dissatisfied with the auto-assignment, and health plans are notified daily of new membership. However, plans do not know they have the client until after the one to two month period (45 days to determine eligibility, 16 days for free look).
health plans led to the thinking at all levels that extensive safeguards needed to be in place to ensure that applicants had the opportunity to select appropriate health plans. Thus, families were given a generous amount of time to pick a plan, as well as latitude and time around switching, if dissatisfied. Ironically, these generous policies – introduced to bring about better quality of care – may actually work against quality in that they also contribute to short tenures in health plans.

Now that managed care has become more established and states have more experience in overseeing plan practices, it may be possible to implement policies that work toward more rapid enrollment in a health plan. This may be especially true if Michigan’s experience holds true more generally, that more time does not appreciably decrease the auto-assignment rate.
## Table 2
**Gap Between Time Medicaid Coverage Begins and Enrollment in a Health Plan**

<table>
<thead>
<tr>
<th>Medicaid Coverage</th>
<th>Arizona</th>
<th>Michigan</th>
<th>New York</th>
<th>Oregon</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Begins</td>
<td>1st of month applied</td>
<td>1st of month applied</td>
<td>Date of application</td>
<td>Date of application a</td>
<td>Date of application</td>
</tr>
<tr>
<td>Time to Determine Eligibility for Applicant</td>
<td>45 days</td>
<td>45 days</td>
<td>45 days</td>
<td>45 days</td>
<td>45 days</td>
</tr>
<tr>
<td>Applicant Receives Medicaid Card</td>
<td>After eligibility determined</td>
<td>After eligibility determined</td>
<td>After eligibility determined b</td>
<td>After eligibility determined</td>
<td>After eligibility determined</td>
</tr>
</tbody>
</table>

### Enrollment in Health Plan

| Earliest Client can Pick a Plan | Day of Medicaid application | After eligibility determined | Day of Medicaid application | Day of Medicaid applications | Day of Medicaid application |
| Who Assists Clients with Enrolling into a Plan | Department of Economic Security | Enrollment Broker | Enrollment Broker | Health Plans | CBO |
| Child is on Health Plan Rolls | Day eligibility determined | 1st of the next month after health plan is chosen | One month after Medicaid eligibility is determined | 7-10 days after Medicaid eligibility is determined | Within 15 days after health plan is chosen c |

**Best Case Scenario: Length of Gap Between Medicaid and Health Plan Enrollment for Clients Who Choose a Plan at Earliest Time**

<table>
<thead>
<tr>
<th>Number of Months</th>
<th>1-2 months d</th>
<th>2-4 months</th>
<th>2-3 months</th>
<th>2 months</th>
<th>2 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Auto-Assignment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time to Chose a Plan before Auto-Assigned</td>
<td>Until eligibility determined</td>
<td>60 days after eligibility determined</td>
<td>60 days after eligibility determined</td>
<td>Until eligibility determined e</td>
<td>4-5 weeks after eligibility determined f</td>
</tr>
<tr>
<td>Free-Look Period</td>
<td>16 days</td>
<td>90 days</td>
<td>60 days g</td>
<td>30 days</td>
<td>N/A h</td>
</tr>
<tr>
<td>Percent Auto-Assigned</td>
<td>50%-60%</td>
<td>40%</td>
<td>20%</td>
<td>Data Not Reported</td>
<td>10%-15%</td>
</tr>
<tr>
<td>Locked into a Plan</td>
<td>12 months 1</td>
<td>12 months</td>
<td>12 months j</td>
<td>6 months j</td>
<td>N/A</td>
</tr>
<tr>
<td>Option to Switch Plans</td>
<td>At recertification</td>
<td>Once a year at open enrollment</td>
<td>At recertification</td>
<td>At recertification</td>
<td>At any time</td>
</tr>
</tbody>
</table>

**Worst Case Scenario: Length of Maximum Gap Between Medicaid and Health Plan Enrollment for Clients Who Are Auto-assigned to a Plan and Change Plans**

<table>
<thead>
<tr>
<th>Number of Months</th>
<th>1-2 months</th>
<th>7-8 months</th>
<th>4-5 months</th>
<th>3-4 months</th>
<th>2-3 months</th>
</tr>
</thead>
</table>

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*Oregon requires each application to be date stamped. If the application is received by the Department of Human Services (DHS) within 30 days of the date stamp then eligibility is retroactive to the date stamp, otherwise eligibility begins the day that DHS receives the application.

b In New York, if a client enrolls in Medicaid with a health plan, they are temporarily enrolled in the plan under SCHIP and receive a temporary SCHIP card at the time of application. Once Medicaid eligibility is determined, then a new Medicaid card is sent to them.

c Pennsylvania plans receive a list of enrollees about every 15 days. This can vary depending on when eligibility is determined and when in the month plan was chosen.

d In Arizona, plans are notified within one to two months of enrollment. The client’s enrollment is actually retroactive to the date of Medicaid eligibility. However, plans do not know they have the client until after the one to two month period.

e In Oregon, children are automatically assigned to a plan the day of application for Medicaid. Adults in Oregon are given 60 days before they are auto-assigned.

f Pennsylvania has a default in the system that automatically assigns each client to a plan when client applies for Medicaid. This
assignment is not seen by clients and any plan selection the client makes overrides this default assignment.

\(^g\) In New York, if a client is auto-assigned, he/she is given 60 days for the free-look period. Those who are not auto-assigned have 30 days to switch plans.

\(^h\) Pennsylvania allows clients to change plans at any time.

\(^i\) Arizona, New York, and Oregon operate their Medicaid programs under an 1115 waiver and therefore the lock-in provisions differ from the Medicaid managed care rule of the Balanced Budget Act.
Frequency and Ease of Eligibility Re-Determination Periods

The delay in enrolling in a health plan would be a one-time issue if extending Medicaid eligibility occurred smoothly. If the eligibility renewal were a smooth and streamlined process, then the front-end delays, no matter how long, would not create a significant problem. However, as will be shown, Medicaid eligibility renewal often is not a smooth process. Thus, the problems of churning and discontinuity in Medicaid are compounded by even greater discontinuities in the health plans.

In all states, families need to prove that the child meets the eligibility specifications before securing coverage. States re-evaluate the child’s eligibility periodically in a process called recertification or re-determination. In this study, four of the states re-determined eligibility every 12 months, while one (Oregon) re-determined every six months. It is noteworthy that in our prior study, Oregon, with its six-month re-determination period, had the lowest proportion of two-year-old children continuously enrolled for a year. Nationally, in 2003, 41 states had set the re-determination period at 12 months, while nine set the re-determination period at six months. Studies have shown that many children – even eligible children – fail to re-determine eligibility on time and subsequently fall off the rolls. Thus, length of the re-determination period makes an enormous difference in the proportion of children who are continuously enrolled for a year.

Time in Health Plans under Different Re-Determination Scenarios

The sizeable gap between the time Medicaid coverage begins and the time children are enrolled in a health plan, means that health plans have children as members for a relatively short amount of time before the children need to re-determine eligibility. As previously discussed, that time will vary according to state policy and also by whether the child picked a plan or was auto-assigned. In the best-case scenario, the child picked a health plan, and was enrolled in it within two to three months of the initiation of Medicaid coverage. This means that the health plan in states with 12-month eligibility periods would have the child as a member for nine to 10 months before the child needed to re-determine eligibility. The time would be shorter in states with six-month eligibility periods. Health plans in these states could have members for as short a time as three months, even if enrollment went smoothly.

In a worst case scenario, if the child’s application did not designate a plan, the child would be auto-assigned at the end of the grace period and would possibly switch after the free-look period. In this case, as shown earlier, there could be a gap of three to seven months before enrollment in a health plan. This would mean that the health plan in a 12-month eligibility state would have the child as a member from five to nine months before the child needed to re-determine eligibility. In a state with six-month eligibility re-determination, a health plan may have a child for as little as one month before the re-determination period.
Given the size of the gap at the time of initial enrollment, it is essential for children who continue to meet the eligibility requirements to extend their eligibility period smoothly. Too often, this does not happen. As will be shown in the next section, retention rates can be as low as 50 percent.

What We Know about Proportion of Children Who Do Not Re-Determine on Time

Most states do not keep track of the number of children who fail to re-certify when their initial period of coverage is up, and thus, the extent of the problem is not fully known. Our knowledge of this issue comes, instead, from special studies, sometimes of SCHIP children, rather than Medicaid. These studies, taken together, indicate that approximately half of all children fail to re-determine eligibility on time and are removed from the rolls. Studies in New York, focusing on SCHIP, found that approximately 50 percent of the children fail to re-certify on time and are dropped from the rolls. A major cross-state study substantiated this finding of approximately half of the children dropped at each re-determination period not only in New York, but also in Oregon and Kansas as well. As part of this study, Arizona estimated that about 36 percent of those clients who are discontinued from Medicaid each month are due to a failure to complete the process (34 percent for SCHIP children).

Many of these children are still eligible. Two separate investigations of SCHIP children in New York showed that fewer than 10 percent of the children who were dropped were ineligible. An Arizona study found a larger number of children ineligible—but still fewer than 20 percent. Not surprisingly since they are still eligible, many of the children who are dropped successfully re-enroll in the ensuing months. The New York SCHIP study also showed that approximately 66 percent of the children who were dropped, come back on the rolls within 12 months. As part of the present study, Michigan reported to us that 35 percent of its Medicaid children who did not recertify on time came back on the rolls within 90 days.

What Happens When Children Do Not Re-Determine Eligibility on Time

In all states, if Medicaid children do not prove their continuing eligibility through the re-determination process before their 12-or six-month coverage period is over (or within a 45- day grace period), they are removed from the Medicaid and health plan rolls. If the children still meet the requirements for Medicaid coverage, they may reapply and, if they continue to be eligible, regain coverage. For individual members, the process of re-applying is not very different in these states from re-determining, and may mean that there may not be strong incentives for an individual to re-determine on time.

However, there are adverse consequences for the Medicaid office. Because the Medicaid office has closed the file and must reopen it, there is greater administrative cost to the state associated with a new enrollment rather than a re-determination. Children are put back into the same health plan if they re-enroll within 90 days (Arizona, Michigan, and New York) or six months (Pennsylvania) so that they do not have to go through the
process of re-enrolling in the health plan. If, however, the new application for Medicaid is submitted after this three-or six-month grace period, the family needs to formally re-enroll in a health plan. For a family, this process means there is a delay in getting into a health plan; for Medicaid, it means that there is an additional cost of processing the enrollment. For health plans, it means additional time and cost in updating their rolls.

**Ease of Re-Determination**

Because breaks in coverage occur around each re-determination period, even for children who remain eligible, state policies to make the re-determination process easier would decrease the proportion of eligible children with breaks in service. In most states, the requirements for re-determination mirror those for initial enrollment. That is, families still need to prove that they meet the income, residence, age, and citizenship requirements. Of the five states, Arizona, Oregon and Pennsylvania permit applicants to mail in their paperwork at enrollment, and Arizona and Pennsylvania also allow applicants to phone in information.

Michigan permits self-declaration of income for Medicaid children at both enrollment and re-determination periods and confirms the accuracy of reports through audits of a sample of applications each month. Because gathering the documents to prove income is the most difficult part of the application process, self-declaration of income eases the application process considerably. Several of our study states (New York, Pennsylvania, and Oregon) cross-checked the income documentation submitted on the Medicaid application with extant state databases, such as the wage reporting system or databases for other social programs. There is often a three-month lag in wage data in these systems, but still, self declaration with cross checking on all or a sample of applicants is feasible in most states. In Arizona, enrollment personnel check extant databases if the applicant does not supply income documentation, to determine eligibility.

**Record-Keeping about Short Tenures, Churning, and Disrupted Coverage**

It is important to note that states are often not aware of how many children lose coverage at re-determination periods. Likewise, they do not keep track of how many children subsequently regain coverage in a short period. We were able to report this information for New York because a special study had been carried out and for Michigan and Arizona because data was constructed in response to our request. Because gaining and losing coverage has such implications for continuity and accountability of care, as well as cost associated with reopening case files, it will be important to monitor these transactions. This is especially important since some states are increasing the frequency of re-determination to reduce costs. Nationally, three states had done so in 2002; and in our study, Arizona reported that they will move from a 12- to six-month re-determination in the fall of 2003.

Health plan reporting compounds the lack of knowledge about short tenures. States and health plans are encouraged to use HEDIS methodology when monitoring quality. For
most preventive measures, this methodology requires that health plans report the number of eligible children (i.e., those who meet the 12-month continuous enrollment requirement) and the proportion of those who meet the performance standard. They are not asked to report on the proportion of children who meet the 12-month continuous enrollment criterion, nor are they asked to specify the number of children in the plan and indicate how many are and are not included in the performance measure. For example, under HEDIS, when health plans report the proportion of two-year-olds who are up-to-date in their immunizations, they report the number of two-year-old children who have been with the plan for 12 months, and the proportion of those who are up-to-date. They do not report how many two-year-olds are in the plan or number of children who are not included in the performance measure. Thus, the problem of short tenures is not monitored and comprehensive data have not been available for the policy debate.

Some states have developed alternate reporting methodologies to HEDIS to compensate for short tenures in Medicaid managed care. For example, Oregon requires plans to submit administrative data that they use to monitor measures on a member-month basis, which does not rely on enrollment tenures to be included in the measure. Pennsylvania has developed 15 additional measures focusing on utilization of care as well as screening for priority diseases and many of these require shorter enrollment tenures, such as three months, to be included in the measure.

There has been reluctance, especially from health plans with commercial as well as Medicaid members, to adopt alternate methodologies for performance measurement. These plans need to use HEDIS methodology for commercial members and express reluctance to adopt different measurement methodologies for Medicaid members.

Implications of Disrupted Coverage

Disrupted coverage has several implications. For a child, it may mean disrupted service or breaks in continuity of care, although few studies have examined the consequences. Because Medicaid is designed to pay medical bills from the time of application, or even three months retroactively before the application, the families may not be any worse off if they let the coverage lapse until they need it. For the state, however, it means additional costs to reprocess eligible children. For health plans, it means that they may not have children as members long enough to have an impact on their health care. For accountability, it means that a small proportion of Medicaid children are included in the HEDIS performance measurement. This means that when a health plan reports its performance, the performance may be biased because it is only for that portion of the children who had been enrolled continuously for 12 months. Further research is needed to determine the type and level of bias. In addition, more research is needed to determine if the disrupted coverage affects overall quality and continuity of care.
### Table 3
**Application and Recertification in Medicaid**

<table>
<thead>
<tr>
<th>Medicaid Application</th>
<th>Arizona</th>
<th>Michigan</th>
<th>New York</th>
<th>Oregon</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Period</td>
<td>12 months</td>
<td>12 months</td>
<td>12 months</td>
<td>6 months</td>
<td>12 months</td>
</tr>
<tr>
<td>Where Client can</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apply for Medicaid</td>
<td>Department of</td>
<td>Family</td>
<td>Income Support</td>
<td>Department of</td>
<td>County Assistance</td>
</tr>
<tr>
<td></td>
<td>Economic Services</td>
<td>Independence</td>
<td>Centers</td>
<td>Human Services</td>
<td>Centers</td>
</tr>
<tr>
<td></td>
<td>Mail in (clients</td>
<td>Agency</td>
<td>Community-</td>
<td>Certified</td>
<td>Community-Based</td>
</tr>
<tr>
<td></td>
<td>can download</td>
<td></td>
<td>Based Organizations</td>
<td>provider sites</td>
<td>Organizations</td>
</tr>
<tr>
<td></td>
<td>the application</td>
<td></td>
<td>With a health</td>
<td>Mail in</td>
<td>Mail in</td>
</tr>
<tr>
<td></td>
<td>online, request</td>
<td></td>
<td>plan</td>
<td>(clients can</td>
<td>(clients can</td>
</tr>
<tr>
<td></td>
<td>it to be mailed</td>
<td></td>
<td></td>
<td>request it to be</td>
<td>request it to be</td>
</tr>
<tr>
<td></td>
<td>them)</td>
<td></td>
<td></td>
<td>mailed to them)</td>
<td>mailed to them)</td>
</tr>
<tr>
<td></td>
<td>Phone</td>
<td></td>
<td></td>
<td></td>
<td>Phone</td>
</tr>
<tr>
<td></td>
<td>Provider sites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any AHCCCS site</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where Client Can</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recertify for Medicaid</td>
<td>Same as above</td>
<td>Same as above</td>
<td>Same as above</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>or Mail in</td>
<td>or Mail in</td>
<td>or Mail in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income Verification</td>
<td>2 months</td>
<td>Self-declared c</td>
<td>4 consecutive</td>
<td>3 months</td>
<td>1 month</td>
</tr>
<tr>
<td>Required for</td>
<td></td>
<td>weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross Check Eligibility</td>
<td>Only if</td>
<td>No, conducts</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>with Extant Databases</td>
<td>documentation</td>
<td>monthly audit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>is incomplete</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Recertification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Put into Same Plan</td>
<td>90 days</td>
<td>90 days</td>
<td>90 days</td>
<td>Need to re-select</td>
<td>6 months</td>
</tr>
<tr>
<td>If Re-Enroll within</td>
<td></td>
<td></td>
<td></td>
<td>plan</td>
<td></td>
</tr>
<tr>
<td>Proportion of Children who Recertify on Time</td>
<td>Data not reported</td>
<td>Data not reported</td>
<td>50% d</td>
<td>Data not reported</td>
<td>Data not reported</td>
</tr>
<tr>
<td>Proportion of Children Who Recertify within 90 Days</td>
<td>Data not reported</td>
<td>35%</td>
<td>Data not reported</td>
<td>Data not reported</td>
<td>Data not reported</td>
</tr>
<tr>
<td>Recertification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reminder is Sent Out</td>
<td>60 days prior</td>
<td>30 days prior</td>
<td>60 days prior</td>
<td>30 days prior</td>
<td>30 days prior</td>
</tr>
</tbody>
</table>

\[a\] Arizona changed to a six month eligibility period as of October 2003 due to cost containment issues.

\[b\] In Arizona, clients can apply at Federally Qualified Health Centers. If the client is a pregnant woman, she can also apply at a doctor’s office.

\[c\] Michigan allows self-declaration of income for Medicaid children only.

\[d\] This number is from a New York study conducted by Bachrach and Tassi, 2000.
Instability in the Health Plan Market

A final factor contributing to short tenures in health plans is instability in the managed care plan market, brought about by health plans leaving the market, merging, or (to a lesser extent) entering the market. When health plans leave the market, families choose or are assigned to another plan. Four of our five study states have had stable health plan markets, Oregon is the exception. In all but one state (Pennsylvania), the time in the first plan is not counted in the continuous enrollment time. Thus, high levels of plan volatility in most states will result in children having short tenures in their second health plan, even though tenures in Medicaid or even tenures in Medicaid managed care may be longer.

In Oregon six plans either left certain service areas or the Medicaid market altogether. The other states have more stable managed care markets, but still experienced some fluctuation. Arizona rebids contracts every five years, and thus, maintains stability within the five-year increments. In the last bid cycle, only one health plan left the Medicaid market completely, another left certain counties (rural counties) and a third plan entered the market. Michigan rebids contracts for two years with an option to renew for up to an additional three years. In Michigan, two health plans voluntarily left the market entirely in the last bid cycle, affecting two counties. New York negotiates contracts annually, and has a large number of health plans in the state as a whole and in its counties. Still, the market has been stable in New York: only two health plans have left the market since 1999.

Pennsylvania provides an interesting example, not only because the managed care market is extremely stable – only one health plan left in the last three years – but also because of its policy for defining what it means to be continuously enrolled. The plan closing in Pennsylvania affected five of Pennsylvania’s 25 mandatory counties. Children who had been in this plan were transferred to other health plans, but the time-in-plan did not begin anew. Instead, time in the first plan was counted toward the continuous enrollment period for accountability purposes. Pennsylvania was the only state to adopt this policy; in all the other study states, if a health plan left the market, time in that plan was not counted toward the continuous enrollment time for children.

Arizona also provided an interesting example of a policy to minimize disruption in care in the event of plan switching or transfers. In Arizona, the leaving plan notifies the receiving plan of the member’s primary care provider for all transfers. If the leaving member is in active care, then the leaving plan sends, in addition, specifics of the care to the new plan. Examples of this include: the diagnosis, any approved procedures, medications, supplies, and durable medical equipment. Thus, the receiving plan has information on diagnosis and prior care, and does not have to begin again to determine needs.

Center for Health Care Strategies, Inc. Policies and Practices that Lead to Short Tenures in Medicaid Managed Care--18
### Table 4

#### Health Plan Instability

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Plans</td>
<td>9</td>
<td>17</td>
<td>28</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>Length of Contract</td>
<td>5 years</td>
<td>2 years</td>
<td>1 year</td>
<td>1 year</td>
<td>3-5 years a</td>
</tr>
<tr>
<td>Number of Plans per County</td>
<td>2-6</td>
<td>1-9</td>
<td>1-9 b</td>
<td>0-5</td>
<td>3</td>
</tr>
</tbody>
</table>

#### Medicaid Market Instability

<table>
<thead>
<tr>
<th>Number of Plans Leaving 1999-2003</th>
<th>2 plans</th>
<th>2 plans</th>
<th>2 plans</th>
<th>6 plans</th>
<th>1 plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Counties with Mandatory Medicaid Managed Care Counties Affected by Plans Leaving 1999-2003</td>
<td><em>All 15 counties</em></td>
<td><em>64 out of 83 counties</em></td>
<td><em>24 out of 57 counties</em></td>
<td><em>22 out of 36 counties c</em></td>
<td><em>25 out of 68 counties</em></td>
</tr>
<tr>
<td>Number of Counties Affected By Plans Leaving 1999-2003</td>
<td>6 rural counties</td>
<td>2 counties</td>
<td>Not Available</td>
<td>16 counties</td>
<td>5 counties</td>
</tr>
<tr>
<td>Percent of Medicaid Enrollees Affected</td>
<td>1%</td>
<td>Less than 1%</td>
<td>Not Available</td>
<td>11% d</td>
<td>10%</td>
</tr>
</tbody>
</table>

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a Pennsylvania’s contracts vary in length by region.

b The number of health plans per county in New York vary from 1-9 with the exception of New York City, which has 22 health plans.

c In Oregon, the majority of the remaining 14 counties, mandatory managed care is based on zip code.

d This percentage is based on a study conducted by Oregon that found an 11% plan switching rate and the majority of it was attributed to plan instability. (Bayley B et al. Continuity & Turbulence in an Expanded Medicaid Managed Care Program, The Oregon Health Plan Experience. Center for Outcomes Research & Education. April 2001.)
Policy and Practices that Lead to Short Tenures in Medicaid Managed Care

Recommendations, Best Practices, and Further Study

Short tenures make it difficult, if not impossible, for health plans to manage and be held accountable for the care of the children in their charge. Our investigation in five states showed that as long as Medicaid eligibility is retroactive and health plan enrollment prospective, health plan tenure will be approximately two to four months shorter than Medicaid. Based on these findings and through discussions with the five participating states as well as with experts in the field, we have identified best practices and recommendations for addressing the issue of short tenures in Medicaid managed care. We have split these best practices and recommendations into two categories: A) recommendations for addressing the problem of short enrollment tenures in Medicaid managed care and reducing discontinuous coverage and B) recommendations for measuring performance and monitoring quality given the short enrollment tenures of Medicaid managed care enrollees. Finally, we provide recommendations for further study that is needed to better inform the design of policies and practices around quality of care in Medicaid managed care.

Lengthen Enrollment Tenures in Managed Care and Reduce Discontinuous Care

As has been discussed in this report, there are many implications to short enrollment tenures and disrupted coverage on the care of children as well as on the system. For children it can mean disrupted coverage and breaks in continuity and for states and health plans it leads to additional costs for re-enrollment. To address this issue, recommendations include: 1) minimize the time it takes to establish a connection with the health care system; 2) lengthen enrollment in plans; and 3) develop systems to help plans manage continuity of care.

1) Minimize the Time it Takes to Establish a Connection With the Health Care System

The process by which enrollees are connected with a health plan and subsequently, the health care system consists of several steps that follow eligibility determination. In addition, a gap between Medicaid enrollment and plan enrollment is likely to be common in states that use enrollment brokers because the two processes are separate. Our examination of the plan enrollment procedure identified four potential opportunities for reducing the length of time to plan enrollment and access to stable health care coverage, including: a) reduce the time between Medicaid application and plan enrollment, b) enhance educational services and provide incentives for assisting clients with choosing a plan, c) provide assistance to clients in connecting with the health care system, and d) decrease the time it takes for plan to receive a new list of enrollees.

a) Reduce the time between Medicaid application and plan enrollment. As our report shows, in a typical scenario, it can take two to four months after the client applies for Medicaid, for the clients to show up on the rolls of a health plan. This period generally
reflects the amount of time it takes to become enrolled in a plan either by choosing a plan or by auto-assignment. This is of particular concern for states that have enrollment brokers which causes a potential disconnect between Medicaid enrollment and plan enrollment. Pennsylvania has addressed this issue by having an enrollment broker located at their larger Medicaid enrollment sites to assist clients with enrolling in a health plan at the time of application for Medicaid, before eligibility is determined. This reduces the time until plan enrollment because clients select a plan at the same time the Medicaid application is processed and thus can be enrolled in a plan as soon as Medicaid eligibility is determined. Additionally, technical assistance with choosing a plan at application also reduces the necessity for auto-assignment (see below also).

Another best practice for reducing the time for clients in choosing a plan is to allow clients to choose a plan at the time of application to Medicaid. Plan enrollment occurs at the time of Medicaid eligibility determination and clients are auto-assigned if a plan has not been designated. In Arizona and Oregon, clients can choose a plan on the Medicaid application and are automatically assigned to a plan at the time eligibility is determined if the client has not chosen one. Michigan reported in this study that 80 percent of their applicants that choose plans do so within two weeks. If this holds true for other states as well, it would benefit clients for plan enrollment to happen sooner than a 60-day period.

b) Enhance educational services and provide incentives for assisting clients with choosing a plan. Another way to decrease the amount of time that it takes for clients to enroll in a plan and to ensure that they are choosing an appropriate plan the first time and thus reducing the number of clients who change plans, is to increase the educational assistance provided to clients. Pennsylvania is one of our study states that has put extensive resources into educating client in choosing a health plan. The state developed financial incentives for the enrollment broker to ensure that the education assists clients in choosing an appropriate plan for their needs. The contract between the state and the enrollment broker holds the broker liable if more than 10 percent of the clients who choose a plan with the broker request a plan transfer within 90 days of enrolling with the plan. The thought process behind this is that if the brokers are doing their job, then clients receive adequate assistance in choosing a plan that fits their needs, and therefore do not need to transfer plans.

c) Provide assistance to clients in connecting with the health care system. Once a client is in a plan, connecting the client with a primary care physician (PCP) is an important next step in efforts to provide a rapid connection with care, and likely to result in better continuity. One way to do this is to establish contracts with health plans or enrollment brokers that stipulate establishing a connection with a PCP within a given time frame. Pennsylvania provides financial incentives in their contract with the enrollment broker if clients choose a PCP. Arizona requires their health plans to assign PCPs to their clients if they have not chosen one within 10 days of enrolling in the health plan.
Pennsylvania has taken this one step further in a pilot project with the State’s enrollment broker that assists the client with setting up their first appointment. In this project, the enrollment broker representative facilitated a phone call with the client and the doctor’s office to set up the first appointment. As a result, clients may have their first appointment set up before they even received their Medicaid card. This was a pilot project and may be expanded in the future.

d) **Decrease the time it takes for plan to receive a new list of enrollees.** In addition, once the client has chosen or been assigned to a plan it takes time for health plans to receive information about new enrollees from the states. States periodically provide plans with lists of new enrollees. Of our five states, two did this monthly, two did this about every two weeks and one (Arizona) does it everyday. If states were able to download to plans on a daily basis, this could reduce the gap by up to 30 days.

2) **Lengthen Enrollment in a Health Plan**

The length of plan enrollment is highly affected by the recertification procedure. At the time of recertification, many enrollees lose both Medicaid coverage and subsequently, plan coverage, which is often less than 12 months after enrolling in a health plan. This has been studied more extensively for the SCHIP population, studies indicate that approximately 10 to 50 percent of children fail to re-determine eligibility on time. In addition, a study in New York also indicates that of the children who fell off the rolls, 66 percent return to Medicaid within 12 months. As part of our study, Michigan reported that 35 percent of their Medicaid children who did not recertify on time came back within 90 days. Even when an individual is reenrolled in Medicaid, in some cases, the enrollee also must reenroll in the health plan leading to a gap in plan enrollment. To help address the issue of disrupted managed care coverage caused by the Medicaid recertification process and reenrollment in a health plan, states can: a) lengthen tenures in plans by modifying Medicaid eligibility period, b) ease the recertification process, and c) eliminate gaps in plan enrollment resulting from the recertification process.

a) **Lengthen tenures in plans by modifying Medicaid eligibility period.** In order to meet the continuous enrollment requirement for many performance measures, it is necessary for clients to be enrolled in a health plan for at least 12 months. Currently, the Medicaid eligibility period begins retroactive to the date of the Medicaid application or to the first of the month of the application to provide coverage for clients during the application processing. Retroactive coverage enables applicants to have immediate health care needs covered by Medicaid, which is desirable to both patients and providers. However, plan enrollment cannot occur until eligibility has been determined, and occurs about two months after the Medicaid eligibility period begins. The result is that patients are in Medicaid for 12 months, but in a plan for 10 months before recertification is required. By modifying the 12-month eligibility period to account for the front-end delay to plan enrollment and to maintain the retro-active period, the eligibility period can be extended to 14 months (to account for the two months used to determine eligibility).
This would allow for more enrollees to meet the continuous enrollment requirement for performance measures.

b) *Ease the recertification process.* Many states have begun simplification of the recertification procedure, by eliminating face-to-face interviews, and reducing documentation requirements. However, the process still leads to many children falling off the rolls. Michigan simplified the process of income verification, which can be difficult for many clients, by requiring several months of proof of income. Michigan, like 11 other states, allows self-declaration of income for children enrolling in Medicaid. However, Michigan does perform monthly audits of a sample of applicants each month using extant data. In Florida, passive reenrollment also has reduced the number of children who fall off during recertification points. Longer eligibility periods and less frequent recertification points also would assist clients in maintaining continuous coverage. Although the majority of states have 12-month eligibility periods for children in Medicaid, nine states have six month periods. Furthermore, due to budget constraints, some states requiring recertification every 12 months plan to require more frequent recertification.

c) *Eliminate gaps in plan enrollment resulting from the recertification process.* If children do not renew within 45 days of the end of their eligibility they are removed from Medicaid rolls and the file is closed in the Medicaid office. This grace period does not necessarily apply to health plan enrollment. Children may fall off the health plans rolls the day that eligibility ends, not after the 45-day grace period. After this point, children who come back on to Medicaid must then go through the enrollment process again, possibly resulting in the same gap as before if they need to choose a health plan once again. States have implemented policies to reinstate children into their former health plan if they re-enroll within a specified period of time (90 days for Arizona, Michigan and New York and six months for Pennsylvania; Oregon does not have this policy). This makes the re-enrollment process easier for the client; however, in order to prevent the gap at recertification, it is necessary to provide the same 45-day grace period for health plan enrollment as is provided for Medicaid recertification.

3) **Develop Systems to Help Plans Manage Continuity of Care**

Despite efforts to maintain continuous enrollment in health plans, it is not uncommon for a plan to leave and enter the market or to merge with another plan, and for clients to change plans. It is likely that as enrollees move from one plan to another, their health information can be lost. Methods for managing and monitoring a patient’s care in these circumstances include: a) facilitating the transfer of patient information between plans, and b) develop systems to monitor performance across plans (e.g. registries).

a) *Facilitating the transfer of patient information between plans.* To help maintain continuity of care for patients who move between plans, Arizona has developed a transition coordinator process that allows them to facilitate a smooth transfer of patient information between plans and providers. For enrollees that are in active care, a
transition coordinator is assigned at both plans and helps transfer information from one plan to the other, which helps to maintain continuity of care. The receiving health plans believe that it is important to get medical histories for their transferring patients, especially for those in active care and have special needs. This process not only assists the patients, but also provides information necessary for providers and plans to manage the care of their enrollees.

b) Develop systems to monitor performance across plans (e.g., registries). In terms of measuring quality while clients are moving or the plan market is changing, states may need to turn to other data sources when monitoring quality. Registries collect information across all plans, and thus, provide a source of data for managing patient care even when a client has switched plans. In some states, immunization registries have been able to receive information for immunizations that have been conducted by providers, and supplement plan data when reporting on children who are up-to-date for immunizations.

**Improve Practices around Performance Measurement and Quality Monitoring**

Short tenures and discontinuous coverage also have implications for quality monitoring and accountability. It takes time beyond initial enrollment in a health plan, for that plan to be able to manage care of their new enrollee. Plans need time to ensure that the client is assigned to a primary care physician and to take steps for affecting their care. Short tenures also leave many children outside of the accountability structure because those with short tenures are not included in performance measurement. Strategies that have been identified include: 1) monitor enrollment data in health plans, 2) use modified performance measures, and 3) monitor performance of Medicaid enrollees across all plans.

**1) Monitor Enrollment Data in Health Plans**

Since it is possible that length of enrollment can impact not only the plan’s ability to impact their health care, but also to measure quality, it is first necessary to monitor enrollment data in the health plans. Before being able to monitor quality for enrollees in Medicaid managed care, it is necessary to understand who is included in the performance measure, i.e., how many and which enrollees meet the continuous enrollment requirement. Furthermore, such data can be used to develop strategies for retaining enrollees and improving processes of reenrollment. Strategies include: a) use existing data sources or b) collect additional enrollment data.

a) Use existing data sources. States and health plans are encouraged to use HEDIS methodology when monitoring quality and many of the preventative measures require that plans report the number of eligible children and the proportion of those who meet the performance standard. This methodology does not take into account the issue of short tenures. One way to improve the ability to see an accurate picture is to use existing enrollment data, to track the length of enrollment in a health plan, and to require the
reporting of proportion of enrollees included in performance measures. This information is available in state enrollment databases; however not all currently calculate it. These three figures together would provide states with a more complete picture of who is being measured in the HEDIS quality monitoring process.

b) Collect additional enrollment data. In addition it would be useful for states to track how many enrollees fail to recertify and how many subsequently reenroll in the health plan. Most states do not keep track of these numbers so the extent to which failure to re-determine is a problem is not known. This has been studied more extensively for the SCHIP population studies indicate that approximately 10 to 50 percent of children fail to re-determine eligibility on time. In addition, a study in New York also indicates that of the children who fell off the rolls, 66 percent return to SCHIP within 12 months. As part of our study, Michigan reported that 35 percent of their Medicaid children who did not recertify on time came back within 90 days. The tracking of this data would allow states to gain a better picture of how many children do not reenroll at recertification and might be used to develop new policies to increase retention.

2) Use Modified Performance Measures

Given the small percentage of plan enrollees that would be included in performance measurement, modified HEDIS performance measures and other measurement methods have been used by states to better reflect care provided to enrollees in Medicaid managed care. States can: a) develop measures that account for short enrollment tenures, and b) develop measures that do not rely on continuous enrollment requirements.

a) Develop measures that account for short enrollment tenures. In order to account for short enrollment tenures when measuring quality, states have developed modified measures to measure quality. For example, Pennsylvania developed 15 additional measures (additional to HEDIS) that health plans are required to report on and they vary in their continuous enrollment requirement. For example, they require three months continuous enrollment for measures dental evaluations, hearing assessment and vision assessment. The measure for asthma ED use requires 6 months continuous enrollment with no gap or one year with one gap. Oregon also has previously used a modified HEDIS methodology in their measurement, allowing for two gaps that add up to a break of 45 days.

b) Develop measures that do not rely on continuous enrollment. States also have developed other strategies to measure quality, not using a continuous enrollment requirement. For example, Oregon also uses member months (1,000 member months) as the denominator for some of their measures, which would include members regardless of their length of enrollment, and would include services rendered to all their members.
3) Monitor Performance of Medicaid Enrollees across All Plans

Performance measures that rely on continuous enrollment in a specific health plan may not capture the majority of MMC enrollees. However, tenures in Medicaid often can be longer. Furthermore, there is a need to monitor health care for enrollees who go on and off Medicaid. To monitor performance of all Medicaid beneficiaries, states can a) use statewide encounter data to measure performance and they can b) use registries to measure performance.

a) Use statewide encounter data to measure performance. One option is to measure Medicaid wide rates using a continuous enrollment requirement. This would allow states to track all enrollees in the Medicaid program without needing to account for plan level churning. Currently, none of our study states do this however, Arizona, Michigan, Oregon, and Pennsylvania all have encounter data available to use for such an analysis.

b) Use registries to measure performance. As indicated previously, using registries as a data source might be another way to track preventive services and to monitor care despite short tenures in plans. Currently, immunization registries have records for all children and can be used to report immunization rates on all children. This method provides up-to-date records for children regardless of plan enrollment.

Further Study

Short enrollment tenures in a health plan and in Medicaid have several implications for quality of care. Since eligibility for Medicaid begins at least on the date of application, clients may apply for coverage when they need care. However, studies have shown that breaks in coverage and discontinuity can lead to delaying needed care, and result in avoidable illness. Furthermore, anecdotal evidence suggests that individuals do not use care as if they have stable coverage until they are informed that eligibility is determined and they have been enrolled in a plan, which can be several months after application. Patients may not use preventive care or have access to medications or special services during these gaps in eligibility or plan enrollment. For health plans, breaks in plan enrollment lead to a loss of information that makes it difficult to monitor a patient’s care when they are not covered by the plan, and such patients also would not be included in many of their performance measures.

However, little is known about how short enrollment tenures in health plans affect both quality of care, and performance measurement. Additional research and more data on how short enrollment tenures in health plans affect the quality of care for Medicaid managed care enrollees will be able to help elucidate the extent and nature of the issue. Further research studies are recommended to:

- Examine enrollment patterns of Medicaid enrollees in health plans. Performance of health plans may be affected by the stability of their population, and whom they are measuring. This study could show variation in enrollment lengths between plans,
and can help plans understand the nature of their population and the relevance of their measures.

- **Determine differences in quality of care by enrollment history.** Stable coverage and continuous care under a provider or plan can lead to better care management and more preventive care. By looking at standards of care that are affected by these services, one can examine the extent to which quality measures differ by enrollment length or enrollment history.

- **Explore the use of new measures that would not rely on continuous enrollment.** Since the current performance measures only include a fraction of the plan's population, it is possible that they do not accurately reflect the care provided to the rest of their enrollees. However, plans must have an enrollee for an adequate amount of time to manage and affect their care. Thus, one can explore new measures that do not rely on continuous enrollment in the plan, but reflect quality of care, to supplement existing performance measures.

The movement of Medicaid to managed care not only helps to control costs, but it also brings with it the ability to establish a medical home for enrollees and to hold plans accountable for quality. However, due to practices and policies in the Medicaid program, many Medicaid managed care enrollees have short enrollment tenures making it difficult to monitor and measure the quality of their care. Policies and practices that address the issue of short enrollment tenures and performance measurement in Medicaid managed care are recommended. In addition, further study would be helpful in informing the design of such policies and practices to address the issue of performance monitoring in Medicaid managed care and to ensure that the accountability structure has the ability to assure quality care for this population.
ENDNOTES


