New York State Coalition of Prepaid Health Services Plans

Enrollment Churning In Medicaid

Coverage Gaps Undermine the Managed Care System and Continuity of Care for the Chronically Ill

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About the NYS Coalition of Prepaid Health Services Plans

The 14 health plan members of the New York State Coalition of Prepaid Health Service Plans (PHSP Coalition) serve 1.75 million members, representing over 61 percent of the State's Medicaid managed care, 58 percent of the State's Family Health Plus, and 48 percent of the State's Child Health Plus enrollees. The PHSP Coalition prepared this report to provide policy makers, public officials, and other stakeholders with information and new quantitative research on enrollment churning in the Medicaid managed care and Family Health Plus programs. It is our hope that it will contribute to the dialogue on, and spur concrete actions to address, the problem of discontinuities in health care coverage for low-income patients.

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EXECUTIVE SUMMARY

Over the past ten years, New Yorkers have seen dramatic growth in the public health insurance options for low-income individuals and families, including the development of Family Health Plus (FHPlus) and the expansion of the Child Health Plus (CHPlus) program.[1] Even with these program developments, a large number of people remain uninsured. As many as 2.6 million New Yorkers – 13.5 percent of the population – lack health insurance.[2] Almost 1.3 million uninsured New Yorkers are in fact eligible for coverage through one of the state's public health insurance programs.[3]

Increasingly, New York's public insurance programs have moved toward serving their respective populations through a managed care delivery system in which beneficiaries are required to enroll in a managed care plan and select a primary care physician. In 1999, New York State implemented mandatory managed care enrollment for Medicaid beneficiaries.

Today, New York has established the mandatory Medicaid managed care program in 23 counties, including all of New York City. In total, 68 percent of the State's Medicaid beneficiaries are now enrolled in a managed care plan.[4] New York's CHPlus and FHPlus programs are administered entirely through managed care, with no fee-for-service option.

New York's rationale for embracing a managed care model for its public programs was to control costs and "improve the health status of low-income New Yorkers by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered; and
- Expanding coverage to additional low-income New Yorkers with resources generated through managed care efficiencies."[5]

Achieving these goals through the managed care delivery model relies heavily on maintaining continuity of care, such that patients and providers have stable and ongoing partnerships in order to improve overall patient care, health and well-being. In the managed care delivery system, as in every health care delivery system in our country, continuity of care is inextricably linked with continuity of health insurance coverage.[6]

The annual recertification process in New York's public insurance programs is the single most significant threat to eligible enrollees' ability to maintain coverage. According to the New York City Human Resources Administration (HRA), 70 percent of enrollees in 2005 submitted recertification materials, but over one-third of these recertification packages were incomplete, primarily due to their failure to submit correct

documentation of income. The remaining 30 percent of Medicaid and FHPlus beneficiaries slated to recertify coverage during the year failed to submit any materials at all. As documented in prior studies, many of these enrollees remain eligible for public insurance programs and re-enroll subsequent to losing their coverage. This cycle of enrollment, loss of eligibility, and re-enrollment in health insurance programs – known as "churning" – imposes a significant burden on enrollees, providers, health plans, and the broader public health insurance system.

Previous research indicates that half of publicly insured managed care patients are disenrolled from the Medicaid and FHPlus programs at recertification, thus losing their health insurance coverage and health plan membership.[7] Three previous studies regarding enrollment churning demonstrate that many of those disenrolled at recertification eventually find their way back onto a public program, but only after several months of being uninsured and only at significant and unnecessary administrative cost.[8]

Churning in public insurance programs undermines efficiency and quality of care, and is particularly detrimental in a managed care delivery model. Churning interferes with plans' efforts to improve beneficiaries' care-seeking behaviors, disrupts patient-provider relationships, and results in lapses in access to preventive care and treatment for chronic conditions for low-income people. Additionally, health plans that serve New York's public health insurance programs spend millions of dollars to reach out to, enroll, and start treatment programs for patients whose enrollment tenure is too short for clinical interventions to be meaningful or for financial investments to be recouped. Churning also drains hospital and community health center resources as they struggle to continue caring for patients who lose their insurance.

Using administrative data on involuntary disenrollment of more than 33,000 Medicaid managed care and FHPlus enrollees, this study documents the current state of churning in those programs and examines its impact on individuals with chronic medical conditions. Despite many years of qualitative and quantitative evidence of the prevalence and negative impact of churning, this study finds that there has been little improvement in disenrollment rates from New York's public health insurance programs. Specific findings include:

- Involuntary disenrollment at recertification in New York's public health insurance programs remains high at 46 percent.
- Public insurance beneficiaries with one or more chronic health conditions, including asthma, hypertension and diabetes, are less

likely to lose insurance coverage at recertification. Those beneficiaries with chronic diseases are 16.5 percent less likely to be involuntarily disenrolled at recertification than those without chronic diseases.

- Despite this fact, nearly one-third (32 percent) of beneficiaries with known chronic conditions lose their health insurance coverage at recertification.

- Chinese speakers are much more likely to be involuntarily disenrolled than English speakers and Spanish speakers.

These findings suggest that New York State has not made material progress in reducing churning and confirms that churning is a problem even for the sickest beneficiaries in the Medicaid managed care and FHPlus programs. Based on these findings, we make the following recommendations regarding regulatory and policy changes which would, if adopted, decrease the cycle of churning and improve continuity of care in the State's public health insurance programs:

Streamlining Improvements

- **Implementation of "self-attestation" of income and residency at renewal.** Allow beneficiaries to attest to changes in personal information, including residency, without additional documentation. Also allow beneficiaries to attest to income, with verification using third-party computerized databases maintained by the state and federal government.

- **Elimination of the Medicaid and FHPlus asset test.** The asset test requires beneficiaries to report their family's assets, including such things as life insurance and savings accounts. Such reporting is confusing and cumbersome and deters many eligible people from completing the Medicaid and FHPlus renewal processes. The state could remove a significant portion of the recertification form relating to the resources of household members by eliminating the asset test.

- **Expand the use of "ex parte review" by local DSS.** Require local districts to consistently check beneficiary case records in other public benefit programs as a basis for redetermining Medicaid eligibility.

Analysis and Process Improvements

In addition to the streamlining improvements discussed above, State and local Medicaid officials should implement a comprehensive statewide data collection system for the purpose of understanding issues and pitfalls in the recertification process and identifying additional policy and regulatory changes that would reduce churning. A statewide data collection standard should include data

collection capturing:

- **Recertification return rate.** The percentage of Medicaid enrollees due to renew coverage who return their forms and documentation to the local district.

- **Completion rate.** The percentage of beneficiaries who return completed renewal forms and documentation.

- **Ineligible rate.** Of those beneficiaries who submit completed paperwork, the percentage who are disenrolled due to program ineligibility.

- **Recertification rate.** The percentage of those due to recertify who successfully renew coverage.

- **Reenrollment rate.** The percentage of beneficiaries disenrolled at renewal who reenroll in Medicaid or FHPlus within 3 months, 6 months and one-year of disenrollment.

BACKGROUND

New York's Uninsured

In 1990, 13.7 percent of New Yorkers under the age of 65 lacked health insurance. By 2000, despite years of economic growth and declining unemployment, the percentage of nonelderly uninsured in the state had grown to 17.2 percent.[9] When measured again in 2005, there was a significant decrease in the non-elderly uninsured to 15.3 percent, largely as a result of expansions of state-subsidized health insurance programs, including Family Health Plus and Healthy NY.[10]

Many uninsured individuals in New York are eligible for public health insurance programs, including Medicaid and its various expansion programs. In 2003, over 1.3 million New Yorkers, including 450,000 children and 880,000 adults, were eligible for public health insurance programs but not enrolled. Those eligible but not enrolled New Yorkers constituted roughly 45 percent of the State's uninsured.[11]

New York's Public Insurance Programs and Historically High Rates of Involuntary Disenrollment

Increasingly, New York State has moved toward delivering public health insurance through managed care programs. In 2001 the New York State Legislature enacted a Medicaid managed care expansion, the Family Health Plus program, which has significantly expanded access to insurance coverage for low-income adults. Today FHPlus covers over 500,000 low-income adults. With the implementation of mandatory managed care and the institution of facilitated enrollment, New York's Medicaid managed care program has grown exponentially as well, more than tripling in enrollment between 1999 and 2004.[12] New York's Medicaid managed care program covered 2 million beneficiaries as of September 2006. See Appendix A for a description of New York's Medicaid and Medicaid expansion managed care programs.

Despite net enrollment growth in New York's public health insurance programs in recent years, a variety of studies conducted in New York State in 1999 and 2000 documented high rates of involuntary disenrollment in public managed care programs. Many researchers and policymakers have identified the annual recertification process, particularly the documentation requirements, as major barriers to maintaining health coverage in publicly sponsored health programs.[13] One study found that approximately one-half of the children due to recertify their eligibility for the CHPlus program each month fail to complete the recertification process and are involuntarily disenrolled, accounting for more than 60 percent of all those leaving the CHPlus rolls.[14] The same study found that between 1998 and 2000, twelve Medicaid managed care plans, which at the time served 49 percent of New York State's Medicaid

managed care beneficiaries, reported losing approximately 4 percent of their membership each month (or 48 percent annually) as a result of involuntary disenrollment.[15] Also in 2000, both the New York City HRA and health plans documented that about 50 percent of New York's Medicaid beneficiaries due to recertify each month fail to do so and fall off the rolls.[16]

The primary rationale for recertification requirements is to screen out individuals who are no longer eligible for publicly subsidized health insurance, generally because of increases in family income. A recent Commonwealth Fund study of the recertification process examined family income fluctuations for families of children who were due to recertify their CHPlus coverage.[17] The study found that only a tiny fraction of CHPlus enrollees who were involuntarily disenrolled — less than 7 percent — lost eligibility based on income or family size changes, illustrating that very few of those who fail to certify are disenrolled for reasons of actual ineligibility.[18] Further, children in families that failed to recertify and lost coverage had significantly *lower* incomes than families that completed the recertification process. This suggests that the complexity of the recertification process has a disproportionate impact on lower-income families, the very families most likely to continue to be eligible for subsidized coverage.

These concerns have prompted a number of pieces of legislation in New York State over the past five years aimed at simplifying the recertification process. The most significant, the Health Care Reform Act of 2002 (HCRA 2002), mandated that certain aspects of the recertification process for all public programs in New York State be streamlined by April 2003. Specific streamlining measures implemented as a result of HCRA 2002 include:

- Elimination of the face-to-face interview at recertification for all public health insurance programs;
- Simplification of recertification forms for all public health insurance programs;
- Elimination of documentation of child care expenses and available health insurance at recertification for the CHPlus program;
- Elimination of income documentation at recertification provided that household members with countable income provide their social security numbers for the CHPlus program; and
- Allowing attestation of changes in address at recertification for the CHPlus program.

These streamlining measures have had limited success. The rate of failure to return recertification paperwork has decreased to 30 percent in New York City (from nearly 50 percent in 2001) since the implementation of the mail-in recertification form authorized by HCRA 2002.[19] However, the rate of involuntary disenrollment at recertification remains high, at 46% in the Medicaid and FHPlus programs.

Disruptions in Enrollment Undermine the State's Managed Care System

New York State has embraced managed care as its delivery system of choice for public health insurance programs. CHPlus and FHPlus have no fee-for-service option, and accordingly the 385,000 children enrolled in CHPlus and the 505,000 adults enrolled in FHPlus receive their care through a managed care delivery system.[20] While Medicaid has a fee-for-service option, the Medicaid managed care program is now mandatory for most beneficiaries and is expanding. Medicaid managed care plans now cover 68 percent of New York's Medicaid managed care eligible population. As further evidence of the State's commitment to the managed care model, SSI Medicaid beneficiaries as well as those with serious and persistent mental illness are now mandated to participate in the managed care program; these beneficiaries had previously been exempt from managed care enrollment.

Churning undermines both the quality of care benefits of managed care delivery systems and the financial benefits to the State gained by delivering health services in a managed care environment. Managed care plans improve the quality of care received by enrollees over time by enabling and encouraging appropriate use of primary care, expanding access to specialty care providers, and helping members and providers monitor and manage chronic conditions. By enrolling in a health plan and choosing a primary care provider, low-income patients have regular access to primary and preventive care, specialty care, and an array of care management programs. The implications of allowing large numbers of patients to experience gaps in their health care coverage include disruptions in continuity of care, ineffective disease management, and diminished plan accountability. Research has shown that discontinuities in care can result in missed opportunities for preventive and primary care, avoidable use of emergency rooms, unnecessary hospitalizations, lower birth weights, higher infant mortality rates, and worse overall health outcomes.[21]

Churning also impacts plan accountability, because in order to track improvements in quality of care, health plans must measure indicators of quality over periods longer than 12 months. Gaps in coverage prevent plans from monitoring provider performance over a prolonged period of time, which is necessary to improving outcomes. Quality Assurance

Reporting Requirements (QARR) data collected by the State Department of Health show that Medicaid managed care outperforms both fee-for-service and national quality benchmarks on virtually every quality measure, particularly those for the management of chronic illnesses.[22] From a quality-of-care perspective, New York's move to managed care is working, and would be even more effective with a recertification policy supporting continuity of coverage measured in years, not months.

Cost control is also cited as a major reason for New York State's implementation and expansion of managed care for government-sponsored health insurance programs, as medical costs through the Medicaid fee-for-service system are growing much more quickly than costs in Medicaid Managed Care. A 2003 survey conducted by the Business Council of New York State showed that from 2000 to 2002, per-enrollee costs in Medicaid managed care grew at a slower rate than per-enrollee costs in Medicaid fee-for-service – 2.3 percent versus 4.9 percent respectively – when looking at fee-for-service populations receiving medical services equivalent to Medicaid managed care.[23] Total fee-for-service costs grew 9.2 percent over the same period—four times as fast as the growth in Medicaid managed care—and commercial health insurance premiums in New York State grew by 10 percent per year.[24]

Managed care has proven to be a successful strategy for controlling healthcare costs, but churning threatens the financial stability of managed care in the long run. Plans providing Medicaid managed care services bear enormous up-front costs for each new enrollee, including administrative expenses for outreach, marketing and enrollment, health care expenses associated with baseline physicals, and other critical activities, such as health screening and member education. Typically, these costs are recouped over the period of enrollment. However, high rates of churning mean that for many enrollees, plans are not able to recover these costs. There is also adverse selection among the members who choose to stay enrolled. As this study confirms, the cumbersome recertification process means that members with extensive needs, severe health problems and high utilization, including those with chronic conditions, are most likely to successfully recertify.

In addition to the financial implications for Medicaid managed care plans, churning places an undue financial burden on the health care system as a whole. When individuals have no health coverage, they often access primary care in the emergency room, which is much more expensive than equivalent services provided in an outpatient setting. Additionally, individuals without access to primary care often do not seek care until their condition has deteriorated, meaning that they are sicker

and require more extensive and sophisticated treatments. By giving enrollees access to primary care services and a consistent primary care provider, managed care systems decrease health care costs overall.

Current Disenrollment Rates and Impact on Individuals With Chronic Medical Conditions

As New York State's managed care system continues to expand and mature, it is critical to understand the current state of churning in the Medicaid managed care and FHPlus programs. It is particularly crucial to examine the impact of churning on Medicaid beneficiaries with chronic medical conditions, given the State's recent policy decision to mandate that more seriously ill Medicaid beneficiaries to enroll in the managed care system.

Study Methodology

Data for the quantitative analysis conducted as part of this study is drawn from records of Medicaid managed care and FHPlus enrollees due to recertify during the first quarter of 2004. Data was provided by three New York State PHSP plans with membership in the greater metropolitan area of New York City, including Westchester and the Hudson Valley, and represents all plan members due to renew during this period excluding those with less than one year of continuous enrollment prior to their recertification date. In total, there were 33,326 individual records in the sample.

Each plan provided detailed data on members due to recertify, including age, sex, county and ZIP code of residence, primary language, enrollment data, recertification date, coverage termination date (if any) and whether the member had been diagnosed with asthma, diabetes or hypertension.[25]

Findings

Based on data provided by three PHSP plans, we find that overall involuntary disenrollment rates remain high—over 46 percent overall. Some of these involuntarily disenrolled individuals lost coverage because they did not submit their recertification forms in a timely fashion, others submitted incomplete recertification information, and still others lost coverage because they were deemed ineligible due to changes in their income, family size, or other factors used to determine eligibility.

Information provided by HRA indicates that roughly 30 percent of all individuals due to recertify coverage do not return their mail-in recertification forms.[26] Given that more than 46 percent of those due to recertify are involuntarily disenrolled, and 30 percent of those due to recertify do not return recertification materials, we can conclude that 16 percent of those due to recertify lose coverage either because they returned incomplete or flawed recertification materials

or because of actual ineligibility. As demonstrated by prior research, many fail to submit completed recertification materials due to the complicated recertification requirements, including complex income documentation rules.

Without controlling for other factors, we find that those with chronic diagnoses are far less likely to be involuntarily disenrolled (32.3 percent vs. 46.8 percent). However, churning remains a pervasive problem for those with chronic conditions. Almost one-third of all individuals with chronic diseases are involuntarily disenrolled at renewal.

Table 1: Frequency of Involuntary Disenrollment by Chronic Disease Diagnosis

	No Chronic Diagnosis*	Single Chronic Diagnosis	Multiple Chronic Diagnoses	Chronic Diagnosis Overall	Overall
Involuntary Disenrollment (%)	46.8%	32.4%	32.0%	32.3%	46.1%

* Chronic Diagnoses sampled: Asthma, Diabetes and Hypertension. 4.9 percent of individuals sampled received treatment for one or more of these diagnoses.

Multivariate Analysis

Based on regression analysis, we find a number of variables which affect the probability of involuntary disenrollment. The key variable assessed, Chronic Diagnosis (whether an individual enrollee had been diagnosed with a chronic health condition), had a strong negative correlation with disenrollment, and was statistically significant. Among all of the variables in the model, Chronic Diagnosis also had the largest impact on involuntary disenrollment. The computed risk difference suggests that those with diagnosed chronic conditions are 16.5 percent less likely to be involuntarily disenrolled than those without chronic conditions.

A number of individual-level control variables were also significantly correlated with higher rates of disenrollment. In contrast to adults 18-65, individuals under 18 were more likely to be involuntarily disenrolled (2.8 percent). Females were slightly more likely to be involuntarily disenrolled than males (1.2 percent), and residents of New York City were more likely to be involuntarily disenrolled than Upstate residents (9.3 percent). Non-English speakers were more likely to be involuntarily disenrolled than English speakers. Spanish speakers were slightly more likely to lose coverage than English speakers (1.7 percent), and Chinese speakers were substantially more likely to lose coverage than English speakers (11.9 percent). There was no statistically significant impact for speakers of other non-English languages.

Table 2: Involuntary Disenrollment – Logistic Regression (N=33,326)

Variable	Coefficient	Percentage Point Impact
Constant	-0.130	
Chronic Diagnosis	-0.667***	-16.5%
Age		
Under 18	0.115***	2.8%
18 – 65 Years Old	--	--
Female	0.049*	1.2%
NYC	0.375***	9.3%
Language		
English	--	--
Spanish	0.071*	1.7%
Chinese	0.509***	11.9%
Other Non-English	0.073	1.8%
Chi-Square Significance	0.000	
Pseudo R^2	0.017	
% Cases Predicted	55.7	
-2 Log Likelihood	512.190	

* Significant at $p < 0.05$
** Significant at $p < 0.01$
*** Significant at $p < 0.001$

The above model provides insight into some factors that do, and others that do not, impact involuntary disenrollment. In general, we conclude that chronic disease diagnosis is a powerful and significant factor in maintaining coverage in Medicaid managed care and FHPlus. That children are more likely to be involuntarily disenrolled than adults is troubling, but the effect size is fairly small. Some of the impact of the findings on New York City residents may be attributed to individual health plan practices, rather than a significant difference between enrollment decisions and conditions for residents of different regions, since data from only one Upstate plan was included in the sample.

After the findings on chronic disease diagnosis, the model results on enrollee language are the most striking. Spanish speakers are more likely to be disenrolled than English speakers, but the impact is fairly small and not highly significant. As such, we find that Spanish speakers face only moderate barriers to maintaining coverage compared to

English speakers. Chinese speakers, on the other hand, clearly face significant barriers to maintaining coverage; as compared to English speakers, Chinese speakers are 11.9 percent more likely to be involuntarily disenrolled. This finding points to the need for additional support for Chinese speakers seeking to maintain coverage under New York's public managed care programs.

Summary of Key Findings

- Involuntary disenrollment at recertification in New York's public health insurance programs remains high at 46 percent.
- Public insurance beneficiaries with one or more chronic health conditions, including asthma, hypertension and diabetes, are 16.5 percent less likely to lose insurance coverage at recertification than those without chronic conditions.
- Despite this fact, nearly one-third (32 percent) of beneficiaries with known chronic conditions lose their health insurance coverage at recertification.
- Chinese speakers are much more likely to be involuntarily disenrolled than English speakers (11.9 percent).

DISCUSSION AND RECOMMENDATIONS

A. Health Plan Renewal Outreach

In order to better understand the beneficiary data gathered from health plans, we surveyed member services and case management directors of four Medicaid managed care health plans in New York State regarding recertification outreach, particularly for those members with chronic health conditions. The survey instrument is included in Appendix B. All plans surveyed reported an extensive member recertification process for all their members. The surveys did not indicate any universal standard or practice among plans, but each plan reported regularly contacting members several times prior to their recertification deadlines. Most of the plans reported beginning this process 90 days from the mail-in recertification deadline, using a combination of phone and mail contact to encourage members to recertify. However, despite these extensive outreach activities, involuntary disenrollment rates remain high.

Some of the difficulties experienced by plans in attempting to contact their members are mitigated by case management and regular contact with physicians and plan administrators. Plans have extensive case management systems to serve the needs of those with chronic conditions, including those with asthma, diabetes, and hypertension. All plans use multiple forms of outreach to those with chronic conditions to help them manage

their care and renew their health insurance coverage, including written information (in a variety of languages), reminder notices and phone calls, and care management seminars. The plan case managers also assist in the recertification process by reminding members about upcoming recertification deadlines and referring a member services representative to assist in that process.

Although none of the plans indicated that they specifically provide a higher level of recertification outreach to members with chronic conditions, information gleaned from these surveys indicated that those with chronic conditions have much more interaction with their health plan and with health care providers. We can infer that this repeated contact plays a positive role in engaging members with chronic conditions during the recertification process, leading to lower rates of involuntary disenrollment.

B. Recommendations

Despite years of research demonstrating the prevalence of churning and specific reforms targeted to reducing it, this study reveals that gaps in coverage remain a significant problem in New York's public health insurance programs, with serious implications upon the quality and consistency of care, particularly for low-income New Yorkers with chronic health conditions. Following are recommendations for policy and process changes that New York State should implement to reduce churning. These improvements fall into two categories: streamlining improvements and analysis and process improvements.

Streamlining Improvements

- **Implementation of "self-attestation" of income and residency at renewal.** A number of states have sought to ease burdensome documentation requirements by allowing beneficiaries to attest to changes in personal information (including income and residency) at renewal, without providing additional documentation. This information is then verified by matching it against wage reporting systems and other computerized databases maintained by the state and federal government. Many states also conduct phone verification samples for applicants not found in government databases. If there is a conflict between the data attested to as part of the application and verification findings, applicants are then asked for additional documentation. An amendment to State regulations would be necessary in order to implement attestation of income and residence at renewal.

- **Elimination of the asset test in Medicaid and FHPlus.** The asset test requires beneficiaries to report their

family's assets, including such things as life insurance and savings accounts. Such reporting is confusing and cumbersome and deters many eligible people from completing the Medicaid and FHPlus renewal processes. The state could remove a significant portion of the recertification form relating to the resources of household members by eliminating the asset test.

- **Expand use of "ex parte review" by local DSS.** Local districts already have access to a variety of information in government records, which could serve as a basis for redetermining Medicaid eligibility as Medicaid beneficiaries often receive other public benefits. "Ex parte review" refers to the procedure of checking other government records for information to demonstrate beneficiaries' continued eligibility for Medicaid. If the records provide sufficient information, a beneficiary is not required to participate at all in the certification process. If sufficient information is not found, then the district can ask the beneficiary to furnish whatever information is needed in order to complete the recertification application. Other states have found this renewal process to be effective in maintaining the continuous enrollment of Medicaid beneficiaries.[27] Neither state law nor regulation prevents a district from processing an "ex parte review"; however, few districts, if any, use the related databases for purposes of recertifying Medicaid eligibility.

Analysis and Process Improvements

In the process of collecting recertification and disenrollment data for this study, it became clear that system-wide data is not available concerning a variety of recertification issues. Consistent and accessible data is necessary to determine where and when the recertification process breaks down. While this report extrapolates some conclusions based on the data provided to us by health plans, a comprehensive statewide or standardized county data collection system would be far more effective at identifying key areas where policy makers should act to reduce churning. Statewide recertification data standards should include at least the following:

- **Recertification return rate.** The percentage of Medicaid enrollees due to renew coverage who return their recertification forms and documentation to the local district.

- **Completion rate.** The percentage of beneficiaries who return complete renewal forms and documentation.

- **Ineligible rate.** Of those beneficiaries who submit completed paperwork, the percentage of those who are

disenrolled due to program ineligibility.

- **Recertification rate.** The percentage of those due to recertify who successfully renew coverage.

- **Reenrollment rate.** The percentage of beneficiaries disenrolled at renewal who reenroll in Medicaid or FHPlus within 3 months, 6 months and 1 year of disenrollment.

CONCLUSION

Churning remains a significant problem in New York's public health insurance programs, and is particularly detrimental to the managed care system in which the State has invested. Involuntary disenrollment of eligible beneficiaries undermines quality and continuity of care, efficiency of care delivery, and the financial stability of managed care plans and providers. The negative impact of churning is felt most by low-income individuals, particularly those with chronic medical conditions, for whom access to providers and medications and continuity of care are critical. At the same time, churning has serious implications for the State's ability to provide cost-efficient and effective health care through its Medicaid managed care program.

For New York's Medicaid managed care system to achieve the goals envisioned when it was implemented a decade ago, policymakers must make definitive changes to the recertification system to improve continuity of coverage and, therefore, continuity of health care. Only through the commitment and action of Medicaid program officials and policymakers will the State's Medicaid managed care system continue to make strides in quality improvement and cost containment in delivering health care to New York's most vulnerable residents.

APPENDIX A:
DESCRIPTION OF NEW YORK'S MEDICAID MANAGED CARE PROGRAMS

Medicaid

New York's Medicaid program offers health coverage for families and childless adults eligible for or receiving cash assistance, including very low-income, working families; pregnant women; children; individuals with disabilities; and the elderly. Generally, the income eligibility threshold for single adults (who are neither elderly nor disabled) ranges from 50 to 75 percent of the federal poverty level (FPL), depending on the county of residence and utility expenses. The income threshold for parents of dependent children ranges from 55 to 92 percent of FPL, depending on family size. Pregnant women and infants under one in families with income up to 200 percent of FPL, children ages one to five in families with income up to 133 percent of FPL, and children ages 6 to 18 in families with income up to 100 percent may also qualify for Medicaid.

Child Health Plus

Child Health Plus consists of two components, CHP A and CHP B. CHP A is Medicaid for children, while CHP B provides health benefits for children with family income above Medicaid limits, up to 250 percent of FPL. In New York, CHP A is treated as a component of the state's Medicaid program in terms of benefits, eligibility and reporting, while CHP B is a Medicaid expansion and thus is separate from the broader Medicaid Managed Care program. Unlike the Medicaid program, local governments contribute nothing to CHP B funding and have no role in eligibility determinations for CHP B. Instead, eligibility determinations are made by the health plans that participate in the program. The CHP B benefit package, while comprehensive, is more limited than the Medicaid benefit package. For example, long-term care services are not covered and mental health services are subject to annual caps. Unlike Medicaid, CHP B benefits are provided only through managed care plans. CHP B has no fee-for-service component.

Family Health Plus

Family Health Plus (FHPlus) was established in 2000 as a hybrid of Medicaid and CHP B. It provides coverage for adults with dependent children and childless adults who have income slightly above the Medicaid limits—up to 100 percent of FPL for childless adults and 150 percent of FPL for parents. Couples with no children qualify with incomes below 133 percent of FPL. The program was incorporated into New York's Section 1115 waiver and is funded with Medicaid dollars. Accordingly, local governments pay one-quarter of the costs of FHPlus and administer the program. FHPlus provides a more limited benefits package than Medicaid—long-term care services

are not available and mental health benefits are capped. Furthermore, FHPlus offers benefits only through managed care and has no fee-for-service component.

APPENDIX B:
HEALTH PLAN INTERVIEW INSTRUMENT

The following instrument was used to conduct interviews of four health plans to get a better understanding of how each conducts activities around health screening, patient education, disease management and renewal outreach. Results from the interviews have been incorporated into the study. Utilization, member services, and care management staff from the following plans were interviewed: Community Premier Plus, Health Plus, Hudson Health Plan, and MetroPlus Health Plan.

* * * * * * * * * * *

Your health plan is participating in a study of Medicaid member renewal and reenrollment rates and how those rates differ for Medicaid/FHPlus members with chronic conditions. Data from plans suggest (not surprisingly) that people with chronic illnesses are more likely to renew their coverage. Additionally, people with chronic conditions who lose their coverage are more likely to re-enroll.

To help us better understand (and reflect in the study report) the resources and supports that people with chronic illness receive when they join a Medicaid managed care plan, we have a few questions about plan activities in health screening, patient education, disease management and renewal outreach.

Health Screening, Education and Disease Management

- How does the plan identify members with chronic conditions like diabetes, asthma and heart disease?
- Once these members are identified, does the plan provide specific educational resources to help members manage their disease(s)? Can you describe these member education efforts?
- Does the plan provide other disease management resources or tools to help members manage their conditions? Can you describe these resources/programs?
- Do members with multiple chronic conditions receive additional resources or support? Can you describe these resources or supports?
- Does the plan communicate with members' providers about their chronic conditions? Can you describe provider communications?
- Are there other ways in which the plan helps providers manage patients' chronic conditions?

Renewal

- Does the plan do anything to remind members to renew their Medicaid/FHPlus coverage when they are close to their recertification date?
- Does the plan do outreach to members to help them renew their Medicaid/FHPlus coverage?
- Does the plan provide any additional renewal support to members with chronic conditions?

APPENDIX C:

Study Methodology – Multivariate Analysis

Multivariate analysis provides a rigorous way of testing the observations provided by the descriptive statistics. We used logistic regression to assess the impact of chronic disease diagnosis and a series of other independent control variables on whether individuals were involuntarily disenrolled. Along with chronic disease diagnosis, the independent control variables considered were enrollee age, enrollee gender, enrollee location (New York City vs. Rest-of-State), and enrollee primary language. All information was drawn from data provided by the three PHSP plans.

The model was highly statistically significant but had fairly low explanatory power (goodness-of-fit). Various interaction and effects were also assessed, but were not included in the final models. The impact of multiple chronic diagnoses vs. chronic diagnosis overall was also modeled, but not found to be statistically significant.

All cases in the sample of those due to recertify during the first quarter of 2004 were included in the multivariate analysis (N=33,326).

ENDNOTES

[1] See Appendix A for program descriptions.
[2] Bureau of the Census, August 2006.
[3] United Hospital Fund 2005. Based on data from the 2004 Current Population Survey, Annual Social and Economic Supplement.
[4] NYS Department of Health statistics, June 2006.
[5] 1115 Waiver Extension Request, November 23, 2005.
[6] John Z. Ayanian, Joel S. Weissman, et al. "Unmet Health Needs of Uninsured Adults in the United States," Journal of the American Medical Association. 2000; 284:2061-9
[7] Deborah Bachrach and Anthony Tassi, "Coverage Gaps: The Problem of Enrollee Churning in Medicaid Managed Care and Child Health Plus," NYS Coalition of Prepaid Health Services Plans, June 2000. Data provided by health plans.
[8] Michael Birnbaum and Danielle Holahan, "Renewing Coverage in New York's Child Health Plus B Program: Retention Rates and Enrollee Experiences," United Hospital Fund, 2003; A. W. Dick, R. A. Allison, S. G. Haber, C. Brach, and E. Shenkman, "Consequences of States' Policies for SCHIP Disenrollment," Health Care Financing Review, Spring 2002, 23(3); Bachrach and Tassi, 2000.
[9] 2001 Current Population Survey, Annual Social and Economic Supplement.
[10] 2006 Current Population Survey, Annual Social and Economic Supplement.
[11] United Hospital Fund 2005. Based on data from the 2004 Current Population Survey, Annual Social and Economic Supplement.
[12] Data drawn from NYSDOH Statewide MMCOR Reports, Year-End 1999 and 2004.
[13] Dick et al., 2002; Leighton Ku and Donna Cohen Ross, "Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families," The Commonwealth Fund, December 2002.
[14] Bachrach and Tassi, 2000.
[15] Ibid.
[16] Ibid.
[17] Lipson, Karen, Eliot Fishman, Patricia Boozang, and Deborah Bachrach, "Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Program," The Commonwealth Fund, August 2003.
[18] Lipson, et al, 2003.
[19] Personal communication with the New York City Human Resources Administration.
[20] New York State Department of Health, September 2006.
[21] Bachrach and Tassi, 2000.
[22] "Medicaid Managed Care in New York," NYS Coalition of PHSPs, December 2003; New York State Medicaid Fee-For-Service HEDIS/QARR Project, New York State Department of Health, July 2003.
[23] Business Council of New York State Annual Survey of Employer Compensation, 2003.
[24] Ibid.
[25] Raw data was coded into binary and categorical variables for descriptive and multivariate analysis, detailed below. The multivariate analysis for this study utilizes logit regression with involuntary disenrollment as the dependent variable. Computed risk differences are used to illustrate the impact on risk of disenrollment associated with each independent variable, holding all else constant. See Appendix C for additional information on study methodology.
[26] Personal communication with the New York City Human Resources Administration.
[27] Washington State conducts ex parte reviews on children on Medicaid who have an open case for food stamps. Maryland's Medicaid eligibility system interfaces with its wage reporting system to automatically extend transitional Medicaid to close welfare cases.

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