

Coverage and Managed Care Enrollment Patterns among Long-Term Beneficiaries in New York's Medicaid Program

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The Medicaid Institute at United Hospital Fund is working to improve the Medicaid program in New York by providing information and analysis and developing a shared vision for change.

The Medicaid Institute
at United Hospital Fund

James R. Tallon, Jr.
President

David A. Gould
Senior Vice President for Program

Medicaid Institute
at United Hospital Fund
Empire State Building
350 Fifth Avenue, 23rd Floor
New York, New York 10118-2300
(212) 494-0700
www.medicaidinstitute.org

ELIZABETH PATCHIAS Health Policy Analyst, United Hospital Fund
MICHAEL BIRNBAUM Director of Policy, Medicaid Institute, United Hospital Fund

For nearly a decade, New York has made Medicaid managed care (MMC) mandatory for most adults and children receiving Medicaid benefits, with the goal of improving beneficiaries' access to services and quality of care.¹ The managed care model relies on the premise that Medicaid's long-term beneficiaries will develop stable relationships with health care providers, and that their health plans will have the resources and incentives to manage their care effectively, leading to better service utilization, improved health outcomes for the patient, and potential savings for Medicaid. But even among beneficiaries with long-term and continuous Medicaid coverage, there is measurable instability in MMC enrollment.

Tod Mijanovich, of the Center for Health and Public Service Research at New York University's Wagner School of Public Service, provided statistical programming and analysis of the Medicaid paid claims file in the preparation of this issue brief.

¹ Sparer M. 2008. *Medicaid Managed Care Reexamined*. New York: United Hospital Fund.

The loss of Medicaid coverage during the annual renewal process—known as churning—is well-documented. An estimated 46 percent of beneficiaries in New York are involuntarily disenrolled at some point in their Medicaid coverage.² Because retaining Medicaid coverage is an underpinning of the MMC model, state policymakers, health plans, analysts, and consumer advocates have focused considerable resources and attention on simplifying the Medicaid renewal process.

This analysis focuses on a complementary, but lesser-known, issue: instability of enrollment in MMC itself. To evaluate this instability, we used the Medicaid paid claims file, along with ancillary eligibility and provider files, to examine the coverage and enrollment patterns of the 1.5 million non-elderly and non-disabled beneficiaries in New York City with more than two years of coverage over a four-year period. Because these beneficiaries had twenty-five or more months of Medicaid coverage out of the forty-eight months between January 2002 and December 2005, and by definition completed two or more renewals or applications during their spells of coverage, we classified them as long-term Medicaid enrollees.³ The effects of Disaster Relief Medicaid on this population are discussed in the Appendix.

Among these beneficiaries—who had some degree of success in retaining Medicaid—we found high rates of continuous Medicaid coverage yet markedly unstable MMC enrollment. We examined several policy-related factors that can lead to unstable managed care enrollment. We also found, however, that nearly a third of the study group had instability in their MMC enrollment patterns that was not explained by policy.

Frequency and Duration of Gaps in Medicaid Coverage

A clear majority (68 percent) of the state's 1.5 million long-term Medicaid enrollees had no gaps in coverage over the four-year study period. This pattern held true for specific populations within the study group, with 63 percent of adults and 72 percent of children maintaining continuous coverage. Within each subgroup, we also compared beneficiaries receiving and not receiving cash assistance to determine whether those receiving

² Boozang P, I Braslow, and A Fiori. 2006. *Enrollment Churning in Medicaid: Coverage Gaps Undermine the Managed Care System and Continuity of Care for the Chronically Ill*. New York: Manatt Health Solutions.

³ In this paper, "long-term" refers to the length of time beneficiaries are receiving any Medicaid benefits, and is not related in any way to "long-term care."

Medicaid automatically as a component of their cash benefits had significantly different enrollment patterns; they did not. We found that those not receiving cash benefits had only a slightly higher rate of continuous coverage (64 percent versus 59 percent for adults, 74 percent versus 70 percent for children) (Table 1).

The presence of over a million long-term enrollees in New York City with continuous Medicaid coverage has two policy implications. First, it indicates that a substantial cohort has stable coverage with a low level of churning. Second, it suggests that the significant rates of churning may be highly concentrated within a distinct group of short-term enrollees.

**Table 1
Coverage Across Populations**

	N	% with continuous coverage	% with disruptions to coverage
Overall Population	1,527,588	68%	32%
Adults	638,186	63%	37%
Children	889,402	72%	28%

While 32 percent of long-term enrollees experienced some disruption in coverage, they mainly experienced a small number of gaps. Most adults (77 percent) and children (86 percent) who experienced any disruption in coverage had only one gap. These gaps also tended to be relatively short. Forty-one percent of adults and 44 percent of children experiencing gaps regained Medicaid coverage within three months; 63 percent of adults and 65 percent of children regained coverage within six months (Table 2). However, while long-term Medicaid beneficiaries' coverage gaps were infrequent and brief, even short gaps can be problematic for beneficiaries. They can lead to a loss of primary care and preventive services, and to difficulty paying medical bills. For New York's sizable cohort of long-term Medicaid enrollees, the policy challenge in terms of coverage gaps is translating relatively stable coverage into continuous coverage.

Transitions between Fee-for-Service and Medicaid Managed Care

Relatively stable or continuous long-term Medicaid coverage does not necessarily mean stable or continuous enrollment in MMC. Most long-term enrollees were enrolled in both FFS and MMC at different points during their Medicaid spell. The high prevalence of FFS enrollment

Table 2
Coverage Gaps Across Populations

N =	Overall Population 1,527,588	Adults 638,186	Children 889,402
Among those with gaps,			
% with one	82%	77%	86%
% with two	16%	19%	13%
% with three or more	2%	4%	1%
% with gaps lasting			
one to three months	42%	41%	44%
four to six months	22%	22%	21%
seven or more months	36%	37%	35%

is partly due to the fact that mandatory managed care was being implemented during the study period. To adjust for the effects of the MMC phase-in, we identified those in the study group who made a single transition from FFS to MMC with no gap in between. Beneficiaries who made this transition by the end of their third month of coverage were assumed to be subject to mandatory MMC and transitioning within the period that the state grants beneficiaries to select a health plan.⁴ The remaining beneficiaries with this single transition—who were in FFS for more than three months—were considered to be affected by the phase-in, as they would not have enrolled in MMC if it had not become mandatory during the study period. These beneficiaries (some 430,000) were removed from the sample to ensure that our analysis was not biased by one-time, policy-driven transitions from FFS to MMC.

Among the adjusted population, 54 percent of long-term beneficiaries were enrolled in both FFS and MMC over the course of the study period. Only 22 percent were in MMC exclusively during their spells on Medicaid; twenty-four percent were exclusively in FFS. While those beneficiaries solely in MMC or FFS had only one type of enrollment, their enrollment was not necessarily continuous. In fact, only 21 percent of the study group had MMC continuously—with no transitions and no gaps—and 15 percent had FFS continuously (data not shown). Taken together, this means that only 36 percent of the population had continuous coverage with a single type of enrollment (MMC or FFS), and nearly as many had continuous FFS enrollment as were continuously enrolled in MMC.

⁴ The plan selection period generally affords beneficiaries two full months as well as one partial month in FFS. During these months, beneficiaries who gain Medicaid through a hospitalization or who have other immediate health needs are covered retroactively. This period assures that providers are fairly reimbursed and that plans are not held responsible for medical expenses incurred before a beneficiary becomes enrolled in the health plan.

Explaining the Absence of MMC Enrollment

Twenty-four percent of long-term beneficiaries had no MMC coverage during the study period. Specifically, 39 percent of adults and 10 percent of children had only FFS Medicaid coverage; these individuals were likely exempted (i.e., allowed to opt out) or excluded (i.e., prohibited from enrolling) from MMC. In New York City, there are currently about twenty reasons for exemption from MMC (e.g., an HIV/AIDS diagnosis, residence in a substance abuse treatment program, or homelessness) and about twenty reasons for exclusion (e.g., placement in foster care, or becoming eligible for Medicaid only after spending down a portion of one's income). There are significantly fewer children than adults in these categories because most exemptions and exclusions relate to diagnoses and patterns of service use particular to adults (Table 3).

Explaining the Instability of MMC Enrollment

With 54 percent of the population enrolled in both MMC and FFS while on Medicaid, we examined the potential reasons for this prevalence of FFS enrollment in a population facing mandatory managed care.

One common pattern for long-term enrollees was a single move from FFS to MMC, with no coverage gap. This type of pattern could be considered transitional FFS enrollment, given that it covers a time when a beneficiary transitions to MMC. As noted above, such a pattern is likely to occur at the start of Medicaid coverage if a beneficiary takes advantage of the sixty-day period permitted for MMC plan selection. Fourteen percent of all long-term enrollees (8 percent of adults and 20 percent of children) made this change by their third month of coverage, indicating transitional FFS. These beneficiaries, therefore, could be characterized as having stable MMC enrollment, since they remained in MMC for the duration of their spell on Medicaid after this short initial period in FFS (Table 3). We identified 40 percent of beneficiaries who demonstrated different transitional patterns between FFS and MMC. Seven percent experienced FFS enrollment with a gap before transitioning to MMC, while an additional 7 percent experienced two transitions between FFS and MMC with a gap in between (data not shown). There is a range of circumstances that could explain these enrollment patterns. One scenario is a repeat of the transitional FFS period preceding MMC plan selection, after a gap in coverage following disenrollment at renewal. Another is the potential for

**Table 3
Enrollment Patterns Adjusted for Phase-In**

	Overall Population	Adults	Children
Total Population	1,527,588	638,186	889,402
Adjusted Population	1,099,863	485,021	631,475
% of beneficiaries with:			
FFS only	24%	39%	10%
MMC only	22%	11%	31%
Both FFS and MMC:			
One FFS to MMC transition	14%	8%	20%
Additional or different transitions	40%	42%	39%

beneficiaries to move between FFS and MMC if their status as an excluded or exempt beneficiary changes. This process represents an additional challenge for beneficiaries, some of whom qualify under multiple exemptions and must secure a different exemption as their circumstances or program rules change.

Examining Issues Related to Enrollment Transitions

Two enrollment policies may explain some of the observed movement between FFS and MMC. First, Medicaid coverage is retroactive and enrollment in a health plan is prospective. Health plans do not cover beneficiaries until after they have been deemed eligible for Medicaid, but the state, in order to cover the immediate health needs of beneficiaries, begins Medicaid coverage retroactive to the date of the Medicaid application. Second, when a beneficiary misses a renewal deadline but then reenrolls in MMC, the state retroactively covers Medicaid services used during the gap by reimbursing providers on an FFS basis, protecting plans from the costs of services rendered during enrollment gaps.

Some beneficiaries who experience FFS transitionally, either at the start of their spell or after a gap in coverage, have an acute medical event that requires hospital admission. Such beneficiaries, known as “inpatient enrollees,” represent an important policy challenge. They are typically adults who are hospitalized while uninsured and gain (or regain) Medicaid coverage through the efforts of the hospital.⁵ Indeed, the potential for a hospital admission during a gap in MMC enrollment is the main impetus for the aforementioned policy regarding lapsed renewals. However, among the long-term beneficiaries who are the subject of this analysis, just 3

percent began their spell on Medicaid with a hospitalization, and even fewer beneficiaries were hospitalized during a gap in coverage.⁶ Given that a very small share of long-term beneficiaries are inpatient enrollees, transitions from FFS to MMC enrollment are primarily unrelated to coverage that begins during hospitalization. It is, however, important to note that there may be a greater share of coverage spells beginning with hospital admissions for short-term enrollees.

Another issue related to enrollment patterns is plan switching, which can occur for a host of reasons, including beneficiary dissatisfaction, plan consolidation, or plans exiting the market altogether. Among beneficiaries with any MMC enrollment during their spell, 77 percent remained with the same plan and experienced no plan switching whatsoever; 21 percent experienced only one switch between MMC plans; and only 2 percent experienced two or more switches.⁷ To examine how these switches affect coverage, we looked at the percentage of beneficiaries moving between two MMC providers who experienced a gap in the process: less than 1 percent lost coverage in the process of switching plans, a finding that held true for both adults and children. Because plan switching affects such a small percentage of the overall population and rarely results in a break in coverage, it is not a significant cause of transitions between FFS and MMC.

Policy Implications

This analysis found that, among long-term Medicaid enrollees—those with more than two years of coverage during a four-year period, all of whom by definition have gone through two or more renewals or applications during the study period—two-thirds had no coverage gaps and retained Medicaid continuously for their observed spell of coverage. Although a third of long-term enrollees did experience disruptions in coverage, these gaps tended to be minimal. However, for a cohort nominally facing mandatory MMC, there was a high level of interaction with FFS enrollment. In other words, these long-term enrollees had stable Medicaid coverage yet unstable MMC enrollment.

⁵ Birnbaum M, K Haslanger, J Billings, T Mijanovic, and E Shapiro. 2004. *Estimating the Cost of Enrolling New York City's Eligible but Uninsured Adults in Medicaid*. New York: United Hospital Fund.

⁶ Given that any of the long-term enrollees in the study group could be an inpatient enrollee, these figures were derived using the entire sample. Specifically, to measure whether beneficiaries regain coverage via a hospitalization, we looked at all those with a hospitalization in the month of a return to coverage, or in the following month (to adjust for retroactive coverage). We found that 99 percent of long-term enrollees had no hospitalization within two months of a return to coverage. When we extended the period of returning to coverage to six months, the results were similar.

⁷ Given that any long-term enrollee in the study group could switch plans, these figures were derived using the entire sample.

The fact that mandatory MMC was in its implementation phase during the study period explains many of the single transitions we observed from FFS to MMC. Once beneficiaries subject to the phase-in were removed from our sample, however, we found that unstable MMC enrollment persisted for a significant number of beneficiaries. For some beneficiaries, there are practical reasons why FFS remains a part of their coverage, such as New York’s policy of allowing sixty days of FFS enrollment while beneficiaries facing MMC select a health plan. This type of transition, however, which is a short-term one, affected only a small percentage of the study population. For the remaining 40 percent of long-term beneficiaries, there is significant room for improvement in the number of transitions between FFS and MMC, to promote stable MMC enrollment.

Ultimately, it is in the state’s interest to facilitate Medicaid beneficiaries’ continuous enrollment in an MMC plan and to promote policies that make the goal of a medical home attainable. In fact, the state’s Quality Assurance Reporting Requirements—the primary mechanism used to evaluate managed care plans’ performance—rely heavily on measures that examine individuals enrolled continuously in a single MMC plan. When an MMC plan invests in the long-term health of its beneficiaries, better health outcomes and potential Medicaid savings can be achieved. As New York moves forward with coverage expansions that rely on Medicaid and care management strategies that rely on MMC, state policymakers should revisit the complex and difficult issues surrounding the instability of MMC enrollment for those with stable long-term Medicaid coverage.

Appendix: Data, Methods, and Key Terms

This analysis uses the Medicaid paid claims file and ancillary eligibility files from the New York State Department of Health for 2002 through 2005. It includes non-elderly, non-disabled adults and children in New York City who had Medicaid coverage for the majority of the study period—at least twenty-five months out of forty-eight. An adult is defined as a beneficiary who was 21 before January 1, 2002, and who had not yet turned 65 as of December 31, 2005.

Streamlined initial enrollment under Disaster Relief Medicaid was in effect through January 31, 2002, the first month of the study period, and automatic renewal of coverage was in effect for the majority of 2002. These temporary policy changes may decrease estimates of enrollment instability, thereby understating the principal finding of the analysis.

For the purposes of this analysis, “coverage” refers to whether an individual is insured by Medicaid; “enrollment” refers to whether a beneficiary is enrolled in fee-for-service or managed care. A “spell” is the period of time a beneficiary is covered by Medicaid, spanning the first and last months of coverage within the study period. A “gap” is a period within a spell when the beneficiary has no Medicaid coverage. “Transition” refers to movement between FFS and MMC. A “switch” is a move from one MMC plan to another.