HEALTHY KIDS
POLICIES AND PRACTICES THAT LEAD TO CHURNING IN MEDICAID MANAGED CARE

Conducted By:

Gerry Fairbrother, Ph.D.
Heidi Park, Ph.D., MPH
Arfana Haidery, MPH

The New York Academy of Medicine
Division of Health and Science Policy

The Center for Health Care Strategies (CHCS), in Lawrenceville, NJ, provided funding for Policies and Practices that Lead to Churning in Medicaid Managed Care. This Grant was made possible through a separate Grant to CHCS by the Robert Wood Johnson Foundation.

BACKGROUND:

Michigan's Medicaid managed care program was implemented in 1997 (children's Medicaid is also known as Healthy Kids) and is administered through the Medical Services Administration under Michigan's Department of Community Health. SCHIP dollars have been used to establish both a separate program, MIchild, and to expand the Healthy Kids program.

MICHIGAN	
Size of State (2003)[a]	10,050,446
Number of Medicaid Health Plans	17
Commercial Plans or Medicaid Only Plans	▪ Mostly Medicaid only
Payment to Plan	▪ Capitated
SCHIP Separate, Medicaid Expansion, or Both	▪ Both
Medicaid Income Eligibility Threshold	
Ages 0-1	185% FPL
Ages 1-6	150% FPL
Ages 6-18	150% FPL
Total Medicaid Enrollees [b]	1,191,456
Percent in Medicaid Managed Care [b]	75%
SCHIP Income Eligibility Threshold	
Ages 0-19	200% FPL
Total SCHIP Enrollees [c]	47,244
Percent in Managed Care	100%

[a] Population data is from Census Bureau State Population Estimates July 1, 2002.
[b] Data from Medicaid Managed Care Enrollment as of December 31, 2002 CMS.
[c] Monthly Enrollment for December 2002.

MEDICAID MANAGED CARE:

In Michigan, about 75% of Medicaid enrollees were in Managed care at the end of 2002. Currently there are 17 plans that participate in the Medicaid program. In 2000, there were 19 plans with one plan pulling out of the Medicaid program in 2001 affecting 9,000 clients and a second plan scheduled to pull out of the market in the fall of 2003, affecting 39,835 enrollees. When a plan leaves the Medicaid program, clients receive a letter saying that they will be transferred to a new plan. Clients are given the opportunity to choose another plan at this point but if they do not, they will be assigned to a plan by the state. In the past, network and service area terminations have been more common then plans pulling out of the Medicaid market. In 2000, 71,006 (1%) clients were affected by a network or service termination of a plan; however this number has decreased since then, with plan switching affecting less than 1% of clients in 2002.

The instability of the managed care market in 2000 for Michigan occurred at the end of the first contracts established with managed care plans for the Medicaid program. Michigan re-bids contracts for 2 years with an option to re-new for up to an additional 3 years. The first contracts began in 1997 and as the first two years came to an end and substantial changes were made to provider networks and plan services areas. For this

reason, the market was not stable during 1999 and 2000, and this is seen in plan enrollment and disenrollment.

As described by Michigan staff, plans tend to pull out of rural areas. Michigan is about 2/3 rural and 1/3 urban and plans have difficulty establishing provider networks in these areas. The rates paid by the state to plans are adjusted for rural and urban areas and most of the plans pay providers FFS rates. However, providers do not look at managed care favorably stating that they moved to rural areas so they would not have to deal with managed care and as a result, plans are blocked out by providers.

ENROLLMENT AND RECERTIFICATION PROCESS:

Eligibility for Medicaid managed care is determined in the Family Independence Agency (FIA) which is Michigan's public assistance, child and family welfare agency. Client must go to this agency to apply for Medicaid. Once determined eligible (about a 45 day process), the client will receive a Medicaid card and enrollment in the program is retro-active to the first of the month of the date on the application.

Once eligibility is determined, the process to choose a plan begins. The names of eligible clients are sent in an electronic file to the enrollment contractor, Michigan Enrolls, on a daily basis. Within 3 days of receiving this file, Michigan Enrolls sends out a managed care enrollment packet to clients. This package includes the application for choosing a plan, quality information about participating health plans and information about how to enroll in and how to choose a plan. Clients can enroll in a plan through the mail, they can call the customer assistance line or they can co to a local field office to enroll.

Clients are encouraged to either call in or go to a local office so enrollment counselors can walk them through the process and help clients successfully choose a plan that is available to them. Michigan has found that individuals who enroll through the mail in application tend to choose plans that have the best performance based on the information given in the packet. The problem these clients then run into is that often, plans may be closed to enrollment in their county, may not be available in their county or their doctors may not participate with that plan. Therefore, if a client calls in or visits the office, the enrollment counselor tells the client about all of their plan options and helps them choose based on their desired PCP. If the client does not have a PCP in mind, the counselor will assist the client in choosing one by providing several options based on location. The counselor also educates the client on how to use the ER, about their co-pays as well as their prescription benefits.

The clients have 60 days to choose a plan before they are auto-assigned based on an algorithm that includes price and quality scores assigned to each plan by the state. Michigan has about a 40% auto-assignment rate. Of the individuals who do choose, the state has found that the majority (80%) choose, within 14 days and therefore the State planned to reduce the time to choose a plan from 60 to 30 days on October 1, 2003. Once a plan is chosen, enrollment in a plan begins on the first of the next month. The client also receives a plan card (in addition to the Medicaid card they receive once they are

eligible for Medicaid) at this point along with a letter explaining that the client has 90 days to try out the plan before he or she is locked-in to the plan.

Having a lock-in policy requires states to have an open enrollment period at least once a year, for Michigan this period is in May. Prior to open enrollment, Michigan Enrolls sends out letters informing clients of the open enrollment period (they sent about 450,000 letters out to all mandatory clients in 2002). Even during this open enrollment period plan switching is fairly low, less than 3%. The top four reasons that clients gave for disenrollment from a plan, excluding the category of other, were 1) PCP client wanted was not in plan, 2) client moved, 3) client was dissatisfied with the plan, and 4) the doctor advised the client to switch plans.

Recertification for the Medicaid program occurs once a year based on the clients eligibility period. At this point, the FIA send out a letter 30 days prior, reminding clients of the recertification process and it occurs through the same process as enrollment does. If a clients fails to recertify within the 45 days given to recertify, but re-enrolls in the program within 90 days of the case closing, then these clients are automatically put back into the plan they had previously been in, without requiring the enrollment contractor to re-market plans to the clients. As part of this study, Michigan reported that about 35% of their children recertify within 90 days.

MEDICAID ENROLLMENT	
Enrollment in Medicaid	
Where Apply	▪ Family Independence Agency (FIA)
Medicaid Coverage Begins	▪ 1st of month applied
Time to Determine Eligibility for Applicant	▪ about 45 days
Income Verification	▪ Self-declared [a]
Cross Check Eligibility with Extant Databases	▪ No, conduct monthly audit
Eligibility Period	▪ 12 months
Applicant Receives Medicaid Card	▪ After eligibility determined
Enrollment in Health Plan	
Earliest Client can Pick a Plan	▪ After eligibility determined
Who Assists Clients with Enrolling into a Plan	▪ Enrollment Broker
Child is on Health Plan Rolls	▪ 1st of the next month after health plan is chosen
Time to Chose a Plan Before Auto-assigned	▪ 60 days after eligibility determined
Free Look Period	▪ 90 days after choose plan
Percent Auto-assigned	▪ about 40%
Locked in to a Plan	▪ 12 months
Option to Switch Plans	▪ Once a year at open enrollment
RECERTIFICATION PROCESS	
Where Client can Recertify for Medicaid	▪ Family Independence Agency (FIA) ▪ Mail in
Put into same Plan if Re-enroll within	▪ 90 days
Recertification Reminder is Sent Out	▪ 30 days prior
Proportion of Children who Recertify on Time	▪ Data not reported
Proportion of Children Who Recertify within 90 Days	▪ 35%

[a] Michigan allows self declaration of income for Medicaid children only.

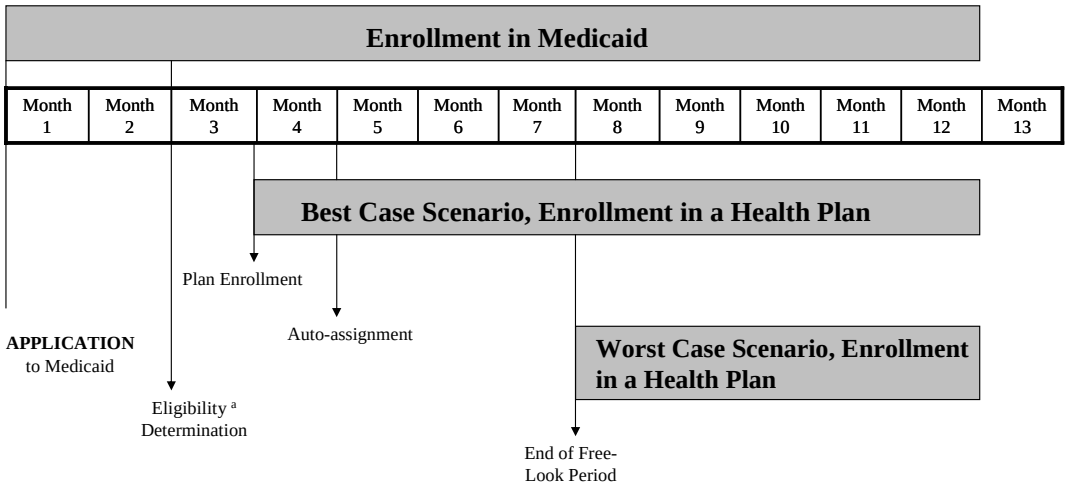
QUALITY AND PERFORMANCE MEASUREMENT:

Health plans are monitored on a number of factors during annual site visits and through data submission. HEDIS is submitted each year. Health plans contract with vendors who produce a HEDIS audit report and this is then sent to the state. The state in turn pulls out certain measures and compares plans with the mean. Health plans must also report encounter data and they are monitored on its timeliness and volume. Plans must also submit an audited financial statement, a physician directory and their complaint and grievances file each year. In addition, the contracts require health plans to develop work plans and projects for improvement. A minimum performance standard is set in their contracts and plans are evaluated against this number.

Financial incentives are provided to plans in the form of bonuses from a pool of money withheld from their payments. Each year, .0025% of payments to plans is and put into the bonus pool. A portion of this pool will go to all plans to help fund education initiatives; however, in addition to this money plans may receive an increased portion of money from the pool based on quality rankings assigned by the state using performance targets. The auto-assignment process also provides financial incentives for plans to improve on quality through an algorithm using quality ranking as part of the formula. Non financial incentives also exist for plans. Plan performance results are made public through the information mailed to clients and available on the web. In addition, Michigan also requires all of their health plans to be NCQA or JACHO accredited.

SUMMARY:

The major factor in Michigan's Medicaid managed care program contributing to short enrollment tenures in Medicaid managed care is the gap between Medicaid eligibility and enrollment in a health plan. The time between the day of enrollment in Medicaid and the day of enrollment in a plan may be as long as 3 months (as shown in the diagram below).



[a] Enrollment in Medicaid is retro-active. Clients do not know they are enrolled in Medicaid until eligibility is determined

A method of addressing enrollment tenures when measuring quality in Michigan includes setting up special initiative to focus on areas of concern. These initiatives target areas and use alternative data sources measure rates, not involving continuous enrollment, such as the immunization registry data reports.