

medicaid
and the uninsured

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**MANDATORY MEDICAID MANAGED CARE—PLAN AND ENROLLEE PERSPECTIVES
ON THE ENROLLMENT PROCESS**

Participation in mandatory managed care programs under Medicaid has been growing at a fourfold pace over the past decade, yet little is known about the process of beneficiary enrollment and how it may affect the overall success of Medicaid managed care programs. The enrollment process provides an important opportunity for states and managed care plans to educate beneficiaries about the concept of managed care, how to access services, how to “navigate” the Medicaid managed care system, and how to use available services most effectively, emphasizing preventive care in order to avoid treating preventable conditions in an emergent setting.¹ In addition, states’ enrollment policies determine the degree of choice beneficiaries have in choosing their plan and primary care provider (PCP), a choice that is of critical importance to Medicaid beneficiaries and a predictor of their future satisfaction with managed care.² States’ enrollment policies also have the potential to influence the number and stability of covered lives available to managed care plans, and may affect plans’ decisions regarding continued participation in Medicaid managed care programs.

This issue paper discusses the enrollment process from the perspectives of both beneficiaries and participating plans in nine states with mandatory Medicaid managed care programs: California, Connecticut, Florida, Maryland, Michigan, Missouri, New Mexico, Oklahoma, and Oregon. Because of the unique organization and size of the California Medicaid system, two counties were studied in depth, bringing the total number of study sites to ten. Specific questions addressed include:

- How does the enrollment process work?
- What degree of control do beneficiaries have in selecting a plan and/or a provider and how do beneficiaries make their selections?
- How does the management and efficiency of information systems affect beneficiaries and plans?
- How do state policies regarding the assignment of individuals not selecting their own plans (autoenrollment policies) impact plan participation in Medicaid? What effect do efforts to stabilize enrollment through plan lock-in and guaranteed eligibility policies have on plan participation?

The paper concludes with a summary of issues emerging in this study and suggests several strategies to improve beneficiary and plan satisfaction with mandatory Medicaid managed care.

Study Design

Case studies were conducted in ten mandatory Medicaid managed care programs in nine states to examine both the enrollment experiences of Medicaid beneficiaries and the experiences of managed care plans participating in these programs.³ Site visits to the nine study states occurred during the first six months of 1998. States, selected to reflect a range of experiences with and types of mandatory Medicaid managed care programs, include: California, Connecticut, Florida, Maryland, Michigan, Missouri, New Mexico, Oklahoma, and Oregon.

Beneficiary experiences were assessed through a series of focus groups in all but one state for a total of 24 focus groups with 162 participating beneficiaries. About one-quarter of these focus groups were deliberately composed exclusively of Hispanic, African American, Asian American, and HIV-infected Medicaid beneficiaries in order to more accurately represent the diverse population enrolling in mandatory Medicaid managed care programs. While the use of focus groups limits the generalizability of the study's findings, these focus group findings provide a picture of how beneficiaries experienced enrollment under their states' mandatory Medicaid managed care programs and suggest insights about beneficiary experiences overall.

State policies and plan perspectives were assessed during the course of 10 site visits in the nine states in which representatives of three to four managed care plans were interviewed, together with state Medicaid officials, FQHC representatives, and community advocates. Managed care plans were selected to include a variety of characteristics ranging from large for-profit plans with substantial managed care experience to provider/safety net-sponsored plans organized to deal with the advent of Medicaid managed care. The structured interviews were guided by protocols designed to solicit plan perspectives on these areas of interest: 1) how the enrollment process worked; 2) what kind of choices of plans and providers beneficiaries were able to make; 3) whether there were certain state enrollment policies and practices that affected the plans' willingness to participate; 4) whether the lack of beneficiary choice and/or the autoenrollment procedures created particular problems for the plans; and 5) how plans felt about their ongoing participation in Medicaid managed care.⁴

Enrollment Processes and Practices

The basic features of the Medicaid managed care programs and markets in the ten study sites are presented in Tables 1 and 2 on the next page, and the enrollment processes are outlined in Table 3. Beneficiaries are typically permitted between 14 to 45 days to choose a plan, with most states allowing 30 days. Six of the ten programs use enrollment brokers to enroll beneficiaries, and five of these also permit community based organizations to assist beneficiaries through the enrollment process.

Overall, among the ten study programs, procedural similarities in the enrollment process outnumber differences, although there is substantial variation in the commitment of resources for outreach and education and the level of effort states expend to avoid autoenrollment. As shown in Table 3, voluntary enrollment rates vary from a low of 26 percent in Florida, to a high of 100 percent in Oregon, where enrollees must designate a plan at the time of enrollment.

Table 1**Mandatory Medicaid Managed Care Program Characteristics**

Program	Initiative Type/Name	Program Type	Waiver Type	Year Implemented	Geographic Coverage
California (Los Angeles County)	Two-Plan Model	Full Risk	1915(b)	1996	County
California (Santa Clara County)	Two-Plan Model	Full Risk	1915(b)	1996	County
Connecticut	Connecticut Access	Full Risk	1915(b)	1995	Statewide
Florida	MediPass and HMO	Full Risk and PCCM	1915(b)	1991*	Statewide
Maryland	HealthChoice	Full Risk	1915(b)/1115	1991/1996	Statewide
Michigan	Comprehensive Health Plan Program	Full Risk	1915(b)	1997	5 counties and expanding statewide
Missouri	MC+	Full Risk	1915(b)/1115	1995/1998	4 regions (planning to expand to 5)
New Mexico	Salud!	Full Risk	1915(b)	1997	Statewide
Oklahoma	SoonerCare	Full Risk and PCCM	1915(b)/1115	1995/1996	SoonerCare Plus in urban areas
Oregon	Oregon Health Plan	Full Risk	1115	1994	Statewide

*In December 1995, Florida received a renewal of its 1915(b) waiver, and in 1996, Florida amended its waiver to allow the state to award auto-enrolled lives to either HMOs/PHOs or MediPass.

Table 2**Managed Care Program Market Characteristics**

Program	Commercial MC Penetration ¹	Medicaid MC Penetration	Total Medicaid MC Enrollment	Plan Licensing Requirements	Plans Participating in Medicaid by Type			
					Commercial	Provider-Sponsored	Publicly-Sponsored	Total
California (Los Angeles County)	40%	38%	1.8 million	State-licensed HMOs	1		1	2
California (Santa Clara County)	40%	42%	63,000	State-licensed HMOs	1		1	2
Connecticut	30%	60%	220,000	Lower solvency required for provider-sponsored plans	5	2		7
Florida	23%	78%	1.1 million	State-licensed HMOs	13	(1) ²	2	15
Maryland	31%	80%	330,000	Lower solvency required for provider-sponsored plans	3	6		9
Michigan	22%	38%	460,000	Meet state "Qualified Health Plan" requirements to apply for state license within one year	17	1		18
Missouri	24%	42%	248,000	State-licensed HMOs	9	2	1	12
New Mexico	15%	75%	201,000	State-licensed HMOs	3			3
Oklahoma	10%	50%	144,300	State-licensed HMOs	3		2	5
Oregon	45%	90%	337,800	Provider-sponsored plans exempt from HMO licensure	14	1		15

¹A FQHC-sponsored plan had been established but was not yet operational at the time of this study.

²Source: InterStudy Competitive Edge 6.2, Part II: HMO Industry Report. September 1996. Please note that only the state-wide penetration rate was available for California.

Table 3

Enrollment Policies for Mandatory Medicaid Managed Care Programs

	California (Los Angeles County)	California (Santa Clara County)	Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
Populations Required to Enroll	AFDC/TANF	AFDC/TANF	AFDC/TANF	AFDC/TANF/SSI	AFDC/TANF/SSI	AFDC/TANF/SSI	AFDC/TANF	AFDC/TANF/SSI	AFDC/TANF	AFDC/TANF/SSI
Length of Choice Window	30 days	30 days	30 days	30 days	21 days	30 days	30 days	16 days	14 days	45 days
Method of Enrollment	In person and by mail	In person and by mail	In person, by telephone, and by mail	In person, by telephone, and by mail	In person, by telephone, and by mail	In person, by telephone, and by mail	By telephone, and by mail	By telephone, and by mail	In person, by telephone, and by mail	In person and by mail
Who Enrolls Beneficiaries	Broker	Broker	Broker	Plans	Broker	Broker	Broker	Fiscal Agent	State/DHS and broker	State
Voluntary Enrollment Rate	68%	71%	90%	26%	60%	50%	80%	48%*	40%	100%
Involvement in Enrollment										
Plan	No	No	No	Yes	No	No	No	No	No	No
Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	No	Yes
Provider	Yes	No	Yes	No	Yes	Yes	No	Yes	No	No
CBO										
Health Status Collected	No, except pregnancy status	No, except pregnancy status	No	No, except pregnancy status	Yes	No	Yes	No	No	No, except pregnancy status

*In Regions I-III only

Note: CBO = Community-Based Organization; PCP = Primary Care Provider

Overall, the voluntary enrollment rate in the ten programs studied averaged 63 percent. Therefore, while the autoenrollment rate averaged 37 percent across all programs, less than half of enrollees were making their own plan selection in Florida, Oklahoma, and New Mexico.

Unfortunately, beneficiaries across all programs consistently reported a pervasive lack of relevant information about the enrollment process, the implications of enrollment for seeking and obtaining care, as well as which providers are available under the available plans. Particularly during the initial conversion to managed care, the enrollment process coupled with serious deficiencies in state data and management information systems frequently created confusion, anxiety, and fear among beneficiaries.⁵ Uncertainties about initial enrollment, compounded by the lack of information, sometimes resulted in a rush of beneficiaries to get enrolled before they lose what they believe will be their only chance to choose a plan and provider. These circumstances are most often found in states that implement managed care quickly, without making adequate preparations for the transition.

Once enrolled, regardless of whether voluntarily or through autoenrollment, the lack of information regarding both the enrollment process and how to use managed care systems is a serious problem. Beneficiaries frequently report that, once in managed care, they have trouble getting care because they do not know which physicians they can see, and do not know how to make managed care work for them or their families.

Focus group beneficiaries reported that they like to seek assistance and information about managed care from their current providers or community based organizations (CBOs). For many beneficiaries, their relationship with their provider or CBO is premised on trust and familiarity, and they want to depend upon this relationship for help navigating managed care enrollment. This dynamic seems particularly important for Asian and Hispanic Americans whose current providers may be more culturally sensitive and able to help minority beneficiaries overcome cultural and language barriers that may be present during the enrollment process.

The Importance of Choice to Beneficiaries

Although states' primary emphasis during the enrollment process is usually on choosing a plan, most beneficiaries are more concerned about being able to choose their primary care provider.⁶ Indeed, beneficiaries generally do not focus on reasons for choosing a plan beyond whether their provider is in the plan's network. This may be due to the difficulty in distinguishing among plans based on the available information. Many beneficiaries perceive the only relevant difference among plans to be in their provider networks.

Indeed, beneficiaries report that the ability to choose their primary care provider is the most important aspect of enrolling in managed care, and their reasons for selecting particular providers are consistent with reasons given by commercial managed care enrollees. Specifically, beneficiaries' provider choices are typically based on the desire to have a provider who is known and trusted to them—usually a current provider or a provider who has been treating their children; a provider who is nearby and/or accessible; a provider who speaks their language and/or is trusted in their cultural community; a provider recommended by friends; or a provider associated with a trusted community institution, such as a community health center. For beneficiaries with special needs, such as HIV-infected persons, the ability to access current specialty providers is also essential.

Lack of Accurate Information about Provider Networks Undermines Beneficiary Choice

Lack of information about managed care plans' provider networks is a common problem in all of the study programs. For example, as can be seen in Table 4 on the next page, eight of the ten programs ostensibly offer beneficiaries an opportunity to choose their provider at the time of plan enrollment, but the information on plans' provider panels is usually inaccurate, inaccessible, or unavailable. In essence, beneficiaries may be given the opportunity to choose, but are not given the information necessary to make a choice.

Beneficiaries express frustration with the lack of information about which providers are in the available plans, and their inability to figure out how to retain their current provider. Particularly disconcerting to beneficiaries is the receipt of large packets of information in the mail that are incomprehensible and unhelpful. Beneficiaries frequently recount their experiences with being unable to continue seeing their regular provider, being assigned to a new provider because they had not been able to choose, or being assigned when they thought they had in fact chosen.

Table 4

Selection of Primary Care Provider (PCP)

	California (Los Angeles County)	California (Santa Clara County)	Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
PCP Selection at Enrollment ¹	Yes, strongly encouraged	Yes, encouraged	No, not Available	Yes, available	Yes, strongly encouraged	Yes encouraged	Yes encouraged	Yes encouraged	Yes available	No
Broker Required to Ask about PCP Selection	Yes	Yes	No ²	Not applicable	Yes	Yes	Yes	No	No	No
Availability of Provider Network Information	Yes, but cumbersome directories that were difficult to use	Yes, but cumbersome directories that were difficult to use	No	No	Yes, but directories were often inaccurate	No	No	Yes, but panels were incomplete and no directories for Region I	No	No
Require Plan to Give Member PCP Choice ³	No	No	Yes	No	No	No	No	Yes	No	Not applicable
Time Frame for Assignment of Non-Selecting Members	7 days	7 days	5 or fewer days	Before effective enrollment date (few days)	No data	10 days	15 days	30 days (period for beneficiary to choose)	14 days	30 days
Match Non-Choosing Beneficiaries with Provider	Yes	No	No	No	Yes	Informal effort	No	No	No	Not applicable

¹ All states, except Oregon, included a place on the enrollment form to indicate a PCP choice. In the case of Florida, PCP choice could be indicated on the plans' pre-enrollment forms.

² Broker conducted PCP choice pilot in 1996 and will begin to solicit PCP choice at enrollment as of July 1998.

³ While contracts between the state and plans require plans to give non-choosing beneficiaries a chance to choose their provider, these requirements are subject to the provision "when practicable." Only two states require plans to give non-choosing beneficiaries a chance to choose their PCP notwithstanding practicalities. Also, while these contracts require and/or encourage plans to honor PCP choice, this is again subject to the plans' judgment about practicalities but does not appear to be subject to much state oversight. All plans reportedly allow beneficiaries to switch providers freely although some plans may limit the number of switches allowed per year.

The lack of provider information can actually reduce the potential of managed care to increase access by interrupting established provider relationships. For example, some beneficiaries report deliberately choosing certain plans such as Blue Cross/Blue Shield because they desire a more traditional (i.e., mainstream) health insurance program. However, these beneficiaries are frequently surprised to discover later that their regular provider is not in the plans' network, or that "mainstream" providers are not available. Other beneficiaries often do not understand the significance of choosing a primary care provider within the context of managed care, and believe, in the absence of information to the contrary, that they can continue to use their existing provider irrespective of which plan they join.

Moreover, even when beneficiaries do choose their PCP during enrollment, states expect plans to honor beneficiaries' choices only "to the extent practicable." In effect, states give plans relatively unqualified discretion to make alternative PCP assignments if provider panels are full. Nonetheless, although there is little state oversight of the extent to which plans disregard beneficiaries' PCP choices, plans report that they generally are able to honor beneficiary PCP selections, and that it is a priority to do so.

If beneficiaries do not choose their PCP during enrollment, it may be helpful to offer beneficiaries another opportunity to select their primary care provider after they are enrolled with a plan. As Table 4 shows, however, only two states (CT and NM) *require* plans to give nonselecting members a chance to choose their PCP—otherwise, plans are required to give

nonselcting new members the chance to choose their providers, again, only “to the extent practicable.” Approximately half of the plans report giving nonselecting new members a chance to choose their PCP. Beneficiary selection rates are reported to be fairly low in these circumstances, i.e., approximately 30 to 40 percent. However, as Table 4 also shows, plans frequently operate under short state-imposed deadlines for connecting new members with providers, making it difficult for plans to solicit choices from new members.⁷

When beneficiaries fail to make a PCP selection either during enrollment or after, plans generally assign them to providers based on geographic proximity. Indeed, plans usually receive no other information about plan members; as shown in Table 3, only two states collect health status information and only three states collect pregnancy information on new members.⁸ In states that are willing and able to provide information to plans on beneficiaries’ prior providers, plans report making an effort to match beneficiaries accordingly. However, plans report that it is generally not easy to achieve these linkages, and plans’ interest and enthusiasm for pursuing them is quite variable.⁹

Plan Switching Policies

Due to the lack of information available to beneficiaries about plans and providers, most states have adopted liberal switching policies, allowing beneficiaries to change plans monthly without cause (see Table 5 on the next page). As might be expected, the most common reason for plan switching is the inability to find one’s provider in the plan. Similarly, most plans permit members to switch providers at their discretion, so long as the new provider is in the plan’s network. In fact, when autoassigning nonselecting members to a PCP, several plans report randomly assigning, without considering geography or other criteria, because members can easily switch providers if they so desire.

Plans do not have much documentation on the rate of provider switching but some report that provider switch rates are low. Consistently, beneficiaries who are autoenrolled in plans or autoassigned to providers frequently report that they just “stay put” and try not to switch because they believe the state’s choice of their provider is probably as good as their own choice. Asian and Hispanic beneficiaries seem less likely to try to switch, although these beneficiaries also report having more trouble understanding how to go about switching providers.

On the other hand, to the extent that beneficiaries take advantage of the ability to switch plans and providers liberally, this policy works to devalue the development of stable provider relationships, and may have serious and negative consequences for the stability of plan membership. Accordingly, most of the study states are contemplating restrictions on their liberal switch policies in the future.

Enrollment Issues for Plans

Lack of Information Adversely Affects Plans As Well As Beneficiaries

The lack of information that seems to pervade many states’ enrollment processes affects plans as well as beneficiaries. For example, plans frequently report serious problems receiving

Table 5

Medicaid Managed Care Plan Switching Policies

	California (Los Angeles County)	California (Santa Clara County)	Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
Plan Switch Policy	Monthly without cause	Monthly without cause	Monthly without cause	Anytime without cause	Without cause within 30 days*	Anytime without cause*	Anytime without cause	Without cause within 30 days*	Without cause within 30 days	Switch only with cause
Method for Switching	Request disenrollment materials by telephone or by postcard and complete disenrollment form	Request disenrollment materials by telephone or by postcard and complete disenrollment form	Request disenrollment materials by telephone or by mail and complete disenrollment materials	Switch from MediPass to a HMO or from a HMO to MediPass by calling AHCA; switch between HMOs by calling the state or the HMO or by mail through the plan	Switch by calling broker	Switch by calling broker	Switch by contacting state	Switch by calling fiscal agent	Must contact OHCA/state to switch	Must apply to OMAP/state for good-cause switches
Plan Lock-in Policy	No	No	No	No	Yes	Yes, if federally-qualified HMO	No	Yes, if federally-qualified HMO	Yes	Yes
Disenrollment Rate/Churning	4–5% (disenrollment rate)	No data	21% (cumulative plan switch rate)	No data	No data	No data	2% (plan switch rate)	13% (plan switch rate)	7% (plan switch rate)	No data
Notable Features of Switching e.g., Switching Policy Different During Initial Implementation	Disenrollment form is same form used for enrollments—switching actually results in disenrollment from one plan and enrollment in another	Not clear whether change in availability of disenrollment forms has affected the switch rate (no longer available in providers' offices)	Advocates believe that beneficiaries switch plans instead of using grievance procedures to problem solve; state considering implementing lock-in policy	Disagreement among informants regarding how long it takes to effect a plan switch	More flexible switch policy, i.e., allowed more than one "free" switch	During open enrollment, beneficiaries are notified of their right to switch, but they are not provided w/forms to initiate switch—effort to discourage beneficiaries	State can expedite for cause (15 days) and emergency switches (3 days); standard switches can take 45 to 60 days to process	For-cause switch requests must be made in writing to the state	State applies liberal interpretation of 30-day free switch rule and AE beneficiaries frequently given 60 days to switch; loose interpretation of "good cause"	State hopes to expedite biannual re-enrollment process by sending beneficiaries copies of original eligibility application to be verified and returned

*Without cause within 30 days if federally-qualified HMO.

timely and accurate data from states regarding which beneficiaries are actually enrolled in which plans. Despite the fact that plans are often required to make contact with and arrange initial appointments for beneficiaries within five to ten days of their plan selection, the information provided to plans about new plan members by the state and/or enrollment broker is frequently incomplete and/or inaccurate. Indeed, plans in Connecticut report that, although many beneficiaries chose their PCP during enrollment, the enrollment broker does not routinely communicate this information to plans. Nonetheless, a plan's failure to meet the requirement of contacting new members within a specified timeframe can result in loss (i.e. reassignment) of the member and loss of capitation payments. Plans complain about difficulties in meeting these requirements in situations where beneficiaries are switching, disenrolling, and reenrolling as well as using services inappropriately because they don't understand managed care. These additional administrative burdens exacerbate the challenge faced by plans to just break even under Medicaid managed care.

Table 6

Plan Participation in Mandatory Medicaid Managed Care

	California (Los Angeles County)	California (Santa Clara County)	Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
Number of Plans	2	2	7	15	9	18	12	3	5	15
Type of Plans	Commercial Plan (CP); Local Initiative (LI)*	Commercial Plan (CP); Local Initiative (LI)*	2 FQHC-owned	2 publicly-sponsored	2 FQHC-owned	1 FQHC-owned	2 FQHC-owned; 1 publicly-sponsored	All commercial	2 publicly-sponsored	1 FQHC-owned
Plan incentives										
1) Distribution of Autoenrolled Individuals Based on Score	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Not applicable
2) Lock-in Policy	No	No	No	No	Yes	Yes	No	Yes	Yes	Yes
3) Guaranteed Eligibility	No	No	Yes, 6 mos.	Yes, 12 mos.	Yes, 6 mos.	No	No	No	Yes, 6 mos.	Yes, 6 mos.
4) Retroactive Re-enrollment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Notable Features of Plan Participation	Tensions between LI and CP (CP receives fewer lives) in light of falling Medicaid rolls	Tensions between LI and CP (CP receives fewer lives) in light of falling Medicaid rolls	Potential for more plans dropping out after loss of two large commercial plans	Plans permitted to enroll in pre-enrollment process; Plans slated to receive all AE lives until parity is reached w/MediPass	Plans not happy about instability of plan membership and state allowances for free switches	Diversity of plans: clinic plans, federally-qualified HMOs and non-federally-qualified HMOs	Plans concerned about neutral development of MC+ broker role encouraged participation	Potential development of tribal health plan as competitor to 3 participating plans	Plans all losing money; concerns about future participation in Sooner-Care	Difficulty recruiting plans for rural areas

*It is important to note, however, that the commercial plan has two plan partners and the local initiative plan has seven plan partners for a total of eleven participating plans. Note: AE refers to auto-enrolled lives.

Unstable Enrollment Patterns and Declining Caseloads Are Troubling to Plans

Plans in the nine study states are uniformly troubled about two other enrollment-related issues:

- unstable enrollment patterns, including fluctuating and short eligibility periods, and
- fewer than expected covered lives caused by declining Medicaid caseloads.

Policies that might address these plan concerns, such as distribution of autoenrolled lives or periods of guaranteed eligibility and provisions for plan lock-in, have not been uniformly adopted by states (see Table 6 above), or have been implemented in a manner that does not alleviate the problems plans are experiencing.

For example, while five of the ten programs have some type of lock-in policy (i.e., Maryland, Michigan, New Mexico, Oklahoma, and Oregon), all but one of these states offer beneficiaries at least a 30-day period for switching plans without cause, thereby diluting the policy’s impact. The other study programs have policies that allow plan beneficiaries to switch plans anytime without cause. With respect to guaranteed eligibility, Table 6 shows that only three states, Maryland, Oklahoma, and Oregon, had policies guaranteeing six months of eligibility at the time of this study.¹⁰ Plan informants in both Maryland and Oklahoma, however, reported that the effectiveness of these policies is undermined by problems with information systems that cause uncertainty about where beneficiaries are actually enrolled and that subsequent switching tends to negate the value of guaranteed eligibility.¹¹

Similarly, autoenrollment policies, specifically, states' approaches to distributing autoenrolled lives among participating plans, do not provide strong incentives for plan participation, nor are they a critical factor in helping plans to enroll a critical mass of Medicaid members. Although plans are generally eager to respond to autoenrollment-related incentives such as awarding autoenrolled lives based on competitive bid scores, states do not use autoenrollment policies simply to encourage plan participation in general. To the contrary, states appear equally interested in supporting specific types of plans such as public plans or full-risk HMOs through autoenrollment incentives. Such policies establishing preferred distribution of autoenrolled lives for non-commercial plans frequently frustrate officials from commercial plans, who perceive that they are being placed at a disadvantage in the market.

Overall, there was little evidence that states have a difficult time getting plans to participate in their Medicaid managed care programs—these circumstances may explain the lack of importance afforded to enrollment policies as incentives. Plan officials in several states report that the general guarantee of large blocs of covered lives associated with mandatory managed care is the important factor in their participation. However, many plan representatives, as well as some state officials raised concerns about the ongoing participation of large commercial plans. For example, Connecticut, Oregon, and Missouri have all experienced the loss of major commercial plans from their Medicaid programs.¹² Plan withdrawal from Medicaid managed care due to a variety of reasons, including low Medicaid capitation rates and higher than expected costs, has become front-page news in many states.¹³ Consequently, these findings, based on information collected during the first six months of 1998 may become less informative as mandatory Medicaid managed care programs mature over time.

Beneficiary Choice Often Not Recognized By Plans As A Major Issue

Ensuring and/or promoting beneficiary choice of primary care provider is generally not a paramount concern for plans. However, to the extent that plans recognize that a lack of choice may lead to frustrated new plan members and impede plans' ability to get new plan members into care quickly, plans report increased concerns about beneficiary choice issues. Indeed, as discussed further in the following section, improving the enrollment process and enhancing beneficiary choice could go a long way toward ameliorating many of the concerns raised by plans.

Discussion and Conclusions

Improving the Enrollment Process and Enhancing Beneficiary Choice Can Ameliorate Beneficiaries' and Plans' Concerns About Participating in Medicaid Managed Care

States and plans are both dealing with the implications of the changing population served by the Medicaid program as well as the conflicting demands of developing and/or participating in the Medicaid market. Escalating monetary losses and increased competition for Medicaid lives have heightened plans' enrollment concerns, particularly regarding the need for stable plan membership. States' efforts to correct the lack of choice often inherent in the enrollment process by establishing liberal switch policies may well represent a commendable effort to promote

choice, however this study suggests that such policies may destabilize plan membership and frustrate plan participation. As the Medicaid market continues to shrink in terms of covered lives, and as plans grapple with unanticipated challenges, states will face increased pressure to modify certain aspects of their enrollment procedures to encourage plan participation.

Under current circumstances, the lack of education and explanation offered to beneficiaries during enrollment about managed care results in some beneficiaries not understanding the importance of choosing their plan and provider, or the implications of enrolling in managed care for how and where they seek care. Many beneficiaries are surprised to learn that managed care brings restrictions on where they can go for services and that they may not be able to see their current provider once enrolled in a plan. The lack of important information about which providers are available under participating plans undermines the ability of enrollees to make meaningful choices.

On the other hand, improving enrollment procedures and enhancing the ability of beneficiaries to choose their primary providers could potentially ameliorate plans' concerns and improve beneficiaries' experiences under mandatory managed care. For example, providing beneficiaries with accurate, timely information to make informed choices regarding their plans and providers could result in: 1) reduced provider switching by beneficiaries which introduces administrative complexities, and reduced plan switching, which is plainly undesirable to plans and something beyond their control so long as states maintain liberal switch policies; 2) improving beneficiaries' ability to use services more appropriately and reduce ER visits; 3) increasing beneficiaries' satisfaction with services; and 4) encouraging beneficiaries to make a greater effort to stay enrolled in Medicaid because they are satisfied with their health care. In addition to enhancing beneficiary choice, states' willingness to guarantee longer periods of Medicaid eligibility could result in plans' willingness to invest resources toward ensuring beneficiary choice in anticipation of having satisfied and well-functioning plan members for longer periods of time.

Implementing Effective Management Information System Technology Is Essential

Improvements in three areas could improve the enrollment process and enhance the ability, willingness, and capacity of beneficiaries to choose their providers and plans, and of plans to serve their members. First, solving the problem of inaccurate and/or inadequate information is critical to the basic integrity of managed care. States' often outdated and management information systems are at the root of many problems in the enrollment process, most notably: 1) the inability to maintain accurate and up-to-date information about provider networks; 2) the inability to communicate consistently between plans and providers about beneficiaries' status; and 3) the inability to record beneficiaries' choice and communicate their choice to plans. The use of sophisticated and well-designed management information systems could ameliorate most of these communication and information deficits.

An important question is whether states and plans can purchase the management information system (MIS) technology necessary to develop "real-time" provider network databases that can convey precise and up-to-date information to support timely informing and effective choice. The appropriate MIS technology could provide immediate electronic access to current provider

network information, and render the need for “hard copy” and cumbersome provider directories obsolete. Such an approach would require changes in enrollment procedures to ensure beneficiary access to electronic provider information.

Increasing Community-Based Outreach and Education Programs Could Improve Beneficiaries’ Ability to Navigate the Managed Care System

Second, the enrollment process could be enhanced by more face-to-face, community-based outreach and education programs that can give beneficiaries direct, accessible, and ongoing assistance with managed care enrollment, establishing provider relationships, and navigating the managed care system in general. As this report indicates, states are increasingly using CBOs during enrollment to improve beneficiary understanding of managed care and participation in enrollment. To the extent that beneficiaries seek to rely on their providers and community-based organizations for information and guidance during enrollment, and that states allow and/or promote such reliance, these entities will become increasingly significant factors influencing beneficiaries’ choice of providers and plans. These community-based efforts should be encouraged and funded as part of the overall administrative budget for state Medicaid managed care programs. The role of the broker and community-based organizations is particularly key in these efforts. To the extent that substantial responsibilities are awarded to these entities, state officials must provide adequate resources and training, and set clear guidelines for oversight and monitoring outcomes related to improved opportunities to choose providers. Indeed, beneficiaries and plans will both benefit if states require brokers to promote beneficiary choice and ensure that the information is timely and accurately conveyed to all parties involved.

Stressing the Importance of Choice and Education Among All Stakeholders Is Critical

Finally, ongoing and accessible education about choice and education in managed care, which involves all stakeholders, is necessary. Traditionally, many states have played a relatively passive role in educating beneficiaries about the health programs they offer. The complexities and novelty of new Medicaid managed care arrangements necessitate a more active educational role on the states’ part if beneficiaries are to fully realize the benefits managed care has to offer. Transitioning to a more active educational role may require some retraining of existing state program staff who are not accustomed to providing this service and may not fully appreciate its necessity.

Many beneficiaries express strong interest in understanding managed care along with a clear realization that this new program will affect how they access care, and that they need to know more than simply how to get enrolled. Certain types of beneficiaries (e.g., those whose first language is not English) may be more susceptible to waive opportunities to choose and/or to being unwilling to assert choice or get engaged in the managed care system without an appropriate intermediary, such as their provider or a CBO representative. On the other hand, it is likely that systematic improvements in the enrollment process will depend more on budget and market demands and less on the desire to inform and educate beneficiaries. The tradeoffs

necessitated by the tension between the pressures for cost-savings and the commitment to ensure real choice are increasingly recognized as a troubling dynamic in Medicaid managed care.¹⁴

Summary: Strategies for Improving Enrollment

Drawing from the responses of both plans and enrollees, the following strategies for improving enrollment and promoting and enhancing beneficiary choice emerge:

- ❖ Implementing up-to-date management information systems that can meet the needs of all participants in managed care for timely and accurate information about provider networks and beneficiary choices for plans and providers;
- ❖ Enhancing efforts for advance preparation for mandatory enrollment periods with comprehensive information and education available to all stakeholders;
- ❖ Imposing more responsibilities on, as well as providing more resources to, brokers to make choice of providers during enrollment more accessible;
- ❖ Ensuring that comprehensive provider information is available before mandatory enrollment begins with a particular focus on information required by persons with special needs;
- ❖ Ensuring that thorough explanations of provider networks are developed and available including how to access certain traditional providers (i.e., safety net providers) and specialty care;
- ❖ Allowing a greater role for providers in educating patients about managed care and helping them to enroll that balances provider abuse concerns with patient needs;
- ❖ Continuing to increase the role of, as well as resources allocated to and oversight of, community-based organizations, especially organizations associated with persons with special needs or with harder-to-serve populations, involved in the enrollment and education process; and
- ❖ Expanding periods of guaranteed Medicaid eligibility so that plans are assured longer periods of enrollment with new plan members.

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Appendix A

The research on which this policy brief is based used a case study approach in nine states to conduct a detailed examination of states' enrollment policies and practices under mandatory Medicaid managed care and of the enrollment experiences of Medicaid beneficiaries and managed care plans participating in mandatory Medicaid managed care programs.^{xv} Although not reported here, this study also involved an assessment of the effects of mandatory Medicaid managed care enrollment policies on federally qualified health centers (FQHCs) and their ability to survive a changing healthcare system.¹⁶ Site visits to the nine study states occurred during the first six months of 1998. States, selected to reflect a range of experiences with and types of mandatory Medicaid managed care programs, include: California, Connecticut, Florida, Maryland, Michigan, Missouri, New Mexico, Oklahoma, and Oregon.

The overall research goals were threefold: 1) to gain a better understanding of states' evolving enrollment policies and practices for their mandatory Medicaid managed care programs; 2) to assess the role played by enrollment in developing Medicaid managed care markets; and 3) to examine the experiences of Medicaid beneficiaries and of FQHCs as they are required to participate in mandatory Medicaid managed care programs.

Beneficiary experiences were assessed through a series of beneficiary focus groups in all but one state for a total of 24 focus groups with 162 participating beneficiaries. About one-quarter of these focus groups were deliberately composed exclusively of Hispanic, African American, Asian American, and HIV-infected Medicaid beneficiaries.¹⁷ Focus groups were not intended to, nor were they designed to, be representative of the experiences of all beneficiaries in a particular state or site. While the use of focus groups limits the generalizability of the study's findings, these focus group findings provide a picture of how these beneficiaries experienced enrollment under their states' mandatory Medicaid managed care programs and suggest insights about beneficiary experiences overall.

State policies and plan perspectives were assessed during the course of 10 site visits in the nine states through which representatives of three to four managed care plans were interviewed in each state, along with state Medicaid officials, FQHC representatives, and community advocates. Managed care plans were selected to include a variety of characteristics ranging from large for-profit plans with substantial managed care experience to provider/safety net-sponsored plans organized to deal with the advent of Medicaid managed care. The structured interviews were guided by protocols designed to solicit plan perspectives on these areas of interest: 1) how the enrollment process worked; 2) what kind of choices of plans and providers beneficiaries were able to make; 3) whether there were certain state enrollment policies and practices that affected the plans' willingness to participate; 4) whether the lack of beneficiary choice and/or the autoenrollment procedures created particular problems for the plans; and 5) how plans felt about their ongoing participation in Medicaid managed care.

Notes

- ¹Maloy, K.A., Rosenbaum, S., et al. (1997). *The Role of Autoenrollment in Mandatory Managed Care*. Washington, DC: The Center for Health Services Research and Policy, The George Washington University, October.
- ²Gawande, A., Blendon, R. et al. (1998). “Does Dissatisfaction with Health Plans Stem from Having No Choices?” *Health Affairs*. 17:5, September/October; Davis, K., Collins, K. et al. (1995). “Choice Matters: Enrollees’ Views of Their Health Plans.” *Health Affairs*. 14:2, Summer.
- ³Funding for this study was provided by the Center for Health Care Strategies, a Robert Wood Johnson Foundation-funded project, The David and Lucile Packard Foundation, the Kaiser Family Foundation, and the Health Resources and Services Administration’s Bureau of Primary Health Care.
- ⁴For a more complete description of the study upon which this report is based, see Appendix A.
- ⁵These findings are addressed in more detail in Maloy, K.A., Rosenbaum, S. et al. (1999). *Results of a Multi-Site Study of Mandatory Medicaid Managed Care Enrollment Systems: Implications for Policy and Practice*. Washington, DC: The Center for Health Services Research and Policy, The George Washington University, March.
- ⁶This finding is not surprising and is consistent with other evidence about the concerns of managed care enrollees. See Gawande et al. (1998) and Davis et al. (1995).
- ⁷The purpose of these short time frames (e.g., Connecticut requires assignment within five days) reportedly is to promote getting beneficiaries into care quickly.
- ⁸Pregnancy information is collected to support the common requirement that women in their third trimester be given the opportunity to continue with their existing provider.
- ⁹New Mexico informants provided the only specific report of community health centers (CHCs) providing lists of their former and current patients to plans to facilitate plan assignment based on prior provider. New Mexico informants also reported that at least one plan would rather assign to its “own centers” as providers and would not assign new enrollees to the CHCs; consequently the value of these CHC lists to plans was not clear.
- ¹⁰The Balanced Budget Act (BBA) permits states to guarantee six months’ enrollment to any managed care organization enrollee regardless of the federally qualified status of the member’s MCO, and also gives states the option to guarantee eligibility for children under 19.
- ¹¹Connecticut and Florida officials reported that they were planning to institute six month guaranteed eligibility in July 1998. According to the National Academy for State Health Policy, as of August 2000, Florida offers 6 month guaranteed eligibility and Connecticut offers 12 month guaranteed eligibility.⁹
- ¹²See generally Maloy, K.A., et al. (1999).
- ¹³See: National Public Radio Morning Edition piece 9/18/98 by John Hamilton referring to study by Robert Hurley examining plan withdrawal from Medicaid managed care programs. See also Peter Kilborn, “HMOs Are Cutting Back Coverage of the Poor and Elderly,” *New York Times* July 6, 1998 and Suzanne Felt-Lisk, “The Changing Medicaid Managed Care Market: Trends in Commercial Plans’ Participation,” *The Kaiser Commission on Medicaid and the Uninsured*, May 1999.
- ¹⁴Fraser, I., Chait, E., Brach, C. (1998). “Promoting Choice: Lessons from Managed Medicaid.” *Health Affairs*. 17:5, September/October.
- ¹⁵Funding for this study was provided by the Center for Health Care Strategies, a Robert Wood Johnson Foundation-funded project, The David and Lucile Packard Foundation, the Kaiser Family Foundation, and the Health Resources and Services Administration’s Bureau of Primary Health Care.
- ¹⁶The complete findings of this study are reported in detail in Maloy, K.A., et al. (1999), available from the author.
- ¹⁷The results of the focus groups with HIV-infected beneficiaries are reported in detail in Kenney, K., Maloy, K.A., et al. (1999). *Experiences of HIV-Infected Beneficiaries in the Move to Mandatory Medicaid Managed Care in Three States*. Washington, DC: The Center for Health Services Research and Policy, The George Washington University, April.

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