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NATIONAL HEALTH LAW PROGRAM

**Fact Sheet # 1**

# Medicaid Managed Care: Enrollment and Education

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## Introduction

Medicaid managed care plans operate in 47 states and the District of Columbia, enrolling a total of 71% of all Medicaid beneficiaries. When Medicaid expands in 2014, many of the newly eligible beneficiaries will likely enroll in Medicaid managed care plans. This series outlines basic principles of managed care enrollment and education to help beneficiaries and advocates get the most out of Medicaid managed care and hold the plans and state Medicaid agencies accountable.

This Fact Sheet addresses the following topics: choosing a health plan, consumer education, fraudulent and deceptive marketing practices, enrollment brokers, automatic assignment, and disenrollment.

## Choosing a Health Plan

***The Law Says:***

- Enrollment process must link Medicaid beneficiaries with a health plan that is available and accessible to all enrollees (42 U.S.C. § 1396n(b); 42 C.F.R. § 438.206(a)).
- Services should be sufficient in amount, duration, and scope to reasonably achieve the purpose for which they are offered (42 U.S.C. 1396u-2(b)(5); 42 C.F.R § 438.207).
- State Medicaid agencies must monitor enrollment, termination, and grievance procedures (42 U.S.C. § 1396u-2(c)(1)(A)(iii); 42 C.F.R. §§ 438.66(b), 438.416)
- Managed care health plans must provide access to services comparable to those in traditional Medicaid (42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. § 438.206).
- State Medicaid agencies must provide, annually and upon request, a chart comparing managed care plan benefits, cost sharing (if any) as well as quality and performance indicators (42 U.S.C. § 1396u-2(a)(5)(C); 42 C.F.R. § 438.10(i)).

***There Can Be Problems:***

- Beneficiaries are often not informed of the health plan choices available to them.
- Poorly chosen health plans and hasty enrollment lead to confusion, dissatisfaction, unmet needs, heavy turnover, and grievances.
- Enrollment functions may be poorly staffed and lack adequate technological resources.
- Managed care organizations often emphasize enrollment in any plan over consumer education about managed care and how to choose the right plan.
- State Medicaid agencies hastily enroll beneficiaries (e.g. people with disabilities and children with special needs) with whom managed care plans have little experience.
- Families with adolescents have lost access to confidential school-based and teen clinic programs.

***Consumer Protections Are Needed Now:***

- State Medicaid agencies should make greater use of online resources and face-to-face interviews so enrollment specialists can explain health plan options.
- Consumer education should be ongoing and inform people of their options, rights, and responsibilities in easy-to-understand language.
- State Medicaid agencies should ensure uniform health plan descriptions so that people can easily make side by side comparisons.
- People should be given adequate time to choose a plan and people with disabilities should be given a longer period.
- Enrollment of high-need populations into health plans should be phased-in and closely monitored as program gains experience.
- State Medicaid agencies need to have well-defined enrollment policies with clear lines of responsibility and adequate funding.
- Managed care systems should include school-based and teen clinic programs that adolescents can self-select.

## Consumer Education

### *The Law Says:*

- Managed care plans must provide potential enrollees with a description of plans' rules, procedures, benefits, services, and all other information needed, in clear, easy-to-understand language, to make an informed enrollment decision (42 C.F.R. § 438.10).
- States and managed care organizations must make materials available in prevalent non-English languages and provide oral translation services for free. (42 C.F.R. § 438.10(c)).
- State Medicaid agencies must consult the state Medical Care Advisory Committee when reviewing managed care marketing materials (42 C.F.R. § 438.104(c)).

### *There Can Be Problems:*

- Managed care programs have made hasty enrollment the goal over proper consumer education.
- Beneficiaries do not understand how managed care plans work and they continue to use emergency rooms for routine care.
- State Medicaid agencies and managed care plans have not devoted adequate staffing to consumer education.
- State Medicaid agencies and managed care plans do a poor job conveying complex managed care information to the Medicaid populations, particularly those with limited English-speaking ability and high levels of illiteracy.

### *Consumer Protections Are Needed Now:*

- State Medicaid agencies, health plans, providers, and advocates must dedicate both trained staff and adequate resources towards patient education.
- Face-to-face consumer education at enrollment sites, health plans, housing authorities, and community centers must be maximized.
- Consumers should press the state for review and input on drafts of written educational materials.
- All printed consumer education materials should be provided in easy-to-understand language and highly visible formats, pre-tested for readability, competently translated for non-English speaking beneficiaries and available in alternative formats (e.g. Braille, TTY, large print, audio formats).
- State Medicaid agencies should develop easy-to-read charts comparing available health plans and questions to ask prior to choosing a plan.
- Enrollment workers need to provide potential enrollees with accurate lists of available providers, transportation services, and physically accessible sites.

- State Medicaid agencies should require managed care programs to periodically update their provider lists.
- Health Plans must have a member services department that is courteous and can speak the languages of plan members (through competent bilingual staff or interpreters).
- Consumer education should be ongoing and inform beneficiaries to better understand how to use, and if necessary, complain about managed care programs.
- New plan members should be periodically and randomly sampled by an independent entity to verify their understanding of plan provisions.
- States should require each health plan to provide its members with an up-to-date handbook that describes plan operation that has been approved by the state.

## Fraudulent and Deceptive Marketing Practices

### *The Law Says:*

- Managed care plans can't use marketing that is inaccurate or confusing. (42 C.F.R. § 438.104(b)(2))
- Managed care organizations can’t market their plans by contacting potential enrollees through cold calls or door-to-door marketing (42 C.F.R. § 438.104(b)(1)(v)).
- States need to monitor marketing by managed care plans. (42 C.F.R. § 438.66).

### *There Can Be Problems:*

- Managed care plans have told Medicaid recipients things that aren't true:
  - "You can keep your own doctor."
  - "You can get all your services at one single site."
  - "You can leave the plan anytime you want."
  - "You will lose Medicaid if you don't sign up with us."
- Managed care plans have offered gifts to people to get them to enroll: hair products, chicken dinners, scout troop enrollment, smoke detectors.
- Managed care plans have harassed people at home, in grocery stores, at automatic teller bank machines.

### *Consumer Protections Are Needed Now:*

Managed care contracts, rules, and guidelines need to:

- require managed care plans to comply with the laws;
- prohibit door-to-door marketing by managed care plans;
- prohibit gifts and prizes to get people to enroll;
- require managed care plans to report the gifts they use and who received them;
- require the state to approve all marketing materials in advance of their use;
- set up toll-free telephone lines to field concerns;
- sanction plans that break the rules by halting new enrollment, disenrolling the victims of fraud and letting them choose another plan, using money penalties against the plan, terminating the plan from Medicaid;
- report to the state, the media, and to other consumers and consumer organizations if you are the victim of fraud; and
- create a story bank of marketing activities.

## Enrollment Brokers

States frequently contract the education and enrollment function to private companies, commonly referred to as "enrollment brokers."

***The Law Says:***

- States are allowed to contract the enrollment function to enrollment brokers (42 U.S.C. § 1396u-2(a)(4)).

***There Can Be Problems:***

- Enrollment brokers are selected by the state based on their computer processing capabilities rather than their client education and assistance skills.
- Rather than emphasizing face-to-face counseling, enrollment brokers over-utilize the mail and telephone in outreach and enrollment activities.
- Managers whose salaries are linked to enrollment quotas deliver cursory, ineffective information and client education and aim only to get people to sign up with a plan (not necessarily the right plan).
- Toll-free health and information lines often lack appropriately trained personnel and adequate bilingual staffing.
- Contracts with enrollment brokers are often incomplete leading to confusion over important program responsibilities such as education, material development, EPSDT outreach and informing, disenrollment, and complaint processing.
- Enrollment brokers rely too heavily on auto-assignment.

***Consumer Protections Are Needed Now:***

- Plans should emphasize face-to-face enrollment and telephone or mail-in enrollment should only be allowed in limited situations, such as after a face-to-face interview or for homebound populations.
- Staffing at health benefits counselors' offices should reflect the ethnic, linguistic, and cultural demographics of the population served.
- Requests for proposals and model contracts for benefits managers should be comprehensive and clear. States should compare the model contracts against the actual contracts used for health plans.
- States should review and approve all written materials developed by the health benefits managers prior to first use.
- States should monitor performance, payments to, and future contracting with health benefits managers and should measure these against pre-set objective criteria (for example, auto-assignment and disenrollment rates).

- Consumer representatives should press the state to include them on the review committee that selects the health benefits managers.

## Automatic Assignment

### *The Law Says:*

- States may auto-assign beneficiaries who are required to enroll in managed care if they do not choose a plan within a prescribed length of time (42 U.S.C. § 1396u-2(a)(4)(D)(i); 42 C.F.R. § 438.50(f)(1)).
- States must consider existing provider-patient relationships when auto-assigning beneficiaries into managed care plans (42 U.S.C. § 1396u-2(a)(4)(D)(ii)(I); 42 C.F.R. § 438.50(f)(2)).

### *There Can Be Problems:*

- Auto-assigned beneficiaries are often left on their own to figure out how their new health plan works.
- Beneficiaries who are auto-enrolled are assigned to low bidding, inadequately financed managed care plans.
- States' auto-assignment procedures do not account for beneficiaries' recent use of providers, distance of plans from home or limited-English speaking abilities.
- Auto-assignment is viewed by states as an alternative to client education.
- Auto-assignment often results in separating family members into different managed care plans, unnecessarily burdening individuals with multiple providers and extended wait times.

### *Consumer Protections Are Needed Now:*

- Managed care plans should minimally use auto-assignment and maximize client education so that no more than 5-10% of the population will be auto-assigned.
- Populations in active care (e.g. pregnant women) or with special health care needs must never be auto-assigned to a health plan.
- Auto-assignment processes should rotate beneficiaries among participating plans based on provider history, geography, travel time, language needs, special circumstances and plan performance.
- Beneficiaries who are auto-enrolled must be allowed to disenroll from the assigned plan and choose their own plan within appropriate timeframes (e.g. within 10 days after receiving notice of automatic assignment; within 60 days of first use of plan; for good cause at any time).
- States should utilize auto-enrollment performance indicators as part of a comprehensive quality assessment of health plans and should never auto-assign to low-performance plans.
- States should encourage managed care plans to conduct face-to-face outreach and education activities to minimize auto-enrollment.

## Disenrollment

### *The Law Says:*

- Beneficiaries can leave a health plan during open enrollment, within 90 days of auto-enrollment, and at any time for cause (42 C.F.R. § 438.56(c)).
- States must monitor plans' enrollment practices (42 C.F.R. § 438.66).

### *There Can Be Problems:*

Managed Care Plans may:

- improperly disenroll members who develop serious health needs;
- stall the disenrollment of healthy children;
- decline to provide disenrollment forms or lose forms that are filed;
- fail to transmit disenrollment requests to the state;
- refuse to discuss disenrollment requests and/or are rude and disrespectful;
- place callers on endless telephone hold when attempting to disenroll; and
- have inadequate procedures for disenrolling.

### *Consumer Protections Are Needed Now:*

State Medicaid agencies need to place disenrollment guidelines in rules and contracts which provide for:

- elimination of arbitrary disenrollment;
- no requirement that beneficiaries must exhaust health plan's grievance system to disenroll;
- a grace period to disenroll (e.g. within first five days of enrollment; within 30 days of first use, especially where member was automatically assigned);
- determination of timeframe and notice for disenrollment;
- disenrollment carried out by the state agency, not the health plan;
- disenrollment allowed at any time for cause, loss of Medicaid eligibility, move out of service area, or death;
- disenrollment for "good cause" to include: delay in needed services, substandard services, and marketing abuses;
- emergency, expedited, and retroactive disenrollments (especially in cases of delay in urgent medical needs and marketing abuses);
- mandatory consumer satisfaction surveys of beneficiaries who disenroll; and
- collection of disenrollment data to use as a quality of care indicator.

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