Outreach, Marketing, Enrollment and Disenrollment Policies in Medicaid Managed Care: *A Summary of a 1996 Survey of Medicaid Agencies*

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Cornell University

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Introduction

The focus of this paper is on enrollment and disenrollment policy and practice in Medicaid managed care. Specifically, this paper examines policies and practices in risk-based programs with attention to Primary Care Case Management (PCCM) program policies only as they specifically interact with risk-based enrollment policies. In risk-based managed care, a Medicaid agency contracts with an entity (the contractor) to provide or arrange for the provision of an agreed upon set of services in exchange for a set fee per person enrolled per month where the prepaid fee does not vary month to month based on services used by the individual enrollee. In other words, in risk-based managed care the contractor assumes some level of financial risk for providing care to enrollees. A PCCM program in this discussion refers to a fee-for-service system where Medicaid pays a nominal amount per PCCM enrollee per month to the provider/care manager in addition to per service fees.

The basis for this work is a survey conducted in the fall of 1996 concerning program characteristics of each state's Medicaid managed care program. The survey was designed to query about these programs at one point in time, June 30, 1996.[1] This paper highlights the sections of the survey results concerning enrollment: who is enrolled and how they are enrolled. Aspects of disenrollment policy and practice are drawn from this survey as well as from other NASHP work on disenrollment policy, *Enrollment and Disenrollment Policy in Medicaid Managed Care Program Management*, 1996. The report also builds on NASHP survey work on Medicaid managed care in 1990 and 1994.

Even though this paper is based on state practices as or June 1996, the Balanced Budget Act of 1997 (BBA, P.L. 105-33) will change how states conduct outreach, enrollment, and disenrollment in some instances. These changes are noted in the paper. Further, the BBA created a new state/federal program for providing health care coverage for children not otherwise eligible for Medicaid. This will result in new and renewed outreach efforts, that will most likely build on current state outreach programs. How states may approach outreach for the new program is also briefly addressed.

Who Is Enrolled?

Thirty-eight states[2] reported operating one or more risk-based managed care programs in 1996, which is up from 32 and 28 states in our 1994 and 1990 surveys, respectively.[3]

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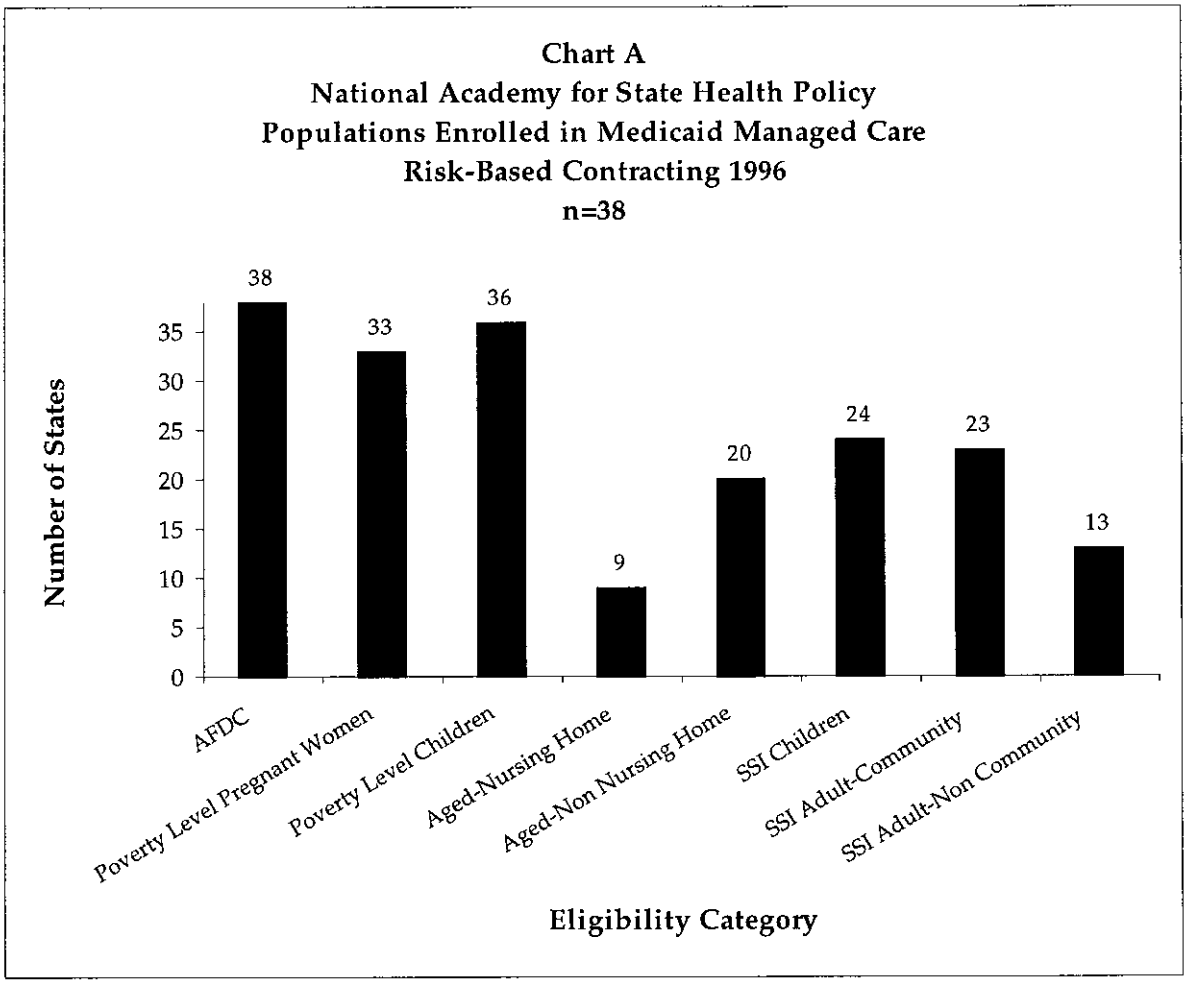
[1]The full survey results are found in *Medicaid Managed Care: A Guide for States*. 3rd Edition. NASHP. Portland ME.

[2]The term "states" also includes the District of Columbia.

[3]A partially capitated program in California was reported as a PCCM program in 1994 but has been categorized as a risk program for reporting on the 1996 survey.

The 1996 survey also showed that with the growth of risk-based programs, there has been a growth in mandatory enrollment policies, and that enrollment policies have become more complex given the growing complexity of state Medicaid managed care programs. This is discussed in more detail later in this paper.



AFDC[4] *and Poverty-Level Children and Pregnant Women*

Chart A shows that all 38 risk contracting states enroll the AFDC population (up from 30 in 1994 and 27 in 1990). Thirty-three states include poverty level pregnant women in their risk contracting (Georgia, Illinois, Maryland, Nebraska and South Carolina do

[4]This paper uses the term 'AFDC' (Aid to Families with Dependent Children) instead of 'TANF' (Transitional Assistance for Needy Families)because that designation was current at the time of the survey.

not); 36 states include poverty level children in their risk programs (Alabama and Illinois do not).

SSI Children[5]

Risk-based contracting for SSI eligible children also grew (doubled) since our 1994 survey: 24 states reported risk contracting for SSI children in 1996 compared to 12 in 1994 and nine in 1990. Of the 24 risk contracting states, three (Iowa, North Carolina,[6] and Washington) do only partial risk for this group and full risk for all other enrolling children. South Carolina does partial risk for this group as it does for all risk-based enrollees. The growth in the number of states enrolling this group demonstrates state interest in folding more of the total Medicaid population into managed care arrangements together with increased knowledge of how to address the complex needs of this group.

Elderly

Nine states reported conducting risk-based managed care programs for the institutional elderly in 1996 — which is the same number as in 1994 although the reporting states have changed since 1994. Six states reported such programs in our 1990 report. The 1996 reporting states are Arizona, California, Florida, Minnesota, Nevada, Oregon, Tennessee, Utah and Wisconsin.[7]

For the elderly living in the community, 20 states[8] have risk programs which is the same as in 1994 and compares to 11 states in 1990.

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[5]The 1994 survey asked for information about special needs children. Unfortunately there was some inconsistency among states as to the definition of special needs. Therefore the 1996 survey asked states to report information about SSI children. (Those children who receive Medicaid due to SSI eligibility.)

[6]North Carolina enrolls special needs children into their Medicaid managed care program and reported these children as part of the SSI-Children eligibility group in this survey.

[7]The 1994 reporting states were Arizona, California, Colorado, Michigan, Minnesota, Nevada, Oregon, Tennessee, and Utah.

[8]This count does not include Michigan. This State includes those people who are AFDC or SSI eligible and over 65 in their managed care programs for the AFDC and SSI eligibility groups and therefore did not report operating a program for the Aged group — even though Aged individuals are enrolled in managed care.

Disability Groups[9]

In addition to the 24 states that operate risk contracting programs for SSI children, 23 operate risk programs for SSI adults in community. While most states operate a risk program for both groups, the District and North Carolina[10] operate programs for SSI children but not adults, while Alabama operates a risk program only for some adults (pregnant women). Overall, this is substantial growth since 1994, when there were 15 states with risk programs for one or more groups of the disabled.

Trends in Categories of Enrollment

In general, a significant development since 1994 in terms of states participating in Medicaid managed care is the growth of risk-based programs that include, or are designed specifically for, the disabled (23-24 states with risk-based programs for SSI relative to 15 in 1994). This shows an evolution in the growth of Medicaid risk-based managed care to include more of the populations with complex (and often costly) health, medical, and social service needs. This is in contrast to one of the more significant findings of the 1994 survey, which was the growth in PCCM programs for the disabled between 1990 and 1994.

While managed care developments affecting the elderly paralleled developments for the disabled populations between 1990 and 1994, there has been less movement of the elderly into risk-based contracting arrangements since 1994, relative to the disabled populations. While the exact reasons for this difference is not clear from the survey, it may be due to the greater prevalence of Medicare coverage among the elderly poor (relative to SSI group eligibility) and the complications that arise in risk contracting for those who are dually eligible (eligible for both Medicare and Medicaid).

Who Must and Who May Enroll?

When reviewing the state-reported information concerning whether state programs are voluntary or mandatory, it is important to keep several points in mind. The most

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[9]Unfortunately care must be taken in the interpretation of these numbers. In 1994, the survey instrument included questions about blind and disabled, mentally ill, and MR/DD as distinct eligibility/enrollment groups. After the 1994 survey many states reported that they did not make distinctions among the SSI population based on the specific "diagnosis" group. Instead they focused on whether or not an individual was in the community. Therefore, the 1996 survey was changed to accommodate state operations by collecting information about SSI children, SSI adults-in the community; and SSI adults-not in the community. This necessary change made multi-year comparisons about disability eligibility group participation in Medicaid managed care difficult.

[10]As previously discussed, North Carolina reported Special Needs Children as SSI-Children in this survey.

straightforward structure is where enrollment in a state's managed care program is either voluntary or mandatory (whether it includes HMO and PCCM or either one exclusively). However, a number of the states that operate programs offering both PCCM and HMO alternatives in the same area have implemented systems where enrollment in an HMO is voluntary but PCCM enrollment is mandatory. (In these states beneficiaries who do not select an HMO are assigned to a PCCM provider.) Or enrollment in HMO may be mandatory in urban areas and voluntary in rural areas.

Further, a state may have different rules in different geographic areas of a state. For example, in one region the demographics may only support one risk-based managed care plan, in which case enrollment would (almost always) be voluntary[11] if the state chose not to supplement with a PCCM program. In another area of the same state, there may be several managed care plans from which to choose, in which case enrollment in an HMO could be mandatory. So enrollment rules may vary by geography and by population so that some Medicaid eligibles are required to enroll while others are not.

The Balanced Budget Act of 1997 now permits states to enroll almost all groups of Medicaid eligibles into risk-based managed care without requiring a waiver to do so. The groups for whom a waiver is still required in order to mandatorily enroll include: children with special health care needs, children in out of home placements or in subsidized adoption, SSI recipients, Medicare eligibles, and technology dependent children receiving services at home (Katie Beckett eligibles) and Indians except in certain circumstances. Beneficiary choice among health plans is still generally required although there are specific exceptions in federal law.

Most states reported risk-based program enrollment policies consistent across all eligibility groups and most states reported operating mandatory programs. The exceptions where enrollment policy varies by population group are: the District (the program for special needs children is voluntary); Montana (mandatory for adults but not children); and New Jersey, Ohio, and Wisconsin (optional for SSI related groups).

As shown in chart B, 31 of 38 risk program states have mandatory enrollment

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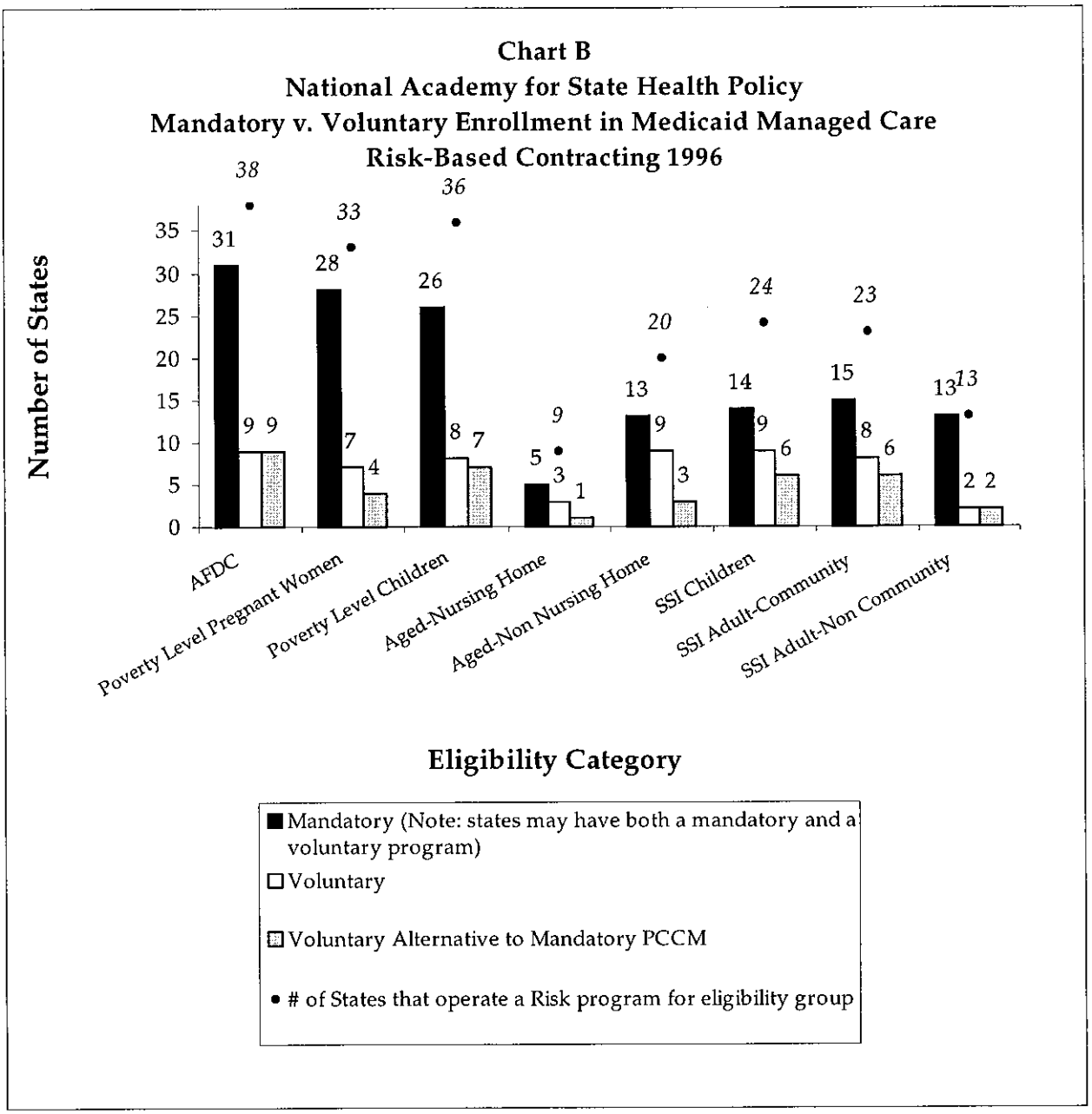
[11]Until recently, states could not avoid the freedom of choice requirement, even under the broad authority and discretion of 1115 waivers. Most recently however, the HCFA has granted two waivers (to Kentucky and Illinois) that limit freedom of choice when there is only one HMO. The Balanced Budget Act amendments of 1997 changed federal law so that waivers are not required to mandatorily enroll all but a few groups, but choice of plans (or plan and PCCM) is still generally required with modifications for rural areas.

programs[12] — enrollment with a risk contractor is mandatory if no other selection is made (such as PCCM). Or in the case of a state like Massachusetts, enrollment into a mental health risk contractor is mandatory if a beneficiary selects a PCCM provider as a source of primary care.



[12]This number includes Iowa, where enrollment into the mental health risk-based program is mandatory.

Of these 31 mandatory enrollment states, 13 also operate voluntary HMO enrollment programs. In California, Michigan, and Pennsylvania the voluntary/mandatory policy is determined by geography. In the District, Montana, and New Jersey, the enrollment policy is applied by eligibility group. In New York, Ohio and Wisconsin, the enrollment policy is based both on geography and eligibility group. In four states (Iowa, Massachusetts, North Carolina, and Colorado) enrollment in a general health MCO is voluntary, but, as discussed earlier, mental health risk program enrollment is mandatory if a beneficiary selects the PCCM program. This mandatory enrollment requirement can vary by geography, as in the case of Colorado, or by eligibility group, as in the case of Iowa.

In addition, in nine other states, HMO enrollment is a voluntary alternative to mandatory PCCM enrollment (Florida, Georgia, Iowa, Maryland, Massachusetts, Michigan, Montana, North Carolina, and Virginia) for some or all groups. In the case of least Massachusetts, this equates with the HMO program as the voluntary alternative to PCCM/risk-based mental health program. There were eight states where PCCM was mandatory and risk-based voluntary in 1994.

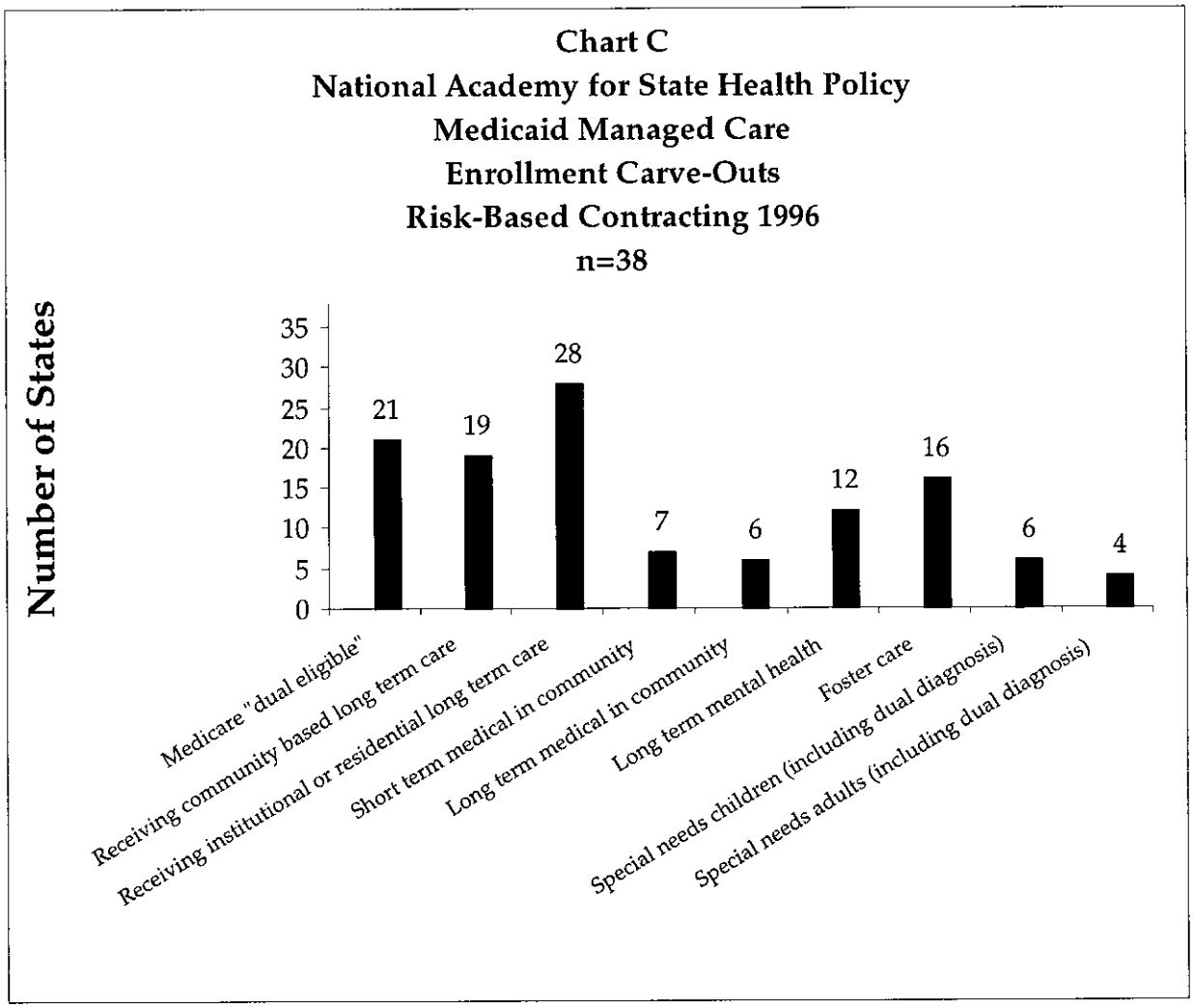
One aspect of mandatory enrollment is auto-assignment wherein if a beneficiary fails to make a selection of provider or health plan, they are automatically assigned to one. Of the 31 states reporting mandatory enrollment into a risk-based MCO, 27 states reported auto-assigning beneficiaries to a plan if no specific choice of plan was made. Two more states, Colorado and Iowa, have mandatory enrollment in a mental health MCO which is automatic if a person chooses a PCCM option, but because there is no 'choice' of the mental health plan, they did not report having an auto-assignment function.

The NASHP work on state disenrollment policies (mentioned previously) highlights how states generally try to minimize the extent to which auto-assignment is employed. Some states provide a long time period in which the beneficiary can make a selection, others use intensive forms of outreach and education in order to encourage a beneficiary to make an informed selection of health plan or provider. These important activities are discussed in more detail below. Because it is difficult to compare auto-assignment rates across states due to varying state definition and methods of counting, it is difficult to know which informing and enrollment practices work best to minimize auto-assignment.

Who is Prohibited from Enrolling and Who May Opt Out?

In addition to basic voluntary or mandatory enrollment policies, certain subgroups can be either prohibited from enrolling into Medicaid managed care or allowed to disenroll from an otherwise mandatory program. These programs are often referred to as enrollment carve-outs. In general, carve-outs are designed to minimize administrative

complexity (such as when a person may have more than one source of health care coverage), avoid a situation of duplicate payments for services (if a Medicaid payment for institutionalized beneficiaries already includes health services), or acknowledge that the managed care system may not be adequate to meet the needs of certain groups (chronically ill children for example). As shown in chart C, one of the most common carve-out among states are people who are eligible for Medicare, where 21 states prohibited enrollment into risk-based programs, (six other states permitted disenrollment. Twenty-eight prohibited enrollment of institutionalized Medicaid



beneficiaries (eight states permitted them to disenroll).

Twenty states prohibited enrollment of people with private sector managed care coverage (six states permitted disenrollment in this case). Eleven states prohibited enrollment of people with any other comprehensive health insurance (while three states

permitted disenrollment). More states permitted/required enrollment of people with general health insurance than permitted enrollment of people with managed care coverage because coordinating benefits with private sector managed care is viewed as more administratively difficult than coordinating with other private sector indemnity coverage. It is difficult to get two managed care systems to work together because of the structure of the managed care system, public or private (administration and payments).

In other enrollment prohibitions, sixteen states prohibited enrollment of children in the foster care system, but only six prohibited enrollment of special needs children (whereas seven states permitted foster child disenrollment from mandatory programs and four allowed special needs children disenrollment). Children in foster care are generally considered to be a subgroup of children with special needs so it is interesting that they are treated separately.

How are Beneficiaries Informed and Enrolled (Marketing And Outreach)?

Who informs beneficiaries of their choices and obligations, and who actually enrolls them into a managed care plan is as important a policy consideration for states as decisions about who should be enrolled and whether the program is voluntary or mandatory.

Helping a Medicaid beneficiary select the health plan or program that can meet his or her needs is the first step in the enrollment process There are two questions that states must answer as they work toward that goal. They are:

- What information do beneficiaries need?
- What are the best means for getting this information to beneficiaries?

Answering either question can be problematic for a variety of reasons. States face major difficulties when providing information to enrollees because different information has a different level of importance for each beneficiary. Information about copayments or pharmacies may be important for some, while access to certain hospitals or specialists may be important to others. Some beneficiaries may not understand the fundamental difference in the PCCM and HMO delivery systems while this is well understood by others. In addition, Medicaid beneficiaries frequently change addresses, may not have a phone, and have many other issues that they may, at the time, consider to be more pressing (e.g., food, shelter, and heat). Finally, as mentioned in the introduction, Medicaid beneficiaries tend to have lower literacy and reading comprehension levels than the general population (or, may be literate but only in a language other than English or Spanish).

All of these factors combine to mean that in an ideal situation each beneficiary would receive information that facilitates comparison only on the variables important to the individual and that the beneficiary would understand the information as presented. Unfortunately, this is not practical unless a state has unlimited funding *and* unlimited time. Instead, states provide a range of information using a variety of techniques, at different times, in different places, and from different people.

Who Informs?

There are some significant changes in informing (outreach, marketing and enrollment) since the 1994 survey. In 1994, most risk-contracting states reported that both the government and health plans shared responsibility for marketing. In 1996, less than half (16 states) have both the health plan and government involved. Ten states (Alabama, Arizona, Colorado, Kansas, Nevada, New Hampshire, Oregon, Rhode Island, Utah, and Washington) reported relying solely on government for marketing and outreach; there were three such states in 1994. Twenty-one states reported that the contracted health plan was responsible for marketing, but only Michigan relied solely on the plan. Ten other states (Georgia, Illinois, Indiana, Michigan, Missouri, Montana, North Carolina, Pennsylvania, Texas, and Virginia) have no government involvement in actual outreach and marketing but rely on health plan and/or health benefit managers. A subset of this group, (Illinois, Indiana, Montana, and Texas) rely on both a benefits manager and health plans exclusively. Only one state, Michigan, leaves the marketing solely up to the health plans with no government or health benefit manager involvement. Chart D demonstrates the range of entities that states used to inform beneficiaries in 1996.

One strategy for informing beneficiaries of their health plan choices is in decline — informing through the plan. States curtailed plan activities because of past marketing abuses by some plan marketing representatives and to ensure that enrollees receive a balanced presentation, the goal of which is to enroll the beneficiary into the plan that best meets his needs — not the plan that best meets the marketing representative's needs. As of June 30, 1996, only four states (Ohio, the District-for its program for SSI children, Illinois, and Michigan) continued to allow door-to-door marketing by plans. This is down from eight in 1994.

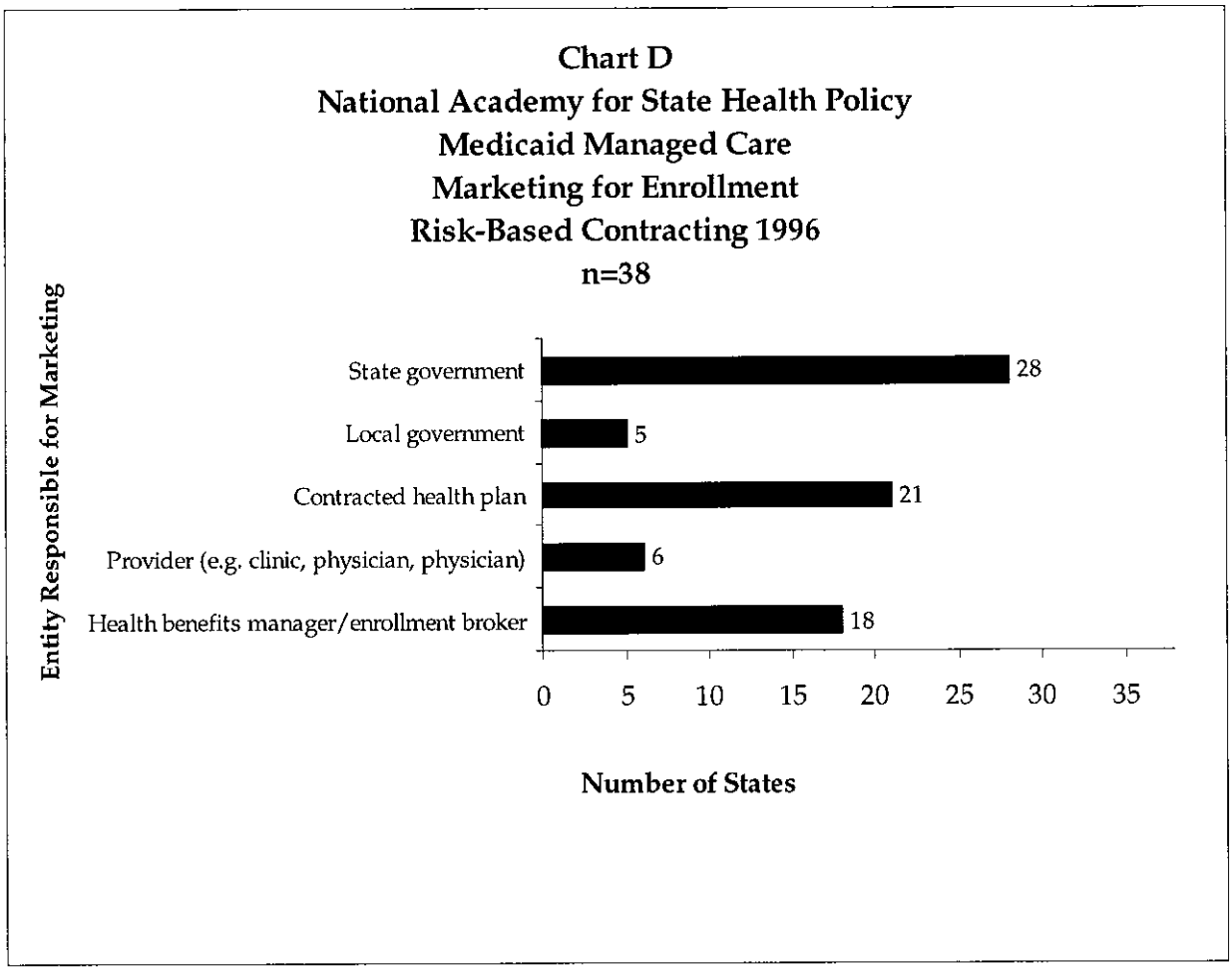
The Balanced Budget Act of 1997 changed existing Medicaid law to prohibit the use of cold call marketing by a Medicaid managed care entity so that plan representatives may not directly contact potential enrollees via phone or door to door marketing to get them to enroll in the particular health plan. States that have relied on this approach in whole or in part will have to re-orient their marketing strategies.

A significant change since 1994 is use of health benefit managers (HBM) in risk contracting programs — eight states reported using them in 1994 which has jumped to 18 in 1996. Five states (Georgia, Missouri, North Carolina, Pennsylvania, and Virginia)

report that responsibility for marketing lies solely with a private HBM for all populations; whereas only Massachusetts reported this situation in 1994. In Massachusetts today, the HBM, state government, and health plans are used, depending on the enrolled population.

The increased use of enrollment brokers is due to a number of factors. The primary reasons are: (1) state interest in having a neutral party that can present the full range of options to each beneficiary in an individualized discussion, and (2) the difficulty of getting authority to hire state staff to perform these functions. Additionally, states report that the use of enrollment brokers has been the most practical route toward meeting the previously discussed ideal informing practice. (Individualized information designed to ensure beneficiary understanding.)

New Jersey and Indiana use enrollment brokers in combination with direct plan marketing activities. (Plan marketing ability is strictly limited. For example, in New Jersey plans may *not* market in the eligibility offices or use door-to-door marketing.) Allowing plans to market directly gives the plan a chance to talk directly to the enrollee



before enrollment. Plans marketing representatives help enrollees select a primary care provider and begin educating enrollees about how to access care. But both states also require that all *enrollment* be done by the enrollment broker, either in-person or over the phone. This gives the enrollment broker an opportunity to ensure that all enrollees understand their full range of options.

Where Beneficiaries Are Informed

Among states operating risk-based programs, only three reported *not* using the welfare/eligibility office for marketing, outreach, or enrollment (although all use other locations). They are Alabama, Arizona, and Maryland.[13] The frequency with which states use this location for outreach reflects the fact that this is one of the few locations where Medicaid beneficiaries can always be found, particularly those that are newly determined eligible for Medicaid and most likely to need to select a plan. (This may change as states implement the new welfare reform laws which break the existing link between eligibility for cash grants and Medicaid.) Four risk-contracting states (Nevada, New Hampshire, Pennsylvania, and Rhode Island) reported that the eligibility office was the *only* place of interaction although most of these states use direct mail as well. Most states reported using the eligibility office in combination with other forms of interpersonal outreach and marketing.

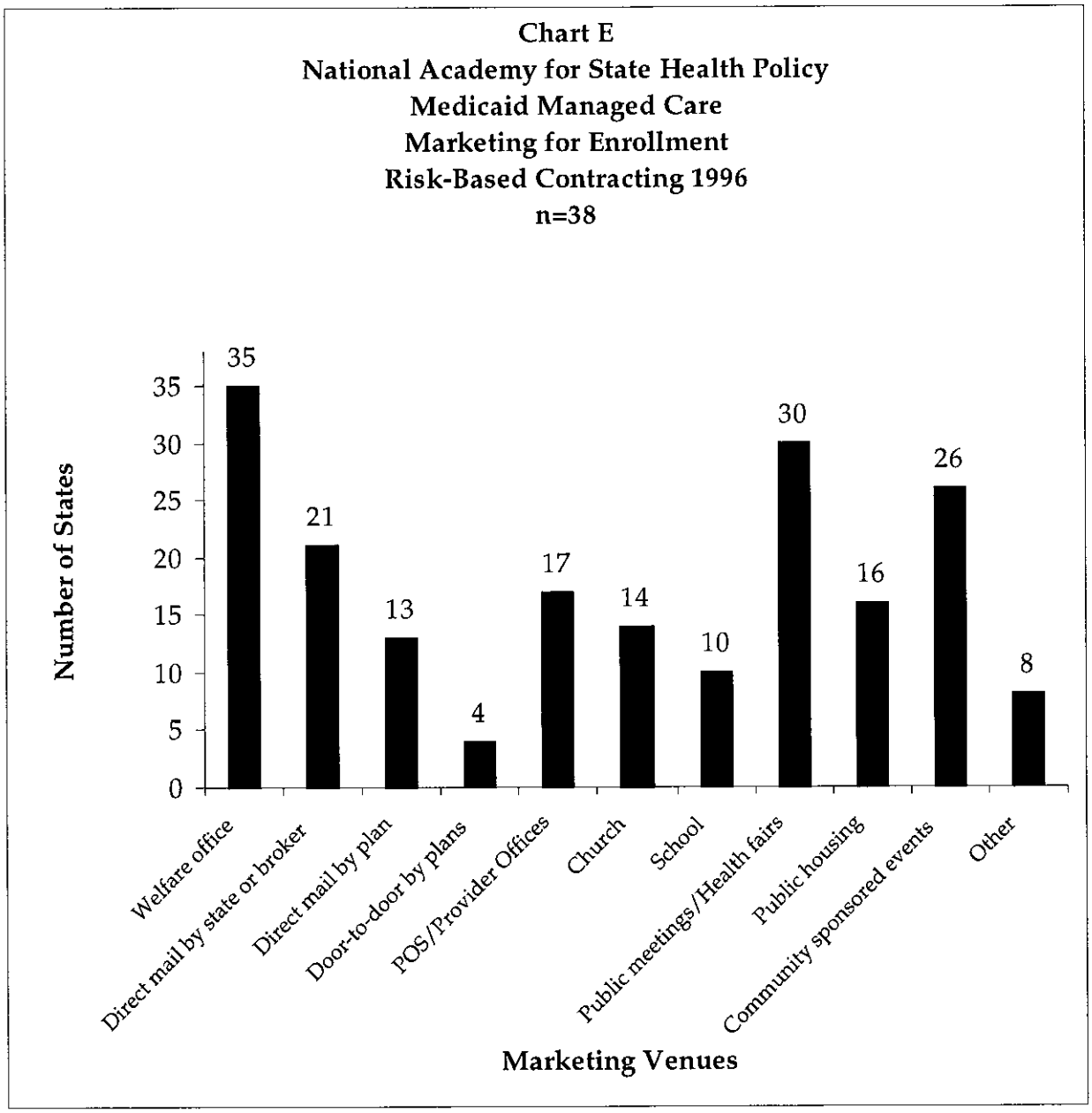
A drawback to using eligibility offices (other than potential effects of welfare reform) is that many beneficiaries may not see the person responsible for helping them select a health plan until after they have completed the eligibility determination process. Since completing that process frequently requires several hours (especially when waiting time is included) beneficiaries may not pay a sufficient amount of attention to plan selection. Quite understandably they may simply want to go home. In North Carolina this was evidenced by the frequency with which beneficiaries chose a particular plan. This State originally arranged their comparative information and enrollment form plan listings in alphabetical order by plan name. Most beneficiaries, who came to the enrollment counselor after completing the eligibility determination process, chose the plan that was listed first.

In 1996, most states reported using a variety of outreach and informing strategies in the community (Chart E). Only six states (Alabama, Colorado, Nevada, New Hampshire, Pennsylvania, and South Carolina) reported not using strategies that employ outreach in churches, schools, public events and or public housing, which is a significant increase from 1994 when only eight states used community-based venues (outside provider

[13]Alabama does not use the eligibility office for enrollment purposes; but, eligibility office staff do provide beneficiaries with some information about the managed care program and a toll-free number to call for more information.

offices) for outreach.

In addition, regardless of how states decide to implement the new State Children's Health Plan program (by expanding Medicaid or creating a new program), this new program will present new challenges to states as they reach out to enroll people who were not previously eligible for state-funded health coverage. However, the lessons and approaches of effective Medicaid in reaching out to poverty level groups of women and children may be instructive and these methods may be viewed as building blocks for new efforts.



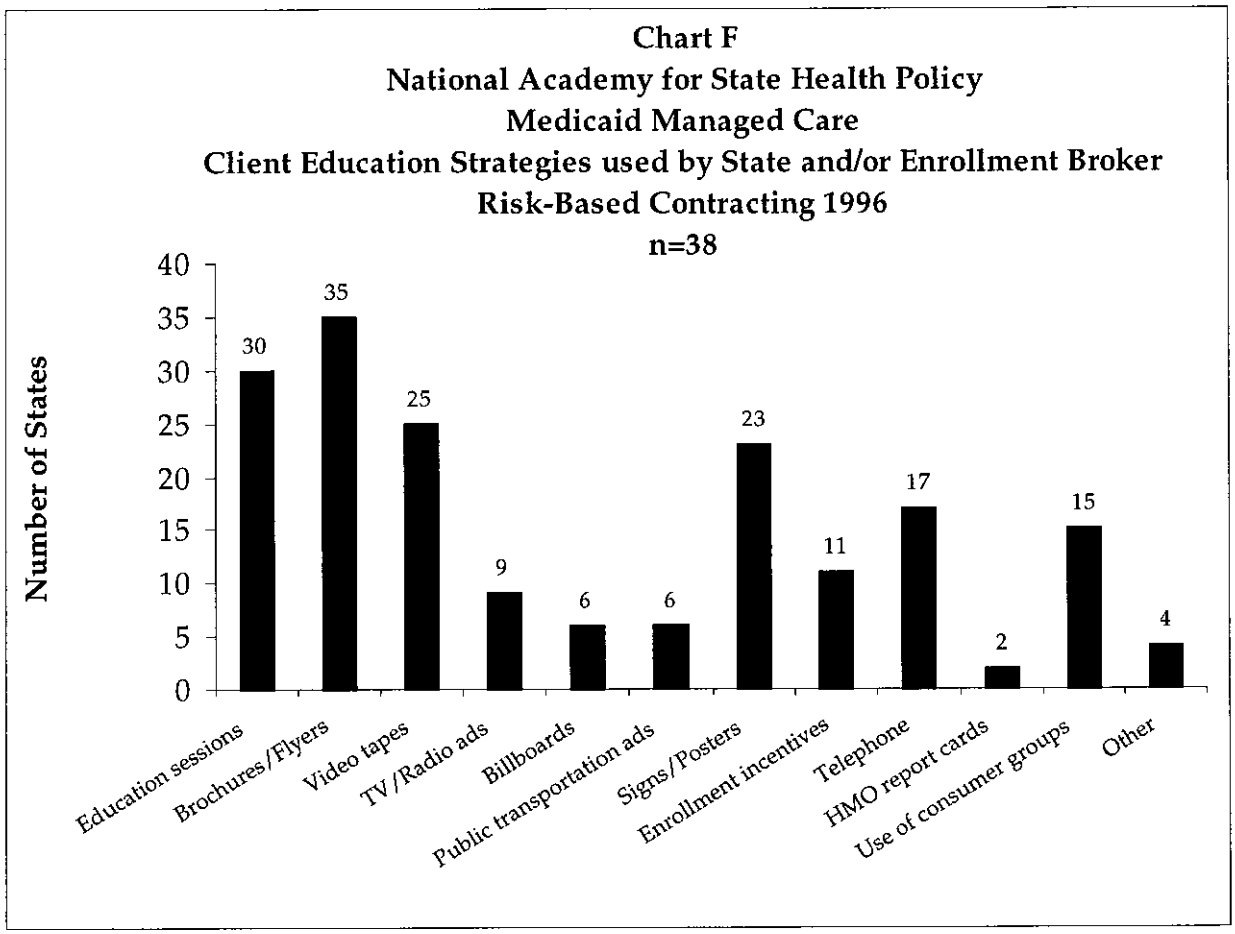
States are considering new and different ways to reach out to non-cash assistance groups. Some of these efforts include public-private partnerships such as working with drugstores (particularly chain drugstores) to include information about available coverage in the form of inserts when prescriptions are filled. Other methods may be to make fliers or brochures available in toy stores, grocery stores, and public health clinics throughout the state. Efforts that can be conducted on a local level include making information available through doctors offices in target areas and making information available through children's clothing and toy consignment shops. How a state approaches this question of outreach for the new children's program will depend on the degree of local control of the program and the extent to which statewide enterprises such as grocery and drug stores are willing to participate and assist. Even states that have made good use of community events and organizations to reach out and inform about the availability of Medicaid may need to expand their activities to reach the new pool of potentially eligible children.

What Materials Are Used for Outreach?
In 1996, 35 states, all except Indiana, Nevada, and Utah, use direct mail by the state or its contracted enrollment broker (22 states), the plan (4 states) or both (9 states). Even though the population is very mobile and state eligibility files frequently carry out-of-date addresses, direct mail still allows states to reach the greatest number of beneficiaries.

There are, however, several drawbacks to direct mail. One drawback is the high percentage of incorrect addresses on the state's eligibility systems, from which most labels for direct mail are generated. This means that direct mail does not always reach its intended party. Even if the mailed material does reach the beneficiary many beneficiaries have low literacy levels or difficulty comprehending English because they speak another language. Finally direct mail may look like another piece of 'junk' mail. To address these problems many states: require that all beneficiary informing material be at the 6th grade reading level or lower; print a statement like "Important Information About Your Health Care" in bold letters on the envelope, make the mailing a color that stands out but does not cause concern (don't use red); include a phone number to call for more information in one if not several prominent places in the packet; use illustrations; include a card that says "For help understanding this material please call XXX-XXXX" in several different languages; and many other strategies.

Chart F illustrates the variety of techniques states use to inform beneficiaries. It also illustrates state commitment to ensuring that all beneficiaries receive the information each individual needs to select a health plan. Fully 30 of the 38 states with risk-based contracts use education sessions to inform beneficiaries. These sessions approach the ideal because the person conducting the session can interview the beneficiary to determine the individual's needs and then help the individual select a health plan that

can meet those unique needs. In addition, the person conducting the session can talk with the beneficiary to ensure the individual understands the information provided and respond to the beneficiary's specific questions.



Sates also extensively use brochures/flyers. These may be used in conjunction with education sessions, direct mail and other strategies. Their versatility probably accounts for much of their popularity. Also more states are beginning to rely on the use of videotapes to inform enrollees. Many states play these tapes in welfare office waiting rooms. This allows the state to reach a larger number of beneficiaries while they are relatively unoccupied with other activities. Finally, it is interesting to note that 15 states now use consumer groups to inform beneficiaries. These groups can be an effective means for reaching Medicaid beneficiaries, since members of these groups may very well be neighbors and friends to other Medicaid beneficiaries. At the very least many members of consumer groups are respected members of their communities and others are more likely to listen to them.

The content of the outreach materials used by states has varied widely; although, the

Balanced Budget Act of 1997 will create some degree of standardization among states and their practices when conducting enrollment. States will have to provide (either directly or through the MCO) information about the benefits to be provided through the MCO and the benefits/coverage available outside the MCO and how to access those other benefits or services. The BBA also requires states to provide certain information in a comparative format which includes all MCO choices the beneficiary may have. The specified comparative information includes a description of the benefits and cost-sharing associated with each MCO, the service areas of each MCO, and quality/performance of each MCO to the extent such information is available.

Disenrollment

The term "disenrollment" within the context of Medicaid managed care can have several meanings: it can mean disenrollment from one health plan to another, it can mean disenrollment from a health plan to the fee-for-service system (including PCCM), and in some states, it can mean disenrollment from the Medicaid program altogether. Disenrollment from a Medicaid managed care plan (whether to another health plan, the fee-for-service system, or from Medicaid altogether) can be for several reasons: loss of eligibility for risk-based coverage,[14] beneficiary-initiated choice, or health plan initiated. Finally, beneficiary-initiated voluntary disenrollment from a health plan can occur at open enrollment periods or at other times when "cause" is demonstrated. These are the general parameters of meaning associated with the term disenrollment however, states have slightly different definitions. Most notably, a number of states with mandatory, risk-based managed care refer to voluntary beneficiary-initiated disenrollments from one plan to another as 'plan switching' while the term voluntary disenrollment refers to a beneficiary who chooses to leave the Medicaid program altogether.

The 1996 survey of Medicaid managed care did not include questions about how beneficiaries may disenroll nor how states categorize the different types of disenrollment. In general though, other work and discussions with states have shown that states typically administer disenrollments directly or through a health benefit manager. Disenrollment is not an area of health plan responsibility.

One issue that affects disenrollment is a Medicaid lock-in, where a beneficiary may only disenroll from a health plan or choose another plan at specified times (open enrollment periods), unless the enrollee has 'just cause' for disenrollment. (Examples of 'just cause'

[14] Loss of eligibility can include loss of any Medicaid eligibility, often due to increased income), or loss of managed care program eligibility (such as when an individual becomes institutionalized or has a hospital length of stay that causes them to revert to fee for service under that state's contract with the health plan or when an individual has available to them another source of insurance coverage that makes coordination with a Medicaid health plan difficult).

may include : (1) the enrollee moves from the health plan's service area; or (2) the enrollee's primary care provider leaves the plan.) Before the BBA, states could not lock-in members of plans other than federally-qualified HMOs nor could states have a lock-in period of more than six months without an 1115 waiver or special federal legislative authority.

In 1996, nine states reported using a six month lock-in (California, District of Columbia, Kansas, Michigan, Missouri, New Jersey, Ohio, Oregon, and Wisconsin). The District was the only state reporting use of lock-in for a voluntary enrollment population (SSI children). California used the lock-in only in the Sacramento area, while Missouri and Kansas used it for federally qualified HMOs only. (Presumably the District and Oregon also do this due to the constraints discussed in the previous paragraph.) New Jersey and Wisconsin have federal legislative exemptions that permit the six month lock-in that would not otherwise be available under the specific circumstances of the contracting plans. Eight states reported use of a six month lock-in 1994.

Five states use a 12 month lock-in (Arizona, Minnesota, Oklahoma, Rhode Island, and Tennessee) which are all 1115 waiver demonstration states. (A 12 month lock-in is only available through an 1115 waiver.) Four states reported a 12 month lock-in in 1994.

The BBA will likely substantially change state practice and policy in this area. The new law allows states to implement (without need of a waiver) an annual lock-in with a 90 day open enrollment period for members of all Medicaid contracted health plans (not just federally-qualified HMOs). Also, states are newly obligated to annually inform all enrollees of their option to change MCO enrollment. This notice must immediately precede the actual open enrollment period.

Conclusion

The general trend among state Medicaid managed care programs is toward fully capitated health delivery/financing systems with mandatory enrollment into those systems. State programs have become increasingly complex as the needs of different enrolling populations are addressed. As these programs expand and the complexity of design grows, issues of beneficiary choice and education about the choices will increase, which affects the enrollment process: who does enrolling, who educates potential enrollees, and how outreach and education is conducted. States are working on these critical issues and have made many program modifications along the way, not the least of which is dedicated enrollment staff (either contractor or state employees) and a variety of approaches to 'get the word out', including group seminars, community events, and videos. States need to consider new and innovative approaches for each new enrolling population to address specific issues of concern or need, and to effectively reach each new audience. This remains the challenge as states expand their programs.

Further Reading

Jane Horvath and Neva Kaye, *Enrollment and Disenrollment in Medicaid Managed Care Program Management,* (Portland ME: National Academy for State Health Policy, 1996).

Neva Kaye, "Consumer Protection in Medicaid Managed Care," *Medicaid Managed Care: A Guide for States,* 3rd ed., (Portland ME: National Academy for State Health Policy, 1997), vol. II, pp. 28-39.

Robert Mollica, et al, *Consumer Protection: Lessons Learned from the States,* no. 1 in The Kaiser-HCFA State Symposia Series: Transitioning to Medicaid Managed Care, (Portland ME: National Academy for State Health Policy, 1996).

Robert Mollica and Paul Saucier, "Contracting Arrangements, Beneficiary Choice, Enrollment/Disenrollment and Tracking," *Protecting Low Income Beneficiaries of Medicare and Medicaid in Managed Care,* (Portland ME: National Academy for State Health Policy, 1997), vol. I.