

Florida Center for Medicaid Issues

March 2001

FLORIDA MEDICAID MANAGED CARE

ANALYSIS OF ENROLLMENT PROCEDURES AND CHOICE COUNSELING

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Abbreviations

AHCA	Agency for Health Care Administration
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Family

March 30, 2001

Mr. Bob Sharpe
Assistant Deputy Director for Medicaid
Agency for Health Care Administration

Dear Mr. Sharpe:

As the State of Florida struggles with the double-digit increases in Medicaid costs and tighter state budget conditions, the Florida Legislature and the Agency for Health Care Administration (AHCA) are seeking to increase efficiency in the Medicaid program. The Legislature has proposed amendments to Florida Statutes that would eliminate the requirement for AHCA to provide choice counseling to Medicaid recipients who are mandated to enroll in Medicaid Options, Florida Medicaid's Managed Care Program; Medipass, Health Maintenance Organizations (HMO), or Provider Service Networks (PSN). In addition, amendments have also been proposed to limit enrollment in Medipass to those counties that have fewer than two HMO choices. The stated intent of this amendment is to "emphasize, to the maximum extent possible, the delivery of health care through entities and mechanisms which are designed to contain costs, to emphasize preventive and primary care, and to promote access and continuity of care."¹

These amendments have the potential to effect AHCA's enrollment policies and procedures for the Medicaid program. In an attempt to assess the impact of these changes, we have reviewed the enrollment process currently in place in Florida Medicaid and enrollment data for Medipass and contracted HMOs. We have also reviewed enrollment procedures used by other state Medicaid programs that have mandatory managed care enrollment for recipients.

¹*Proposed Amendment FS Section 409.9121.*

RESULTS IN BRIEF

Florida statutes currently mandate individuals in specific Medicaid eligibility categories (TANF ‘Temporary Assistance for Needy Families’ and SSI-without Medicare ‘Supplemental Security Income’) to enroll in managed care. The legislated requirement to provide choice counseling to Medicaid recipients was intended to assist individuals in making a voluntary choice of managed care plans. The reality is that efforts to assist individuals in choosing a plan have been largely unsuccessful with Florida reporting a voluntary enrollment rate of 26% in 1998². Although recent enrollment data shows that this percentage may have increased to as much as 40%, a majority of individuals are still being assigned to a managed care plan after failing to choose within the specified time limit.

The proposal to eliminate the requirement to provide choice counseling could provide AHCA with more flexibility in the enrollment process. There is concern, however, that the elimination of the choice counseling will lead to more confusion about plan choices, and even fewer individuals actually choosing a plan. In evaluating the enrollment processes of other states with mandatory managed care, there is great variability in the rate of voluntary enrollment and the mechanisms used to provide recipients with information on managed care plan choices.

Although the use of enrollment brokers has become the most common method among states to educate and disseminate information to Medicaid recipients required to enroll in managed care, there are states that successfully use other practices. The enrollment processes for the states of Oregon and Wisconsin have been reviewed in-depth for this report because of their use of innovative models to enroll recipients in managed care programs and the effectiveness of these models.

The state of Oregon has achieved 100% voluntary enrollment of mandated populations in its managed care plans without the use of an enrollment broker or contracted agent. Oregon’s Medicaid

² *Mandatory Medicaid Managed Care—Plan and Enrollee Perspectives on the Enrollment Process in the Kaiser Commission on Medicaid and the Uninsured (this report was prepared by Kathleen A. Maloy, JD, PhD of the George Washington University Center for Health Services Research Policy, October 2000).*

program, Oregon Health Plan (OHP), requires individuals to choose a managed care plan in its application for eligibility. Because OHP requires individuals to choose a plan as a precondition of eligibility, there is an additional benefit; there is no lag time in which recipients are in traditional fee for service plans.

Although Florida requires all TANF and SSI-without Medicare eligibles to enroll in managed care, the 90-day window allows these recipients to remain in the fee for service plan until a managed care plan has been chosen or assigned. Because of this situation, Florida only averages approximately 85% enrollment of mandatory populations in any given month.

Another state using unique enrollment mechanisms is Wisconsin. Although Wisconsin uses several contracted agents to perform various functions in the enrollment process, they are not the first step in the process. All Medicaid recipients in the mandatory eligibility categories are auto-assigned to a managed care plan as soon as eligibility is determined. Recipients are notified by mail of their eligibility status and the managed care plan to which they have been assigned. The hotline for the enrollment broker is provided to recipients on the eligibility/enrollment notice for those who do not want to accept the assigned managed care plan or who want to learn more about the plans/choices. The auto-enrollment process serves as an incentive for recipients to make a choice if they are not satisfied with the assigned plan.

The mechanisms used by these states allow their Medicaid programs to achieve the maximum cost-saving benefits of mandatory managed care while preserving the opportunity for Medicaid recipients to choose a plan.

BACKGROUND

As mandatory enrollment in managed care plans has become more prevalent in Medicaid programs throughout the United States over the last decade, the importance of information and choice for enrollees has grown. “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, [and] how to ‘navigate’ the Medicaid Managed care system”. Since the concept of managed care is so different from

the concept of traditional Medicaid Fee For Service plans, providing the necessary information to recipients is key to the success of managed care's cost containment strategies. The best way to provide this information to recipients, however, has been debatable.

Many state legislatures and watchdog groups believe there to be a conflict of interest for HMOs/health plans to provide the information directly to potential enrollees. Predatory marketing tactics by some managed care organizations have led many states to restrict this type of direct marketing.³ Some states shifted this responsibility to the eligibility counselors and found that many did not have the necessary knowledge of managed care to educate recipients, resulting in the need for additional training for eligibility staff.⁴ Increasingly, states, like Florida, have chosen to contract out these services to enrollment brokers. According to a survey by the National Academy for State Health Policy, the number of states using enrollment brokers increased by 55% between 1996 and 1998⁴. Based on the data available, however, states using enrollment brokers have not necessarily been more successful in achieving higher voluntary enrollment rates. States with enrollment process similar to that used in Florida, report voluntary enrollment rates ranging from 50% in Michigan, 60% in Maryland, and over 70% in some areas of California. As a result, state Medicaid programs are still searching for the most effective and efficient mechanisms to achieve voluntary managed care enrollment for mandated populations.

ENROLLMENT BROKERS

Since the inception of Medicaid managed care programs, State governments and Medicaid programs have faced many challenges in enrolling Medicaid clients into managed care plans or primary care case management. Some of the difficulty arises from voluntary verses mandatory enrollment requirements, lack of adequate managed care delivery systems and the demographics of

³ *Promoting Choice: Lessons From Managed Medicaid in the Health Affairs* (by Irene Fraser, Elizabeth Chait, and Cindy Brach, September/October, 1998).

⁴ *Medicaid Managed Care Enrollment and Disenrollment: The Experience of Four States in the National Academy for State Health Policy* (prepared under a contract with Cornell University through a grant from The Pew Charitable Trusts by Deborah Curtis, July 1999).

the population being served. In hopes of acquiring economies of scale and expertise in educating consumers, many states have contracted with enrollment brokers to handle their enrollment processes.

There are many obstacles for enrollment brokers to overcome in providing their mission of educating, motivating, and voluntarily enrolling Medicaid clients into managed care plans. Lack of sufficient and correct information is a major hurdle for enrollment brokers. For example, in the electronic transmission of new Medicaid eligibility information from the state to the enrollment broker, client telephone numbers are often not included or are incorrect. This delays efforts to expeditiously contact new recipients to initiate enrollment proceedings.

In addition to telephone efforts, enrollment staff send letters to “new eligibles” with guidelines on choosing a managed care plan and instructions for contacting the enrollment broker within required time frames.

Mandatory assignments or auto-assignments to managed care plans are made if new Medicaid members fail to make a choice. In some states, the state is responsible for making the mandatory assignment even though an enrollment broker has been contracted to handle the enrollment process.

In a study conducted by the Kaiser Commission on Medicaid and the Uninsured, beneficiaries reported that the single most important factor in selecting a Medicaid managed care plan is the make-up of the primary care physician provider network.¹ Even though recipients state that this is their highest priority, the process is so complex that confusion is often the result. In some states, this decision is made during the application process with the governing agency. Other areas use enrollment brokers to coordinate this selection process. In Florida, Medicaid members must contact their chosen managed care plan to select their primary care physician. This selection is sometimes delayed due to lack of phone service, difficulty in comprehending the managed care process and/or lack of interest. If printed provider directories are distributed to new enrollees, the information may not be reliable due to constantly changing provider networks. Since health plans

are often required to supply printed materials in advance, it is not feasible to maintain accurate information.

FLORIDA MEDICAID MANAGED CARE

The state of Florida operates its Medicaid managed care program through a 1915(b) waiver obtained from the Health Care Financing Administration (HCFA) in 1991. In 1998, the state decided to contract with Benova, Inc. to provide enrollment services and choice counseling to Medicaid beneficiaries. The three year agreement commenced on 7/1/98 and the term ends on 6/30/01. The total contract amount is \$39,687,206 and payment is cost-based reimbursement. Thus far, payments made to Benova, Inc. were \$11,993,530 for work completed 7/1/ 98 to 6/30/99 and \$13,643,530 for work completed 7/1/99 to 6/30/00.

Under this contract, Benova, Inc. is responsible for the initial choice counseling contact with new Medicaid eligibles in both mandatory and voluntary enrollment categories. Once an applicant is determined to be eligible for Florida Medicaid, information is electronically transmitted to the broker. These updates are provided to the broker daily. Within five days of receipt of this information, the broker sends voluntary and mandatory enrollment packets to recipients as appropriate. In the packet, information on the available plans, a hotline phone number for more information, and enrollment forms are included. Recipients that are required to enroll in managed care have ten days in which to respond to the initial contact. If no response is received, a reminder letter is sent. After 45 days (from the initial eligibility date) with no response another letter is sent. If a response is still not received, the broker attempts to contact the individual by phone. If the 90-day time limit expires with no choice made, the information is returned to AHCA. AHCA retains the responsibility of making mandatory enrollment assignments when recipients fail to choose a plan within the allotted time frame.

Benova's Florida Community Development and Outreach section is charged with the mission of reaching Florida's Medicaid recipients, encouraging them to learn about managed care, and teaching them to how to select a managed care plan, choose a primary care physician and to enroll in a plan of their choice. The outreach staff conducts outreach sessions throughout the state of Florida.

Twenty-five field choice counselors and four field supervisors are based in North Florida-Tallahassee, Central Florida-Tampa and South Florida-Miami and work with in collaboration with community-based organizations. The primary goal of this outreach is to increase the targeted population's awareness of the need to make a voluntary choice. In addition to community presentations, enrollment staff will meet face-to-face with recipients to assist in the managed care plan selection process. However, as a Benova representative in Miami explained that although some beneficiaries wanted a "face-to-face interaction...the vast majority of people, if they have a choice, look for a fairly businesslike discussion over the phone."⁵

Benova reports that some information problems create difficulty in contacting recipients. For example, when eligibility lists are transmitted electronically to the enrollment broker, client telephone numbers are not included in the information sent. For three years, the Agency for Health Care Administration has attempted to have this information included in the eligibility transmittals, but have been unsuccessful in doing so. If this information could be included, initial contact efforts would be expedited, and the cost of staffing resources spent in getting phone numbers would be greatly reduced.

In addition, enrollment efforts are hampered by the fact that some recipients are not capable of comprehending the printed enrollment materials mailed to them. Some households do not have telephones and have to rely on the good will of neighbors or other family members to communicate or receive information. Lack of interest and unresponsiveness by Medicaid clients continue to impede enrollment goals.

⁵ *Commonwealth Fund Field Report-Educating Medicaid Beneficiaries About Managed Care: Approaching 13. Sue A Kaplan, Jessica Greene, Chril Molnar, Abby Bernstein, and Susan Ghanbapou. May, 2000.*

OREGON HEALTH PLAN

A more in-depth look at the Oregon Health Plan reveals a strong commitment to the use of managed care. The enrollment procedures and eligibility policies are focused on the purpose of enrolling all recipients in managed care and providing stability of enrollment for both recipients and health plans. Separate cost data for the enrollment portion of Oregon's Medicaid program is unavailable since the process is integrated with all other functions of the program.

Oregon operates its Medicaid managed care program through a HCFA 1115 waiver. Their application for Medicaid eligibility requires all applicants to choose a managed care plan in advance of the eligibility determination. In order to assist individuals in making this choice, the state provides printed guides explaining managed care and comparison charts of the available plans. The guides provide information on the basic services all plans are required to provide and survey data on satisfaction and quality for each plan. On a county by county basis, a comparison chart is included in the brochure which explains the basic differences between plans, such as which hospitals and pharmacies are available and any extra or optional services provided by the plan(s). Oregon strictly prohibits direct marketing to individuals by health plans. In the event that an applicant has additional questions, toll-free phone numbers for each plan are provided in the brochure. Individuals may also discuss plans and options with eligibility counselors at regional offices. If an applicant fails to make a choice on the application, the application is denied and returned to the individual with an explanation of the reason for denial. Oregon reports that this occurs with approximately 5% of applications.

Oregon has implemented other policies to ensure health plan stability and continuity of care for recipients. Once an individual chooses a health plan (before eligibility is even determined), they are locked-in to that plan for a minimum of six months. Recipients are made eligible for six-month intervals and are not allowed to change plans, except in rare circumstances. The state provides an open enrollment period bi-annually in which recipients can change plans. These policies provide health plans with stability of enrollment, while simultaneously providing recipients with continuity of care.

WISCONSIN MEDICAID

The Medicaid managed care program in the state of Wisconsin is operated with a 1915(b) waiver obtained through HCFA. Although Wisconsin uses an enrollment broker for some functions in the enrollment process, it is not the traditional model used by other states contracting with a broker. Wisconsin did not provide data on the contract costs associated with its enrollment processes.

Wisconsin's Medicaid program has divided up the enrollment process among the state's Department of Health and Family Services and two contracted agents. The Department of Health and Family Services is responsible for the application process and eligibility determination. Once individuals are determined to be eligible, the state provides that information to its fiscal agent. The fiscal agent is responsible for sending out the enrollment information to recipients. The system used by the fiscal agent, pre-determines the auto-assignment of individuals to plans. The auto-assignment system is random to ensure that each plan gets a "fair share" of enrollees.

The enrollment information provided to recipients states the plan name to which they have been auto-assigned. Recipients are given a toll-free number to contact the enrollment broker if they wish to change their assignment or learn more about the plans. Recipients are allowed 30 days in which to make a change and are locked-in to the auto-assigned or chosen plan for 9 months. Eligibility is redetermined on an annual basis.

The auto-assignment mechanism in Wisconsin's Medicaid managed care program informs recipients of the predetermined plan selection and allows them to choose another plan if preferred. This process provides Wisconsin's Medicaid program with an efficient enrollment process for getting recipients into managed care plans.

KEY DETERMINANTS OF SUCCESS

The design of the enrollment process is a key factor determining the ultimate success and effectiveness of Medicaid managed care. Both Wisconsin and Oregon have designed their managed care enrollment processes to be closely integrated with eligibility determination. This feature allows the programs to minimize communication problems and delays, and enroll recipients into plans efficiently.

No matter how the program is designed, another important component is effective information systems. All participants in the Medicaid managed care enrollment process; state agencies, contracted agents, health plans, and recipients, need accurate and up-to-date information in order to perform their roles. When participants do not have access to needed information, the whole process is delayed and becomes ineffective.

CONCLUDING OBSERVATIONS

The information in this report is intended to provide insight into innovative and successful enrollment procedure that could enhance Florida Medicaid's ability to benefit from its managed care program. Although the states examined in detail may face different challenges than Florida, their experience provides examples of alternative policies that could be useful in dealing with the elimination of the requirement to provide choice counseling.

Copies of this report will be made available to others at your request.

If you or your staff have any questions about this report, please call me at (352) 392-0675. This report was prepared by Ms. Renee Dubault and Ms. Smaro Bloodworth.

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SCOPE AND METHODOLOGY

To determine the enrollment processes used by other states we examined state policy literature on Medicaid Managed Care from health care journals, state policy organizations, and other various sources. Internet sites from several states provided additional detailed information on Medicaid policies and procedures.

In-depth interviews were conducted with staff from Florida's Agency for Health Care Administration (AHCA). Florida's enrollment broker Benova, Inc., Oregon Health Plan, and Wisconsin's Medicaid program to determine details not available through published materials.

Analysis of enrollment data for Florida's Medicaid's managed care plans and Medipass was conducted to determine enrollment rates for mandatory enrollment categories and overall enrollment patterns.