Georgetown University Health Policy Institute
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Managed Care Rules: Enhancing the Beneficiary Experience

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Children in Managed Care

- CMS finalized sweeping changes to Medicaid and CHIP managed care regulations in May 2016
- Regulations set minimum standards; states have flexibility to do more
- Many opportunities for legal and health advocates to take action

Flag potential actions for legal and health advocates

Why are these rules so important?

11% of children in Medicaid/ CHIP are enrolled in FFS

22% of children in Medicaid/ CHIP are enrolled in PCCMs

66% of children in Medicaid/CHIP are enrolled in MCOs

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Source: CMS Medicaid Managed Care Enrollment Report 2013

Managed Care Project

- Series of six explainer briefs and webinars
  1. Looking at the Rule through a Children's Lens (released)
  2. Improving Consumer Information (released)
  3. *Enhancing the Beneficiary Experience (7/19)*
  4. Assuring Network Adequacy and Access to Services (8/5)
  5. Advancing Quality (9/8)
  6. Ensuring Accountability and Transparency (9/29)
- Fall meeting in D.C. with child health and legal advocates to strategize over implementation
- Thanks to Robert Wood Johnson Foundation

Our Topic Today: Enhancing the Beneficiary Experience

- Choice of Delivery System, Plan, or Provider
- Enrollment and Disenrollment
- Beneficiary Support System
- Enrollee Rights

Flag potential actions for legal and health advocates

Background

- No enrollment rules for voluntary managed care; only default enrollment standards for mandatory managed care
- Lack of adequate notice or assistance
- Most states adopted passive enrollment processes, and experience indicates that few people opt out and make an active choice of delivery systems, plans or providers

Timeline

- Choice, enrollment and disenrollment provisions were effective July 5, 2016.
- Beneficiary support system must implement for contracts starting on or after July 1, 2018.
  - States may contract for multiple years.

Find out when your state's next contract period starts.

Choice Basic Rules

MCOs, PIHPs, PAHPs

- Choice of plans is required, except in rural areas

Anthem
Aetna
UniCare
HUMANA
CIGNA
PacifiCare
UnitedHealthcare
Health Net

PCCMs, PCCM Entities

- Choice of provider

Plan Choice Exception for Rural Area

Applies to, MCOs, PIHPs, PAHPs

- Must have choice of providers
- Rural definition consistent with Medicare Advantage county-based classification
  - Micro
  - Rural
  - County with extreme access considerations

Out-of-Network Care Exceptions in Rural Area

Main Provider Not in Network	Other Circumstances
• Main provider must be given opportunity to join network • Same terms/qualifications • 60-day choice/transition period if provider does not join	• Care needed is not available in-network • Service not provided based on moral/religious grounds • Combined services needed and not available in-network • State option to define others

Encourage your state to engage stakeholders in establishing parameters for out of network care

Enrollment Provisions

- Align rules for voluntary and mandatory enrollment
- Previously, only limited guidance for default enrollment process in mandatory managed care
- Set basic, minimum federal rules
- Require states to have an enrollment system
- Require states to send an informational notice to potential enrollees

Differences in mandatory, enrollees cannot choose FFS and Enrollment Confirmation Notice not required

Informational Notices

Applies to voluntary and mandatory managed care

- Sent at time beneficiary becomes eligible to or must enroll in managed care
- Provided in timeframe that allows potential enrollee to use information to make an active choice

Content of Notice

- Explain implications of not taking action and accepting auto-assignment
- Identify choices
- Clear instructions on how to choose
- Comprehensive info on disenrollment options
- BSS contact info
- Comply with consumer information provisions (§ 438.10)

Managed Care Enrollment

Voluntary	Mandatory
• Beneficiary has choice of FFS delivery system or managed care plan • Any Medicaid group may be offered voluntary enrollment	• Must enroll in plan • Exempt groups may only be enrolled with a waiver – Children with SHCN or disabilities – Children receiving foster care or adoption assistance – Native Americans – Dual eligibles

Types of Enrollment Processes

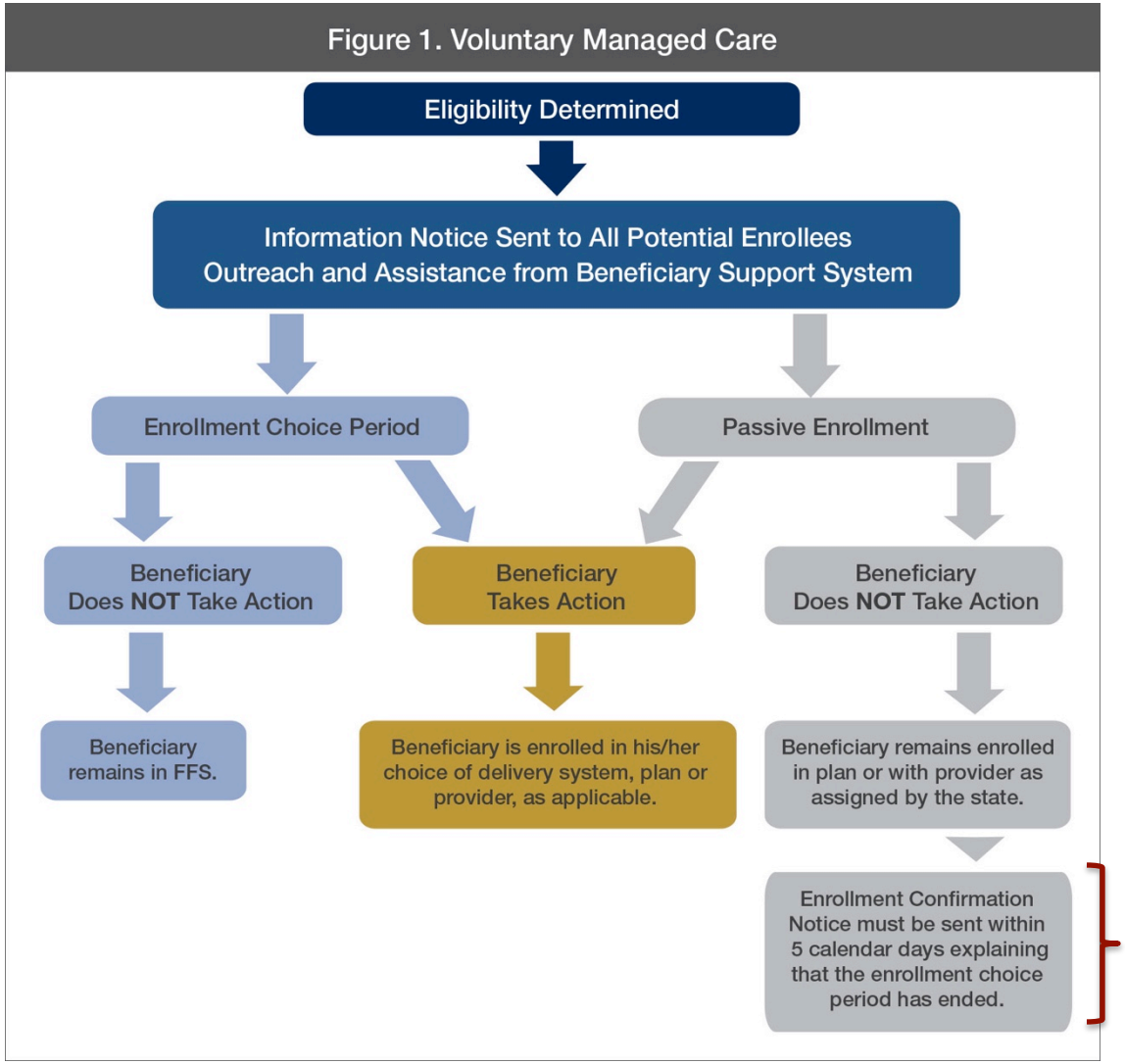
Enrollment Choice Period

- Gives potential enrollee opportunity to select system, plan, or provider
- Services initially delivered through FFS
- If no choice is made, beneficiary:
  - Stays in FFS (voluntary)
  - Auto-assigned to a plan (mandatory)

Passive Enrollment

- State enrolls beneficiary in a plan
- Potential enrollee has period of time to:
  - Opt-out to FFS (voluntary)
  - Keep assigned plan or provider or choice different plan or provider (mandatory)

Encourage your state to engage stakeholders in determining reasonable time for enrollment



Not required in mandatory

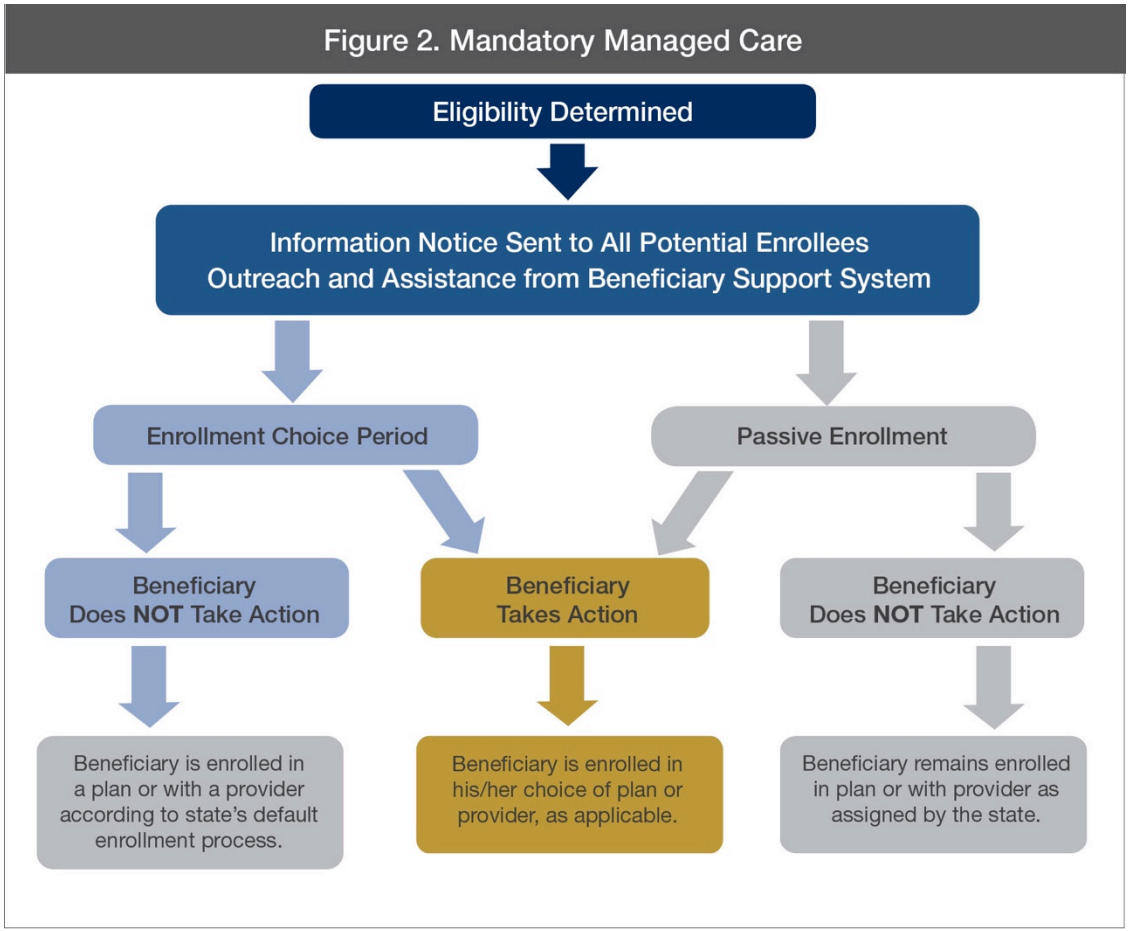


Figure 2. Mandatory Managed Care
Eligibility Determined
Information Notice Sent to All Potential Enrollees
Outreach and Assistance from Beneficiary Support System
Enrollment Choice Period
Passive Enrollment
Beneficiary Does NOT Take Action
Beneficiary Takes Action
Beneficiary Does NOT Take Action
Beneficiary is enrolled in a plan or with a provider according to state's default enrollment process.
Beneficiary is enrolled in his/her choice of plan or provider, as applicable.
Beneficiary remains enrolled in plan or with provider as assigned by the state.

Enrollment Priority

- Priority given to current enrollees if the plan or provider has limited capacity
- Plan must have capacity to enroll
- MCOs must not be subject to intermediate sanctions for violating Medicaid law

Enrollment Default Assignment

- Preserve existing provider-beneficiary relationships
- Foster relationships with providers experienced in serving Medicaid
- Distribute enrollees equitably and not arbitrarily exclude plans or entities
- May use other criteria in assigning beneficiaries

Distributing Enrollees Equitably ≠ Equal Numbers of Enrollees

- Additional assignment criteria
  - Enrollment preferences of family members
  - Previous plan assignments or selections
  - Quality assurance and improvement performance
  - RFP procurement evaluation
  - Accessibility
  - Other reasonable criteria

Encourage your state to engage stakeholders in determining other criteria for auto-assignment.

Disenrollment Requested by Plan

- States may, but are not required to, allow plans to request disenrollment
- Not allowed to be based on:
  - Change in health status
  - Medical utilization
  - Diminished capacity
  - Disruptive or uncooperative behavior
  - Unless continued enrollment impairs plan's ability to furnish services to the enrollee or other enrollees

Encourage your state to engage stakeholders in determining if plans should be allowed to request disenrollment, and, if so, in establishing reasons and processes to monitor plan requested disenrollment.

Disenrollment Requested by Enrollee

- For any reason in first 90 days of enrollment
  - Applies to initial enrollment in successive plans
- At least once every 12 months
  - Similar to open enrollment
  - Must send written notice with thorough explanation of disenrollment rights at least 60 days in advance
- At any time for cause

States are not required to limit disenrollment. If they do, it must be included in MC contracts.

Encourage your state to work with stakeholders in reviewing language regarding disenrollment rights.

For Cause Disenrollment Reasons

- Move out of service area
- Service is not provided for moral or religious objections
- Multiple services needed and not available in-network
- Poor quality of care
- Lack of access to covered services
- Lack of access to providers experienced with enrollee's needs
- MLTSS provider leaves network
- An intermediate sanction is imposed after plan violates federal law.

Encourage your state to engage stakeholders in developing a comprehensive list of 'for cause' disenrollment reasons.

Automatic Re-enrollment

- States may automatically-reenroll a beneficiary in the same plan following a loss of Medicaid eligibility for 2 months or less
- Enrollee must be allowed to disenroll if they missed the annual disenrollment opportunity during the time they lost Medicaid eligibility

Disenrollment Procedures

- States may allow plans to process disenrollment
- Plans may not **deny** a request, but refer to the state
- State must take action to approve or disapprove
- Enrollees may be required to seek redress through the plan/entity's grievance process first
- Effective the first day of the second month following the date of the request (even if grievance process is required)
- Requests not acted upon by effective date are automatically approved
- Denials are subject to timely access to state fair hearing

Beneficiary Support System

Applies to all states with any type of managed care arrangement

- Performs outreach
- Accessible in person, by phone, online, via auxiliary supports
- Provides choice counseling
- Helps beneficiaries understand managed care before and after enrollment
- Must be free of conflicts of interest

Choice Counseling

The provision of information and services designed to assist beneficiaries in making enrollment decisions. It includes answering questions and identifying factors to consider when choosing among plans and providers

Beneficiary Support for LTSS

- Applies to beneficiaries who use, *or express a desire to use,* LTSS
- Serves as customer service center for complaints and issues
- Assistance may include help appealing adverse decisions up to state fair hearing
- Refers enrollees to legal help
- BSS reviews program and complaint data to identify and help state resolve widespread issues

Encourage your state to engage stakeholders in developing its BSS. Advocate for a robust and responsive BSS that has capacity to serve all, and not limit certain services to LTSS.

Enrollee Rights

- Are sprinkled throughout the regulations
- Specific section at § 438.100 lists general rights
- Some limitations (e.g., HIPAA)
- This section incorporates protections from discrimination
- Emphasizes that enrollees not only drive health care decisions but that they have information needed to do so
- Enrollees have options for resolving issues through appeals

Specific Enrollee Rights § 438.100

- Receive information on treatment options/ alternatives
- Participate in health care decisions including the right to refuse treatment
- Not have restraint or seclusion used as discipline, retaliation, or means of coercion
- Receive services according to managed care standards
- Be treated with dignity
- Free to exercise individual rights without retaliation
- Have plans comply with law, including non-discrimination

Options for Resolving Issues

- Appeals and grievance processes
- State fair hearing process

CHIP

Choice

- CHIP allows mandatory, prospective enrollment.
- No choice of plan required.
- Choice of network provider required to extent possible and appropriate.

Beneficiary Support System

- No requirement

CHIP

Enrollment

- Informational notice required.
- Default/auto-assignment process in line with Medicaid.
- Enrollment confirmation notice required.

Disenrollment

- Same provisions as Medicaid.
- With no required plan choice, there may be no alternative upon disenrollment.

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