

## **ANNUAL ENROLLMENT PERIOD FOR HEALTHCHOICES** **September 2011**

**Recommendation** - The Pennsylvania Coalition of Managed Care Organizations recommends that the Department of Public Welfare (DPW) adopt an Annual Enrollment Period for the HealthChoices program effective January 1, 2012, either on a statewide basis or through a phased approach by HealthChoices Zone.

### **Background** -

- Currently, the HealthChoices program allows consumers to change Managed Care Organizations (MCOs) monthly.
- Each month, less than 1% of consumers exercise this right to change plans. There are approximately 82,000 voluntary plan changes annually.
- An independent Enrollment Broker contracted by DPW facilitates consumers' choice of MCO.
- Federal Medicaid regulations permit an Annual Enrollment Period.<sup>1</sup> Generally under this type of Annual Enrollment model, consumers are provided an Open Enrollment period each year in which they can choose to stay with their current MCO or change to a new one. Medicaid recipients have up to 90 days to switch to another plan after their initial MCO choice or assignment.
- Under the Federal rules, States must provide consumers with both a "for cause" exception that permits changes outside the open enrollment period and an avenue to challenge a determination that there is not a good cause for disenrollment.
- More than 20 States use an Annual Enrollment Period for their Medicaid Managed Care programs. Some have been in place for nearly 15 years. A number of these States operate their managed care programs under 1915(b) waivers, which is the authority Pennsylvania uses for Medicaid Managed Care. States with 1915(b) waivers that use Annual Enrollment Periods include Indiana, Michigan, New Mexico, and Virginia.

### **Rationale for Change** -

- **An Annual Enrollment Period would improve quality of care for consumers.** From a consumer perspective, switching MCOs interrupts their continuity of care, an element that is critical to effective health care and fundamental to the success of a managed care approach. Often, consumers who change plans do not form a patient relationship with a medical home, despite the fact that they have a Primary Care Doctor<sup>2</sup>. For others, a change in MCO can sometimes mean a

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<sup>1</sup> 45 CFR §438.56 Disenrollment: Requirements and limitations.

<sup>2</sup> ACAP and The George Washington University. "[Improving Medicaid's Continuity and Quality of Care.](#)" July 2009.

change in Primary Care Doctors, Specialists, and other health care providers. Even if the transfer of medical records goes smoothly, medical history and the personal knowledge of a patient can be lost. Individuals often need to adjust medications since MCOs have different formularies. Moving between MCOs, especially if done frequently, can be particularly disruptive for those with chronic illness or disabilities. Each MCO has Case and Disease Managers who work closely with the consumers and their physicians to develop treatment plans, care support, and tracking of their medical outcomes. We understand that consumer choice of plans is important; however, these quality issues would be minimized or eliminated if enrollment changes happened less frequently.

- **An Annual Enrollment Period would benefit consumers financially.** Changing plans can also potentially result in consumers paying higher annual out-of-pocket copays if they reach the annual limit. Currently, there is no mechanism to pass the amount of co-pays paid each year from one plan to the other. Remaining with a single MCO throughout the year would ensure that consumers would not exceed their copay cap.
- **An Annual Enrollment Period would better prepare consumers for transition to employer-provided insurance or other publicly funded programs available to consumers.** Annual Enrollment Periods are the norm in other health insurance programs.
  - Medicare has a yearly window in which beneficiaries can choose to remain in Fee for Service Medicare or select a Medicare Advantage managed care option.
  - The new Health Care Exchanges to be established under the Patient Protection and Affordable Care Act will also have an Annual Enrollment Period.
  - Nearly all commercially insured individuals are also subject to an Annual Enrollment Period.

Most of these programs use a January 1 start date for their new enrollment year, with an autumn open enrollment time to consider and choose a new plan.

- **An Annual Enrollment Period would reduce Administrative Costs at both the Department and MCO level.** While the percentage of HealthChoices consumers who change MCOs monthly may seem relatively low, the practice results in administrative costs to both DPW and the MCOs. On average, 6,900 consumers move among MCOs each month, accumulating to more than 82,000 plan changes annually. For DPW, each time a consumer changes plans, the Department and its Enrollment Broker are involved in written and/or verbal interaction with the member, changes to the Enrollment file, updates to its Eligibility Verification System, and financial adjustments related to capitation payments as well as risk adjusted rates. The MCOs must have staff review the Eligibility File Changes, often contact the member to arrange a PCP selection,

issue new Identification Cards, provide Member Handbooks and other new member materials, and frequently make arrangements for necessary authorizations for medical and pharmacy services.

- **An Annual Enrollment Period would help improve the accuracy of Quality and Pay for Performance results.** The current system fragments MCOs' and physicians' ability to obtain optimal quality measures since consumers can change MCOs each month. Most standard patient quality measures require 12 months of continuous enrollment in an MCO for the results to be considered valid. Many call for periodic measurement over time by those physicians providing patient care, which is hampered by member changes. Annual Enrollment would provide a full year of measurement by an MCO for continuously enrolled members. Even if the member changed physicians within the MCOs network, the MCO would still have quality indicators for its member.

Closely linked to this issue are both DPW's and the MCOs' various provider Pay for Performance programs. HEDIS data, which is the basis for most Quality Measures used in these Pay for Performance programs, is collected on a Calendar Year basis. Data for consumers who switch MCOs during the year cannot be counted since the HEDIS standard requires 12 months of continuous eligibility and enrollment in the plan for the data to be considered. An Annual Enrollment Period would optimize the amount of valid data to be collected for Performance Measures and improve both accuracy and effectiveness for DPW, the MCOs and the consumer.

- **An Annual Enrollment Period would reduce fraud and abuse.** While MCOs have sophisticated claims and prior authorization systems that track their members' use of benefits, there is no system in place for MCOs to share information between plans about an individual's use of services that have benefit limits. Since many limits are applied on an annual basis, an Annual Enrollment Period would eliminate both inadvertent cases of consumers receiving excess benefits as well as intentional gaming of the system by a small number of others. Annual Enrollment would also strengthen the MCOs' ability to monitor and, if warranted, apply additional restrictions such as "lock-in" of consumers with drug seeking and other inappropriate pharmacy and Emergency Room usage.
- **An Annual Enrollment Period would in no way affect the ability of DPW to perform eligibility determinations at the selected frequency.** The process of consumer enrollment in MCOs takes place separately from DPW's determination of eligibility for Medical Assistance. Consumers would continue to be enrolled in an MCO for the duration of the Annual Enrollment period only if they continue to be eligible for Medical Assistance.

**Recommendations for Implementation** - Based on the significant benefits outlined above, Pennsylvania's Medicaid MCOs recommend that DPW adopt an Annual Enrollment Period for the HealthChoices program with the following components. We understand that waiver modifications may be necessary for the most effective implementation.

- An Open Enrollment Period would take place in October with any Plan changes effective on January 1 of each year. We expect that DPW may choose to modify the process in new zones or zones where there have been new procurements.
- Changing MCOs would be an active choice by consumers. If they do not take any action, consumers would remain with their current MCOs, similar to the way many employer groups handle their open enrollment.
- New members who become eligible throughout the year would remain with their MCO of choice or auto-assign until the end of the year, with an option to change plans during Open Enrollment.
- Individuals who lose and then regain eligibility for Medicaid within the Calendar Year would be automatically reassigned to the MCO in which they had been enrolled during their period of prior eligibility.
- Members who change MCOs during Open Enrollment and new eligibles would have a 90-day grace period after enrollment in their new MCO. During this time frame, they should be able to change MCOs without cause.
- Any other enrollment changes should only be permitted "for cause". Members would be able to use DPW's Grievance and Appeals procedure to contest a denial by DPW of a request to change MCOs for cause.