CHCS Center for Health Care Strategies, Inc.

Technical Assistance Brief

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Enrollment Options for Medicaid Managed Care for People with Disabilities

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A growing number of states are planning, implementing, or expanding Medicaid managed care programs for people with disabilities. States see clear advantages in serving adults with special health care needs through a model that coordinates across systems of care, focuses on improving health outcomes, links consumers with a medical home, and provides a level of budget predictability. As states move forward with new or expanded programs, they must consider design elements that best: 1) meet the needs of their target population (e.g., members with behavioral health conditions); 2) address health plan service requirements (e.g., exceptional needs coordinators); 3) and effectively measure performance (e.g., HEDIS and other measures).

One design element that has critical implications for program success is the enrollment model. This brief is based in large part on a small group consultation with select Medicaid stakeholders including consumer, health plan and state representatives. It outlines state options for enrolling consumers into managed care programs, including mandatory enrollment, voluntary enrollment, or a hybrid approach, and summarizes advantages and shortcomings related to:

- Addressing concerns from the consumer and advocacy communities about managed care models (e.g., choice, provider access, and continuity of care);
- Ensuring appropriate benefits, services, and networks for consumers; and
- Attracting high quality managed care organization (MCO) partners.

Enrollment Models

Voluntary Enrollment Model

In the voluntary enrollment model, consumers have the choice to either participate in the managed care program or receive care in the fee-for-service system. This approach appeals to consumers and advocates because it can address perceptions related to restriction of choice, reduced provider access, and disruption of care. This option supports consumer choice by allowing the consumer to select the care model that is most appealing.

However, states that use a voluntary model may not be able to attract high-quality managed care organizations. With voluntary enrollment, the MCO is less likely to enroll a "critical mass" of membership that will allow the plan to be financially viable and build the infrastructure needed to serve complex populations. This model is also less appealing to states because it reduces the ability to achieve key goals of managed care, including linking consumers with a medical home, providing accountability to deliver improved health outcomes, and achieving a level of budget predictability. Some states (e.g., New York) have used the voluntary model as a transition to an eventual mandatory program. Voluntary programs are in operation in select counties of Washington and California.

This technical assistance brief describes managed care enrollment options for people with disabilities, including a new hybrid model – opt-in, opt-out enrollment – that shows promise for satisfying consumers as well as state and MCO partners.

Table: Summary of Managed Care Enrollment Models

Model	Description	Pros	Cons	State Example
Voluntary	Member chooses to participate in the managed care program or can decide to receive services in the fee-for-service system	• Supports member choice • Can serve as a "transition" to mandatory model • Minimizes consumer/ advocate resistance	• May not provide enough membership for MCOs to be financially viable • Limits the linkage of consumers to medical homes • Provides the state with less budget predictability	• California (select counties) • New York (select counties) • Washington (pilot program)
Mandatory	All eligible members must receive services in the managed care program	• Links consumers with a medical home • Provides states with an accountable system and members with enhanced benefits • Provides enough membership for MCOs to be financially viable • Provides state with budget predictability	• Potential for consumer and advocate resistance due to actual or perceived lack of provider choice • Care system transition may result in changing providers and established systems	• Arizona • Maryland • Massachusetts • Michigan • Ohio • Pennsylvania
Hybrid Mandatory Enrollment with an Opt-Out Provision	All eligible members are enrolled in the managed care program, but can chose to opt-out after a specified time period (e.g., 60-day).	• Likely to provide enough membership for MCOs to be financially viable • Gives MCO the opportunity to prove its value to members • Provides states with an accountable system and members with enhanced benefits • Links consumers to a medical home • Reduces advocate resistance by maintaining FFS option	• States may need to invest in a comprehensive education/outreach program to ensure consumer understanding	• Wisconsin

Mandatory Enrollment Model

In the mandatory enrollment model, all eligible consumers are enrolled to receive health care services via the managed care program. This approach appeals to MCOs because it allows them to more effectively enroll the volume of consumers required to achieve financial viability. In addition, enrolling a critical mass of consumers encourages the MCO to invest in the infrastructure (e.g., specialized staff, data capabilities, care management systems, and robust specialty provider networks) necessary to best serve the population.

States often prefer this approach because it links consumers to a medical home, provides accountability related to improved health outcomes, and provides a greater level of budget certainty. However, this approach has less support from consumers and advocates because it eliminates the choice of care model and heightens concerns about the potential for reduced provider access and disruption of care. Mandatory programs are in operation in Arizona, Maryland, Massachusetts, Michigan, Ohio, and Pennsylvania.

When deciding on an enrollment model, states face a challenging compromise – the approach that gathers the support of consumers and advocates may limit the interest of MCOs, thus reducing the benefits that a managed care system can provide to consumers (e.g., enhanced benefits, care coordination) and states (e.g., an accountable system, predictable costs). However, states are not limited to a voluntary or a mandatory model, there is a third approach being tested that can meet the needs of states, plans and consumers. States can apply a model that combines both voluntary and mandatory policies, then implement this hybrid mandatory enrollment with an opt-out provision model.

Hybrid Mandatory Enrollment with an Opt-Out Provision Model

The mandatory enrollment with an opt-out provision approach requires consumers to enroll in the managed care program for a set period after which they can choose to remain in managed care or opt out to the fee-for-service system. This model, currently in operation in Wisconsin (where it is known as the "all-in/opt-out" policy), addresses the concerns of state, plan, and consumer partners. The consumer and advocacy communities are supportive because consumers can opt-out of the managed care program and revert to the fee-for-service system after a set period. MCOs are supportive because the required initial period of managed care participation allows MCOs an opportunity to prove the value of their plans to consumers and build membership. This approach is also beneficial to the state because it supports an accountable system to improve health outcomes, links members with a medical home, and provides budget predictability.

Case Study: Wisconsin's Supplemental Security Income Managed Care Program

Wisconsin began its managed care program for people with disabilities – the Supplemental Security Income Managed Care Program – in Milwaukee County in April 2005 with the goal of "integrating medical and social services and improving quality, access, and coordination of medical services." Initially, Wisconsin Medicaid officials intended to implement a mandatory program quickly in response to both a legislative requirement to stabilize Medicaid spending and the need to ensure the participation of quality MCOs. However, after working with the consumer and advocacy communities and understanding the depth of resistance to a mandatory program model (key concerns were about continuity of care and provider network issues), Wisconsin decided to consider different approaches.

The state engaged a broad coalition of stakeholders and convened a series of advisory committee meetings with representation from consumers, advocates, MCOs, non-profit organizations, and state officials. Through this process several key program design changes were made, including:

- Establishing an external advocate program;
- Conducting a baseline consumer satisfaction survey to enable pre- and post-implementation comparisons; and
- Changing the program's enrollment approach from a mandatory model to the all-in, opt-out policy.

Wisconsin All-In, Opt-Out Program Description

Wisconsin's Supplemental Security Income Managed Care Program's enrollment model requires all eligible members (SSI and SSI-related, non-institutionalized Medicaid recipients who are 19 or older, and do not participate in a waiver programs) to enroll in a risk-based MCO. The members are required to receive their care from a participating MCO for a minimum of 60 days. After the 60-day period, the member can opt-out of the program and revert to the traditional fee-for-service Medicaid program. As of May 2007, 12% of eligible members have chosen to opt-out. State officials attribute the low opt-out rate to the enhanced services offered by the MCOs, which include care coordinators, patient-specific care plans, and enhanced transportation benefits. In addition, the state believes the high member retention rate can also be attributed to the states' partnership with the consumer and advocacy communities both through shared member program education strategies and an advisory committee.

Wisconsin's Supplemental Security Income Managed Care Program: Facts	
Program Authority:	State plan amendment
Program Start:	April 2005 in Milwaukee County
Geographic Area:	33 additional counties by January 2008
Enrollment:	20,844 enrollees as of May 2007 (75% of eligible population)
Quality Measurement:	The state is in the process of implementing its measurement strategy and will report satisfaction and clinical outcomes in September 2007. The state is also conducting an analysis to better understand the reasons for member opt outs.
Web Site	http://dhfs.wisconsin.gov/medicaid7/index.htm

Conclusion

When developing a managed care program for people with disabilities, states have many design decisions to make, including selecting the enrollment model. Both the voluntary and mandatory enrollment models have been used by states and each offers benefits and drawbacks from the consumer, state, and MCO perspectives; however, states are not limited to the voluntary and mandatory approaches. Wisconsin is pioneering a promising new hybrid model – mandatory enrollment with an opt-out provision – that is flexible and combines the best elements of both the mandatory and voluntary models. This approach has allowed Wisconsin to gain the support of the consumer and advocacy communities and to attract MCO participation, while focusing on the state's goals of linking members to a medical home, developing an accountable system to improve health outcomes, and providing budget predictability.

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Additional Resources

Wisconsin's Enrollment Policy – For additional information on Wisconsin's hybrid enrollment options, please contact Angela Dombrowicki, Director, Bureau of Managed Health Care Programs, Wisconsin Division of Health Care Financing, at dombra@dhfs.state.wi.us or visit the program web site: http://dhfs.wisconsin.gov/medicaid7/index.htm

Managed Care for People with Disabilities Purchasing Institute – CHCS has collected best practices and resources to assist states in developing, implementing, and expanding managed care programs for people with disabilities. Available resources include sample requests for proposals, contracts, health assessment tools, and other administrative resources. Download at http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=359008

Issue Brief: *The Consumer Voice in Medicaid Managed Care: State Strategies* – This issue brief, developed through interviews with state and health plan officials, consumers, and advocates, outlines successful state strategies for bringing key stakeholders into the planning, implementation, and oversight of managed care programs for people with disabilities. Download at http://www.chcs.org/publications3960/publications_show.htm?doc_id=468769

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving the quality and cost effectiveness of health care for Americans with chronic illnesses and disabilities, the elderly, and racially and ethnically diverse populations. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs to better serve adults and children with complex and high-cost health care needs. Its program priorities are: advancing regional quality improvement, reducing racial and ethnic disparities, and integrating care for people with complex and special needs. For more information, visit **www.chcs.org**.

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