NHeLP
NATIONAL HEALTH LAW PROGRAM

"Hold Harmless" Passive Enrollment

Voluntary choice under § 1932 of the Social Security Act (42 U.S.C. § 1396u-2) requires an informed and *affirmative* choice by a beneficiary to participate in a dual eligible integration demonstration (i.e., opt-in). To the extent that MMCO nonetheless permits passive enrollment schemes (i.e., opt-out), NHeLP believes that beneficiaries must be held harmless for the underlying violation of Freedom of Choice. NHeLP recommends that MMCO require dual integration projects to implement minimum standards to guarantee beneficiaries are truly held harmless. NHeLP's suggested minimum standards for hold harmless passive enrollment are detailed below. It is important to note that these standards, when taken together, create the "hold harmless" effect; adopting a small set of these requirements does not cure the violation of Freedom of Choice.

1. Advance Notice

To make an informed choice (particularly in the context of an opt-out), a beneficiary must receive advance notice of the passive enrollment and right to opt-out at any time. The notice must include:

- A clear description of the integration demonstration project;
- A listing of which of the beneficiary's providers (defined as providers the beneficiary has a claim for in the previous 24 months) are and are not participating providers in the demonstration program/network (if MMCO does not require such a listing of providers, then MMCO must require clear instructions on how a beneficiary can access assistance to determine this – asking a beneficiary to contact her providers to ascertain their participation or consult drug formularies is not an acceptable solution);
- A description of the consequences of staying in the demonstration (including restricted provider networks, impact on current medications and treatment plans, and cost-sharing);
- A clear description of how a beneficiary can disenroll from a demonstration, including options to disenroll via mail, email, website, telephone, or phone; and
- Contact information and descriptions for ombudsman/consumer assistance programs.

This notice should be accessible to people with limited English proficiency (LEP) and people with disabilities, satisfying standards of Title VI of the Civil Rights (See 68 CFR 47311), the ADA, as well as § 1557 of the ACA.

- MMCO must require states to consult with beneficiaries and their advocates in designing notices. For example, states should review notices with their MCAC bodies and field test them with dual eligible individuals. In no circumstances should beneficiaries receive notice that is designed solely by an interested party, such as a managed care organization. Notices must be designed or approved by independent or government reviewers. MMCO could develop template notices with stakeholder input.
- Notices must be tested for readability and appropriate grade level; all notices should be at a 6th grade reading level or lower.
- NHeLP recommends that the threshold for translating these notices into all languages in which 5% or 500 LEP persons reside in the local service area. NHeLP also suggests

that all notices include taglines with at least 15 languages to explain how LEP persons can access language services. The American Translators Association has published guidelines for written translation (https://www.atanet.org/docs/Getting_it_right.pdf) that would form a strong basis for additional HHS guidance in this area.

When relevant in implementing the above, MMCO must specifically require compliance with § 1932(a), including § 1932(a)(5) (42 U.S.C. § 1396u-2(a)(5)) requiring information in a chart-like format allowing beneficiaries to compare their options. (MMCO might consider using a format similar to the Summary of Benefits and Coverage format to be used for Medicare plans).

MMCO should require that before an individual can be passively enrolled into a managed care entity there must be at least two additional documented outreach efforts (in addition to the advance notice) to inform an individual of her choice to accept assignment or opt-out.

2. Enrollment/Consumer Assistance

States must be required to conduct independent enrollment and consumer assistance activities.

- For enrollment, NHeLP recommends that MMCO require states to use an independent enrollment broker (IEB) or assume that role themselves. Ultimately, MMCO must require states to have an enrolling entity which is not an interested party. (A managed care plan, for example, is an interested party and may provide biased information.) An IEB can also satisfy consumer assistance requirement.
- The state must be prohibited from relying on the demonstration contractor as the primary (or only) source of consumer assistance. NHeLP also believes this consumer assistance requirement could be satisfied by through state contracting with community-based organizations like Protection and Advocacy System agencies, Area Agencies on Aging, Disability Resource Centers, local ARC affiliates, Independent Living Centers, SHIPs, etc. Consumer navigators and educators could be stationed consumer educators in places where dual eligible people frequently are present; this would reduce the need for passive enrollment.
- The enrollment and consumer assistance entities (whether independent enrollment brokers, state offices, or other contractors) must have access to real-time network provider lists (PCPs, specialists, hospitals, home supports agencies, etc.), drug formularies, and pharmacy networks as well as the capacity to provide personalized counseling to beneficiaries to help them make informed choices. The entity should also have enough information to describe how any current treatment plans will be impacted, if relevant.
- In addition to the capacity to answer specific questions, consumer assistance entities must have a general educational or overview option where individuals can receive basic information about their options and be guided through important content rather than having to ask all of the relevant questions. They must also provide services in a culturally and linguistically appropriate manner by using competent bilingual staff or interpreters.
- While individuals are receiving assistance, there is a significant risk that they may be led astray by aggressive marketing activities conducted by interested parties. MMCO should place meaningful restrictions on marketing practices and materials which may provide inaccurate or biased information. MMCO should require advance approval of all marketing materials, call scripts, and practices. Financial incentives to enroll, such as cash and prizes, should be prohibited.

3. Enrollment System Standards

If MMCO permits states to passively enroll individuals and auto-assign them to a managed care entity, MMCO should adopt minimum standards and use of "smart" auto-assign methods.

- If a state has only one provider network for its dual eligible demonstration, individuals should never be auto-assigned (or passively enrolled) into the network if it does not include their PCP (or specialist if the individual uses one as a PCP). For these individuals the state should use an opt-in system.
- If a state has multiple provider networks for its dual eligible demonstration (such as multiple managed care organizations), the auto-assignment should only allow assignment to networks which include the individual's PCP. If multiple plans include the PCP, then assignment should be based on maximum participation of providers and coverage of services. However, individuals should never be auto-assigned to any entity which does not meet minimum acceptable quality indicators (using standards such as HEDIS measures), regardless of whether their providers are participating in the networks.
- If individuals have no record (or record within the past 24 months) of health history, assignment should be based on some other set of criteria likely to result in effective assignments, such as geographic proximity to providers, provider capacity/performance for relevant diagnoses, and language capacity or accessibility of the provider network.
- Assignment should always be based on person-centered considerations (and quality), such as provider networks, treatment capacity, medication lists, travel distances, etc. Assignment methodologies should never be based on financial considerations. For example, states should not use an assignment methodology that favors a plan because it is the lowest bidder.
- Individuals should never be auto-assigned to any entity which does not have sufficient provider capacity to treat their conditions. Only providers who are actually taking new patients can be counted for this purpose. So, for example, a person with arthritis must not be auto-assigned to an entity if there are not two or more rheumatologists accepting new patients.
- MMCO should establish a maximum threshold for passive enrollment at any given time, with more vulnerable populations with complex health needs phased-in after less complex populations. Extremely large populations transferred at the same time increases the probability and impact of errors, reduces the capacity to address errors, and eliminates the opportunity to identify problems in advance of complex populations being passively enrolled.

Once an individual is auto-assigned, she should receive a clear notice that is linguistically/format appropriate, in a large font, explaining the auto-assignment that has been conducted along with a telephone number and contact person to find out more information.

4. Lock-ins Never Permissible

Hold harmless passive enrollment requires allowing a beneficiary to opt out *any time* they choose. Any lock-in period clearly constitutes an infringement on a beneficiary's Freedom of Choice and is not permissible. MMCO must require any state pursuing a lock-in provision to obtain the necessary Medicaid authority. This applies to any lock-in provision, including one which allows exceptions for "good cause."

5. Continuity of Providers and Treatment

Any passive enrollment system must include protections to ensure continuity of access to providers and treatment plans. A grave problem with passive enrollment occurs when a beneficiary gets auto-enrolled in a new managed care entity and is immediately unable to access her medical providers or medical treatments. Passive enrollment created serious health problems for many individuals in the implementation of the Medicare Part D passive enrollment process and thus MMCO must take certain steps to prevent a recurrence.

- MMCO must require states implement (at least) a 6-month transition period, beginning on the date of the beneficiary's first provider visit after enrollment begins. (For example, if a beneficiary is passively enrolled on January 1st, and next goes to the doctor on March 14th, the transition period would last until (at least) September 13th.
- During the transition period, individuals must not be subject to any of the network limitations of the managed care entity or treatment controls (i.e., prior authorization criteria, quantity limits, step therapies, drug formularies, etc.) with respect to on-going treatment. For example, during transition, a beneficiary could continue to access home support services even if she does not meet the managed care organization's utilization criteria.
- Continuity of treatment must apply to all current treatment plans, and the continuity protection should not be broken because of the end of an authorization period for an on-going service. For example if a beneficiary has a home attendant service that is re-authorized every 3 months, the authorization in place at the beginning of a 6-month transition period would clearly expire in mid-transition period; that expiration should not end the continuity requirement if, in the clinician's opinion, a re-authorization is part of the same treatment.
- MMCO must require provisions for maintaining the approved level of services if the beneficiary changes provider in the middle of an approval period.
- Treatment continuity protections must apply to any service addition or change that is a reasonable, foreseeable or necessary part of a current treatment plan.
- Dual eligible demonstration contractors must be required to develop a plan for how they will handle the end of the continuity period. If a beneficiary's PCP has not joined their network, the state must contact the beneficiary in the 30 days prior to the end of the continuity period to inform the beneficiary their provider has still not joined the network, that the continuity period is ending, and that they have the option of opting out or changing providers.

Conclusion

Considering the history of problems with passive enrollment systems, MMCO must implement significant beneficiary protections – as outlined above – in order to ensure safe transitions for individuals and compliance with Freedom of Choice law. Dual eligible beneficiaries must be held harmless to any attempt to change their insurance coverage through § 1932 (42 U.S.C. § 1396u-2) without their affirmative and informed choice. MMCO should require dual eligibility integration demonstrations to comply with all of the above requirements to create a system that truly protects Freedom of Choice. We look forward to working with MMCO as it develops processes to protect vulnerable individuals.