Engaging Medicare-Medicaid Enrollees: Insights from Three Financial Alignment Demonstration States

August 27, 2014
Welcome and Introductions

**Alexandra Kruse**
Senior Program Officer
Center for Health Care Strategies

**Carolyn Ingram**
Senior Vice President
Center for Health Care Strategies
A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care

- **Priorities**: (1) enhancing access to coverage and services; (2) integrating care for people with complex needs; (3) advancing quality and delivery system reform; and (4) building Medicaid leadership and capacity.

- **Provides**: technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.

- **Funding**: philanthropy and the U.S. Department of Health and Human Services.
I. Welcome and Introductions

II. The Financial Alignment Initiative

III. Massachusetts’ OneCare Program Experience

IV. Ohio’s Integrated Care Delivery System Experience

V. Virginia’s Commonwealth Coordinated Care Experience

VI. Questions and Answers
Movement to Integrated Care

- Financial Alignment Initiative
- Dual Eligible Special Needs Plan Platforms (AZ)
- Stepped Approach - Medicaid Managed Long-Term Services and Supports (NJ)
- Demonstration to Align Administrative Functions (MN)
### Financial Alignment Initiative: Joint State-Federal Demonstrations for Medicare-Medicaid Enrollees*

<table>
<thead>
<tr>
<th>CAPITATED</th>
<th>MANAGED FFS</th>
</tr>
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<tbody>
<tr>
<td>CA, IL, MA, MI, MN,**  NY, OH, RI, SC, TX, VA, WA**</td>
<td>CO, CT, WA**</td>
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<tr>
<td>• Joint procurement of high-performing health plans</td>
<td>• FFS providers, including Medicaid health homes or accountable care organizations</td>
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<tr>
<td>• Three-way contract: Centers for Medicare &amp; Medicaid Services, state, health plan</td>
<td>• Seamless access to necessary services</td>
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<td>• Single set of rules for marketing, appeals, etc.</td>
<td>• Quality thresholds and savings targets</td>
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<td>• Blended payment, built-in savings</td>
<td>• Voluntary, passive enrollment with opt-out provisions</td>
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*As of August 2014

**MN has administrative alignment model with D-SNPs; WA has both a capitated and MFFS model**
One Care: MassHealth plus Medicare

MassHealth Demonstration to Integrate Care for Dual Eligibles

August 27, 2014
Erin Taylor
Contents

- Enrollment Experience
- Early Indicators Project
- Strategies for Continuing to Boost Enrollment
- Post-Enrollment Engagement Activities
Total Enrollment

■ October 1, 2013 first effective date
■ Effective August 1 total number of enrollees: 18,067
  – 6,068 self-selection enrollments (34%)
  – 11,999 auto-assignment enrollments (66%)
    • 5,333 round 3 auto-assignment (July 1, 2014)
    • 2,827 round 2 auto-assignment (April 1, 2014)
    • 3,839 round 1 auto-assignment (January 1, 2014)
■ Enrollment Penetration as of August 1 (% eligible enrolled)
  – 19% overall
  – 24%-37% in auto-assignment counties
■ MassHealth issues monthly reports on enrollment activity to provide general information to stakeholders
Opt Outs

- As of August 1, 2014, 24,775 people had opted out of One Care
- Opt out figures include some people who may be ineligible
- Of approximately 95,700 individuals who received a One Care enrollment packet, roughly 26% have chosen to opt out
Early Analysis of Enrollment Activity

- Early Indicators Project (EIP)
  - Analyzing early quantitative and qualitative indicators to assess the perceptions and experiences of enrollees and those who have opted out
  - Distinct from One Care programmatic evaluation or quality measures

- Key data sources
  - Focus groups
  - Surveys
  - Data reports, including enrollment data, Customer Service, Serving the Health Information Needs of Everyone (SHINE), which is the State Health Insurance Counseling and Assistance Program in Massachusetts
Findings: Early Opt-ins

- Members had good understanding of One Care, found One Care enrollment information easy to understand
- Members found the enrollment process fairly easy
  - Found MassHealth Customer Service to be helpful
  - Made efforts to confirm that providers, pharmacies and medications would be covered before enrolling
- Reasons and hopes for enrolling into One Care
  - Less expensive/no co-payments
  - Having a care coordinator
  - Better dental coverage
  - One insurance/one insurance card
Findings: Early Opt-outs

- Knowledge of and information about One Care
  - Not enough information was provided/too generic
  - Wanted more information about providers and medications covered under One Care
- Deciding to not enroll into One Care
  - Members felt more secure having Medicare *and* Medicaid
  - Several had providers that were not in One Care
- Members expressed concern they may
  - Lose current doctors and medications
  - Not get care when needed
  - Have to wait for approvals for treatment or for appointment
- One Care is new and unknown
  - “…it doesn’t have any history behind it, so you really don’t know what is going to happen in a year or two.”
Strategies for Continuing to Boost Enrollment

- Ongoing targeted outreach efforts to members, providers, advocates and community organizations
  - Provider outreach strategy
    - Advertising in journals and trade publications
    - Newsletter and e-communication
    - Direct mail
  - Community-based organization outreach sessions
- Encouraging plans to continue developing provider networks
- Passive enrollment assignment approach
- Video Vignettes
MassHealth has developed video vignettes to share enrollees’ personal experiences with One Care.

The stories bring to life some of the key features and benefits of One Care from the perspective of enrollees, including:

- Care coordination
- Care team
- Independent living
- No co-payments

MassHealth will use these stories to continue to raise awareness of One Care.
Plan challenges post-enrollment

- Unable to reach some enrollees
  - Most hard-to-reach people are enrolled through auto-assignment, but some enrolled through self-selection
  - For members not utilizing care, plans don’t have provider relationships to leverage to make connections
  - Some people are experiencing homelessness or living in temporary housing, and may not receive information
  - Some members may not read or understand notices
- Some individuals are unwilling to engage in care planning
- Assessment completion and continuity of care period for members who disenroll (either voluntarily or due to eligibility issues) and re-enroll
Post-Enrollment Engagement Activities – Hard-to-Reach Enrollees

- Plans are using different approaches to reach people, including
  - Using claims history and Rx data to reach out to providers
  - Working closely with all providers to try to get the most updated contact information
  - Partnering with pharmacies and leaving a “please contact us” card for members when a script is filled
  - Calling members early in the month before cell phone minutes run out on prepaid phone services

- MassHealth works closely with the plans to understand how they are implementing strategies to meet enrollee assessment and care planning requirements with hard-to-reach members
MassHealth is working with CMS to develop guidance to address:

- Enrollees unwilling to engage in the care planning process
- Members who enroll and disenroll (or are disenrolled because of a change in eligibility status) within 90 days

Guidance will be consistent with contractual obligations
Visit us at www.mass.gov/masshealth/onecare

Email us at OneCare@state.ma.us
MyCare Ohio
Ohio’s Integrated Care Delivery system

Harry Saxe, Project Manager
The Basics

• MyCare Ohio consists of 7 regions and 29 of 88 Ohio counties

• The regions are centered on major metropolitan hubs (Columbus, Cincinnati, Cleveland, Toledo, Dayton)

• The first region went live on May 1, 2014, followed by three each on June 1 and July 1

• Enrollment for Medicaid benefits was required, enrollment for Medicare is optional
Enrollment Process

• Multiple instructional mailings to eligible beneficiaries over a 90-day period encouraging self-selection of a MyCare plan for Medicaid
• Multiple state sponsored regional forums, webinars and conference calls
• Outreach/education via the Dept. of Aging and the Aging and Disability Resource Networks
• Forums conducted by the MyCare managed care plans
• At 30 days from go-live date if no plan selected, auto-assignment initiated
• Auto-assignment predominant
• 90 days to change plans after region go-live date
• All enrollment handled by contracted enrollment broker
Enrollment Status

• 100,000+ enrolled to date
• Roughly 14% of the 100,000+ have chosen to have the MyCare plan provide both Medicare & Medicaid benefits
• To date, 488,000+ claims paid = $208 million
• Medicaid passive suspended until Fall 2014 to avoid conflicting with Medicare enrollment processes
• Newly eligible beneficiaries can still enroll but will not be required to do so
Enrollment Status

- Beneficiaries who have not chosen a MyCare Ohio plan for their Medicare benefits by mid-October will be notified of their assignment to their current MyCare plan for Medicare benefits.
- They can decline that enrollment and continue with their current Medicare arrangement.
- For those who do not decline, as of 1/1/15 their MyCare Ohio plan will begin providing both benefit packages.
Enrollment Successes

• Creation of an enrollment workgroup to assist with:
  – drafting and vetting of letters,
  – developing instructional material
  – conducting focus groups
  – organizing regional forums for beneficiaries and providers

• Transitioning to an implementation workgroup to continue supporting the demonstration

• Use of local stakeholders to support the project
Enrollment Successes

- The development of provider-specific collaboratives working one-on-one with the MyCare Ohio plans to address issues of concern to their members and the population they serve
- Use of one-to-one counseling to assist beneficiaries when choosing a plan
- The development of productive working relationships with CMS, the plans, advocates and provider associations
Enrollment Challenges

• Large numbers of independent providers with little or no familiarity with claims submission to an MCP, steep learning curve requiring hundreds, perhaps thousands of hours of training by plans- ongoing effort
• Plans adjusting to new provider types and unique and often complex FFS reimbursement/billing methodologies
• Unexpected developments (i.e., the primary billing agent for independent providers dropping the service with little notice)
• Enrollment/disenrollment flexibility inherent in the demonstration design contributes to instability
Enrollment Challenges

• No test environment for enrollment
• Providers adjusting to the MCP payment cycle vs. a FFS cycle
• Larger than expected volume of calls to the enrollment hotline created delays
• Complex and nuanced nature of these projects
Lessons Learned to Date

• There is never enough engagement with providers or beneficiaries
• There is never enough time or resources to do the above
• Flexibility in pursuit of benefit integration is an absolute necessity
• Expect the unexpected, you won’t be disappointed
• Prepare for criticism
• Be realistic with yourself and others about expectations
• Prepare for a marathon, not a sprint
Virginia’s Early Dual Demonstration Enrollment Experience

August 27, 2014

Elisabeth Smith, RN
CCC Program Analyst
Virginia Overview

1. Early Enrollment Experiences

2. Retain Enrollments & Re-engage Disenrollments

3. Challenges and Successes with Engaging Enrollees
Early Enrollment Experiences

• Opt-outs are beneficiaries exercising choice
• Majority of opt-outs in each region come directly before or directly after passive enrollment
• Opt-out numbers change frequently & are not yet representative of total population
## Early Enrollment Experiences

<table>
<thead>
<tr>
<th>CCC Region</th>
<th>Total Population</th>
<th>Active Opt-ins</th>
<th>Auto-Assign</th>
<th>Opt-outs</th>
<th>Optout % Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Virginia</td>
<td>21505</td>
<td>1363</td>
<td>12937</td>
<td>4950</td>
<td>23.02%</td>
</tr>
<tr>
<td>Northern Virginia</td>
<td>13634</td>
<td>196</td>
<td>XX</td>
<td>583</td>
<td>4.28%</td>
</tr>
<tr>
<td>Roanoke</td>
<td>9635</td>
<td>286</td>
<td>6726</td>
<td>1351</td>
<td>14.02%</td>
</tr>
<tr>
<td>Tidewater</td>
<td>18522</td>
<td>1055</td>
<td>9315</td>
<td>6648</td>
<td>35.89%</td>
</tr>
<tr>
<td>Western/Charlottesville</td>
<td>5957</td>
<td>205</td>
<td>3907</td>
<td>736</td>
<td>12.36%</td>
</tr>
<tr>
<td><strong>Total Members</strong></td>
<td><strong>69253</strong></td>
<td><strong>3190</strong></td>
<td><strong>32888</strong></td>
<td><strong>14268</strong></td>
<td><strong>20.60%</strong></td>
</tr>
</tbody>
</table>

Total population reflects all beneficiaries eligible for CCC at the beginning of the month. This number includes those who may lose Medicaid eligibility or become newly excluded by the end of this month. The opt-out rate is calculated based on the total population.
Early Enrollment Experiences

- Providers attempting mass opt-outs
  - Respond with memo on beneficiary choice
  - Drafted NF letter to share with bene/rep
  - Targeted trainings
Retain Enrollments & Re-engage Disenrollments

Ensure Care Continues

Investigate Disenrollment Reasons

Consider the Provider Factor
2. Ensure Care Continues (Retain)

- Built-in continuity of care period prevents break in services
- Work with IT to identify and resolve any systems issues quickly
Investigate Disenrollment Reasons (Retain and Re-engage)

• Working with plans to understand disenrollment reasons
  – Report frequency and reasons to State and CMS
  – Exploring disenrollment may be a new process, working with the health plans for scripting and policy creation

• Enrollment broker gathering disenrollment information
Consider the Provider Factor (Retain & Re-engage)

- Single case agreements allow enrollees to continue with current provider
- Providers holding out on contracting creates enrollment confusion or worry for beneficiary
- Engaging providers in multiple settings and methods
  - Training by provider type
  - Weekly call opportunities
  - On-site training by request
  - Regional Townhalls
3 Engaging Enrollees

Challenges

• Contact information for beneficiaries is only as accurate as what is provided to the local eligibility worker

• Phased approach of passive enrollment brings on large numbers of beneficiaries at one time. Can create assessment backlogs-monitor through CMT dashboard.
Engaging Enrollees

Successes

• Engagement from stakeholder advocates with population experience. Mental Health and disability advocates are assisting with education and focus groups

• Medical Transition Report-gives MMPs last 2 years’ Medicaid services and provider contacts to increase ability to engage providers (Challenge: currently no Medicare data)
Resources


• **Building State Capacity to Implement Integrated Care Programs for Medicare-Medicaid Enrollees.** M. Soper. Center for Health Care Strategies, July 2013.

• **Three State’s Paths to Medicaid Managed Long-Term Care; Florida, New Jersey and Virginia.** S. Barth and B. Enssl. Center for Health Care Strategies, July 2013.

• **Options for Attracting and Retaining Enrollment in Financial Alignment Initiatives for Medicare-Medicaid Enrollees.** Integrated Care Resource Center, April 2013.

Contact Us

Carolyn Ingram  
Cingram@chcs.org

Alexandra Kruse  
Akruse@chcs.org
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