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Growing Enrollment in Integrated Programs

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Introduction and Overview

- Medicare-Medicaid Plans (MMPs) in the CMS financial alignment demonstrations can learn lessons about growing enrollment from experienced and successful Dual Eligible Special Needs Plans (D-SNPs)
- The biggest secret is that there isn't a secret
  - Plan enrollment grows over time if plans are able do a good job of serving members and coordinating their services
- The Integrated Care Resource Center (ICRC) is looking at factors accounting for D-SNP enrollment growth between 2008 and 2015 in 13 states with high D-SNP enrollment
  - Will review some initial results of that analysis today

MMP and D-SNP Enrollment Growth

- **MMPs began operating in October 2013, and as of July 2016 there were 373,127 enrollees in 61 plans in 10 states**
  - **CMS allows up-front and continuing passive enrollment, with opt-out and monthly disenrollment options**
- **D-SNPs began operating in January 2006**
  - **CMS allowed one-time passive enrollment of dually eligible beneficiaries into D-SNPs from existing Medicaid managed care plans**
    - Over 212,000 individuals passively enrolled in 14 states (AZ, CA, CO, FL, KY, MN, NJ, NY, OR, PA, TN, TX, UT, and WA)
    - Nearly 75 percent were from AZ, CA, MN, and PA
    - Since then, dually eligible beneficiary enrollment into D-SNPs has been entirely voluntary, and beneficiaries can disenroll monthly
- **Overall D-SNP enrollment has grown from 439,412 in July 2006 to 1,832,882 in July 2016**
  - **356 D-SNPs are operating in 40 states, DC, and Puerto Rico**
    - Wide variation by state and by plan in number of D-SNP enrollees and growth over time
    - Many D-SNPs have closed or consolidated, while others have experienced solid and steady growth
    - Largest plans have 40,000+ enrollees, while many have 10,000-15,000

Initial ICRC Analysis of D-SNP Enrollment Growth

- **ICRC reviewed D-SNP enrollment growth between 2008 and 2015 in 13 states with substantial current enrollment**
  - AZ, HI, LA, MA, MN, NJ, NM, OH, OR, PA, TN, TX, and WI
  - **Focused specifically on D-SNPs in states where there are actual or potential linkages between D-SNPs and "companion" Medicaid plans offering LTSS benefits**
    - AZ, HI, MA, NM, TN, TX, and WI
  - **For comparison, also looked at some D-SNPs with substantial enrollment growth that did not have companion Medicaid MLTSS plans with mandatory Medicaid enrollment**
    - LA – No companion Medicaid plans and no mandatory Medicaid MLTSS program for dual eligibles
    - OR – LTSS not included in capitated Medicaid plans
    - PA – No mandatory Medicaid MLTSS program (although one is now being developed)
- **Interviewed selected states and D-SNPs**
  - **More interviews needed**

Factors That Contribute to D-SNP Enrollment Growth – Actions by States

- **Basic state program design decisions**
  - Require mandatory enrollment of dual eligibles in Medicaid MLTSS (AZ, HI, MN, TN, TX)
  - Require MLTSS plans to have companion D-SNPs, and vice versa (AZ, HI, MN, TN, TX)
- **State efforts to facilitate enrollment of dual eligibles in companion plans**
  - Assign dual eligibles to companion Medicaid plans, with option to choose Medicare FFS or another MA plan (AZ)
  - Limit enrollment in D-SNPs to beneficiaries that choose companion Medicaid plans (MN, NJ)
  - Limit D-SNP enrollment to full duals (AZ, HI, MA, MN, NJ, WI)
  - Send notices to new and current dual eligibles explaining benefits of integrated care, and D-SNP options (AZ, MN)
  - Work with D-SNPs and CMS to allow "seamless conversion" of Medicaid enrollees in companion Medicaid plans into the D-SNP when they become newly eligible for Medicare (AZ, TN)
  - Work with SHIPs and ADRCs to increase beneficiary understanding of integrated care benefits and options (AZ)

Factors That Contribute to Enrollment Growth – D-SNP Actions

- **Initial enrollment**
  - **Marketing to new enrollees, to the extent permitted or encouraged by Medicare and Medicaid rules**
    - July 2014 ICRC TA brief ("Moving Toward Integrated Marketing Rules and Practices for Medicare and Medicaid Managed Care Plans") outlines the basics
      - http://www.integratedcareresourcecenter.com/PDFs/ICRC%20Moving%20Toward%20Integrated%20Marketing.pdf
    - Some states have relatively stringent Medicaid marketing rules
  - **Community outreach**
    - Community events, health fairs
    - Especially important when states place limits on direct marketing to Medicaid beneficiaries
    - Reaches primarily relatively active and healthy beneficiaries, plus caregivers for those who are homebound or less healthy and engaged
  - **Plan name recognition**
    - Impact depends on the plan, state, and market
      - United now generally uses one name in all states, Amerigroup (Anthem) retains the Amerigroup name in Medicaid, Centene uses different names in every state, and large single-state plans can have a marketing advantage in those states

Factors That Contribute to Enrollment Growth – D-SNP Actions *(Cont.)*

- **Enrollment and retention over time**
  - **Building and maintaining relationships with providers**
    - Physicians are most important
    - Home health, HCBS, and nursing facility providers are also important when providing Medicaid LTSS
    - Requires concerted outreach, adequate payment, and attention to provider administrative burden
  - **Relationships with enrollees**
    - Establish relationships as quickly as possible
      - Member services
      - Clinical relationships, starting with health risk assessment
      - Care coordinator
    - Linkage of enrollees to care coordinators is key
      - Personal relationship with a care coordinator is the single biggest factor in maintaining and growing enrollment
      - Care coordinators must provide reliable and timely information, help with navigation, and access to needed care and services

Factors That Contribute to Enrollment Growth – D-SNP Actions *(Cont.)*

- **Specific incentives to better coordinate overlapping services**
  - **Doing a better job of coordinating overlapping Medicare and Medicaid benefits like home health, DME, nursing facility services, and transportation can make a plan more appealing for dual eligibles, but the "face" of these improvements for enrollees will be their care coordinator**
- **Publicly available measures of plan quality and performance**
  - **These measures are not likely to have a significant impact on beneficiaries with limited levels of health literacy, unless states themselves give substantial prominence to plan quality and performance ratings**

Conclusion

- MMPs can draw lessons from experienced D-SNPs to grow enrollment over time
  - Passive enrollment can provide a good start, but Medicare enrollment over time is essentially voluntary for both MMPs and D-SNPs
- States can help with enrollment in integrated plans through program design choices, ongoing encouragement of beneficiary enrollment, and work with plans to improve performance and quality
- Every dually eligible beneficiary does not need help coordinating Medicare and Medicaid services
  - Plans can grow enrollment over time by identifying and serving well those who do

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