Integrated Care Resource Center

TECHNICAL ASSISTANCE BRIEF

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State and Health Plan Strategies to Grow Enrollment in Integrated Managed Care Plans for Dually Eligible Beneficiaries

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IN BRIEF: States and health plans that provide Medicare and Medicaid services to dually eligible beneficiaries can work together to achieve the levels of enrollment that are needed to support effective health plan coordination of these services. States can support enrollment growth through program design decisions, marketing support, and beneficiary education. Health plans have an especially important role in retaining and growing their enrollment in an environment in which enrollment for Medicare services is voluntary. They must consistently demonstrate that they can provide better access to and coordination of Medicare and Medicaid services than other alternatives and ensure enrollees' timely and appropriate care. Plans' ability to retain enrollment can be monitored through a standardized measure of voluntary disenrollment from the plan that is reported each year in the Centers for Medicare & Medicaid Services star ratings system for Medicare managed care plans.

Introduction

States that contract with health plans to provide Medicare and Medicaid services for dually eligible beneficiaries have an interest in helping these plans achieve the levels of enrollment needed to support an effective care coordination infrastructure, which includes staff, management, and information systems.

This technical assistance brief outlines a variety of actions that states can take to support health plan enrollment growth, focusing primarily on the experience of states that have contracted with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) and with Medicare-Medicaid Plans (MMPs) participating in the Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative capitated model demonstrations. Since enrollment in both D-SNPs and MMPs is voluntary for Medicare benefits, both states and health plans that want to grow enrollment in these plans must demonstrate to dually eligible beneficiaries that the coordination of Medicare and Medicaid services available through the plans is an improvement over their other options.

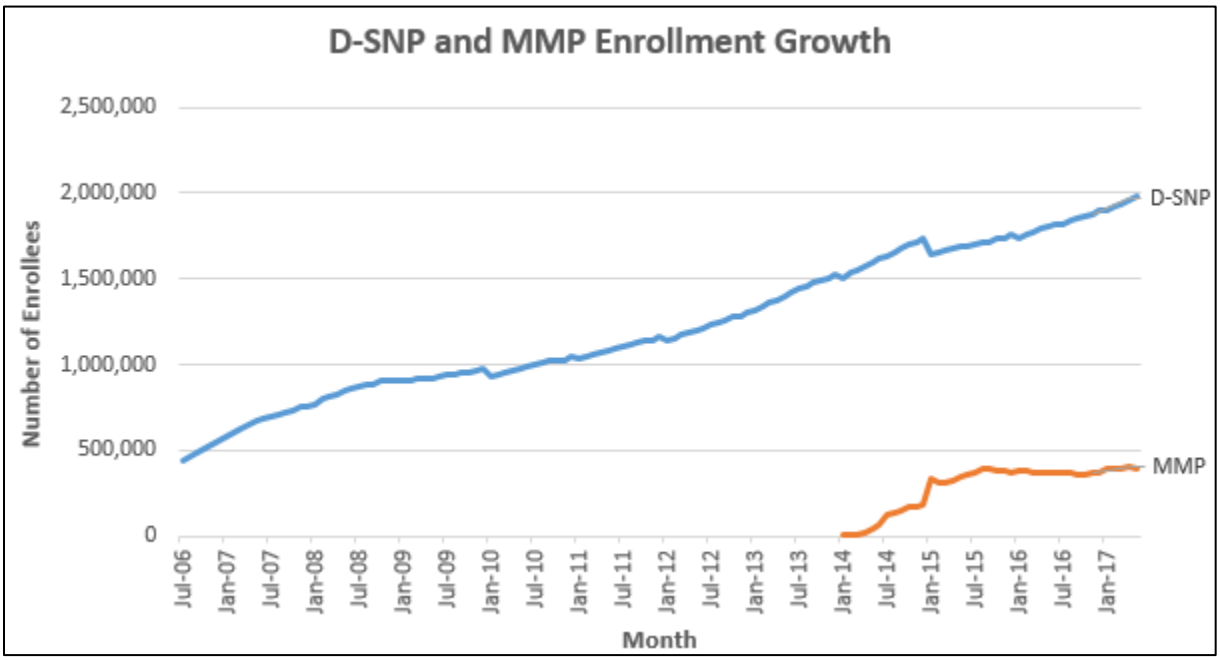
As shown in Exhibit 1, enrollment in D-SNPs in the aggregate has grown fairly steady over time, while MMP enrollment growth has been relatively flat after the initial start-up period (2013 to 2015) of the demonstration programs that are now operating in ten states. Within these aggregate trends, however, there has been substantial variation in enrollment growth among plans and states:

- **D-SNP enrollment growth.** D-SNPs began operating in January 2006, and national enrollment in 226 D-SNPs reached 439,412 in July of that year. Overall D-SNP enrollment has grown steadily over time, reaching 1,976,997 in May 2017, with 377 D-SNPs operating in 43 states and jurisdictions, including the District of Columbia and Puerto Rico. While many D-SNPs have struggled to gain enrollment, with many plans closing or consolidating over the last decade, others have experienced steady and solid growth.

- **MMP enrollment growth.** Enrollment in MMPs started in October 2013 and reached an initial high of 397,165 in September 2015 in the ten states with capitated model demonstrations. Subsequently, enrollment has fluctuated from month to month, and was at 397,776 in May 2017. Some states and MMPs have been more successful in growing enrollment than others.[1]

To get a historical perspective on the factors contributing to enrollment growth, The Integrated Care Resource Center (ICRC) analyzed D-SNP enrollment growth between 2008 and 2016 in 13 states with substantial current enrollment in D-SNPs (Arizona, Hawaii, Louisiana, Massachusetts, Minnesota, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, Tennessee, Texas, and Wisconsin) to identify specific D-SNPs that had significant growth in enrollment over that period. ICRC then conducted selective interviews with representatives of some of those plans to discuss the factors they believe accounted for their enrollment growth.

Exhibit 1. D-SNP and MMP Enrollment Growth, 2006-2017



SOURCE: Centers for Medicare & Medicaid Services. "SNP Comprehensive Report." and "Monthly Enrollment Report by Contract." D-SNP enrollment unavailable in August 2006, October 2006 through Feb 2007, and April 2007.

What States Can Do to Facilitate Enrollment Growth

While growth in enrollment over time depends in large measure on what health plans do to improve care coordination, access to services, and quality, states can play a major role by establishing a framework for enrollment growth and helping plans build and sustain that growth. Important elements of the state role include: (1) program design decisions; (2) communications and Medicaid marketing rules; and (3) ongoing activities to help plans sustain and increase enrollment.

1. Program Design

Basic state program design decisions. Because enrollment in D-SNPs and MMPs is voluntary, as it is in all Medicare Advantage plans, enrollment growth in these plans is generally slow and incremental in the absence of some outside impetus for enrollment. For MMPs participating in the CMS Financial Alignment Initiative capitated model demonstrations, that impetus has come from passive enrollment, in which beneficiaries who do not make a choice are assigned to a plan, but have the option to disenroll from the plan at any time.

For states that rely on D-SNPs for integration of Medicare and Medicaid benefits, the impetus for enrollment can come from state policies that: (1) require dually eligible beneficiaries to enroll in Medicaid managed care plans for their Medicaid benefits; and (2) require Medicaid plans and D-SNPs in the state to operate "companion" plans that enable enrollees to obtain both their Medicaid and Medicare benefits from plans operated by the same entity in the same geographic area. States that have both these requirements include Arizona, Hawaii, Minnesota, New Jersey, Tennessee, and Virginia.[2] Some other states, including Florida, Massachusetts, New Mexico, Texas, and Wisconsin, have variants of this approach that do not require mandatory Medicaid enrollment, or that do not require all Medicaid plans and D-SNPs to have companion plans.[3]

The initial boost to integrated enrollment from these program design features can help plans obtain at least the minimum number of enrollees needed to support an effective care coordination infrastructure.

Program design refinements and enhancements to encourage integration. States that have companion Medicaid and D-SNP plans can further encourage enrollment by dually eligible beneficiaries in aligned plans by: (1) assigning dually eligible beneficiaries in D-SNPs to companion Medicaid plans (Arizona); (2) limiting enrollment in D-SNPs to beneficiaries who choose companion Medicaid plans (Minnesota and New Jersey); and (3) limiting D-SNP enrollment to beneficiaries entitled to full Medicaid benefits (Arizona, Hawaii, Massachusetts, Minnesota, New Jersey, and Wisconsin).[4]

States that operate capitated model financial alignment demonstrations can encourage enrollment in MMPs rather than in less integrated D-SNPs by limiting enrollment in D-SNPs when MMP enrollment options are available. In Cal MediConnect, California's financial alignment demonstration, for example, D-SNPs affiliated with Cal MediConnect MMPs that operate in CalMediConnect service areas are not allowed to enroll beneficiaries eligible for Cal MediConnect.[5]

2. Communication and Marketing

Health plan marketing. Differences between Medicare and Medicaid marketing rules can present difficulties for D-SNPs and MMPs that seek to enroll dually eligible beneficiaries in the same or companion plans for both their Medicare and Medicaid benefits.[6] These differences reflect in part the fact that enrollment in Medicare Advantage plans and MMPs is voluntary, with beneficiaries retaining the right to remain in Medicare fee-for-service, while enrollment in Medicaid managed care is often mandatory, although beneficiaries have a choice of plans.

Medicare Advantage plans rely heavily on direct marketing to potential enrollees through mail, television, and radio, and also use plan-employed or contracted agents and brokers who work directly with potential enrollees. Most Medicaid managed care programs forbid this kind of direct marketing and use of private brokers, relying instead on state-contracted enrollment brokers to assist beneficiaries with their choice of plans.

States that seek to encourage enrollment in integrated managed care programs may want to consider ways to modify their Medicaid managed care marketing rules to take the Medicare rules for D-SNPs into

account. Arizona, for example, explicitly allows D-SNPs to market directly to dually eligible beneficiaries through print, television, radio, and other advertising, although it encourages these plans to market only to enrollees in its companion Medicaid plans.[7] In New York's financial alignment demonstration ("Fully Integrated Duals Advantage" or FIDA), the state increased the dollar limit on nominal gifts to potential demonstration plan enrollees from the state Medicaid managed care limit of $5 per person to the Medicare Advantage limit of $15 per person.[8]

State communications on integrated enrollment. There are several additional steps states can take to encourage dually eligible beneficiaries to enroll in aligned plans for their Medicare and Medicaid benefits. States can send letters to potential dually eligible beneficiaries on state letterhead, as Arizona has done. Through other media and stakeholder forums, states can communicate and promote to dually eligible beneficiaries the advantages of being enrolled in aligned Medicare and Medicaid plans. The plans we interviewed reported that consistent messaging and a variety of content regarding the advantages of aligned plan enrollment are key in communicating with beneficiaries. Beneficiary education should be an ongoing process, not just a one-time event.

Beneficiary enrollment counseling. Coordinating with Medicare State Health Insurance Programs (SHIPs) and state Aging and Disability Resource Centers is another example of how states can inform potential enrollees about their integrated care options. An upcoming ICRC technical assistance brief will outline options for states to work with SHIPs, and it will describe how Arizona, Massachusetts, and Texas have worked with their SHIPs to facilitate integration.[9]

State enrollment brokers. One challenge states face in informing dually eligible beneficiaries about their options for integrated programs is that most Medicaid enrollment brokers have limited or no experience with Medicare managed care options. ICRC has worked with states in the CMS Financial Alignment Initiative capitated model demonstrations to help improve enrollment brokers' ability to counsel dually eligible beneficiaries on their options, and has prepared two technical assistance briefs with guidelines and tips for states.[10]

3. Ongoing Enrollment Support

States participating in the CMS Financial Alignment Initiative demonstrations have a number of options to support enrollment growth in MMPs including:

- **Ongoing MMP passive enrollment.** States may choose to conduct ongoing passive enrollment after the initial passive enrollment waves. This approach will capture individuals who become eligible for Medicare first and gain Medicaid eligibility later, become eligible for Medicaid first and gain Medicare eligibility later, or move into the service area.[11]
- **Annual MMP passive enrollment.** In lieu of or in addition to monthly ongoing passive enrollment, states may conduct annual passive enrollments that are effective January 1st. This approach enables states to passively enroll individuals who regain their Medicaid eligibility after having lost eligibility during the calendar year.[12]
- **State outreach to those who elected to opt out of MMP passive enrollment.** States may conduct outreach and education on the benefits of enrolling in an MMP to dually eligible beneficiaries who have previously opted out of passive enrollment into an MMP.[13]
- **Deeming.** An MMP may choose to provide a deemed continued eligibility period for individuals who lose Medicaid eligibility, as long as the individual can reasonably be expected to regain Medicaid eligibility within a specified period outlined in Appendix 5 of each state's enrollment guidance requirements for MMPs.[14]

- **Rapid re-enrollment.** If an individual is involuntarily disenrolled from an MMP due to a loss of Medicaid eligibility, states may rapidly re-enroll the individual in his/her original MMP. Rapid re-enrollment can only occur if the individual regains Medicaid eligibility no more than two months from the effective date of disenrollment.[15]

States that contract with D-SNPs that operate companion Medicaid plans should consider whether enrollment support options like these could implemented in their states for these integrated plans.

What Health Plans Can Do

Retaining and growing enrollment over time in both D-SNPs and MMPs depends heavily on what health plans themselves do to coordinate and improve access and care.[16] Experienced health plans stress that there are four interrelated components to this:

1. Relationships with Providers

Physicians are the key provider group in either supporting or undermining growth in health plan enrollment, especially for dually eligible beneficiaries who were in Medicare for a significant period before becoming eligible for Medicaid, and have had an established relationship with Medicare providers. Plans must make every effort to include these providers in their integrated plan networks. Payment to physicians is a major factor in getting their participation and support. Integrated plans sometimes pay somewhat more than Medicaid would pay, which may still be less than Medicare fee-for-service payment. Plans that receive capitated payments from the state to cover Medicare beneficiary cost sharing for Medicare-Medicaid enrollees may also be able to ease providers' administrative burden in collecting this cost sharing by handling the transaction entirely within the plan rather than requiring providers to submit "crossover claims" to the state.[17]

2. Relationships with Enrollees

The key to keeping a new enrollee in a plan is establishing a relationship very rapidly. This can be done through:

- **Member services.** Enrollment in an integrated health plan provides an opportunity for the member to experience what it is like to have someone readily available to help them. To be most effective, it should be a very personal interaction, not just an automated or routine response. In New Jersey, the state's Fully Integrated Dual Eligible Special Needs Plans established dedicated member call centers for these integrated products. They have found that using dedicated call centers with staff especially trained to explain benefits and provide other information allows them to better explain their products to both potential and enrolled members.
- **Clinical relationships.** Plans can use information about enrollee care needs from initial health risk assessment questionnaires and data on past service use to work with a new enrollee to establish a plan of care. Plans reported that this must happen very quickly. If there is no contact between a plan representative and a new enrollee within the first three weeks of enrollment in the plan, plans suggested that there is a high risk of disenrollment.
- **Early MMP welcome call/outreach to passive enrollees.** MMPs in some Financial Alignment Initiative demonstrations can reach out to individuals prior to passive enrollment in order to provide information on the upcoming changes in coverage. D-SNPs and other Medicare Advantage plans can make similar calls to new enrollees.[18]

3. Linkages of Enrollees to Care Coordinators

For many enrollees, establishing a relationship with someone they trust is a driving force in their decision to continue enrollment. The beneficiary must feel there is a relationship with the care coordinator. Plans said that that as this relationship improves over time and the enrollee knows there is one number and one place to call to get their questions answered, it lays the groundwork for success in retaining and growing enrollment.

4. Coordinating and Improving Access to Care over Time

Plans must continually demonstrate to their current and potential enrollees that they are adding value compared to other options enrollees have. ICRC has assembled care management resources for states and health plans serving dually eligible beneficiaries that highlight effective approaches to building care management and coordination capabilities over time.[19]

Tracking Medicare Advantage Disenrollment Rates

States can use one of the measures in the Medicare Advantage Star Ratings (i.e., Measure C27, "Members Choosing to Leave the Plan") to assess the success of D-SNPs and MMPs in retaining enrollment.[20] There is some lag in public reporting of this measure – the CY 2017 Star Ratings published in October 2016, for example, covered plan performance in CY 2015 – and not all Medicare Advantage contracts have enough D-SNP enrollment in the measurement year to calculate this measure reliably. However, an ICRC analysis of all 234 SNP contracts listed in the 2017 Star Ratings report indicated that 161 of these contracts included D-SNPs in CY 2015, and 51 of these contracts had D-SNP enrollment of 100 percent.[21] The Appendix table shows the CY 2015 percent of members choosing to leave the plan for these 51 "100 percent" D-SNP Medicare Advantage contracts, by state and by plan.

States that have contracted with D-SNPs can require the D-SNPs to submit their results on this disenrollment measure directly to the state at the same time they submit the information to CMS, so the information could be available to the state before it is published on the CMS web site. The state could also require the D-SNP to tell the state what portion of each contract's enrollment is accounted for by the D-SNP enrollment in that state. With this information, states can compare the performance of all the D-SNPs in the state on this disenrollment measure, although they would not be able to compare the performance of the D-SNPs in their state to that of D-SNPs in other states until CMS publishes the Star Ratings for the upcoming year in October of each year.

Conclusion

The secret to retaining and growing health plan enrollment over time is that there is no secret. Health plans need to demonstrate every day that they are the best option for their enrollees. States need to help plans with marketing and enrollment, give them the support and flexibility they need to manage care effectively and to innovate, and hold them accountable for performance and results.

Appendix: Percent of Members Choosing to Leave the Plan as Measured in 2017 Star Ratings for Medicare Advantage Contracts with 100 Percent D-SNP Enrollees[1,2]

State	Contract Number	Plan Name	Parent Organization	Overall Star Rating[3]	Members Choosing to Leave the Plan Star Rating[4]	Percent of Members Choosing to Leave the Plan[5]	D-SNP Enrollment (Total Contract Enrollment)
AR	H1587	ARKANSAS SUPERIOR SELECT, INC.	Select Founders, LLC	--	--	--	174
AZ	H0321	ARIZONA PHYSICIANS IPA, INC.	UnitedHealth Group, Inc.	3.5	5	7%	37,592
AZ	H4931	UNIVERSITY CARE ADVANTAGE, INC.	Banner Health	3	4	13%	4,969
AZ	H5430	ONECARE BY CARE1ST HEALTH PLAN ARIZONA INC.	California Physicians' Service	3.5	4	12%	1,803
AZ	H5580	SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION	Southwest Catholic Health Network	3.5	5	6%	17,952
AZ	H5587	HEALTH CHOICE ARIZONA, INC.	IASIS Healthcare	3	4	11%	9,846
AZ	H5590	BRIDGEWAY HEALTH SOLUTIONS	Centene Corporation	4	5	4%	1,503
CA	H5433	ORANGE COUNTY HEALTH AUTHORITY	Orange County Health Authority	3.5	4	12%	12,157
CA	H5810	MOLINA HEALTHCARE OF CALIFORNIA	Molina Healthcare, Inc.,	3	4	14%	4,165
CO	H0624	UNITEDHEALTHCARE INSURANCE COMPANY	UnitedHealth Group, Inc.	3.5	4	11%	4,106
FL	H5190	SUNSHINE STATE HEALTH PLAN, INC.	Centene Corporation	--	2	28%	855
FL	H8130	MOLINA HEALTHCARE OF FLORIDA, INC.	Molina Healthcare, Inc.,	3.5	2	29%	1,570
GA	H7173	PEACH STATE HEALTH PLAN, INC.	Centene Corporation	--	--	--	194
HI	H5969	ALOHACARE	AlohaCare	--	--	--	607
HI	R3175	UNITEDHEALTHCARE INSURANCE COMPANY	UnitedHealth Group, Inc.	3.5	5	5%	3,406
MA	H2224	SENIOR WHOLE HEALTH, LLC	SWH Holdings, Inc.	3.5	5	5%	10,624
MA	H2225	COMMONWEALTH CARE ALLIANCE, INC.	Commonwealth Care Alliance, Inc.	4.5	5	5%	6,813
MA	H2226	UNITEDHEALTHCARE INSURANCE COMPANY	UnitedHealth Group, Inc.	4.5	5	5%	14,061

[1] Contract enrollment is as of December 2015. The voluntary disenrollment measure and the voluntary disenrollment percent covers disenrollment during calendar year 2015.
[2] Cells with the symbol (--) signify not enough data was available.
[3] Out of a total of 5 stars. The overall star rating is calculated using weighted averages of each of the measure's Star Ratings.
[4] Star Measure C27: Members Choosing to Leave the Plan. Star Measure is out of a total of 5 stars.
[5] Star Measure C27: Members Choosing to Leave the Plan as a percentage of total enrollment.

State	Contract Number	Plan Name	Parent Organization	Overall Star Rating[3]	Members Choosing to Leave the Plan Star Rating[4]	Percent of Members Choosing to Leave the Plan[5]	D-SNP Enrollment (Total Contract Enrollment)
MI	H5685	HAP MIDWEST HEALTH PLAN, INC.	Henry Ford Health System	2.5	4	16%	920
MI	H5926	MOLINA HEALTHCARE OF MICHIGAN, INC.	Molina Healthcare, Inc.,	3.5	4	11%	9,905
MN	H2416	PRIMEWEST RURAL MN HEALTH CARE ACCESS INITIATIVE	PrimeWest Rural MN Health Care Access Initiative	4.5	5	1%	1,975
MN	H2417	ITASCA MEDICAL CARE	Itasca County Health & Human Services	--	--	--	473
MN	H2419	SOUTH COUNTRY HEALTH ALLIANCE	South Country Health Alliance	4.5	5	2%	1,588
MN	H2422	HEALTHPARTNERS, INC.	HealthPartners, Inc.	4.5	5	2%	3,189
MN	H2425	BLUE PLUS	Aware Integrated, Inc.	4	5	2%	7,872
MN	H2456	UCARE MINNESOTA	UCare Minnesota	3.5	5	2%	10,636
MN	H2458	MEDICA HEALTH PLANS	Medica Holding Company	4.5	5	2%	10,303
MN	H2926	PRIMEWEST RURAL MN HEALTH CARE ACCESS INITIATIVE	PrimeWest Rural MN Health Care Access Initiative	--	--	--	248
MN	H5703	SOUTH COUNTRY HEALTH ALLIANCE	South Country Health Alliance	--	--	--	576
NJ	H3240	AMERIGROUP NEW JERSEY, INC.	Anthem Inc.	3	3	19%	7,570
NM	H9082	MOLINA HEALTHCARE OF NEW MEXICO, INC.	Molina Healthcare, Inc.,	4	5	8%	2,465
NY	H2470	FALLON HEALTH WEINBERG, INC.	Fallon Community Health Plan	--	--	--	40
NY	H3387	UNITEDHEALTHCARE OF NEW YORK, INC.	UnitedHealth Group, Inc.	4	3	22%	21,229
NY	H5992	SENIOR WHOLE HEALTH OF NEW YORK, INC.	SWH Holdings, Inc.	--	--	--	85
NY	H6864	GUILDNET, INC.	Jewish Guild for the Blind	--	--	--	678
OH	H0490	MOLINA HEALTHCARE OF OHIO, INC.	Molina Healthcare, Inc.,	--	--	--	515
OH	H0908	BUCKEYE COMMUNITY HEALTH PLAN, INC.	Centene Corporation	3	4	15%	982
OR	H3814	ATRIO HEALTH PLANS	ATRIO Health Plans	3	5	7%	2,108
OR	H5995	ATRIO HEALTH PLANS	ATRIO Health Plans	3	5	3%	2,972
PA	H4227	VISTA HEALTH PLAN, INC.	Independence Health Group, Inc.	3	3	20%	3,557
PR	H3054	CONSTELLATION HEALTH, LLC.	Constellation Health, LLC.	2.5	2	26%	6,870
TN	H0251	UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.	UnitedHealth Group, Inc.	3.5	5	9%	43,066
TN	H3259	VOLUNTEER STATE HEALTH PLAN	BlueCross BlueShield of Tennessee	3.5	4	12%	8,461

State	Contract Number	Plan Name	Parent Organization	Overall Star Rating[3]	Members Choosing to Leave the Plan Star Rating[4]	Percent of Members Choosing to Leave the Plan[5]	D-SNP Enrollment (Total Contract Enrollment)
TX	H5294	SUPERIOR HEALTH PLAN, INC.	Centene Corporation	4	3	19%	848
TX	H7678	MOLINA HEALTHCARE OF TEXAS, INC.	Molina Healthcare, Inc.,	3.5	4	16%	4,040
WA	H5823	MOLINA HEALTHCARE OF WASHINGTON, INC.	Molina Healthcare, Inc.,	3.5	5	9%	9,477
WI	H2034	COMMUNITY CARE HEALTH PLAN, INC.	Community Care, Inc.	--	--	--	281
WI	H2237	INDEPENDENT CARE HEALTH PLAN, INC.	Independent Care Health Plan Inc.	4.5	5	7%	6,219
WI	H2879	MOLINA HEALTHCARE OF WISCONSIN	Molina Healthcare, Inc.,	--	--	--	743
WI	H5209	CARE WISCONSIN HEALTH PLAN, INC.	Care Wisconsin First, Inc.	4	5	2%	1,015
WI	H8189	MANAGED HEALTH SERVICES, WISCONSIN	Centene Corporation	4	5	8%	1,002

SOURCES: Centers for Medicare & Medicaid Services. "SNP Comprehensive Report." December 2015. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2015-12.html?DLPage=3&DLEntries=10&DLSort=1&DLSortDir=descending; Centers for Medicare & Medicaid Services. "2017 Part C and D Medicare Star Ratings Data." Available at: https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata.html; and Centers for Medicare & Medicaid Services. "Monthly Enrollment by Plan." December 2015. Available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly-enrollment-by-plan.html.

Endnotes

[1] Integrated Care Resource Center. "Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, April 2016 to April 2017." April 2017. Available at: http://www.integratedcareresourcecenter.com/PDFs/MMP_Enroll_by_State_April_2017.pdf.

[2] Pennsylvania's Community Health Choices Medicaid managed long-term supports and services program, scheduled to begin enrollment in 2018, also has both these requirements.

[3] For details, see J. Verdier, A. Kruse, R. Lester, A. Philip, and D. Chelminsky. "State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options." Integrated Care Resource Center. November 2016, pp. 6-11. Available at: http://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues__Options.pdf.

[4] Ibid., p. 11. State and health plan opportunities for care coordination for dually eligible beneficiaries are more limited when Medicaid covers only Medicare beneficiary premiums and cost sharing and not other Medicaid benefits like long-term supports and services and behavioral health.

[5] For details on this California policy, see Department of Health Care Services July 11, 2014 memorandum at this link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-007.pdf, and Cal MediConnect January 2015 Enrollment Frequently Asked Questions at this link: http://calduals.org/wp-content/uploads/2014/10/Jan_enrollment_FAQ_10.16.14.pdf.

[6] M. Soper and R. Weiser. "Moving Toward Integrated Marketing Rules and Practices for Medicare and Medicaid Managed Care Plans." Integrated Care Resource Center. July 2014. Available at: http://www.integratedcareresourcecenter.com/PDFs/ICRC%20Moving%20Toward%20Integrated%20Marketing.pdf.

[7] "AHCCCS Contractor Operations Manual." Chapter 101-Marketing, Section III.C. Dual Eligible Marketing, effective 7/1/16. Available at: https://www.azahcccs.gov/Shared/Downloads/ACOM/PolicyFiles/100/101Marketing.pdf.

[8] Centers for Medicare & Medicaid Services. "Final CY 2017 Marketing Guidance for New York's Medicare-Medicaid Plans." August 18, 2016. Section 70.1.1 – Nominal Gifts. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2017MarketingGuidanceNYRevision081816.pdf.

[9] Integrated Care Resource Center. "Partnering with SHIPs to Support Integrated Care and Medicaid Managed Long-Terms Services and Supports Programs for Medicare-Medicaid Enrollees: Tips for States." (forthcoming).

[10] J. Stone and D. Chelminsky. "Training Enrollment Broker Call Center Staff: Tips for States Implementing Capitated Financial Alignment Demonstrations." Integrated Care Resource Center. December 2015. Available at: http://www.integratedcareresourcecenter.com/PDFs/Train_Enroll_Broker_Call_Staff.pdf; and D. Chelminsky, J. Stone, and C. Postman. "Tips for States Using Enrollment Brokers in the Capitated Financial Alignment Demonstrations: Beneficiary FAQs and Suggested Responses." Integrated Care Resource Center. April 2017. Available at: http://www.integratedcareresourcecenter.com/PDFs/EnrollmentBrokersCFAMemo.pdf.

[11] Centers for Medicare & Medicaid Services. "Medicare-Medicaid Plan Enrollment and Disenrollment Guidance." September 2, 2016. Section 30.2.5.C. See also Sections 30.2.5.K, L, and M. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPEnrollmentManual090216.pdf.

[12] Ibid., Section 30.2.5.D.

[13] Ibid., Section 30.2.4.

[14] Ibid., Section 40.2.3.2.

[15] Ibid., Section 40.2.3.3.

[16] For more details, see: Integrated Care Resource Center. "Options for Attracting and Retaining Enrollment in Financial Alignment Initiatives for Medicare-Medicaid Enrollees," April 2013. Available at: http://www.integratedcareresourcecenter.com/PDFs/ICRC%20-%20Options%20for%20Attracting%20and%20Retaining%20Enrollment%20-%20(4-17-13)%20(3)%20(2)%20(2).pdf.

[17] For additional details on this option, see C. Postman and J. Verdier. "Preventing Inappropriate Billing of Medicare-Medicaid Enrollees: Strategies from States and Dual Eligible Special Needs Plans." Integrated Care Resource Center. (forthcoming).

[18] Centers for Medicare & Medicaid Services. "Medicare Marketing Guidelines." Section 70.6, Telephonic Contact. Available at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2017MedicareMarketingGuidelines2.pdf. In South Carolina, the state encourages MMPs to conduct early welcome calls within one to three calendar days of receiving the enrollment transaction. For passive enrollees, MMPs can contact the future enrollee about 60 days in advance of their enrollment effective date. See Section 2.3.4.5.2 in the South Carolina three-way contract at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SouthCarolinaContract.pdf. Note that MMPs may not complete Health Risk Assessments at the same time as the Early Welcome Call. See Section 30.3.E of the CMS Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. Michigan also encourages MMPs to make outreach calls to passive enrollees beginning 60 days prior to the effective date of coverage. See Section 2.3.6.5 of the Michigan three-way contract at: https://www.cms.gov/Medicare-

Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MichiganThreeWayContractUpdate112016.pdf.

[19] Integrated Care Resource Center. "Spotlight: Care Management Resources for States and Health Plans Serving Dually Eligible Beneficiaries." February 27, 2017. Available at: http://www.integratedcareresourcecenter.com/PDFs/2017%2002%2027%20Spotlight%20Care%20Management%20Resources.pdf.

[20] The Medicare Advantage Star Ratings are available on the CMS at: https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata.html. The technical specifications for Measure C27 are on pp. 49-50 of the document titled "Medicare 2017 Part C & D Star Rating Technical Notes" (Updated 4/4/2017) at that link on the CMS website. The measure includes voluntary disenrollment through the plan and disenrollment because of enrollment in another plan, but does not include members who involuntarily left the plan due to circumstances beyond their control, such as members who moved out of the service area, who were affected by a contract service area reduction, or who were passively enrolled into an MMP.

[21] In addition, 11 contracts had D-SNP enrollment of 75 percent to 99 percent, and 16 had D-SNP enrollment of 50 to 74 percent.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national technical assistance initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit **www.integratedcareresourcecenter.com.**