

Building a Culture of Engagement for Medicare-Medicaid Enrollees: Health Plan Approaches

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IN BRIEF

Medicare Advantage Dual Eligible Special Needs Plans and Medicare-Medicaid Plans that serve individuals eligible for Medicare and Medicaid recognize the value of building trusting relationships with this newly enrolled population. Many are seeking to foster a culture of engagement beginning with the first contact with new members. These person-centered models are guided by members' medical and social needs, as well as individual preferences. This brief presents member engagement approaches used by health plans participating in PRIDE (*Promoting Integrated Care for Dual Eligibles*), a project funded by The Commonwealth Fund to advance strategies for providing high-quality and cost-effective care for dually eligible individuals.

Individuals dually eligible for Medicare and Medicaid often have significant medical, behavioral health, and social service needs. They are more likely than Medicare- or Medicaid-only enrollees to have multiple, chronic physical and mental health conditions.¹ In addition to the low-income levels that qualify them for Medicaid coverage, they also often have low levels of health literacy and education, and unstable housing situations.

Health plans are increasingly serving this population as enrollment grows in both Medicare-Medicaid Plans (MMPs) – through the federal financial alignment demonstrations – and Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). As of July 2015, over 370,000 Medicare-Medicaid beneficiaries were enrolled in MMPs, and 1.7 million were enrolled in D-SNPs.^{2,3} To provide the integrated care required to support these individuals' diverse needs, MMPs and D-SNPs must effectively engage their members. Engaged members are more likely to: (1) allow the plan to complete needs assessments and care plans; (2) participate in person-centered care planning; and (3) actively work with the plan to meet goals (i.e., keeping medical appointments, filling and taking prescriptions as directed, and following other clinical and service provider advice). This type of engagement can be difficult for individuals with mental health and substance abuse issues, unstable housing/chronic homelessness, and language/literacy barriers – subpopulations particularly prevalent among Medicare-Medicaid beneficiaries under the age of 65.

The health plans participating in *Promoting Integrated Care for Dual Eligibles (PRIDE)*, a national initiative focused on advancing strategies to provide high-quality and cost-effective care for dually eligible beneficiaries, offer a unique perspective on member engagement because of their strong roots in local communities. This technical assistance brief, supported by The Commonwealth Fund, shares approaches used by these organizations to foster a culture of engagement and trust with the

members they serve through integrated care programs. While these strategies have not been formally evaluated, they may be useful for other health plans that serve dually eligible populations.

Approaches to Building Trusting Relationships with Members

Building trusting relationships with members requires significant effort. In building a foundation for trust, it is essential to work with individual members – many of whom have complex medical, behavioral health, and social service needs – to identify what is most important to them to live healthy, meaningful lives. Following are key approaches used by *PRIDE* plans:

1. Meet the member's immediate needs first.

While health plans may be inclined to implement care plans as quickly as possible to meet contractual obligations, they may have greater success if they start by addressing issues that members identify as their most immediate needs.

Providing food for the member or for their pet, or explaining a notice from a utility company may help relieve stress. When they are working in the community,

Together4Health staff pass out pairs of socks to members – a meaningful gesture that builds trust. At *Commonwealth Care Alliance*, a care manager found that a member with bipolar disorder was not attending appointments with a psychiatrist because getting to the provider's office required a 12-hour round trip on two buses and a train.

Providing transportation enabled the

member to keep regular appointments, stabilize his condition, participate in developing a care plan, and avoid costly exacerbations of his illness. Going beyond immediate health care needs and addressing more urgent issues can solidify relationships between the health plan and its members.



Organizations Participating in *PRIDE*⁴

- CareSource (Ohio)
- Commonwealth Care Alliance (Massachusetts)
- Health Plan of San Mateo (California)
- Independent Care Health Plan (*iCare*) (Wisconsin)
- Together4Health (Illinois)
- UCare (Minnesota)
- VNSNY CHOICE (New York)

2. Let the member set the pace.

Although health plans must adhere to contractually defined timeframes for completing health risk and comprehensive assessments, letting the member set the pace at which he or she interacts with the plan builds the trust needed for potentially sensitive conversations. All *PRIDE* plans attempt to initiate contact with members soon after enrollment, then offer multiple, ongoing opportunities for engagement. This works well for members who are unfamiliar with managed care health plans and who may have social, cognitive, behavioral, or trust issues. At *CareSource*, instead of an initial in-home assessment, it is often more effective if the care manager's first contact with the member is a simple knock on the door to introduce himself or herself – with the willingness to come back another day if the member prefers. In one instance, a member with behavioral health issues did not fully open the door when the plan's care manager rang the doorbell. The care manager asked general questions about how the member was doing and determined that the gentleman desperately needed a pair of shoes. The care manager brought him a pair of shoes later that day, thereby

building trust and “opening the door” to a follow up conversation about the member’s behavioral health medications and adherence.

3. Empower members to initiate contact.

Offering individuals the opportunity to make the first contact allows them to be in control of when they talk to the health plan – at a time and in a way that best suits them. *Commonwealth Care Alliance* allows members to initiate contact when they are ready by sending “call me cards” with a phone number and contact information for the plan. Plans might also tell members that they can come to the main office or a field office to meet with health plan staff, if that is preferable to meeting in their homes.

4. Hire staff who can relate to members.

Health plans can employ non-licensed extenders, navigators, and community workers to connect with members and educate other health plan staff about the social contexts in which their members live. CareSource Navigators, non-clinicians with connections to the community and culture of its members, are well positioned to build relationships with individuals in the community. These non-licensed staff members often share the same background as members and have an in-depth knowledge of the resources and supports available in their neighborhoods and communities. *UCare’s* staff reflects the diversity of its membership. Nearly 30 percent of *UCare’s* customer service representatives are bi-lingual and fluent in Arabic, Hmong, Somali, or Spanish.

5. Offer alternative settings for contact.

Members may not be comfortable meeting with plan representatives in their homes. In some cases, homelessness or an unstable housing situation may make an in-home meeting impossible. Meeting at the health plan’s offices may also be difficult for members who have disabilities or lack transportation. Instead, plans can offer alternative settings for assessments, care planning, and other in-person interactions where the member is most comfortable. *Health Plan of San Mateo* meets with members in places that are convenient for them – such as mental health support group meetings, adult day health centers, or dialysis facilities – to complete health risk assessments and provide care planning. *Commonwealth Care Alliance* sends care managers into parks and in urban locations where members may be found.

6. Create connections to members through local organizations.

Members may have established relationships with local organizations such as churches, shelters, and advocacy organizations. Establishing formal or informal relationships with these trusted organizations can connect the plan with members and provide a source of information when members experience changes in their health or circumstances, enabling plan staff to proactively address issues such as housing, unstable family support, or increased frailty. *CareSource* works with advocacy groups, food banks, and community leaders such as pastors to share information about the plan and identify the most effective types of member outreach and engagement. *Commonwealth Care Alliance* contracts with Aging Service Access Points, a local Area Agency on Aging office in Massachusetts that provides information and referrals, interdisciplinary case management,

assessments and care planning. The plan also engages with Recovery Learning Communities to encourage peer-supported, trauma-informed care.

7. Identify unique preferences of cultural subpopulations.

By identifying the diverse needs of cultural groups within their member populations, health plans can develop strategies to effectively engage them. *VNSNY CHOICE* opened storefronts in Manhattan and Queens in communities with high populations of Hmong and other Asian members – groups that often prefer in-person contact rather than phone calls. Health plan staff in these storefront centers answer benefits questions and connect members to care managers who can help address member needs. They also assist members and other community members with day-to-day issues (e.g., paying bills, understanding letters about their Medicaid or Medicare eligibility and benefits, or even explaining letters from utility companies).

8. Help members obtain and/or maintain benefits.

Members with complex medical and social support needs either may not know that they are eligible for assistance through other publicly funded programs in addition to Medicare and Medicaid or may have difficulty maintaining their enrollment in these programs. Helping members to access and maintain benefits shows members that the plan cares about their well-being. For example, *Commonwealth Care Alliance* alerts members when they may be eligible for the Supplemental Nutrition Assistance Program. When its members who receive Social Security Income (SSI) lose their benefits, the *Health Plan of San Mateo* uses its contract with the local Legal Aid Society to help members potentially restore their SSI eligibility, which in turn restores their Medicaid eligibility.

Conclusion

The success of integrated care programs provided by MMPs and D-SNPs depends on their ability to effectively engage health plan members in their care. The engagement strategies described here recognize members as individuals with unique experiences, needs, and goals. By creating mechanisms to allow members to interact with health plan staff on their own terms and control the pace and intensity of contact, health plans can create a culture of engagement that builds member trust.

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The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org

ENDNOTES

- ¹ *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies*, Congressional Budget Office, June 2013.
- ² Integrated Care Resource Center. *Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, July 2014 to July 2015*. July 2015. Available at: <http://www.chcs.org/media/ICRC-MMP-Enroll-by-State-July-2015.pdf>.
- ³ Centers for Medicare & Medicaid Services. *Special Needs Plan Data: Comprehensive Report*, July 2015. Available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2015-07.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>.
- ⁴ Together4Health is a coordinated care entity in Illinois.