Integrated Care Resource Center

TECHNICAL ASSISTANCE TOOL

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Training Enrollment Broker Call Center Staff: Tips for States Implementing Capitated Financial Alignment Demonstrations

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IN BRIEF: Many states implementing capitated model financial alignment demonstrations rely on their Medicaid enrollment brokers to provide information to potential enrollees in the demonstrations' Medicare-Medicaid Plans (MMPs). The enrollment brokers' Customer Service Representatives (CSRs) should be able to communicate complete and accurate information about the demonstrations. This tool describes the key areas of information that CSRs should master to improve the quality of decision-support services for beneficiaries who are being passively enrolled in a MMP. States can share this brief with their enrollment brokers to help with training and monitoring of CSRs.

Introduction

States with capitated model financial alignment model demonstrations often rely on their contracted Medicaid enrollment brokers to provide dually eligible beneficiaries with information about integrated Medicare-Medicaid Plans (MMPs). The enrollment brokers' Customer Service Representatives (CSRs) who answer helpline calls are often beneficiaries' primary information resource to help them make important enrollment choices. CSRs explain beneficiaries' choices to participate in or opt out of demonstrations, describe how to maintain continuity of care with their current providers if they decide to enroll in an MMP, and provide other key information.

It is imperative that CSRs communicate full and accurate information to Medicare-Medicaid enrollees. MMPs are designed to offer more coordinated and seamless coverage, but the new delivery systems in the demonstrations will likely change the way some beneficiaries are accustomed to accessing Medicare and Medicaid services. Medicare-Medicaid enrollees often have significant physical and behavioral health challenges, and many have developed trusting relationships with their providers over many years. Beneficiaries need complete and clear information to alleviate uncertainty and confusion about whether and how they will be able to continue to access the services they need from the providers they know.

This tool focuses on CSR communication with beneficiaries who are being passively enrolled in an MMP. It describes the key areas of information that CSRs should master to improve the quality of decision-support services.[1] States can share this brief with their enrollment brokers to help with training and monitoring CSRs.

New Issues in Financial Alignment Model Demonstrations

The demonstrations using the capitated financial alignment model are new and relatively complex programs. Their complexity stems from their combining Medicaid managed care and all of its covered benefits with Medicare Parts A, B, C, and D under one managed care plan. State's enrollment brokers and their CSRs may have little prior experience in explaining to prospective enrollees how this new program,

that combines Medicare and Medicaid benefits, would work. It is especially important for states to work closely with their enrollment brokers on communication strategies throughout implementation of the demonstrations.

Adaptation to State Circumstances

States should adapt the suggestions in this brief to the specific details of their financial alignment demonstrations and Medicaid programs. States should also take into account their Medicaid enrollment broker's contractual responsibilities and existing state oversight mechanisms.

Key Areas of Information CSRs Should Master[2]

CSRs should be able to provide beneficiaries with complete and consistent information about the demonstrations and their choices regarding enrollment and continuity of care for specific medical and pharmacy services. States should ensure that CSRs are consistently using scripts or a set of prepared points to convey complex information to beneficiaries, particularly concerning the benefits of the MMP demonstration. Accurately describing the program and using consistent terminology can help avoid confusion among beneficiaries and strengthen their confidence in their choices. Following are the types of information that states may want to review with their enrollment brokers to ensure that they are adequately addressed in CSR trainings:

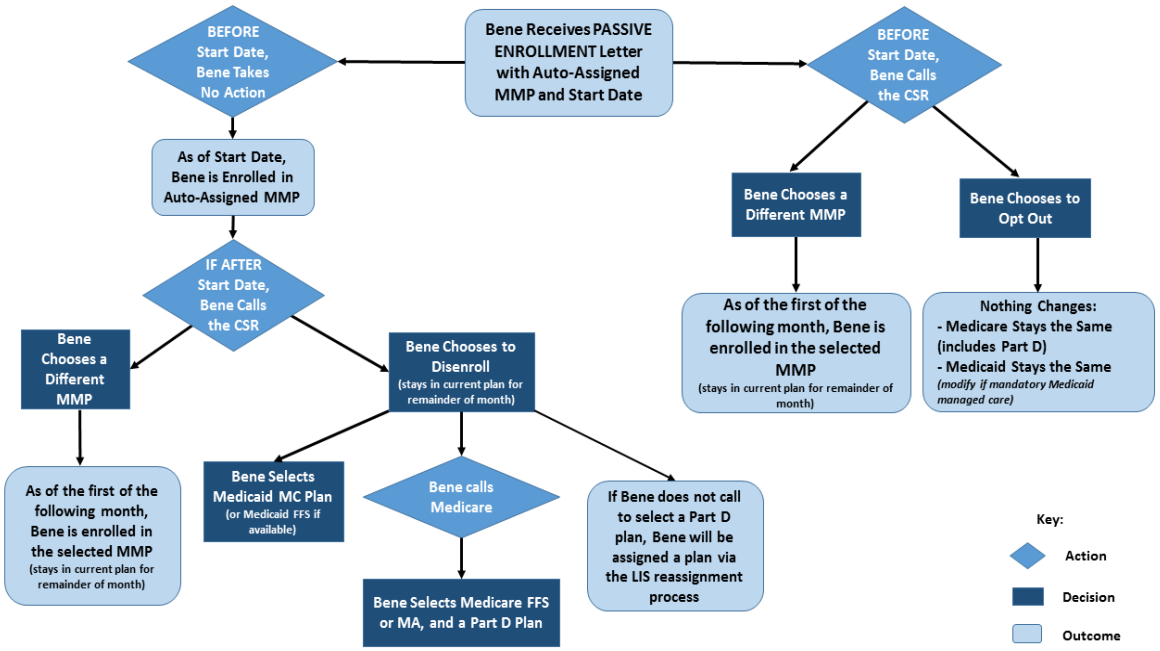
1. **Demonstration Basics.** CSRs must be able to inform beneficiaries about how the demonstration will affect their care by delivering succinct, accurate and complete summaries of the major features of the specific demonstration, including clearly explaining the expected benefits compared to the status quo for Medicare-Medicaid enrollees in that state.

2. **Terminology.** CSRs must understand certain key words and phrases and use them with precision and consistency to help the beneficiary make informed decisions. Following are strategies that CSRs can use to help ensure accurate communication:
   - **Use terminology carefully.** CSRs should be careful not use words and phrases with different actual meanings interchangeably (e.g., opt out and disenrollment).
   - **Understand the intricacies of the demonstration program.** CSRs should demonstrate full awareness of specific implications of a beneficiary's enrolling or opting out of the demonstration program, and be able to clearly explain policies surrounding out-of-network providers, continuity of care, coverage, disenrollment and reinstatement of original coverage, and potential impacts on other coverage.
   - **Offer the right amount of information for beneficiaries to make informed decisions.** CSRs should consistently mention additional and unprompted pertinent information that could help inform a beneficiary's decision.

3. **Opting Out and Disenrolling.** Beneficiaries need to know that they can opt out or disenroll at any time, either before or after their enrollment date. They should also know how to exercise these choices. Further, CSRs need to communicate key dates and deadlines. **Exhibit 1** provides a visual summary of the decisions beneficiaries must make when they choose not to enroll in an MMP ("opting out"). *States should tailor this decision tree with the dates and program features that are specific to their demonstration.*

4. **Choosing to Participate in the Demonstration.** For beneficiaries who choose to participate, CSRs should walk them through their MMP enrollment options and explain the implications of each choice. They must also know how to help beneficiaries identify whether their providers are in a particular MMP's network.

Exhibit 1:[3] Decision Tree for Beneficiaries Choosing Not to Participate in the Demonstration



5. **Continuity of Care.** MMP enrollees may maintain their current providers and continue their prescriptions for specified periods even when those providers and/or drugs are not covered by the MMP (or are covered by the MMP, but have utilization management restrictions like prior authorization requirements). CSRs should be able to communicate these rights to beneficiaries and explain any actions the beneficiary may need to take to maintain continuity of care.

6. **Additional Enrollment Counseling Resources for Beneficiaries.** Additional resources are available to support beneficiary decision-making about enrollment in the demonstrations and other questions (e.g., re-enrollment in Medicare Advantage or Prescription Drug Plans after disenrollment from an MMP). CSRs should provide information to beneficiaries about where to seek additional help, such as calling 1-800-MEDICARE, talking to the State Health Insurance Assistance Program (SHIP), or contacting the Ombudsman's office.

Detailed descriptions of the key information CSRs should master and suggested script language for states' consideration are in the Appendix. States and their enrollment brokers can use the Appendix as a guide for designing CSR training programs. *States should tailor the table to reflect the unique circumstances and policies of their demonstration.*

Enrollment Broker and CSR Oversight

States will need processes to ensure that enrollment brokers and their CSRs are communicating clear and accurate information about demonstration programs to potential enrollees. Texas has developed an approach to oversight of enrollment brokers for its Texas Dual Eligible Integrated Care Project.

Texas' Approach to CSR Training and Enrollment Broker Oversight

In Texas, the enrollment broker is responsible for training its CSRs to respond to calls about the Texas Dual Eligible Integrated Care Project with accurate, complete, and consistent information. To ensure that the enrollment broker's staff is communicating with potential enrollees as intended, the state uses several oversight techniques, all of which are detailed in the state's contractual agreement with the broker. Following are key techniques used by the enrollment broker for CSR training and by the state for performance oversight of the enrollment broker.

Enrollment broker training techniques for CSRs include:

- Providing four weeks of classroom skills building, followed by side-by-side training between senior- and junior-level staff, and job shadowing, during which CSRs learn a variety of information about the demonstration, including state policies and script language, how to speak with a diverse clientele, and when to hand off calls to other appropriate resources; and
- Holding weekly debriefs with CSRs to review recent policies changes and any performance issues.

State oversight techniques include:

- Reviewing a Daily Score Card that describes enrollment broker call center performance metrics, including the total number of calls received, number and length of calls answered, number of calls that disconnected from the queue before being answered, average incoming call answer time, and average length of completed calls;
- Listening to 30 percent of all calls to check for accuracy and completeness;
- Holding monthly check-ins among state staff to assess the enrollment broker's compliance with performance requirements; and
- Holding quarterly meetings with the enrollment broker to assess compliance with key performance requirements stipulated in the contract, determine progress on any remediation plans to address contractual variances, and modify call center scripts as needed.

Conclusion

The need for accurate and consistent communication becomes increasingly critical as more beneficiaries enroll in MMPs nationwide. Beneficiaries may rely solely on their interactions and conversations with CSRs to make their health care coverage decisions. The tips, guidance, and scripts outlined in this tool can help states monitor and work with their enrollment brokers to help ensure that beneficiaries receive the information they need to make choices that work best for them.

Appendix: CSR Training Points

Topic Area	Need-to-Know Concepts and Policies to Cover	Sample Script Language
DEMONSTRATION BASICS		
Demonstration Description	**[DEMONSTRATION NAME]** offers Medicare-Medicaid beneficiaries a new integrated managed care plan **to cover all Medicare and Medicaid services, including Part D prescription drugs**. **[DEMONSTRATION NAME]** offers benefits to beneficiaries that are not available under their current Medicare and Medicaid coverage: • The demonstration is intended to **eliminate the complexity** of having some services covered under Medicare, others covered under Medicaid, and prescription drugs covered under Medicare Part D. Enrollees will get everything under a single plan; • Beneficiaries will be able to use a **single insurance card** for all health care services covered by Medicare and Medicaid, including prescription drugs; • Beneficiaries will have **access to all of the services they have now**, including a broad range of medical and behavioral health services, nursing home care, pharmacy, transportation, and long-term services and supports (LTSS), including personal care, home health, other home services, respite, supplies, and personal emergency response system; and • **Care coordinators** will be designated **for all beneficiaries**. These care coordinators will work collaboratively with beneficiaries and their families to help beneficiaries get what they need where they live.	• The **[DEMONSTRATION NAME]** is a new program for people who have both Medicare and **[NAME OF STATE MEDICAID PROGRAM]**. • **[DEMONSTRATION NAME]** makes it easier for people to get the care they need. It covers all of the same things as Medicare and **[NAME OF STATE MEDICAID PROGRAM]** will cover including doctors, hospitals, home health, and medicines. • **[DEMONSTRATION NAME]** is easy to use. You will have **just one insurance card** instead of two or three. • When needed, a **care coordinator** will help arrange for your care, help you make appointments, and answer your questions.
Continuity of Coverage for Beneficiaries	Beneficiaries will not lose any of their current Medicare or Medicaid benefits nor experience **any gap in coverage**.	• If you enroll in **[DEMONSTRATION NAME]**, you will **not lose Medicare** or **[NAME OF STATE MEDICAID PROGRAM]**. All your medicines will still be covered.
Changes to Out-of-Pocket Costs for Beneficiaries	CSRs **should be able to** clearly communicate the benefits of participation in terms of low out-of-pocket costs. **No premiums, copays, or deductibles** are charged for doctor, hospital, or emergency room visits. Plans may charge small copays for certain prescription drugs. *Modify in instances in which a state charges copays for some Medicaid services or items.*	• **[DEMONSTRATION NAME]** will not cost you anything. There are no premiums, copays, or deductibles. But some of the health plans in **[DEMONSTRATION NAME]** might charge you a small copay for some prescription medicines. If you want, I can find out if any of your medicines would have a copay.
Voluntary Nature of the Demonstration	Participation in this program is voluntary. Beneficiaries can opt out prior to enrollment or disenroll any time after enrollment. Even in states in which Medicaid enrollment into a managed care plan is mandatory, this integrated model remains voluntary.	• You can decide if you want to enroll in **[DEMONSTRATION NAME]**. The program is completely **voluntary.** • If you decide to enroll, you can change your mind and drop out at any time.

Topic Area	Need-to-Know Concepts and Policies to Cover	Sample Script Language
Key Dates	CSRs should tell beneficiaries the following: • Date passive enrollment in the MMP begins. • The deadline to call the helpline and opt out before passive enrollment to avoid any disruption in Medicaid and Medicare coverage. • The last date of beneficiaries' current Medicaid and Medicare coverage before MMP enrollment.	• Because **[DEMONSTRATION NAME]** is new, here are some important dates that you should know. • If you would like to enroll, you do not have to do anything. You will be **automatically enrolled** in the plan that was listed in the letter you received. Your new coverage will begin on **[DATE - EFFECTIVE DATE OF MMP ENROLLMENT]**. • Coverage under your current plans will end **[DATE - END DATE OF CURRENT PLAN COVERAGE]**. • If you decide not to enroll, you need to call us by **[DATE - DAY BEFORE MMP ENROLLMENT]** so you can keep the same coverage as you have right now.
OPTING OUT AND DISENROLLING (See Exhibit 1. Decision Tree for Beneficiaries Choosing Not to Participate in the Demonstration)		
Opting Out Before Passive Enrollment	If the beneficiary chooses to opt out prior to the date of passive enrollment, there will be no change to the beneficiary's Medicare or Medicaid coverage. Beneficiaries who opt out from **[DEMONSTRATION NAME]** will continue to receive their current Medicaid services through the state's existing Medicaid program (either fee-for-service or Medicaid managed care, depending on the state), and will continue to have a choice of original Medicare and a Part D prescription drug plan, or a Medicare Advantage plan and prescription drug plan.	• If you do not to enroll in **[DEMONSTRATION NAME]**, your Medicare and **[NAME OF STATE MEDICAID PROGRAM]** drug coverage will stay the same as it is now.
Disenrolling After Passive Enrollment in a MMP	If a beneficiary disenrolls after passive enrollment, their MMP coverage continues through the end of the current month. *On the first day of the following month after disenrollment*, *Medicare and Medicaid coverage will begin again through separate delivery systems.* New Medicare and Medicaid cards will be mailed to the beneficiaries. • For Medicare, beneficiaries must choose to either participate in Original Medicare FFS or enroll in a Medicare Advantage plan, with or without Part D coverage. If the beneficiary wants to re-enroll into a particular Medicare Advantage and/or Part D plan, the beneficiary must either notify the plan(s) directly or call 1-800-Medicare. • For Medicaid, beneficiaries may be auto-assigned to a Medicaid managed care plan or have the opportunity to choose a plan (if available in that state and/or geographic area). In some states they may be able to enroll in FFS Medicaid.	• You can enroll in **[DEMONSTRATION NAME]** and then **disenroll at any time** if you do not like it. If you disenroll, **[DEMONSTRATION NAME] will** cover you for the rest of that month and you will get your **[NAME OF STATE MEDICAID PROGRAM]** coverage back on the first day of the next month. • You would just need to call 1-800-Medicare if you want to re-enroll in your old Medicare Advantage and/or Part D plans. If you don't call, you will automatically go back into traditional Medicare and be assigned a new Part D plan. • If you disenroll from **[DEMONSTRATION NAME]**, you not lose Medicare or **[NAME OF STATE MEDICAID PROGRAM]** coverage or be uninsured for even a day.
PLAN CHOICE AND SWITCHING PLANS		
Plan Choice	If the beneficiary decides to enroll, they have the choice to select their preferred MMP by calling the helpline prior to, or after, the passive enrollment date. If the beneficiary takes no action, he or she will be passively enrolled into the MMP indicated on their letter.	• If you want to enroll in **[DEMONSTRATION NAME]**, you do not have to do anything. You will be **automatically enrolled** in the plan that was listed in the letter you received and your new coverage will begin on [**DATE –MMP ENROLLMENT DATE**]. • If you want to enroll in **[DEMONSTRATION NAME]**, but you do not want the health plan that was chosen for you, you can choose a different one. Just call us by **[DATE**] and tell us the name of the health plan you want.

Topic Area	Need-to-Know Concepts and Policies to Cover	Sample Script Language
Identifying Which Plans Include the Beneficiaries' Providers in their Networks	CSRs must know how to help beneficiaries identify whether their providers are in a particular MMP's network. Provider and pharmacy directories should be accessible to CSRs, on MMP web sites or otherwise, including lists of providers within Independent Practice Associations contracted to MMPs. CSRs should be able to look up providers by name and identify the plans to which they are connected.	*In states in which CSRs can look up providers and identify their MMP networks:* • I can help you find health plans in your area that include your doctors. We can do that on the phone now. Can you give me the name of your doctor? *In other states:* • I do not have a list of doctors in each health plan. You can ask your doctor if he/she accepts the health plan that you are interested in. You can also call the plan and ask if your doctor is in its network.
Mechanism for Selecting a Different MMP	CSRs must be able to clearly inform beneficiaries that in order to make an affirmative choice of MMP selection, beneficiaries can either: • Respond to the beneficiary notice by the specified date, OR • Communicate a plan preference to the CSR over the phone.	• If you want to choose a different plan, you can tell me now, or you can call us back by **[DATE – DAY BEFORE PROGRAM START DATE]** and tell us which plan you want.
CONTINUITY OF CARE (COC)[4]		
Medical	If a beneficiary's provider is not part of the new MMP network, he or she may continue to see that provider for a maximum of **[NUMBER OF DAYS OF COC PERIOD]** days, from the time enrollment in the MMP begins. CSRs should instruct beneficiaries to talk with their plan representatives once they enroll to ensure that they can continue to see out-of-network providers for the allowable continuity of care period. Beneficiaries may also want to encourage their provider to join the MMP network.	• It is important for you to get the care and services you need. So you might have questions about what will happen if your doctor or other service providers are not part of health plan networks in **[DEMONSTRATION NAME]**. The new plans are designed to ensure the transition is as seamless and easy as possible for you. • If your doctor or another service provider does not participate in a health plan's network, you can keep going to that doctor or using those services for **[NUMBER OF DAYS OF COC PERIOD]** days after you enroll in **[DEMONSTRATION NAME]**. • You will need to call your new health plan **[PROVIDE TELEPHONE NUMBER]** and tell them that you want to keep going to that doctor. • You should ask your doctor or service provider about joining the health plan. If your doctor does join, you can keep going to him/her. • At the end of **[NUMBER OF DAYS OF COC PERIOD]** days, you will need to start going to doctors and other service providers in your health plan's network. You can ask your care coordinator or the health plan about how to find a new doctor.
Medicare Part D	Beneficiaries are guaranteed a one-time fill of a 30-day supply (unless a lesser amount is prescribed) of an ongoing medication within the first 90 days of MMP enrollment for all enrollees. **[For states with more generous rules for pharmacy continuity of care, add text or modify the number of days in the one-time fill or the length of the COC period. Also, add any additional instructions about how to ensure continuous coverage of these medications.]**	• Many medicines are covered by the health plans in **[DEMONSTRATION NAME].** You can call your pharmacy or your health plan to see if your medicines are covered. • If the health plan does not cover a medicine, you can still get a one-time refill of any prescription medicine during the first **[NUMBER OF DAYS OF COC PERIOD]** days after you enroll in **[DEMONSTRATION NAME]**.

Topic Area	Need-to-Know Concepts and Policies to Cover	Sample Script Language
ADDITIONAL DECISION SUPPORT RESOURCES FOR BENEFICIARIES		
Contact Information for Additional Decision-Support Services	CSRs should be able to provide additional resources to beneficiaries for decision support. • For more information about services provided under the MMP, beneficiaries can call or visit the state's Aging and Disability Resource Center/State Health Insurance Assistance Program (ADRC/SHIP) **[customize by state and provide telephone numbers]**. For additional questions about Part D coverage under the MMP, beneficiaries can contact the MMP directly [name and telephone number]. • For questions about Medicare or Part D coverage for those who opt out or disenroll and to reach a Medicare Beneficiary Ombudsman, beneficiaries should call 1-800-MEDICARE. • For assistance selecting a Medicare plan, beneficiaries can use the Medicare Plan Finder at www.medicare.gov/find-a-plan. • CSRs should also be able to guide beneficiaries to the MMP representatives that can answer their specific questions as needed.	• If you have questions about which doctors, pharmacies, and other service providers are in the **[NUMBER OF MMPs IN THE BENEFICIARY'S COUNTY]** health plans in **[DEMONSTRATION NAME]**, you can call them or visit their websites. [Provide telephone number and website address as appropriate.] • If you need help to decide if you want to enroll in **[DEMONSTRATION NAME]** or if you need help to choose a health plan, you can call the **[NAME OF THE ADRC/SHIP IN THE STATE]** (Provide telephone numbers and addresses as appropriate)[5] • If you have questions about your Medicare Part D coverage for medicines, call 1-800-MEDICARE. • You can call us anytime if you have more questions.

FBDE = Full Benefit Dual Eligible; QDWI = Qualified Disabled and Working Individual; QI = Qualifying Individuals; QMB Only = Qualified Medicare Beneficiaries without other Medicaid; QMB+ = Qualified Medicare Beneficiaries with Full Medicaid; SLMB Only = Specified Low-Income Medicare Beneficiaries without Other Medicaid; SLNB+ = Specified Low-Income Beneficiaries with Full Medicaid

Endnotes

[1] From July 2014 to June 2015, the Integrated Care Resource Center (ICRC) conducted a limited number of "secret shopper" calls to enrollment broker helplines in four states implementing capitated financial alignment model demonstrations. ICRC used the information gathered to identify opportunities for states and their contracted enrollment brokers to improve the information provided by CSRs.
[2] States should adapt the training tips in this tool to the specific details of their programs, taking into account their Medicaid enrollment broker's contractual responsibilities and existing state oversight mechanisms.
[3] This figure is a template for states to tailor to reflect the specific nuances and policies of their state.
[4] States may consider mentioning continuity of care for LTSS as a key topic for CSR training. ICRC's secret shopper calls did not address this topic.
[5] States should check with their ADRCs and SHIPs to confirm their capacity to handle the volume of inquiries.