MATHEMATICA Policy Research

REPORT

APPENDICES ONLY

The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries

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APPENDIX A

STUDY DATA AND METHODS DETAILS

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Calculation of State Demonstration Participation Rates

To compare the success of states and MMPs with enrollment (research question 1), we calculated participation rates for each state's capitated model FAI demonstration. We defined state-level demonstration participation rates (PR) as:

$$PR = \frac{\#\ of\ beneficiaries\ \boldsymbol{enrolled}\ in\ state\ demonstration}{\#\ of\ beneficiaries\ \boldsymbol{eligible}\ for\ state\ demonstration}$$

To determine the numerator for our participation rate calculations, we summed the number of enrollees in each state's participating MMPs in December of each calendar year 2014-2017.[1] For 2018, we used monthly MMP enrollment data as of July, the most recent enrollment data available for 2018 at the time of our analyses.

While CMS publishes regular updates on the number of individuals enrolled in each state's demonstration, estimates of the number of individuals eligible for these programs varies widely. We calculated state participation rates using two denominators, derived from different data sources: one published by MACPAC (2018) and another based on state Medicaid officials' self-reported program eligibility estimates collected during this study. We divided the number of beneficiaries enrolled in each state's demonstration by each eligibility estimate to produce a range of the estimated annual participation rates for each state by year (see Table III.1).

Temporal Analysis

To determine whether a major change in state policy or strategy was followed by a marked change in enrollment (research question 2), we used monthly MMP enrollment data to create graphs depicting MMP enrollment trends over the period of time in which each state's program operated. We paired these enrollment graphs with timelines showing implementation of key state enrollment policies, strategies, and activities, and looked for patterns between enrollment fluctuations and the period(s) of time in which those enrollment-related policies, strategies, or activities went into effect. Data for each state's timeline was gathered from information publicly available on CMS and state program webpages,[2] as well as from interviews conducted with state Medicaid officials. State enrollment graphs and timelines are included in Appendix C.

Analysis of patterns between state-level participation rates and state policies/MMP characteristics

To investigate whether state policies and strategies or MMP characteristics are associated with higher or lower FAI demonstration participation (research questions 2 and 3), we collected information on states' enrollment and marketing policies and state and MMP characteristics and

[1] Monthly MMP enrollment data extracted from CMS monthly enrollment by contract reports, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract.html

[2] CMS webpages containing each state's three-way contract and other important program information are available here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html. Several FAI demonstration states also maintain program webpages on their state Medicaid department websites.

matched that information to state participation rates to identify associations between certain policies or characteristics and higher or lower participation rates. Specifically, we analyzed information about state and MMP prior experience with managed care, states' use of specific enrollment-related policies and marketing strategies, Medicare Advantage (MA) plan penetration in each state, and state passive enrollment intelligent assignment algorithms.[3] We collected data for this analysis from a variety of publicly available sources:

- Data on state's prior experience with managed long-term services and supports (MLTSS) was gathered from CMS Medicaid managed care enrollment reports (2011-2016),[4] three reports discussing state MLTSS programs (Kasten et al. 2017; Lewis et al. 2018; Libersky et al. 2016), and state websites.
- Data on state enrollment and marketing policies was gathered from CMS FAI webpages and demonstration three-way contracts, state-specific appendices to national demonstration enrollment guidance,[5] an Integrated Care Resource Center (ICRC) webinar on demonstration enrollment processes and strategies,[6] MACPAC state fact sheets,[7] a CMS Marketing Practices and Beneficiary Disclosure Requirements comparison table,[8] state websites, and interviews with state Medicaid officials.
- Data on state MA penetration from 2012-2017 was gathered from the Kaiser Family Foundation's annual Spotlight briefs on MA enrollment.[9]
- Information about the elements included in states' passive enrollment intelligent assignment algorithms was gathered from CMS FAI webpages and demonstration three-way contracts, state-specific appendices to national FAI demonstration enrollment guidance, state websites, and interviews with state Medicaid officials.

[3] We verified the accuracy and completeness of state information collected for these analyses with state representatives as part of our interview process. The MMP data compiled did not require verification.

[4] CMS Medicaid managed care enrollment reports are available at https://www.medicaid.gov/medicaid/managed-care/enrollment/index.html

[5] State-specific appendices to national enrollment guidance available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPEnrollment.html

[6] "Enrollment Processing and Strategies to Grow Enrollment for States Participating in the Capitated Model Financial Alignment Initiative." (February 22, 2018). Integrated Care Resource Center Webinar. Slides available at http://www.integratedcareresourcecenter.com/PDFs/ICRC_SHC_Strategies_to_Grow_Enrollment_02-22-18_for_508.pdf

[7] January 2018 MACPAC fact sheets available at https://www.macpac.gov/publication/financial-alignment-initiative-for-beneficiaries-dually-eligible-for-medicaid-and-medicare/

[8] Table available at Available here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MktgPracticesandBeneDisclosReqsComparisonTableCY2018_03282018.pdf

[9] The Kaiser Family Foundation Spotlight on Medicare Advantage Enrollment for 2017 is available at https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/

- Data on MMP characteristics was gathered from the March 2018 CMS MA plan directory file,[10] CMS Special Needs Plan (SNP) comprehensive reports,[11] CMS MA service area reports,[12] and CMS Medicaid managed care enrollment reports.

Qualitative interviews

In June and July of 2018, we conducted telephonic interviews with state Medicaid officials representing all 11 capitated FAI demonstrations, as well as with leaders and managers from 13 MMPs. Interviews with state Medicaid officials were 90 minutes, and interviews with MMP representatives were 60 minutes. All interviews included structured questions regarding the degree to which the following eight program elements have promoted or hindered demonstration enrollment: (1) state use of passive enrollment, (2) other enrollment processes, (3) official state enrollee communications, (4) state or MMP marketing/outreach to beneficiaries, (5) provider education and engagement activities, (6) engagement with other stakeholders, (7) state and MMP collaboration, and (8) MMP models of care and approaches to care coordination. Interviewees were also asked to describe any other factors that had promoted or hindered demonstration enrollment.

Interviews were recorded to ensure the accuracy of written interview notes. After completion of all interviews, interview notes were cleaned and finalized, and two reviewers conducted a structured qualitative analysis to identify interview themes. Independent reviews were followed by consensus meetings to consolidate the most common themes for inclusion in our study findings.

Analysis of interviewee rating scales

Before each interview, we asked state and MMP respondents to complete a rating scale, indicating the degree to which they thought each of the eight program elements described above promoted or hindered demonstration enrollment, on a scale of 5, where 1 = "strongly hindered," 2 = "slightly hindered," 3 = "no effect," 4 = "slightly promoted," and 5 = "strongly promoted". The rating scale also included an "other" category. When respondents indicated a topic in the "other" category on their rating scale, that topic was specifically discussed during their interview.

We calculated average ratings for all 25 respondents that completed a rating scale, as well as average ratings separately for states $(n-10)$ and MMPs $(n-15)$[13] in order to identify differences across the two types of respondents. We also examined the frequency of each response among states and MMPs, respectively, to identify whether certain elements received a higher number of

[10] CMS Medicare Advantage Plan Directory file available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Plan-Directory.html

[11] CMS SNP comprehensive reports available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

[12] CMS MA service area reports available here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Contract-Service-Area-by-State-County.html

[13] One state (VA) did not complete a ratings sheet and two of the 13 MMP interviews included representatives operating in two states, for a total of 15 MMP respondents.

'5s' or '1s'. Finally, we also compared each interviewee's ratings to their interview comments about each program element to identify any discrepancies (that is, instances where ratings were positive, but comments were negative, or vice versa).

Our analyses showed little variance in average ratings, and questionable validity as respondents' ratings sometimes conflicted with their comments during the interviews. Consequently, we decided not to use the rating scale responses to create a numeric scoring system to rank each program element's level of influence on enrollment.

APPENDIX B

POPULATIONS INCLUDED IN FAI CAPITATED MODEL DEMONSTRATIONS

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Table B.1. Populations included in FAI capitated model demonstrations

	Over age 65	Under age 65[a]	Community dwelling, no HCBS	LTSS—Facility	LTSS—HCBS waiver participants[b]	Statewide demonstration
California	yes	yes	yes	yes	yes	**no**
Illinois	yes	yes	yes	yes	yes	**no**
Massachusetts	**no[c]**	yes	yes	yes	**no[e]**	**no**
Michigan	yes	yes	yes	yes	yes	**no**
New York—FIDA	yes	yes	**no**	yes	yes	**no**
New York—FIDA-IDD	yes	yes	**no**	yes	yes	**no**
Ohio	yes	yes	yes	yes	yes	**no**
Rhode Island	yes	yes	yes	yes	yes	yes
South Carolina	yes	**no**	yes	**no[d]**	yes	**no**
Texas	yes	yes	yes	yes	yes	**no**
Virginia	yes	yes	yes	yes	yes	**no**

Source: Medicare-Medicaid Financial Alignment Initiative Final Memorandums of Understanding (MOUs): Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html.

Notes: All demonstration projects enroll only full-benefit dual eligibles (FBDEs)—individuals entitled to Medicare Part A benefits, enrolled in Medicare Part B, and eligible for or enrolled in Part D, and receiving full Medicaid benefits.

[a] California, Illinois, Massachusetts, Michigan, New York (FIDA and FIDA-IDD), Rhode Island, Texas, and Virginia demonstration enrollees must be age 21 or over; Ohio enrollees must be age 18 or over.

[b] LTSS-HCBS is selected in the table above if the state includes at least some HCBS Waiver populations/services in their Financial Alignment Initiative demonstration. Several states exclude individuals eligible for or enrolled in certain HCBS Waivers/Programs but include other HCBS populations/services.

[c] Although Massachusetts excludes individuals over age 65 from their demonstration, if an enrollee turns 65 while enrolled in the demonstration, they may remain enrolled as long as they continue to maintain their FBDE status and have no other comprehensive private or public health insurance.

[d] Individuals already enrolled in South Carolina's demonstration and who later enter a nursing facility may remain enrolled in the demonstration.

[e] Although Massachusetts excludes 1915(c) waiver participants from its demonstration, HCBS such as community support services, personal assistance services, and Long Term Supports (LTS) coordination services are covered benefits in the demonstration.

Table B.2. Populations excluded from FAI capitated model demonstrations

	Duals with other (public or private) health insurance	Duals with I/DD receiving institutional care	Duals with I/DD receiving HCBS waiver services	Residents of certain institutions or facilities *(other than I/DD facilities)*[a]	Certain Medicaid waiver participants *(other than I/DD waivers)*[b]	Duals with ESRD[c]	Duals receiving hospice services[d]	Duals in the CMS Independence at Home program	Duals in the Money Follows the Person (MFP) program	Duals on Medicaid with a spenddown	Duals eligible only for Medicaid via specific partial-benefit programs[e]	Duals expected to be eligible for Medicaid for only a short period of time[f]
California	X	X		X	X	X						
Illinois	X	X	X							X	X	
Massachusetts	X	X		X	X							
Michigan	X			X	X		X		X	X		
New York (FIDA)		X	X	X	X		X				X	X
New York (FIDA-IDD)				X	X		X				X	X
Ohio	X	X	X					X		X		
Rhode Island		X		X			X			X		
South Carolina	X	X	X	X	X	X	X			X		
Texas		X	X		X			X				
Virginia		X	X	X	X	X	X	X	X	X	X	X

Source: Medicare-Medicaid Financial Alignment Initiative final memoranda of understanding (MOUs): https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html.

Notes: All states except for South Carolina and Rhode Island exclude full-benefit dual eligibles (FBDEs) in certain geographic regions from their demonstration projects because the demonstrations operate only in certain counties/regions within each state (South Carolina and Rhode Island's projects are statewide). All states exclude PACE enrollees from their demonstration projects; if enrollees disenroll from the PACE program, they will become eligible to enroll in a FAI demonstration health plan. All states must also exclude individuals with retiree health coverage because that coverage often is nonrecoverable once lost (MedPAC 2016). **In addition to the categories represented above, a few states also exclude very small, specific populations not included in the table.**[g]

[a] Several states (Michigan, New York (FIDA and FIDA-Intellectual or Developmental Disability [IDD], Rhode Island, and Virginia) exclude individuals in state psychiatric hospitals; New York (FIDA and FIDA-IDD) also excludes individuals in any inpatient psychiatric facility. Virginia and New York (FIDA and FIDA-IDD) exclude residents of long-term substance abuse treatment centers. New York (FIDA and FIDA-IDD) excludes individuals in assisted living facilities. California excludes participants in its Assisted Living Waiver and residents of Veterans' Homes. New York's FIDA-IDD program excludes residents of Developmental Centers and Skilled Nursing Facilities. South Carolina excludes individuals in nursing facilities at the time of enrollment, but if an individual already is enrolled in the demonstration and later enters a nursing facility, the person may remain enrolled.

[b] **California** excludes participants in the Nursing Facility/Acute Hospital, HIV/AIDS, Assisted Living, and In-Home Operations 1915(c) Waivers. **Massachusetts** excludes participants in 1915(c) Waivers. **Michigan** excludes participants in the MI Choice 1915(c) Waiver. **New York's FIDA Demonstration** excludes participants in the Traumatic Brain Injury (TBI) 1915(c) Waiver (as well as those receiving I/DD Waiver services). **New York's FIDA-IDD Demonstration** excludes participants in any 1915(c) Waiver other than the OPWDD Comprehensive Waiver (excluded waivers include TBI, Nursing Home Transition and Diversion, and

Table B.2 (*continued*)

Long-Term Home Health Care). **South Carolina** excludes participants in any Medicaid HCBS waivers other than the Community Choices Waiver, the HIV/AIDS Waiver, and the Mechanical Ventilation Waiver (excluded waivers include Head and Spinal Cord Injury, Community Supports, Medically Complex Children, and Psychiatric Residential Treatment Facility Alternative CHANCE, as well as I/DD waivers). **Texas** excludes participants in the Community Living Assistance and Support Services (CLASS), and Deaf/Blind with Multiple Disabilities Program (DBMD) waivers (as well as I/DD waivers). **Virginia** excludes participants in the Day Support Waiver, the Technology Assisted Waiver, and the Alzheimer's Assisted Living Waiver (as well as I/DD waivers).

[c] All states that exclude individuals with ESRD specify that the exclusion is for individuals with ESRD at the time of eligibility determination/enrollment. If an individual is already enrolled in the demonstration and later develops ESRD, that person is allowed to remain enrolled if she or he wishes.

[d] With the exception of Michigan, all states that exclude individuals receiving hospice services specify in their MOUs that they exclude only individuals receiving hospice services at the time of eligibility determination/enrollment. If an individual is already enrolled in the demonstration and later elects to receive hospice services, that person is allowed to remain enrolled if he/she wishes.

[e] Illinois excludes individuals enrolled in the Breast & Cervical Cancer or Medicaid partial benefit programs. New York (both FIDA and FIDA-IDD) excludes individuals in the Family Planning Expansion program, the Foster Family Care demonstration, the Breast & Cervical Cancer program, and the Emergency Medicaid program. In its FIDA MOU, New York also excludes a program that provides services only for tuberculosis. Virginia excludes individuals in the Virginia Birth-Related Neurological Injury Compensation program.

[f] New York (FIDA and FIDA-IDD) excludes individuals expected to be eligible for Medicaid for less than six months. Virginia excludes individuals expected to be eligible for Medicaid for less than three months, as well as individuals who qualify only for retroactive Medicaid coverage.

[g] Additional populations excluded from certain FAI demonstrations but not included in the table above are the following: Participants in a specific program through the AIDS Healthcare Foundation (California); "individuals previously disenrolled due to Special Disenrollment from Medicaid Managed Care" (Michigan); and "individuals eligible for the Medicaid buy-in for workers with disabilities and meet a nursing facility level of care," also known as "The Sherlock Plan" (Rhode Island).

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APPENDIX C

ENROLLMENT GROWTH GRAPHS AND TIMELINES USED IN TEMPORAL ANALYSIS

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Figure C.1. California MMP enrollment by plan, January 2014 – March 2018

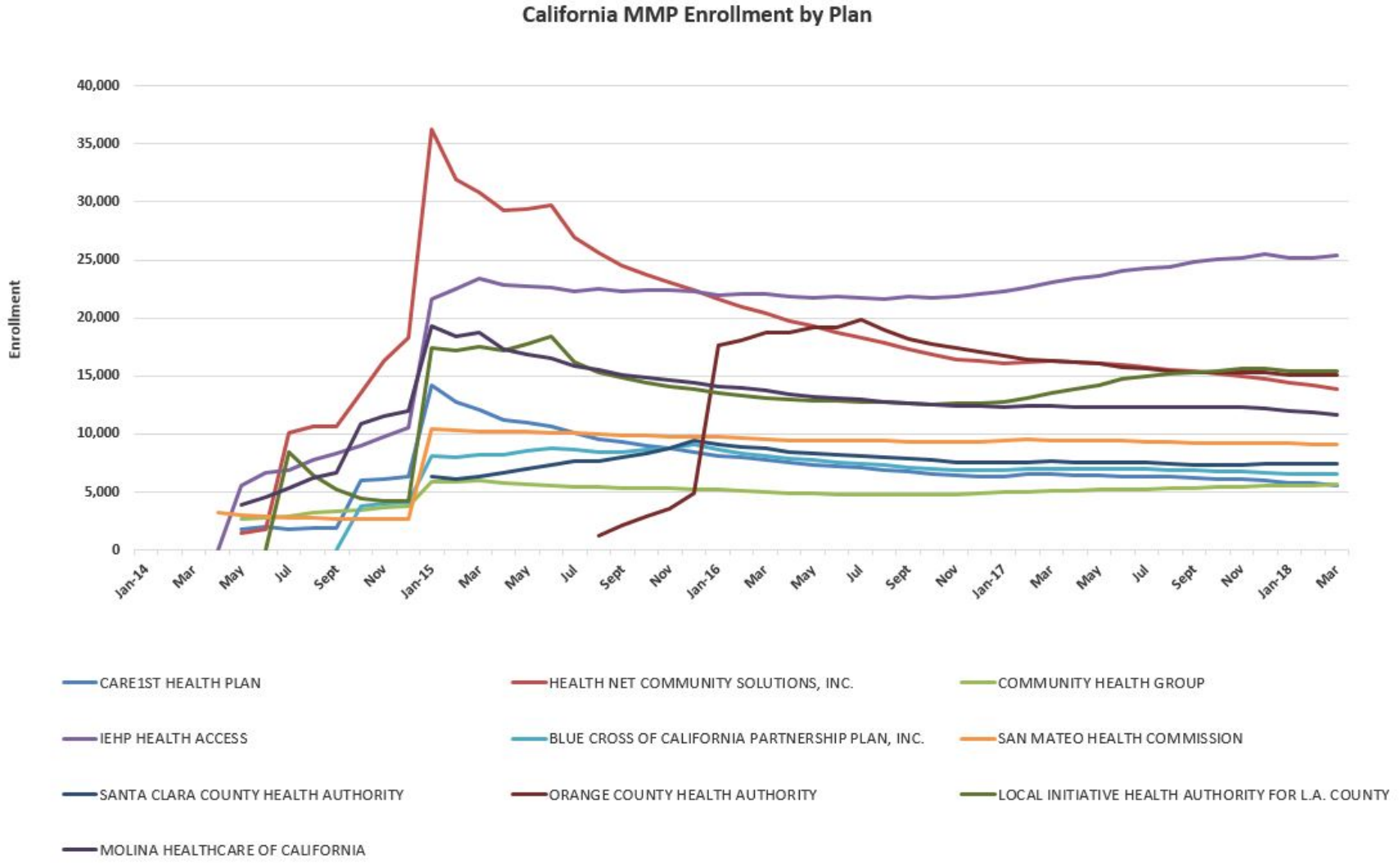
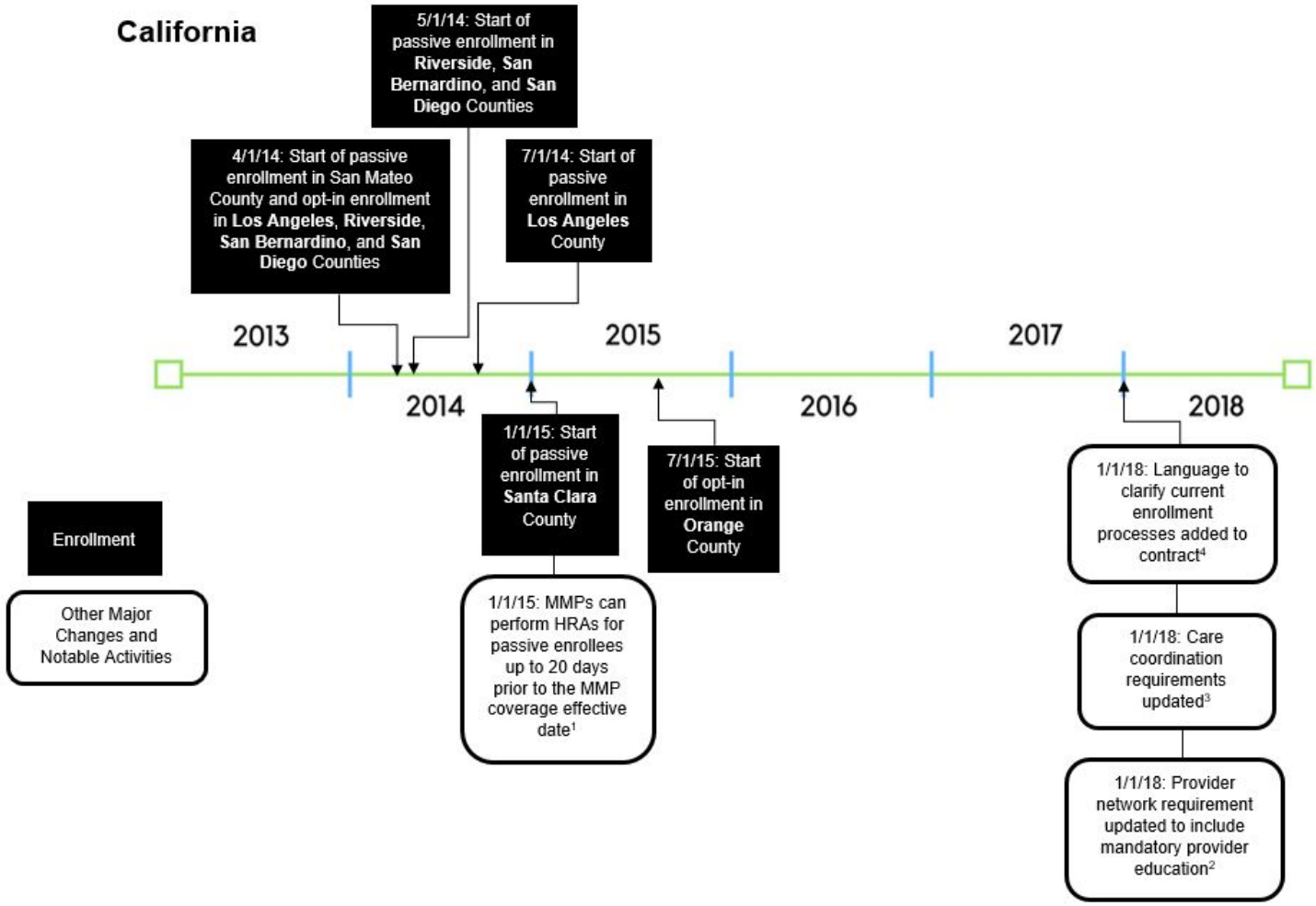


Figure C.2. California timeline of enrollment and other major changes/notable activities



[1] With prior approval from CMS and the state, MMPs in California may perform Health Risk Assessments (HRAs) for passively enrolled MMP members up to 20 days prior to the MMP coverage effective date, in addition to sending a welcome letter to welcome the new enrollees to the plan.

Figure C.2 (*continued*)

[2]California updated their three-way contract with CMS and MMPs to reflect the state's current demonstration enrollment processes, including adding language about **streamlined enrollment** (Sections 1.99, 2.3.1.7, 2.17.1.1.2), clarifying how the state's intelligent assignment process works for **beneficiaries in Dual Special Needs Plans (D-SNPs) with corresponding MMP products** (Sections 2.3.1.5.3.1.2), and adding language about deeming (see Sections 2.3.2.3 and Appendix J).

[3]Updated contract includes **updated care coordination requirements**, including new requirements that MMPs provide **adequate care coordinator to enrollee ratios** (Section 2.5.2.7.1) and that **care coordinators provide their contact information to enrollees** and **revisit ICT participation when an enrollee changes primary care providers** (Section 2.5.2.8.8.). The new contract also includes a mandate that MMPs **engage with enrollees annually about care planning** if an enrollee refuses to participate in care planning initially (Section 2.5.2.10), and a requirement that MMPs **share assessment, Interdisciplinary Care Plan (ICP), and other pertinent information with the new MMP** when a beneficiary moves from one MMP to another (Section 2.5.2.12). The new contract also requires MMPs to include names and contact information for care coordinators, PCPs, and IHSS workers in each member's care plan (Sections 2.5.2.11.1, 2.5.2.11.2, and 2.5.2.11.8), as well as a **current list of the enrollee's medication** (Section 2.5.2.11.3).

[4] Updated contract also includes updated provider network requirements, including **mandatory provider education** (on beneficiary's grievance, appeal, and fair hearing rights and the procedures and timeframes involved) to be conducted by MMPs with their network providers (see 2.9.10.2).

Figure C.3. Illinois MMP enrollment by plan, January 2014 – March 2018

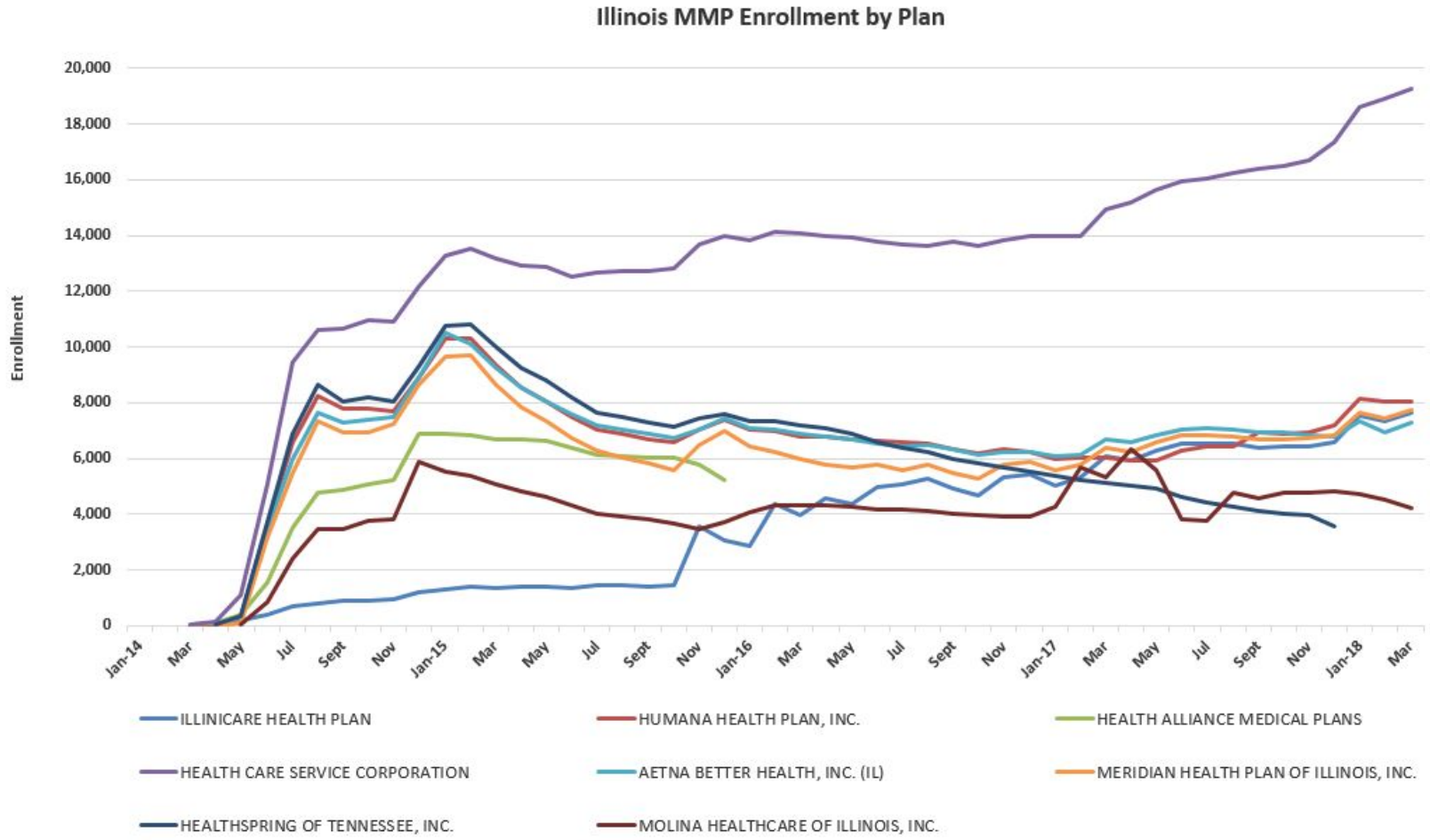
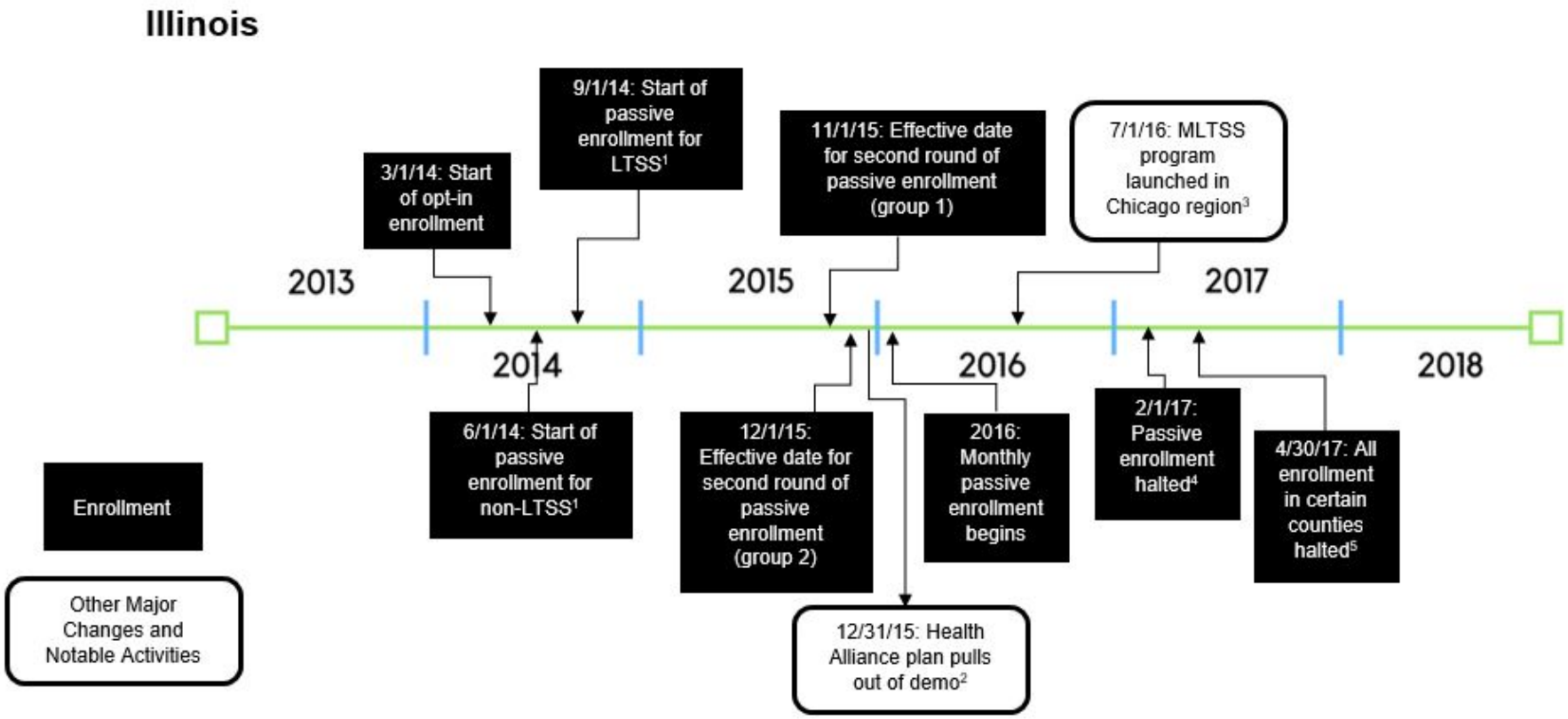


Figure C.4. Illinois timeline of enrollment and other major changes/notable activities



[1] Passive enrollment was conducted in phases over several months, starting with individuals NOT receiving LTSS, then proceeding to individuals receiving LTSS in September/October 2014.

[2] After Health Alliance dropped out of program, only one plan (Molina) operated in the central Illinois region. As a result, passive enrollment was halted in this region.

[3] Individuals eligible for demonstration who chose to opt out (and receive LTSS) were notified that they must enroll in a managed care plan for LTSS.

[4] Passive enrollment scheduled to start up again (for Molina only) in central Illinois, with Meridian planning to enter market. Meridian decided not to enter the market, so passive enrollment was halted. Central Illinois became a voluntary enrollment region.

[5] Sangamon, Christian, Logan, Piatt, Macon and Menard counties.

Figure C.5. Massachusetts enrollment by plan, January 2014 – March 2018

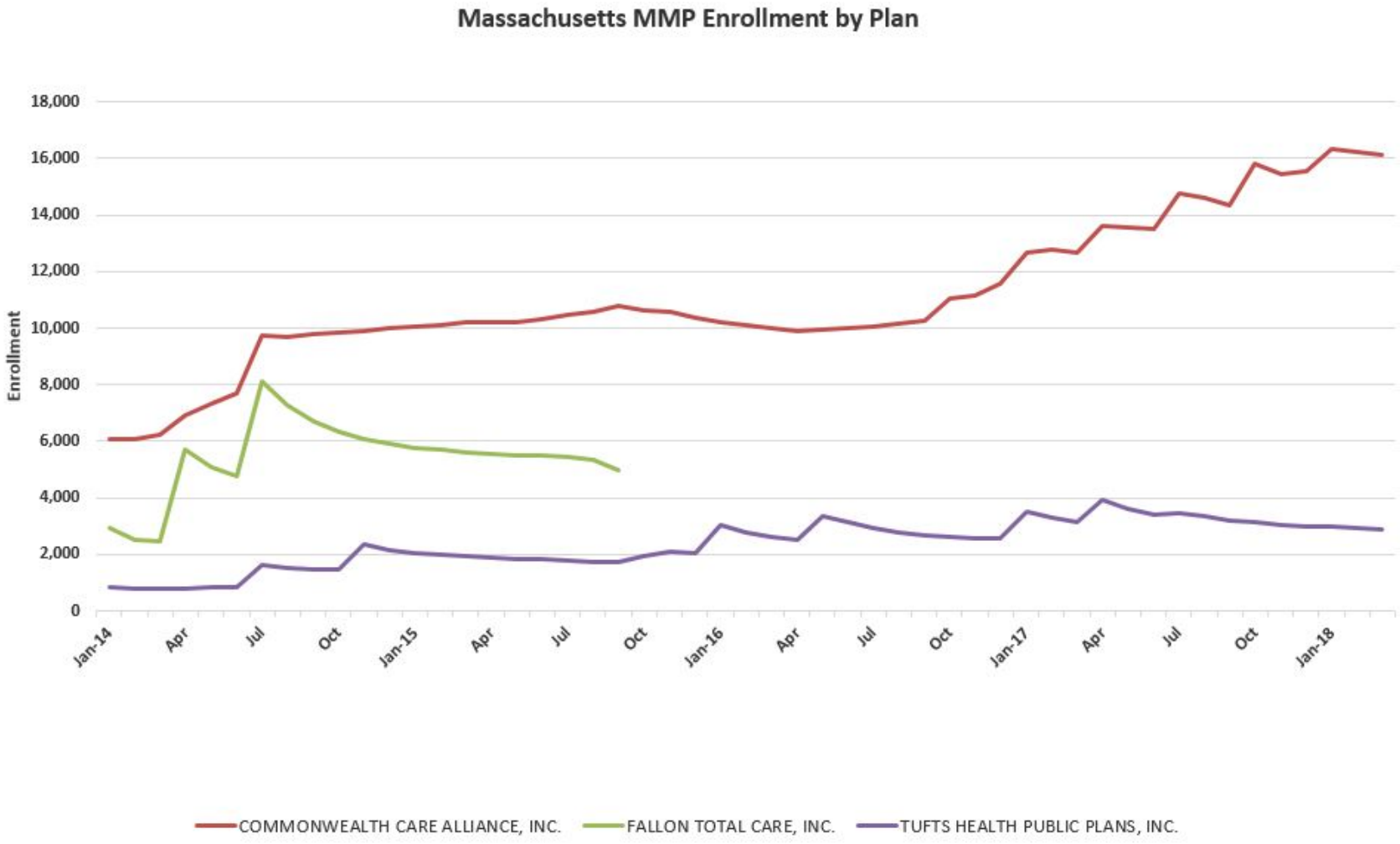
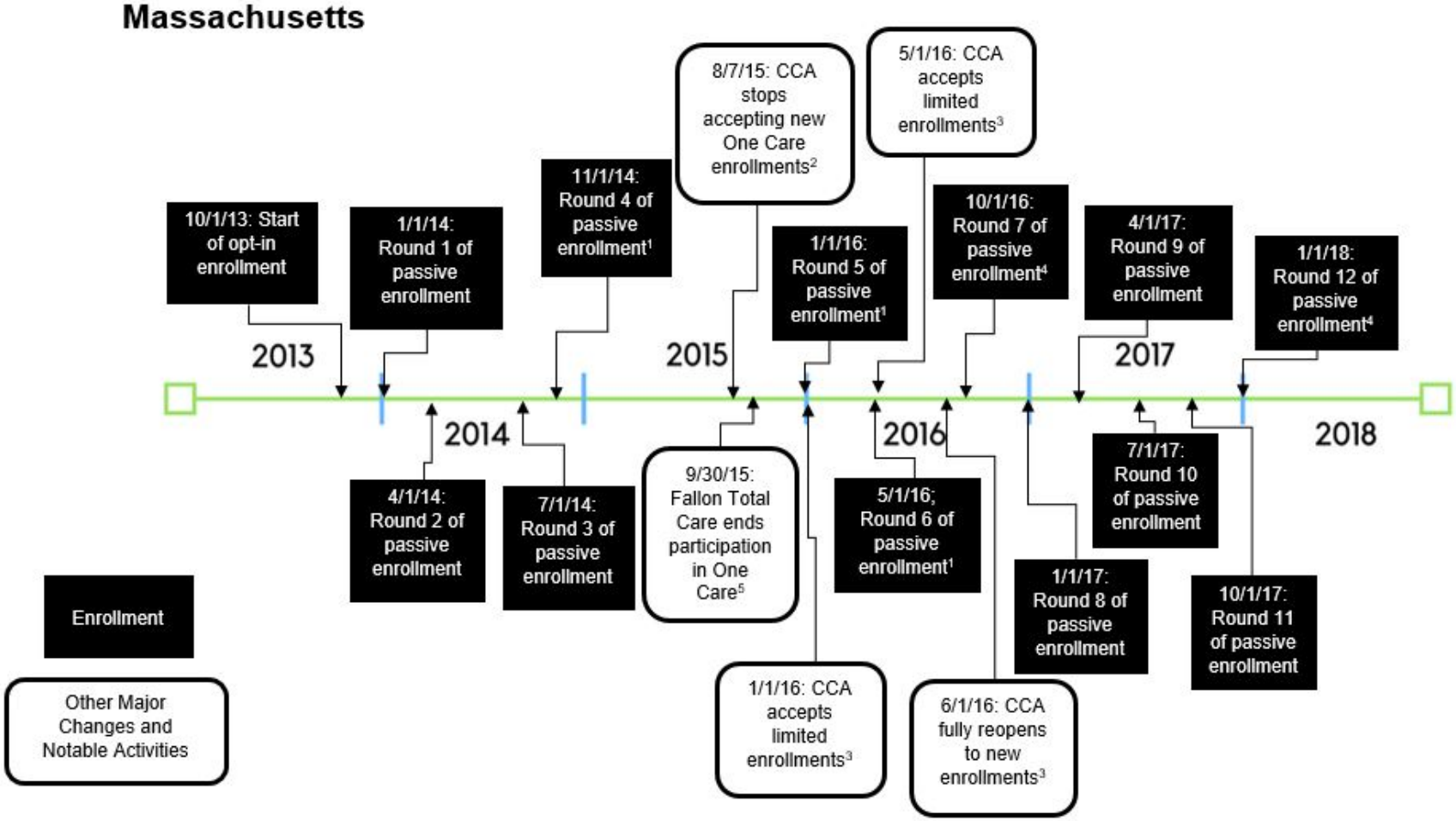


Figure C.6. Massachusetts timeline of enrollment and other major changes/notable activities



[1] Consisted of only auto-assignments to Tufts Health Plan.

[2] CCA temporarily stopped accepting new One Care enrollments. Members previously enrolled with CCA for One Care were able to re-enroll.

[3] CCA accepted limited enrollments for January 1 and May 1 in 2016, and in May fully reopened to new enrollments for June 1, 2016 and later dates.

[4] Consisted of only auto-assignments to CCA.

Figure C.6 (*continued*)

[5] During the first two years of the demonstration, the state did not allow/conduct passive enrollment in counties with only one plan. After Fallon Care dropped out of the program, the state relaxed this regulation and began allowing passive enrollment in counties with only one plan. CCA operates in Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties. Tufts Health Plan operates in Middlesex, Suffolk and Worcester counties.

Note: Plans can choose to opt in to specific rounds of passive enrollment.

Figure C.7. Michigan enrollment by plan, January 2014 – March 2018

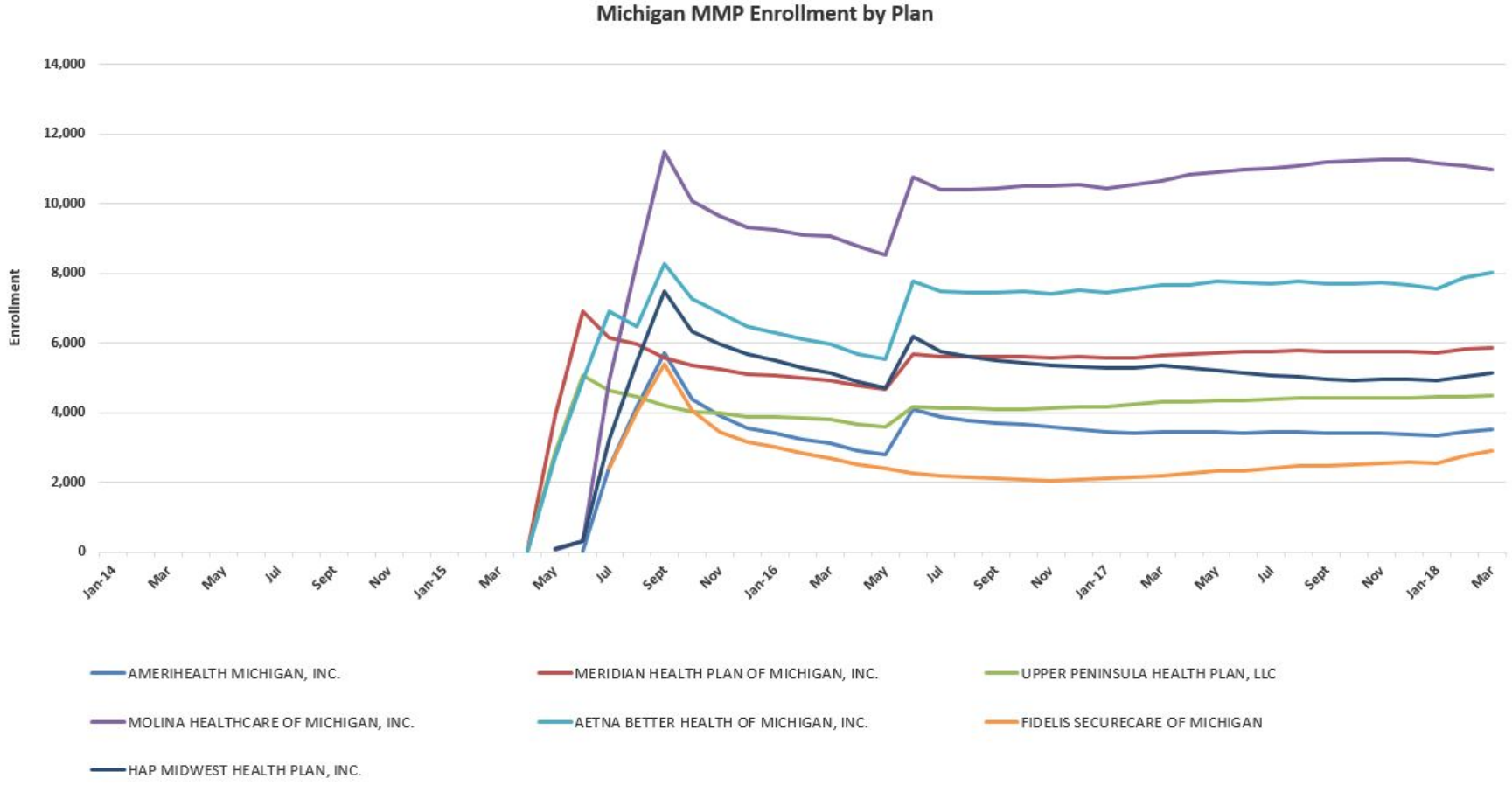
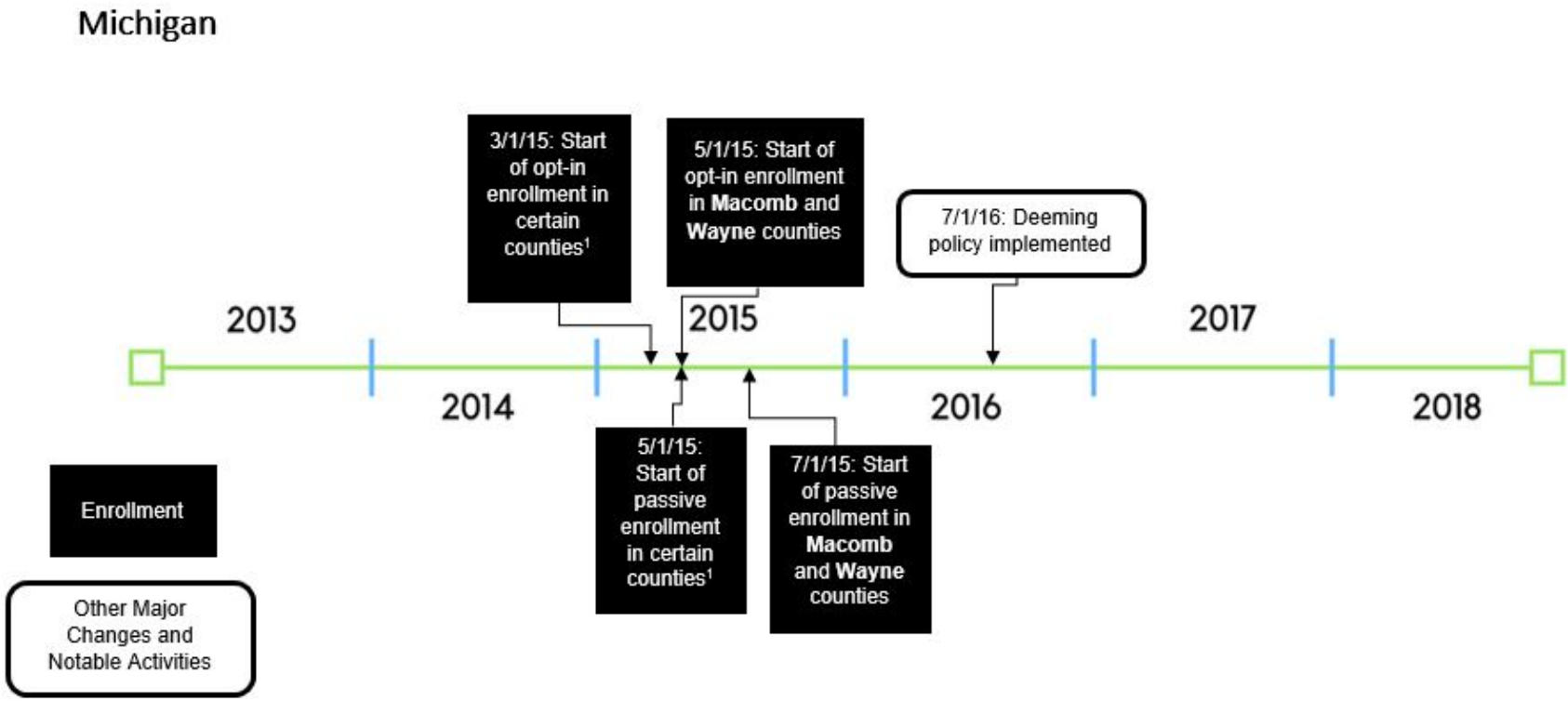


Figure C.8. Michigan timeline of enrollment and other major changes/notable activities



Note: On-going monthly passive enrollment began in 2016.

[1] Upper Peninsula (Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft counties) and southwest Michigan (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Saint Joseph, and Van Buren counties).

Figure C.9. New York FIDA MMP enrollment by plan, January 2014 – March 2018

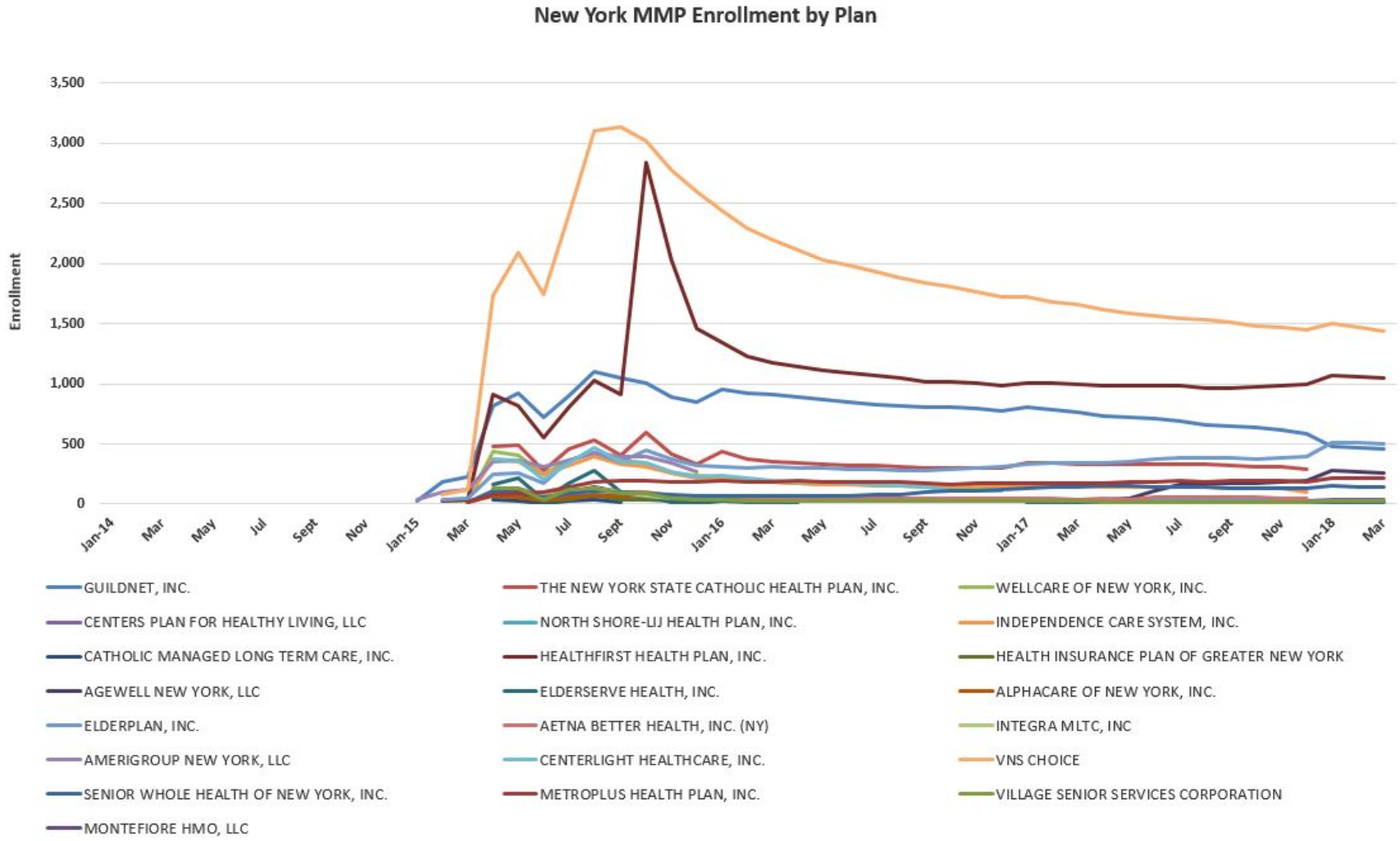
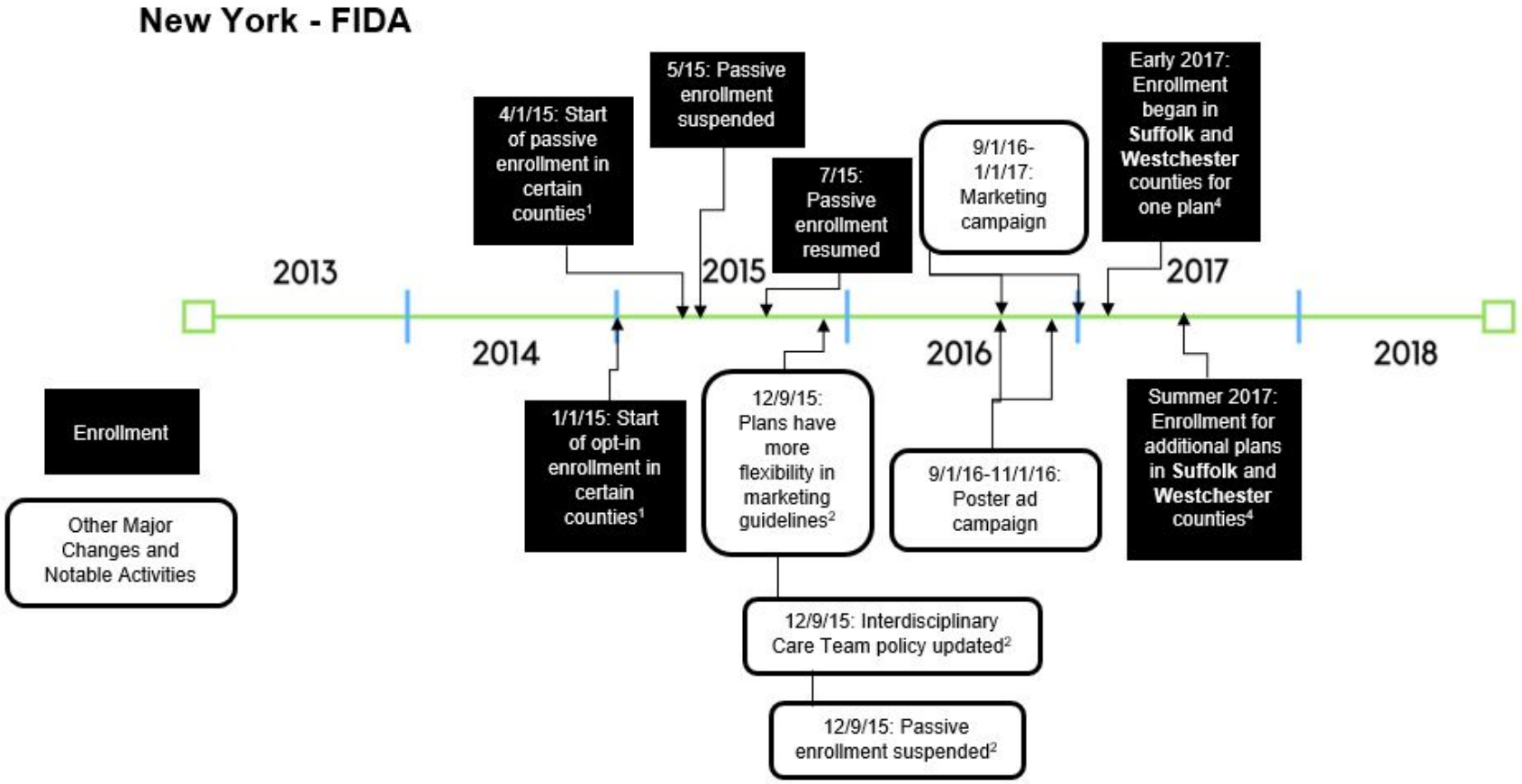


Figure C.10. New York FIDA timeline of enrollment and other major changes/notable activities



[1] Bronx, Kings, Nassau, New York, Queens, and Richmond counties.

[2] Revised Interdisciplinary Care Team policy (IDT policy), suspended passive enrollment, and gave plans more flexibility in marketing guidelines (to market multiple lines of business to beneficiaries, make outbound calls to current Medicare or Medicaid plan enrollees, conduct in-person marketing appointments when solicited by the individual, conduct promotional activities and provide nominal gifts up to $15 (in line with Medicare guidance), mail educational materials to beneficiaries who have opted out of the demonstration (with prior approval from the New York Department of Health), send enrollment requests to the state enrollment broker, and stay on the line with beneficiaries calling to enroll).

[3] New York, Long Island, Rockland, and Westchester counties.

[4] Initially, enrollment was available in one plan; additional plans became available in the summer of 2017.

Figure C.11. Ohio MMP enrollment by plan, January 2014 – March 2018

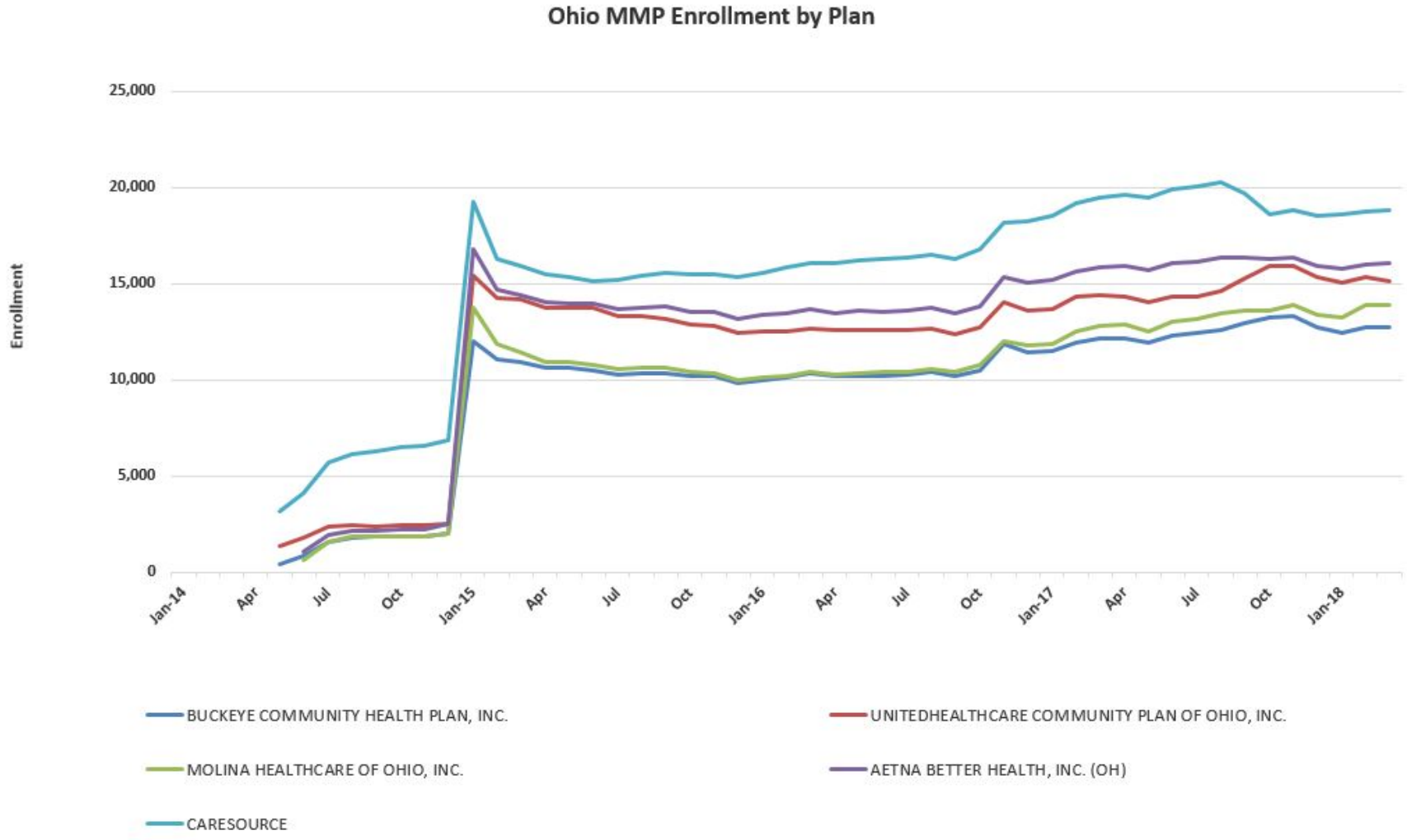
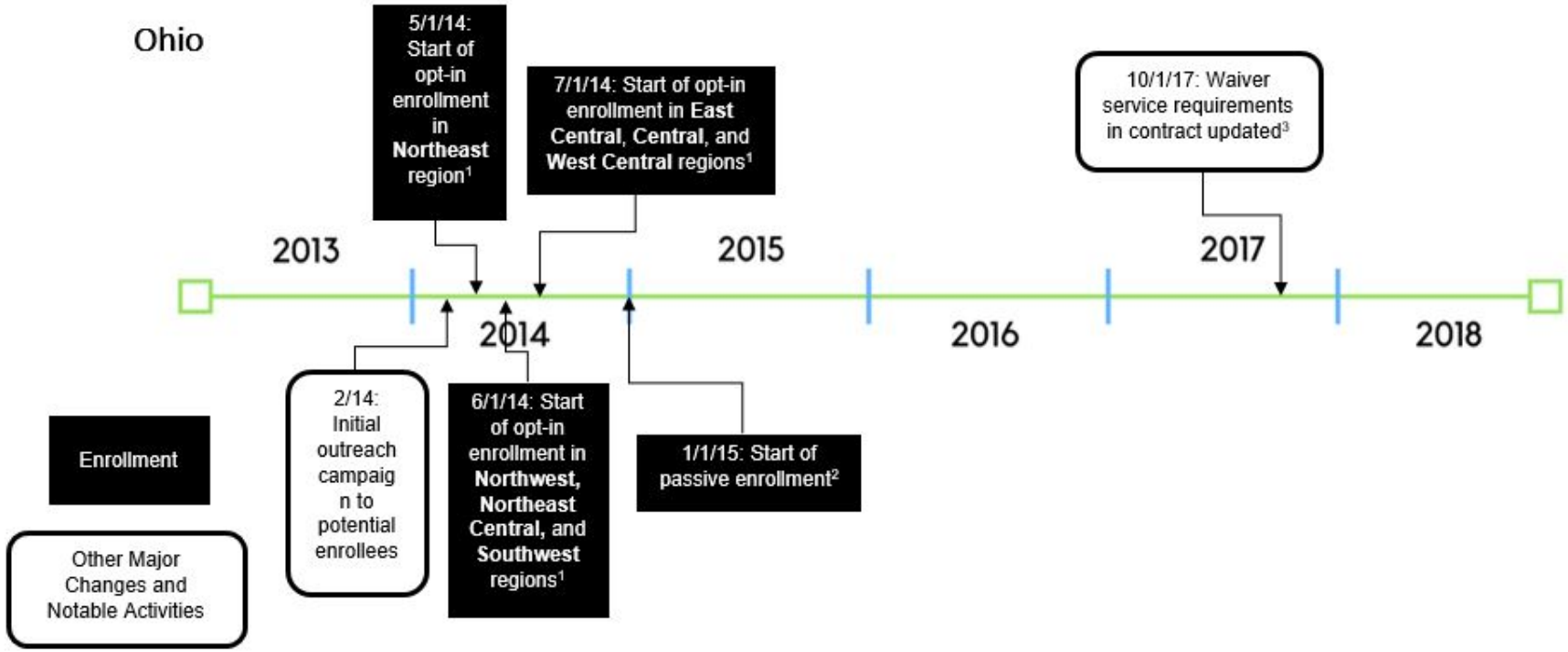


Figure C.12. Ohio timeline of enrollment and other major changes/notable activities



[1] Opt-in enrollment rolled out in tandem with passive enrollment into Medicaid-only side of MyCare. Northeast Region: Cuyahoga, Geaga, Lake, Lorain, and Medina counties. Northwest Region: Fulton, Lucas, Ottawa, and Wood counties. Northeast Central Region: Columbiana, Mahoning, and Trumbull counties. Southwest Region: Butler, Clermont, Clinton, Hamilton, and Warren counties. East Central Region: Portage, Stark, Summit, and Wayne counties. Central Region: Delaware, Franklin, Madison, Pickaway, and Union counties. West Central Region: Clark, Greene, and Montgomery counties.

[2] Initial passive enrollment in large waves, then shifted to steady monthly passive enrollment.

[3] Updated waiver service requirements in contract to read: "A Beneficiary who is enrolled in the HCBS waiver will be afforded the opportunity to select a Waiver Service Coordinator to facilitate and manage the delivery of waiver services authorized in the waiver service plan. The ICDS plan must contract with the AAAs and may contract with other entities that have experience working with people with disabilities (e.g., centers for independent living and disability-oriented case management agencies, etc.) as the primary waiver service coordination option for individuals aged sixty (60) and over. For individuals under the age of sixty (60), the ICDS Plan may perform Waiver Service Coordination as part of comprehensive Care Management and/or contract with entities that have experience working with people with disabilities. The ICDS Plan may assume the responsibility of waiver service coordination entity for any individual, regardless of age, if the individual selects or requests a change in the waiver service coordination entity, or if the Plan, CMS, or ODM identify a performance issue that affects an individual's health, welfare, and safety." (Section 2.5.3.3.5.4.1.1)

Figure C.13. Rhode Island MMP enrollment by plan, January 2014 – March 2018

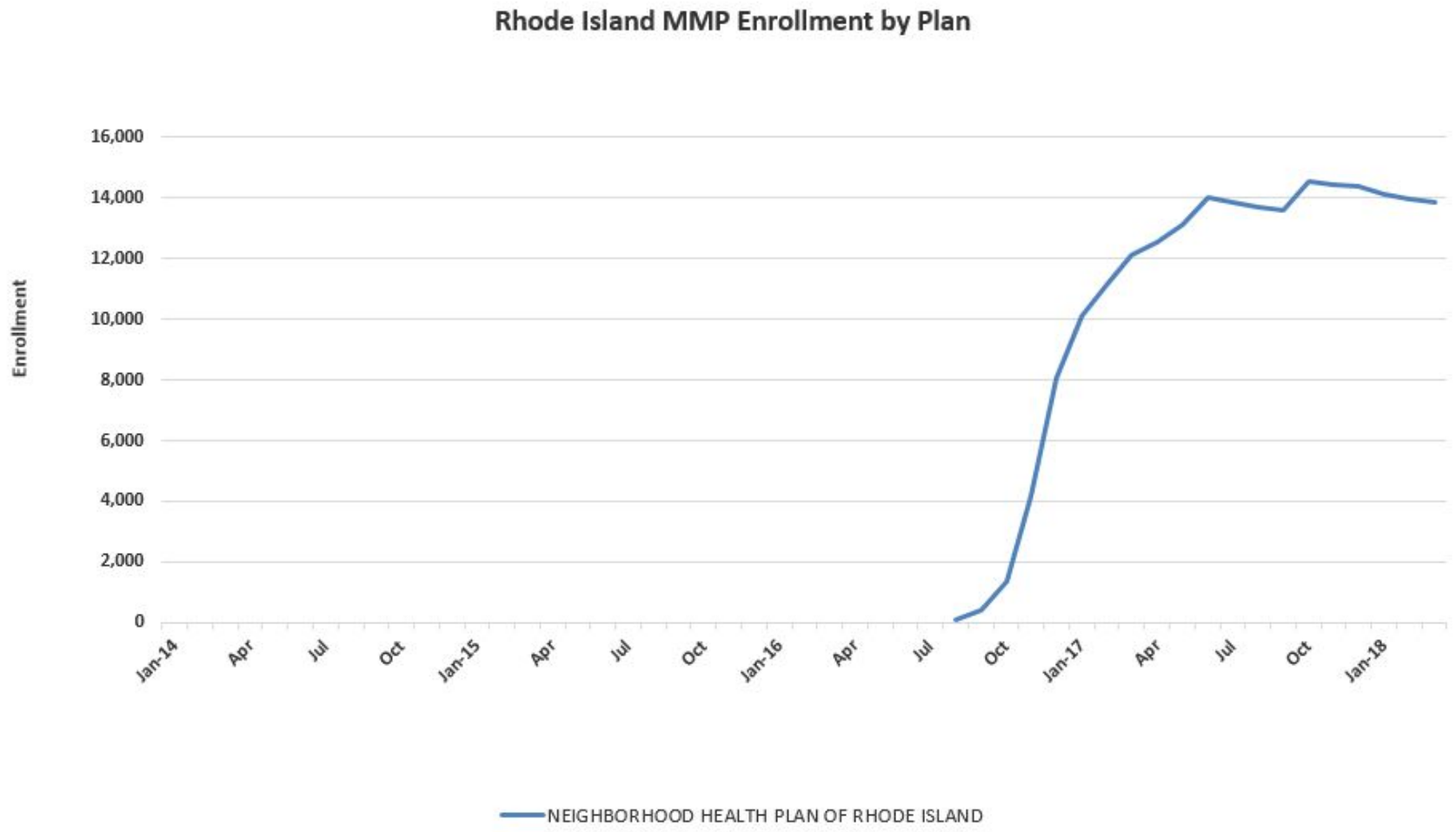
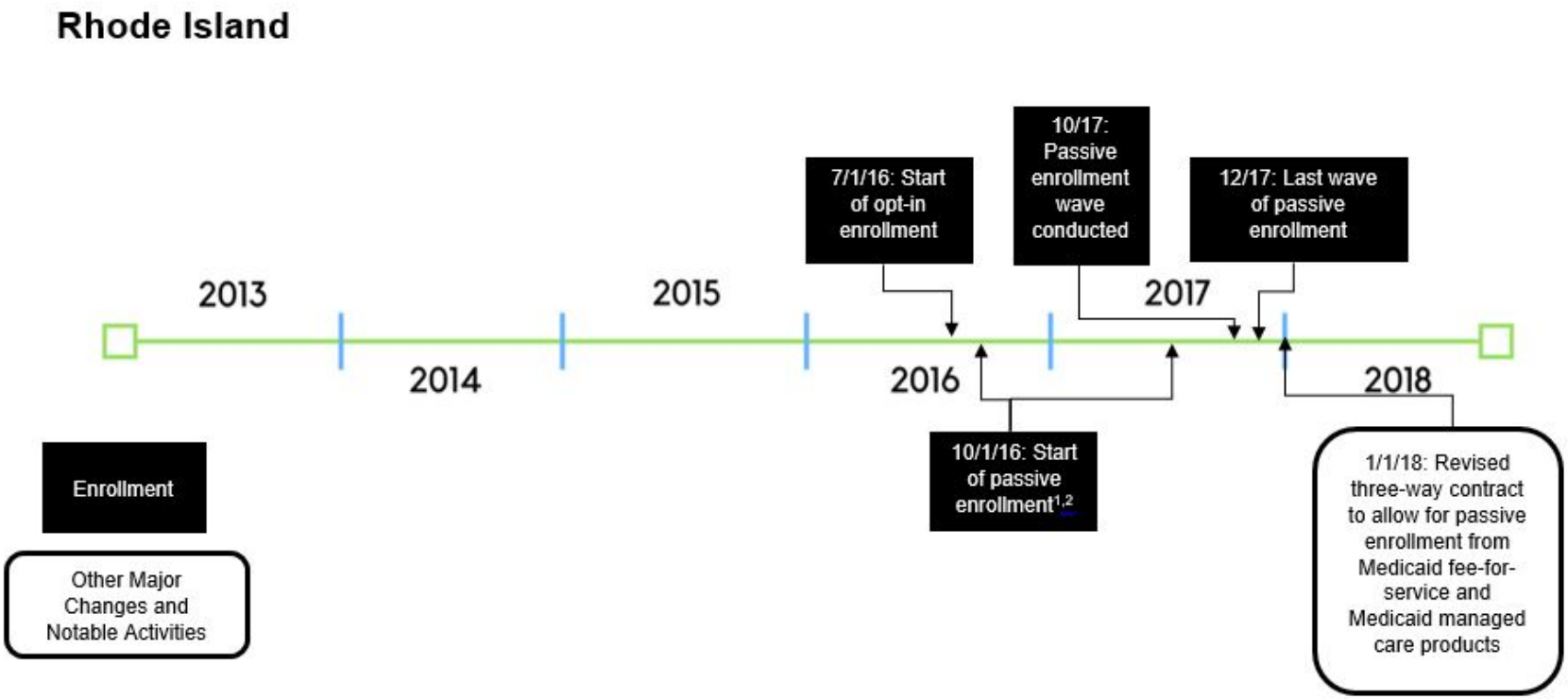


Figure C.14. Rhode Island timeline of enrollment and other major changes/notable activities



[1] Three-way contract states passive enrollment would be rolled out in six monthly waves.

[2] Full year of monthly passive waves through June 1, 2017. Three waves were conducted for different populations: (1) nursing facility residents; (2) individuals living in the community with long term care needs; and (3) individuals living in the community with no long term care needs (three additional waves).

Figure C.15. South Carolina MMP enrollment by plan, January 2014 – March 2018

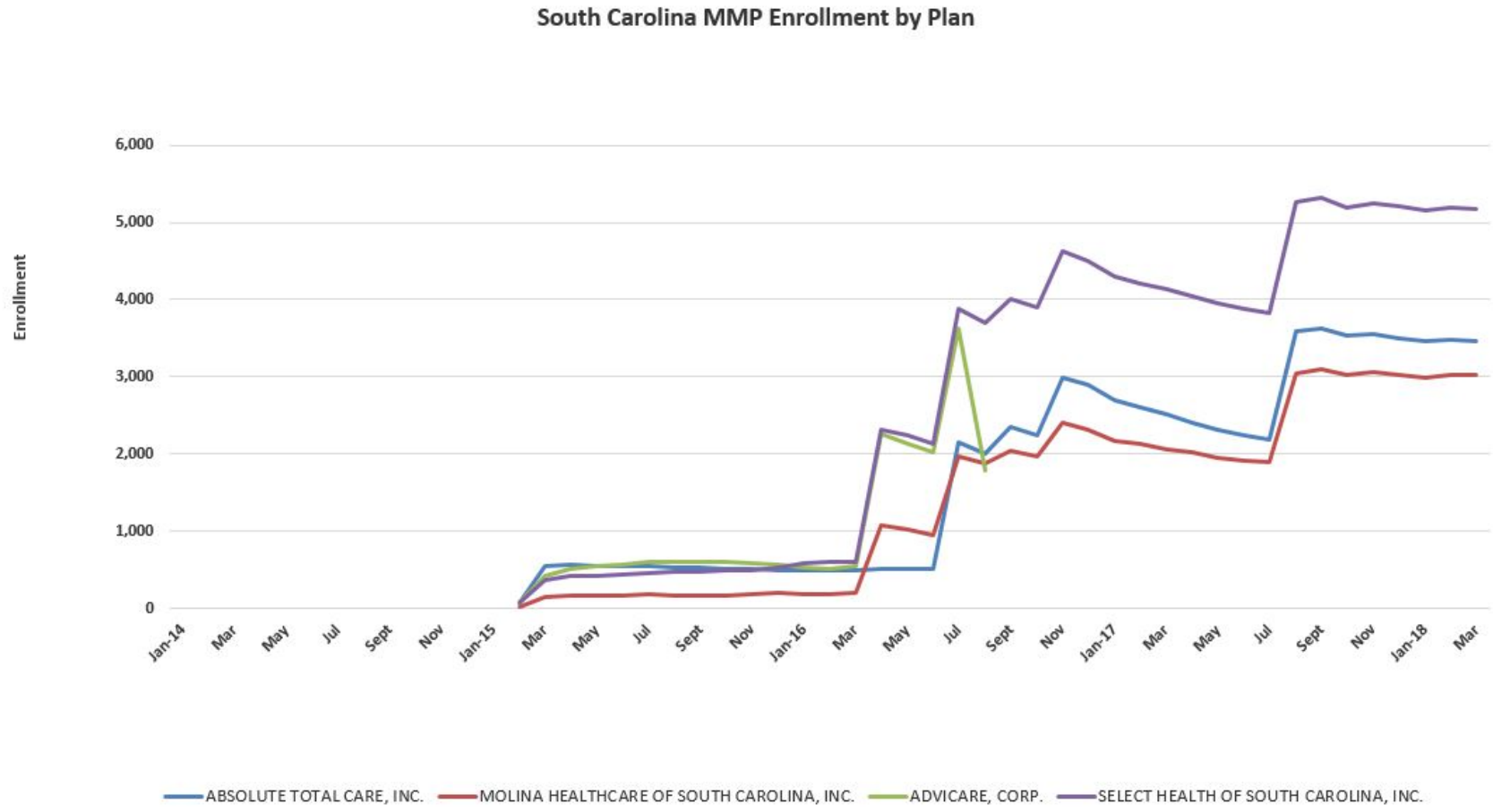
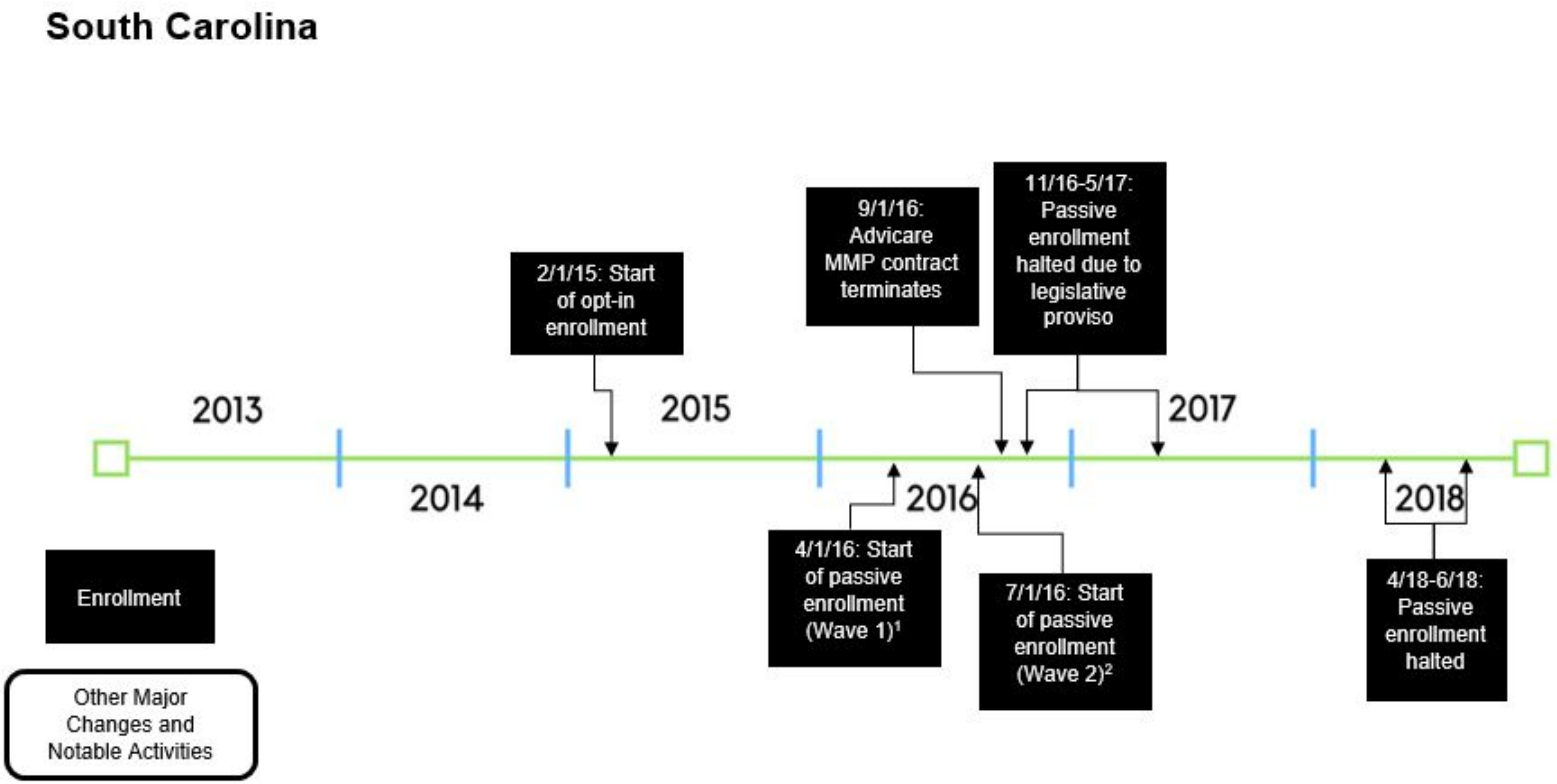


Figure C.16. South Carolina timeline of enrollment and other major changes/notable activities



Note: Aiken and Dorchester counties are eligible for "choice only" enrollment. Eligible beneficiaries in choice only counties must actively choose to participate and cannot be auto-enrolled into the program. In addition, the following counties are not participating in the South Carolina demonstration: Lancaster, Horry, Darlington, Sumter, and York.

[1] Abbeville, Anderson, Bamberg, Barnwell, Cherokee, Chester, Edgefield, Fairfield, Greenville, Kershaw, Laurens, Lexington, McCormick, Newberry, Oconee, Pickens, Richland, Saluda, Spartanburg, Union.

[2] Allendale, Beaufort, Berkeley, Calhoun, Charleston, Chesterfield, Clarendon, Colleton, Dillon, Florence, Georgetown, Greenwood, Hampton, Jasper, Lee, Marion, Marlboro, Orangeburg, Williamsburg.

Figure C.17. Texas MMP enrollment by plan, January 2014 – March 2018

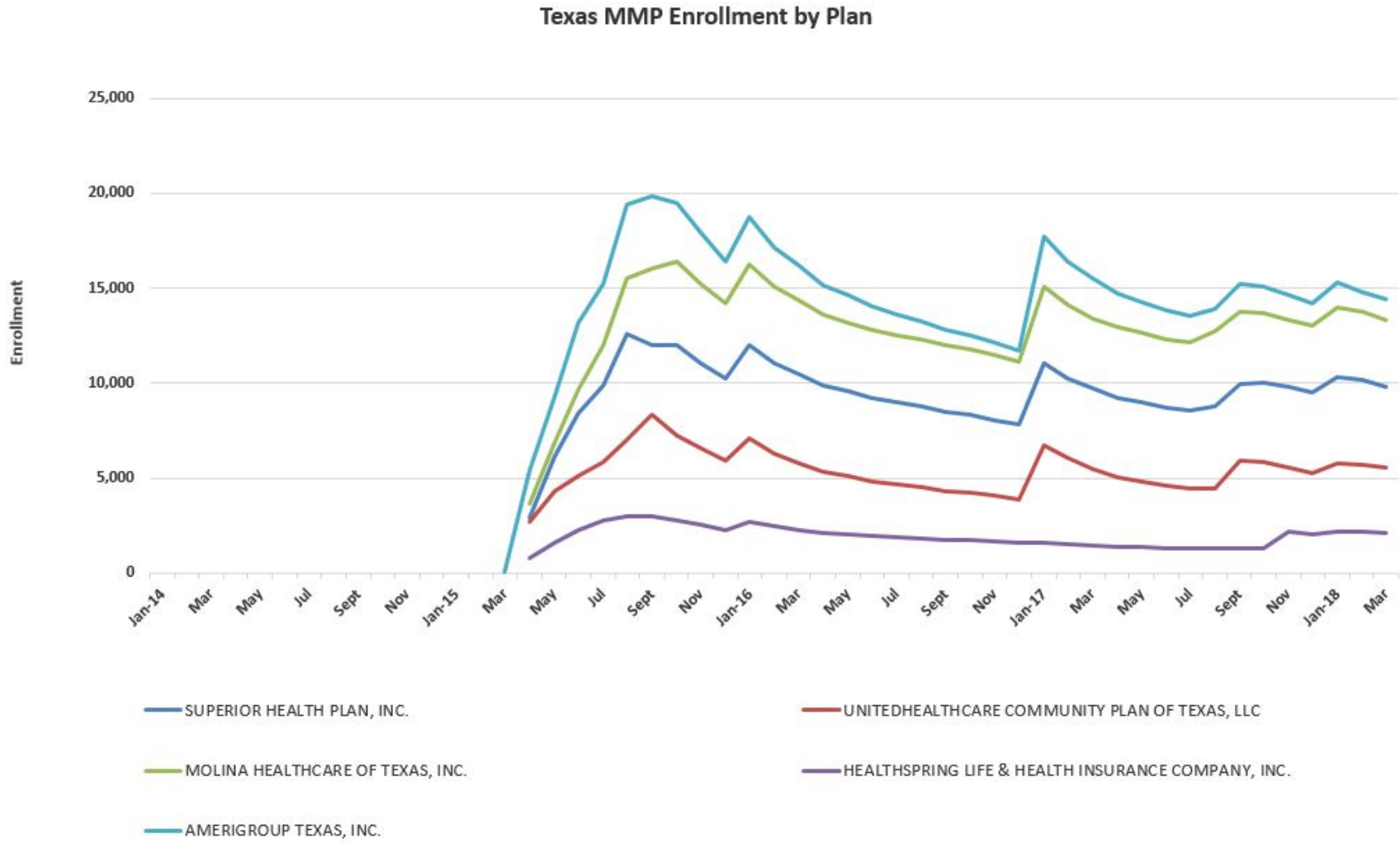
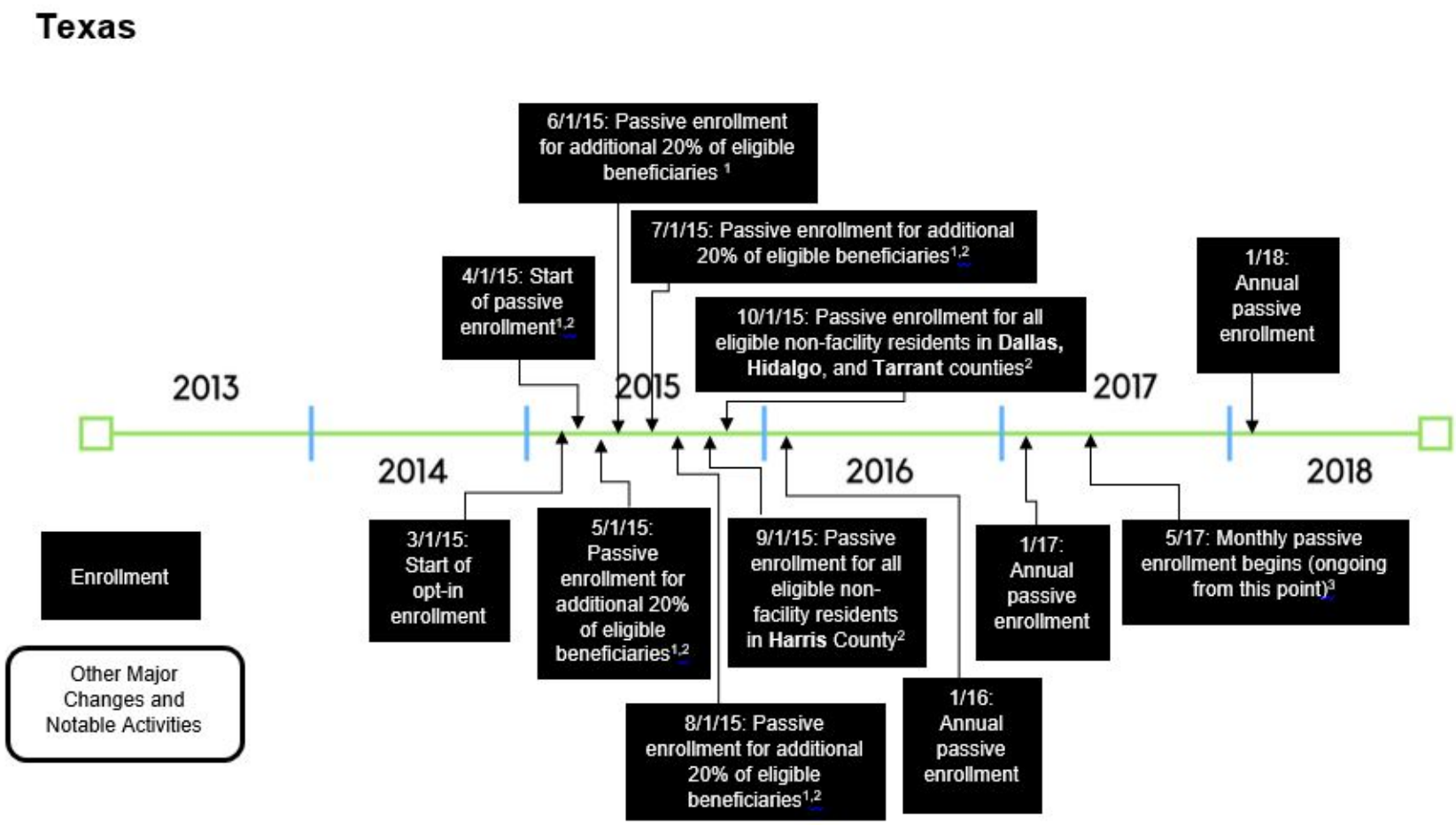


Figure C.18. Texas timeline of enrollment and other major changes/notable activities



[1] Twenty percent of eligible beneficiaries who do not live in nursing facilities, by zip code, in all demonstration counties—approximately 21,000 people.
[2] Passive enrollment in Texas is restricted to individuals who age into Medicare eligibility and individuals who are enrolled in a Star Plus plan through an MMP parent company.
[3] Between October 2015 and January 2017, Texas only conducted passive enrollment once annually. From May 2017 onward, the state has conducted ongoing monthly passive enrollment waves, in addition to an annual passive enrollment wave in January of each year.

Figure C.19. Virginia MMP enrollment by plan, January 2014 – March 2018

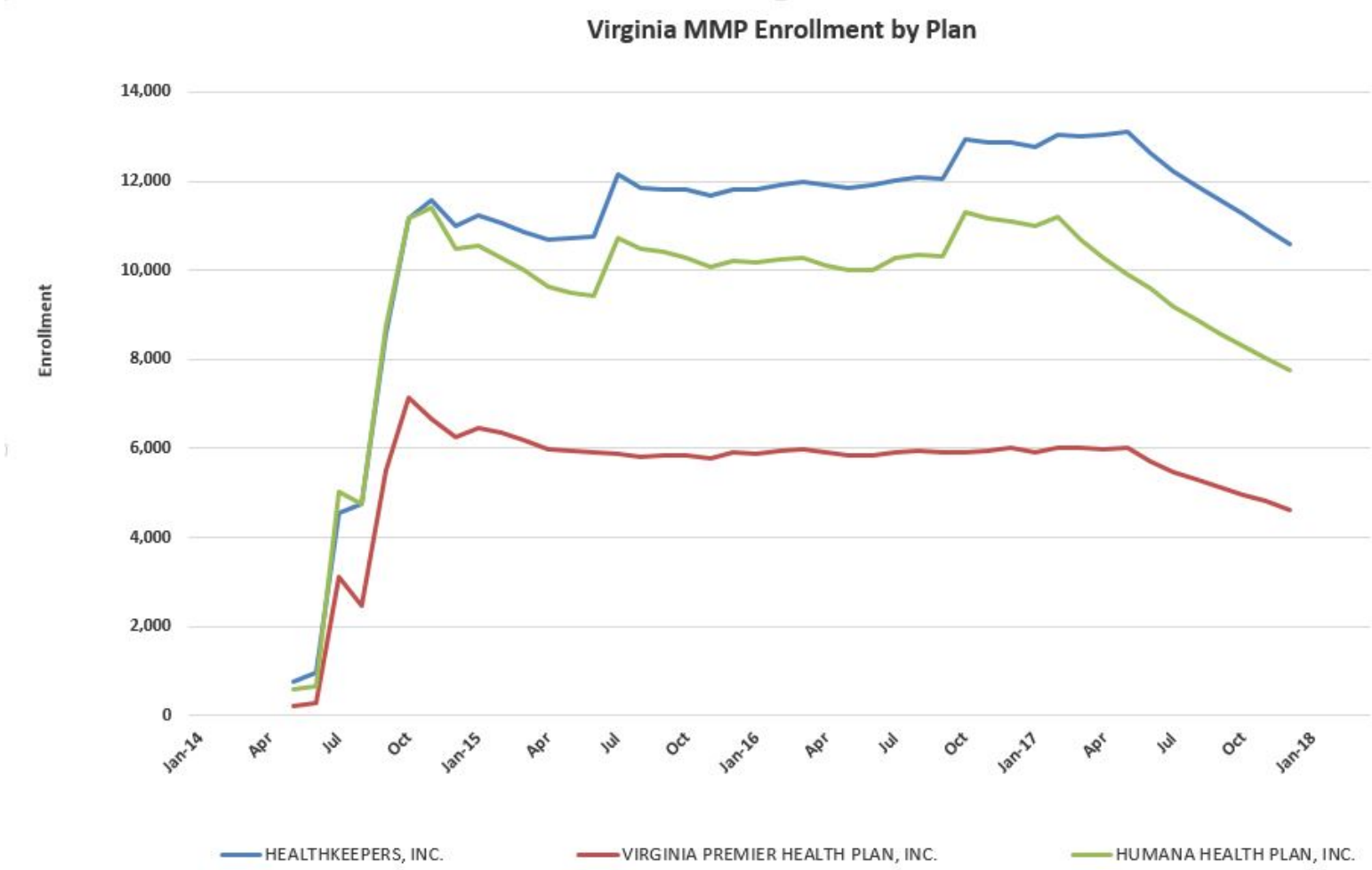
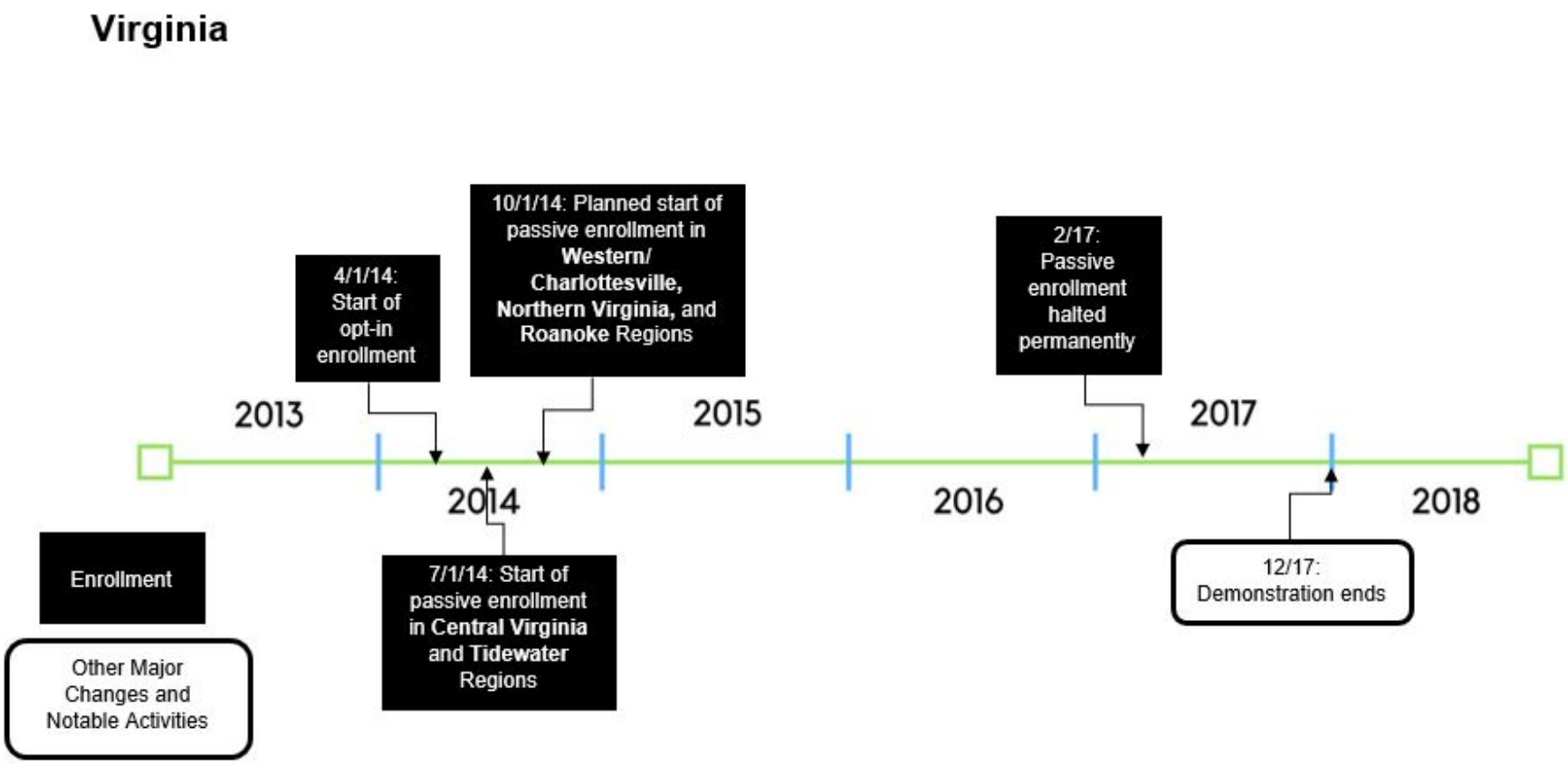


Figure C.20. Virginia timeline of enrollment and other major changes/notable activities



APPENDIX D

D-SNP PRESENCE IN CAPITATED MODEL FAI DEMONSTRATION STATES, FEBRUARY 2015

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Table D.1. D-SNP presence in 10 FAI demonstration states, February 2015

	CA	IL	MI	NY	OH	SC	TX	VA
Number of D-SNPs operating in state	30	6	7	41	11	3	21	2
Total statewide D-SNP enrollment	173,346	9,429	18,394	175,649	10,818	20,283	130,514	1,306
Number of D-SNPs operating in MMP counties	24	5	7	36	10	3	21	2
Total D-SNP enrollment in MMP counties	118,836	8,322	11,691	157,250	10,260	20,283	90,615	920
Number of MMP parent companies who also offered a D-SNP	7[a]	4	5	12	3	0	5	1
Number of MMPs operating in state	10[a]	8	7	23	5	4	5	3

Sources: MMP counties collected from information in state websites and demonstration three-way contracts. D-SNP data extracted from the February 2015 CMS SNP Comprehensive Report and the February 2015 CMS Monthly Enrollment by Contract/Plan/State/County Report. Both reports are available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html

Notes: Rhode Island is excluded from this table because it had no D-SNPs in 2015. Massachusetts and the New York FIDA-IDD demonstration are also excluded because the D-SNPs operating in those states served different populations than those served by the FAI demonstrations. California, New York, and Texas are especially notable in this table because (1) these three states had more than 10 D-SNPs operating in MMP counties and (2) more than 50,000 D-SNP enrollees in those counties – a substantial competitive presence that may have served to impact MMP enrollment if D-SNP parent companies were incentivized (financially or otherwise) to maintain those enrollees in D-SNPs, instead of moving them into MMPs.

[a] In 2015, two California MMPs were independent licensees of the same parent company (Anthem) – CareMore CalMediconnect and Anthem Blue Cross CalMediConnect. Because these two organizations are owned by the same parent company and the parent company serves as the key point of comparison for MMPs and D-SNPs here, we have counted these two plans once (as if they were a single plan) in this table.

[b] New York's FIDA-IDD demonstration and Rhode Island's demonstration did not begin until 2016; both have used a single MMP.

[c] New York's FIDA-IDD demonstration serves only adults with intellectual and/or developmental disabilities (I/DD). While these individuals are allowed to enroll in D-SNPs, they are not typically a substantial portion of D-SNP enrollees.

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APPENDIX E

STATE ENROLLMENT POLICIES AND PROCESSES FOR FINANCIAL ALIGNMENT INITIATIVE (FAI) CAPITATED MODEL DEMONSTRATIONS, JULY 2018

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Table E.1. State enrollment policies and processes for Financial Alignment Initiative (FAI) capitated model demonstrations

State	Opt-In enrollment start	Initial passive enrollment start	Delay between opt-in and passive enrollment	Ongoing passive enrollment *(January 2018)*	Passive enrollment of Medicare Advantage (MA) plan members	Deeming[a]	Rapid reenrollment[b]	Entity(ies) allowed to initiate MMP enrollment transactions[c]: State or enrollment broker (vendor listed)	Entity(ies) allowed to initiate MMP enrollment transactions[c]: MMPs	Opt out rate	Effective date of opt out rate
CA	4/1/2014	4/1/2014	0 months	No	No	Yes[e]	No	Maximus sends to state and state processes.	In certain circumstances[c]	50%[f]	May 2016[f]
IL	3/1/2014	6/1/2014	3 months	Monthly	Yes[d]	No	No	Maximus		No data available[g]	N/A
MA	10/1/2013	1/1/2014	3 months	Quarterly	No	No	No	Maximus		34.9%	May 2018
MI	3/1/2015	5/1/2015	2 months	Monthly	Yes[d]	Yes[e]	No	Maximus		No data available[g]	N/A[g]
NY (FIDA)	1/1/2015	4/1/2015	3 months	No	No	Yes[e]	No	Maximus	In certain circumstances[c]	49%	May 2016
NY (FIDA-IDD)	4/1/2016	N/A[e]	N/A[e]	No	N/A (no passive enrollment)	Yes[e]	No	Maximus		N/A (no passive enrollment)	N/A (no passive enrollment)
OH	5/1/2014	1/1/2015	8 months	Monthly	Yes[d]	No	No	Automated Health Systems		30-33%	July 2018
RI	7/1/2016	10/1/2016	3 months	Quarterly[k]	No	No	No	State enrollment hotline		5.8%[h]	January 2018[h]
SC	2/1/2015	4/1/2016	14 months	Monthly	No	No	No	Maximus		25%	April 2016
TX	3/1/2015	4/1/2015	1 month	Monthly	Yes[d]	No	No	Maximus		19.7%[i]	May 2018[i]
VA	4/1/2014	7/1/2014	3 months	Monthly	Yes	No	No	Maximus		No data available	N/A

Sources: Centers for Medicare and Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO) Financial Alignment Initiative Demonstration state webpages and three-way contracts. Available here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

State-specific appendices (Appendix 5) to FAI national enrollment guidance. Available here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPEnrollment.html

"Enrollment Processing and Strategies to Grow Enrollment for States Participating in the Capitated Model Financial Alignment Initiative." (February 22, 2018). Integrated Care Resource Center Webinar. Slides available here (chart on slide 35): http://www.integratedcareresourcecenter.com/PDFs/ICRC_SHC_Strategies_to_Grow_Enrollment_02-22-18_for_508.pdf

Medicaid and CHIP Payment Advisory Commission (MACPAC) state Financial Alignment Initiative Demonstration fact sheets, updated January 2018. Available here: https://www.macpac.gov/publication/financial-alignment-initiative-for-beneficiaries-dually-eligible-for-medicaid-and-medicare/

State websites and interviews with state Medicaid officials

Table E.1 (*continued*)

[a] Deeming is a procedure through which MMPs can continue to cover members who have experienced a temporary or short-term loss of Medicaid eligibility or change in eligibility status, on the assumption that they will regain eligibility.

[b] Rapid Re-enrollment is a process through which members can be quickly put back into their MMP after experiencing a loss of coverage.

[c] In order for a beneficiary to be enrolled in an MMP, the state or another entity (for example, an Enrollment Broker) must submit a request to CMS to enroll the beneficiary into the plan. This request submission is known as an "enrollment transaction." In most states' FAI demonstrations, health plans are not allowed to submit enrollment requests on behalf of beneficiaries – the beneficiaries themselves (or a legally authorized representative) must contact the state or the state's Enrollment Broker to enroll. California and New York allow specific exceptions to this policy wherein health plans may initiate these enrollment transactions on behalf of eligible beneficiaries. In California, County-Operated Health System MMPs in San Mateo and Orange Counties may submit enrollment transactions (both voluntary enrollments and disenrollment requests) for individuals currently enrolled in the MMP's Medi-Cal plan. In New York's FIDA Demonstration, MMPs "may accept new enrollment requests directly from new-to-service individuals and may submit these to Maximus using the U-File process. FIDA plans may not accept requests for enrollment from individuals currently enrolled in another FIDA plan or request for disenrollment from individuals enrolled in their Plan. In addition, they cannot accept opt-out requests directly from individuals and may not process such request themselves." (New York State-Specific Appendix to National Enrollment Guidance, available here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYApp5101916.pdf) New York's U-File process began in December 2015; to date, there has been limited use of this option.

[d] MA plan members may be passively enrolled into an MMP if the MMP is operated by the same parent company as their Medicare Advantage plan. (The member is auto-assigned to the MMP from the same parent company as their current MA plan.)

[e] MMPs in California may choose to provide 1-2 months of deemed continued eligibility for individuals who lose MMP eligibility due to a loss or change in Medicaid eligibility status or a temporary move out of the service area, as long as the individual can reasonably be expected to regain Medicaid eligibility during the deemed eligibility period. MMPs are not mandated to provide deemed coverage, but if they do choose to provide it, they must apply criteria consistently across all plan members and inform plan members and the state of its deeming policy. MMPs in Michigan may choose to provide 3 months of deemed continued eligibility for individuals who experience a short-term loss of Medicaid eligibility. MMPs are not mandated to provide deemed coverage, but if they do choose to provide it, they must apply criteria consistently across all plan members and inform the plan members and the state of its deeming policy. MMPs in New York may choose to provide 3 months of deemed continued eligibility for individuals who experience a short-term loss of Medicaid eligibility. MMPs must alert the state by January 20 annually of their decision regarding use of a deeming policy.

[f] California no longer calculates opt out rates because they no longer use passive enrollment. A May 1, 2016 Cal-MediConnect enrollment dashboard (available here: http://calduals.org/wp-content/uploads/2016/05/CMC-Enrollment-Dashboard-May-Final.pdf) shows significant variation in opt out rates across FAI demonstration counties, ranging from a 10 percent opt out rate in San Mateo County to a 58 percent opt out rate in Los Angeles County.

[g] Illinois and Michigan do not calculate opt out rates for their Demonstrations. However, Michigan's state enrollment dashboard from February 2018 (available here: https://www.michigan.gov/documents/mdhhs/MI_Health_Link_Public_Dashboard_502731_7.pdf) cites a 35.1 percent participation rate across all demonstration counties (with county-level participation rates ranging from 20.6-51.7 percent). A 35.1 percent overall participation rate implies that 64.9 percent of eligible beneficiaries have opted out or disenrolled from the program, presuming all eligible beneficiaries have now been passively enrolled into the Demonstration at some point.

[h] Rhode Island halted the use of passive enrollment as of January 1, 2018. Rhode Island's opt out rate was 15.8 percent in January 2017, but decreased to 5.8 percent by January 2018.

[i] The opt out rate for Texas only represents those that took place between June 2017 and May 2018.

APPENDIX F

STATE MARKETING AND OUTREACH POLICIES AND PRACTICES IN FINANCIAL ALIGNMENT INITIATIVE (FAI) CAPITATED MODEL DEMONSTRATIONS, JULY 2018

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Table F.1. State marketing/outreach policies and practices in Financial Alignment Initiative (FAI) capitated model demonstrations

State	Welcome calls to passive enrollees prior to effective date?	MMPs allowed to conduct early HRAs with passive enrollees?	Outreach to individuals who opt out of the Demonstration?	Use of streamlined enrollment?	MMP-employed staff may assist prospective enrollees with filling out enrollment applications?	MMP-employed sales agents may conduct 1-on-1 marketing appointments if solicited by the prospective enrollee?	MMPs allowed to use independent sales agents/ brokers?[a]
CA	No	Yes[b]	No	Yes[d]	Yes	Yes	Yes[g]
IL	No	Yes	No	No	No	No	No
MA	Yes	Yes	No	No	Yes	Yes	No
MI	Yes	Yes	Yes	No	No	No	No
NY (FIDA)	No	Yes	No	Yes[d]	Yes[e]	Yes	No
NY (FIDA-IDD)	No	No	No	No	No	Yes	No
OH	No	No	No	No	No	No	No
RI	No	N/A[c]	No	No	Yes[f]	Yes	No
SC	Yes	Yes	No	No	No	Yes	Yes
TX	No	Yes	No	No	No	Yes	Yes[g]
VA	No data available	No data available	No	No data available	No data available	No data available	No data available

Sources: Financial Alignment Initiative state-specific appendices (Appendix 5) to FAI national enrollment guidance. Available here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPEnrollment.html

CY2018 Medicare-Medicaid Plan (MMP) Marketing Practices and Beneficiary Disclosure Requirements Comparison Table. (March 28, 2018). Centers for Medicare & Medicaid Services (CMS). Available here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MktgPracticesandBeneDisclosReqsComparisonTableCY2018_03282018.pdf

"Enrollment Processing and Strategies to Grow Enrollment for States Participating in the Capitated Model Financial Alignment Initiative." (February 22, 2018). Integrated Care Resource Center Webinar. Slides available here (chart on slide 35): http://www.integratedcareresourcecenter.com/PDFs/ICRC_SHC_Strategies_to_Grow_Enrollment_02-22-18_for_508.pdf

State websites

Interviews with state Medicaid staff

Table F.1 (*continued*)

[a] All MMPs in all states are allowed to use plan-employed agents to market the MMP.

[b] Effective January 1, 2015.

[c] Because all members in Rhode Island's MMP must first be enrolled in the state's MLTSS program (through the same single health plan), the MMP is able to use the existing assessment from the MLTSS program when the member enrolls into the MMP, negating the need for immediate assessment in the MMP.

[d] Certain MMPs in certain counties in California are allowed to use streamlined enrollment processes to submit opt-in enrollments on behalf of potential members who are currently enrolled in a Medi-Cal Medicaid Managed Care plan through the same parent organization. County-Operated Health System (COHS) MMPs are not allowed to use streamlined enrollment.

[e] Only applies to "new-to-service" enrollees (who are not currently enrolled in a FIDA plan or MLTSS plan) via the "U-File" process. (U-File process in place since December 2015.)

[f] Rhode Island allows MMP staff to provide enrollment application assistance to members in the MMP's other lines of business who want to be enrolled in the MMP.

[g] Currently, California and Texas MMPs may only compensate independent agents/brokers for MMP enrollment when individuals are enrolling in MMPs offered by the same parent organization as their previous coverage. In CY2019, California MMPs may request approval from the state to compensate independent agent/brokers for MMP enrollments. In reviewing these requests, the state intends to prioritize requests from MMPs with no other Medicare Advantage products in their MMP service area. (CMS Memorandum from June 11, 2018; available here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CAAgentBrokerCompensationPolicyUpdateCY2019_06112018.pdf)

APPENDIX G

STATE EXPERIENCE WITH MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS) PRIOR TO IMPLEMENTATION OF FINANCIAL ALIGNMENT INITIATIVE (FAI) CAPITATED MODEL DEMONSTRATIONS, JULY 2018

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Table G.1. States' experience with Managed Long-Term Services and Supports (MLTSS) prior to implementation of Financial Alignment Initiative (FAI) capitated model demonstrations

State	FAI demonstration start date	State MLTSS program[a] start date	State MLTSS program served dually eligible beneficiaries prior to FAI demonstration?	MLTSS mandatory for dually eligible beneficiaries when demonstration began?	MLTSS program covers HCBS, NF or both?	MLTSS program covers same/similar population(s) as FAI demonstration?
California	4/1/2014	4/1/2014[b]	Yes[b]	Yes	Both	Yes (+Medicaid only and partial benefit dually eligible beneficiaries)
Illinois	3/1/2014	7/1/2016	No	No	Both	Yes
Massachusetts	10/1/2013	3/1/2004	Yes	No	Both[e]	No[g]
Michigan	3/1/2015	10/1/2013[c]	Yes	No	HCBS Only	Yes[c] (+ children)
New York	1/1/2015	1/1/1998[d]	Yes	Yes	Both[f]	Yes (+ dually eligible and non-dually eligible individuals age 18+ in need of LTSS)
Ohio	5/1/2014	5/1/2014	No	Yes	Both	Yes
Rhode Island	7/1/2016	11/1/2013	Yes	No	Both	Yes (+ Medicaid only)
South Carolina	2/1/2015	N/A	No	N/A	N/A	N/A
Texas	3/1/2015	1/1/1998	Yes	Yes	Both[f]	Yes (+ Medicaid only and children)
Virginia	4/1/2014	8/1/2017	No	No	Both	Yes (+ Medicaid only)

Sources: Centers for Medicare & Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO) Financial Alignment Initiative Demonstration state webpages available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

CMS Medicaid Managed Care Enrollment Reports (2011-2015). Available at: https://www.medicaid.gov/medicaid/managed-care/enrollment/index.html

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Kasten, J., Lipson, D., Saucier, P., and Libersky, J. (June 2017). "Who Enrolls in Medicaid Managed Care Programs that Cover Long-Term Services and Supports." Medicaid 1115 Demonstrations Issue Brief. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-ib1-508-mltss-enrollment.pdf

Libersky, J., Stepanczuk, C., Lester, R., Liao, K., and Lipson, D. (March 2016). "Medicaid Managed Long-Term Services and Supports: Themes from Site Visits to Five States." Mathematica Policy Research Working Paper. Available at: https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicaid-managed-long-term-services-and-supports-themes-from-site-visits-to-five-states

State websites

Table G.1 (*continued*)

[a] Start dates are for standalone MLTSS programs (not including FAI demonstration).

[b] California operated a couple of very small, local (and voluntary) MLTSS programs prior to launching their FAI demonstration, but did not run any comparably sized MLTSS programs until they launched their Medi-Cal MLTSS program (concurrently with their FAI demonstration).

[c] Michigan operated two MLTSS programs prior to the start of its FAI demonstration. The MI Choice program (whose enrollees match the FAI demonstration population most closely) began on October 1, 2013. The Medicaid Managed Specialty Supports & Services Program (MSS&S), began on January 1, 1998. Michigan's MI Choice MLTSS Program serves older adults and adults with physical disabilities, and the MSS&S Program serves children and adults with mental health and I/DD. Michigan's FAI demonstration serves older adults, adults with physical disabilities, and adults with I/DD.

[d] New York's Managed Long Term Care (MLTC) program has operated since January 1, 1998. New York's second MLTSS program serving dually eligible beneficiaries, Medicaid Advantage Plus, began January 1, 2006.

[e] The Massachusetts (OneCare) Demonstration includes HCBS as covered benefits, but the HCBS covered are not provided via 1915(c) waiver authority.

[f] New York began enrolling new nursing facility residents into their MLTC program in 2012, and existing residents in 2015. Texas began enrolling nursing facility residents into their MLTSS programs in 2015.

[g] In Massachusetts, the OneCare Financial Alignment Initiative Demonstration and the Senior Care Options (SCO) program (the MLTSS program that existed in Massachusetts prior to the Demonstration) serve different populations. OneCare serves individuals under the age of 65, and SCO serves individuals age 65 and over. However, OneCare members are allowed to 'age in place' and remain in the Demonstration when they turn 65, as long as they remain otherwise eligible for the Demonstration. This leads to a small amount of overlap in the two programs' populations.

APPENDIX H

MEDICARE-MEDICAID PLAN (MMP) CHARACTERISTICS AND PRIOR MANAGED CARE EXPERIENCE IN FINANCIAL ALIGNMENT INITIATIVE (FAI) DEMONSTRATION STATES BEFORE IMPLEMENTATION, JANUARY 2018

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Table H.1. Medicare-Medicaid Plan (MMP) characteristics and prior managed care experience in Financial Alignment Initiative (FAI) demonstration states before implementation[a]

State	Medicare-Medicaid Plan (MMP) marketing name[b]	Tax status[b]	Local, regional or national plan[c]	Managed care experience with dually eligible beneficiaries in state prior to Demonstration			Years of managed care experience in state *(MMC, MLTSS or Medicare Advantage, regardless of whether plan enrolled dually eligible beneficiaries)*[f]			
				D-SNP[d]	Medicaid Managed Care (MMC)[e]	MLTSS[e]	At least 3 years	At least 2 years	At least 1 year	Less than 1 year
CA	Anthem Blue Cross Cal MediConnect	For profit	National	No	Yes	No	X			
CA	Health Net Cal MediConnect Medicare Medicaid Plan	For profit	National	Yes	Yes	No	X			
CA	Molina Healthcare of California	For profit	National	Yes	Yes	No	X			
CA	Care1st Health Plan	Nonprofit	Local	Yes	Yes	No	X			
CA	Community Health Group	Nonprofit	Local	Yes	Yes	No	X			
CA	IEHP DualChoice	Nonprofit	Local	Yes	Yes	No	X			
CA	L.A. Care Cal MediConnect Plan	Nonprofit	Local	Yes	Yes	No	X			
CA	OneCare Connect	Nonprofit	Local	Yes	No	No	X			
CA	Health Plan of San Mateo	Nonprofit	Local	Yes	Yes	No	X			
CA	Santa Clara Family Health Plan Cal MediConnect	Nonprofit	Local	No	Yes	No		X		
IL	Aetna Better Health Premier Plan	For profit	National	No	No[g]	No[g]	X			
IL	Humana Gold Plus Integrated	For profit	National	No	No	No	X			
IL	IlliniCare Health	For profit	National	No	No[g]	No[g]				X [h]
IL	MeridianComplete	For profit	National	Yes [i]	No	No			X	
IL	Molina Healthcare of Illinois	For profit	National	Yes [i]	No	No			X	
IL	Blue Cross Community MMAI	Nonprofit	National	No	No	No			X	
MA	Commonwealth Care Alliance, Inc.	Nonprofit	Local	Yes	Yes	Yes	X			
MA	Tufts Health Plan	Nonprofit	Local	Yes [i]	Yes	Yes	X			
MI	Aetna Better Health Premier Plan	For profit	National	No	No	No	X			
MI	AmeriHealth Caritas VIP Care Plus	For profit	National	No	No	No				X
MI	HAP Midwest MI Health Link	For profit	Local	Yes	Yes	No	X			
MI	MeridianComplete	For profit	National	Yes	Yes	No	X			
MI	Michigan Complete Health [j]	For profit	National	Yes	No	No	X			
MI	Molina Healthcare of Michigan	For profit	National	Yes	Yes	No	X			
MI	Upper Peninsula Health Plan (UPHP) MI Health Link	For profit	Local	Yes	Yes	No	X			
NY FIDA	AgeWell New York FIDA Plan	For profit	Local	No	No	Yes		X *(MLTSS only)*[h]		

State	Medicare-Medicaid Plan (MMP) marketing name[b]	Tax status[b]	Local, regional or national plan[c]	Managed care experience with dually eligible beneficiaries in state prior to Demonstration			Years of managed care experience in state *(MMC, MLTSS or Medicare Advantage, regardless of whether plan enrolled dually eligible beneficiaries)*[f]			
				D-SNP[d]	Medicaid Managed Care (MMC)[e]	MLTSS[e]	At least 3 years	At least 2 years	At least 1 year	Less than 1 year
NY FIDA	Centers Plan for FIDA Care Complete	For profit	Local	No	No	Yes			X (*MLTSS only)*	
NY FIDA	SWH Whole Health FIDA Plan	For profit	Regional	Yes	Yes	Yes	X			
NY FIDA	Elderplan FIDA Total Care	Nonprofit	Local	Yes	Yes	Yes	X			
NY FIDA	RiverSpring FIDA Plan (Elderserve Health, Inc.)	Nonprofit	Local	No	Yes	Yes			X	
NY FIDA	GuildNet Gold Plus FIDA	Nonprofit	Local	Yes	Yes	Yes	X			
NY FIDA	Healthfirst Medicare Plan	Nonprofit	Local	Yes	Yes	Yes	X			
NY FIDA	MetroPlus FIDA	Nonprofit	Local	Yes	Yes	Yes	X			
NY FIDA	Village Care MAX Full Advantage FIDA	Nonprofit	Local	No	No	Yes		X *(MLTSS only)*		
NY FIDA	VNSNY CHOICE FIDA Complete	Nonprofit	Local	Yes	Yes	Yes	X			
NY FIDA-IDD	Partners Health Plan	Nonprofit	Local	No	No	No				X
OH	Aetna Better Health of Ohio, MyCare Ohio	For profit	National	No	No	No	X			
OH	Buckeye Health Plan - MyCare Ohio	For profit	National	Yes	No[g]	No	X			
OH	Molina Healthcare of Ohio	For profit	National	Yes	No[g]	No	X			
OH	UnitedHealthcare Community Plan	For profit	National	Yes	No[g]	No	X			
OH	CareSource MyCare Ohio	Nonprofit	Regional	Yes	No[g]	No	X			
RI	Neighborhood Health Plan of Rhode Island	Nonprofit	Local	No	Yes	Yes		X		
SC	Absolute Total Care	For profit	National	No	No[g]	No		X		
SC	Molina Healthcare of South Carolina	For profit	National	No	No[g]	No			X	
SC	First Choice VIP Care Plus	For profit	National	No	No	No		X		
TX	Amerigroup STAR+PLUS MMP	For profit	National	Yes	Yes	Yes	X			
TX	Cigna-HealthSpring Care Plan	For profit	National	Yes	Yes	Yes	X			
TX	Molina Healthcare of Texas	For profit	National	Yes	Yes	Yes	X			
TX	Superior Health Plan	For profit	National	Yes	Yes	Yes	X			
TX	United Healthcare	For profit	National	Yes	Yes	Yes	X			
VA	Anthem Healthkeepers	For profit	National	No	No[g]	No	X			
VA	Humana Gold Plus Integrated	For profit	National	Yes	No	No	X			
VA	Virginia Premier Complete Care	Nonprofit	Local	No	No[g]	No			X	

Note: Data in this table was gathered from a variety of sources, all of which are listed in the footnotes corresponding to each column in the table. This data was not provided, reviewed, or verified by Medicare-Medicaid plans.

Table H.1 (*continued*)

[a] This list only includes MMPs that were active in states' Demonstrations as of January 1, 2018. MMPs in Illinois, Massachusetts, New York, and South Carolina that withdrew from the Demonstration before that date are not included in this table. Excluding these plans did not affect our analysis of enrollment trends because the MMPs that withdrew typically (1) had very low enrollment (for example, fewer than 500 enrollees) throughout their participation in the Demonstration or (2) experienced declining enrollment before dropping out of the Demonstration.

[b] Source: CMS Medicare Advantage Plan Directory File, March 2018. Available here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Plan-Directory.html

[c] Source: National plans verified by Parent Company listed in CMS Medicare Advantage Plan Directory File, March 2018. Available here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Plan-Directory.html. Local and Regional plan status verified through information on individual plan websites.

[d] Source: CMS Special Needs Plan (SNP) Comprehensive Reports (January 2010, January 2011, January 2012, January 2013, January 2014, January 2015). Available here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

[e] Source: CMS Medicaid Managed Care Enrollment Reports (2011-2015). Available here: https://www.medicaid.gov/medicaid/managed-care/enrollment/index.html (used reports for year prior to each state's demonstration enrollment commencement – for example, 2013 report for California information, 2014 report for New York information, etc.).

[f] Sources: For Medicaid Managed Care experience: CMS Medicaid Managed Care Enrollment Reports (2011-2015), available here: https://www.medicaid.gov/medicaid/managed-care/enrollment/index.html. For Medicare Advantage experience: CMS Medicare Advantage Service Area Reports (January reports for 2011-2016), available here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Contract-Service-Area-by-State-County.html

[g] These organizations had Medicaid Managed Care plans (and/or MLTSS plans, as indicated) prior to the Demonstration, but did not serve dually eligible beneficiaries in those plans prior to the Demonstration.

[h] MMP Parent Company began offering a Medicare Advantage plan in the state in January of the same year that state's Demonstration began.

[i] Meridian and Molina offered D-SNPs for the first time in Illinois in 2013 (the year prior to Demonstration implementation), but by December 2013, Molina's D-SNP had 0 enrollees, and Meridian's had 26. Similarly, Tufts offered a D-SNP in Massachusetts for the first time in 2013 (10 months prior to Demonstration implementation) that only had 44 enrollees in December of 2013.

[j] Michigan Complete Health was formerly known as Fidelis SecureCare, which had a D-SNP plan in Michigan for at least 3 years prior to the state's Demonstration implementation.

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