



REPORT

FINAL REPORT

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

December 4, 2018

Debra J. Lipson
Erin Weir Lakhmani
Alena Tourtellotte
Danielle Chelminsky

Submitted to:

Medicaid and CHIP Payment and Access Commission (MACPAC)
Project Officer: Kirstin Blom
Contract Number: MACP18411T1

Submitted by:

Mathematica Policy Research
1100 1st Street, NE
12th Floor
Washington, DC 20002-4221
Telephone: (202) 484-9220
Facsimile: (202) 863-1763
Project Director: Debra Lipson
Reference Number: 50604

This report was prepared under contract to the Medicaid and CHIP Payment and Access Commission (MACPAC). The findings, statements, and views expressed in this report are those of the authors and do not necessarily reflect those of MACPAC.

This page has been left blank for double-sided copying.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the support of the Medicaid and CHIP Payment and Access Commission (MACPAC) for funding this study, and appreciate guidance from Kirstin Blom, Kate Kirchgraber, Kristal Vardaman, and Anne Schwartz at MACPAC throughout the project. At Mathematica, we thank our colleague James Verdier for his expert insight and helpful review and comments on a draft of the report. We also thank William Garrett, Amanda Bernhardt, Sharon Clark, Colleen Fitts, and Jennifer Baskwell for editorial and production assistance.

In addition, we extend special thanks to the state Medicaid agency staff and senior executives and managers of managed care plans who generously gave their time for interviews and shared their knowledge and experience with the Financial Alignment Initiative capitated model demonstrations. We are inspired by their dedication to delivering more coordinated services and integrated Medicare-Medicaid benefits to dually eligible beneficiaries.

This page has been left blank for double-sided copying.

CONTENTS

EXECUTIVE SUMMARY	ix
I. INTRODUCTION.....	1
II. DATA AND METHODS	5
III. MAJOR FINDINGS	7
A. Beneficiary participation rates	7
B. Key factors affecting enrollment	8
IV. FACTORS ASSOCIATED WITH HIGHER ENROLLMENT.....	10
A. Passive enrollment	11
B. Alignment of key design features of FAI demonstrations with state managed long term services and supports (MLTSS) programs.....	13
C. Positive beneficiary relationships with care coordinators.....	15
D. Secondary factors associated with higher enrollment.....	16
1. Medicaid deeming policies.....	16
2. Collaboration with established, trusted community-based organizations (CBOs)	17
3. Strong provider networks	17
4. Emphasis on certain outreach messages.....	17
V. FACTORS ASSOCIATED WITH LOWER ENROLLMENT	19
A. Insufficient LTSS provider support and engagement with MMPs	19
B. Secondary factors associated with lower enrollment	20
1. Beneficiaries' ability to enroll in, disenroll from, or change MMPs at any time.....	20
2. Influence from acute, primary care and specialty providers	21
3. Systems and data exchange issues	21
4. Complex beneficiary enrollment notices	21
C. State use of an independent, third party enrollment broker	22
D. Role of competition and financial incentives in MMP enrollment	23
VI. CONCLUSIONS.....	26
REFERENCES.....	32

APPENDICES BOUND UNDER SEPARATE COVER

This page has been left blank for double-sided copying.

TABLES

III.1	FAI eligible beneficiary participation rates by state, 2014-2018	7
III.2	Major factors affecting enrollment in FAI capitated model demonstrations	9

FIGURES

III.1	FAI eligible beneficiary participation rates by state, 2014-2018	8
IV.1	Texas MMP enrollment timeline	12
IV.2	Alignment of key program features between states' FAI demonstrations and MLTSS programs	15
V.1	D-SNP enrollment in FAI demonstration states, February 2015.....	25

This page has been left blank for double-sided copying.

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) launched the Financial Alignment Initiative (FAI) demonstration in 2011 to test models of coordinated care that hold promise for reducing the cost of care and improving health outcomes for people eligible for both Medicare and Medicaid – dually eligible beneficiaries. In the FAI capitated model, 10 states and CMS contract with integrated Medicare-Medicaid plans (MMPs), which are paid a fixed monthly rate for each member to provide and coordinate Medicare and Medicaid benefits. Only full-benefit dually eligible beneficiaries are eligible to enroll in MMPs, and each state can restrict eligibility based on age, region within the state, and other criteria. Enrollment is voluntary in all states, and dually eligible beneficiaries can enroll in, disenroll from, or change plans at any time.

Total enrollment in the FAI has been lower than anticipated. In 2017, on average, about 29 percent of eligible individuals were enrolled in MMPs across the 11 demonstrations operating in 10 states that year.¹ However, the share of eligible beneficiaries enrolled in MMPs has varied across states, from about 4 percent in New York to more than 67 percent in Ohio, and some MMPs have been more successful than others in maintaining or growing enrollment over time.

This study sought to identify which program elements, state policies, and health plan characteristics and strategies are associated with variation in beneficiary participation rates and enrollment trends in each state’s demonstration. Previous studies of enrollment in the FAI demonstrations have examined a single state or a subset of demonstration states, described experiences during initial program roll-out, and obtained opinions primarily from beneficiaries. This study examined the experience of all 10 FAI capitated model demonstration states over the life of each state’s demonstration, took into account the views of state officials and MMP representatives, and considered a broader set of factors that might affect enrollment than prior studies. This study also used both quantitative and qualitative measures to assess the factors associated with enrollment in all 10 FAI capitated model demonstration states. It focused on three key questions:

1. Which states and MMPs have been the most effective in enrolling eligible beneficiaries to date and increasing participation rates over time?
2. Which **state** policies and strategies have been most (and least) effective in increasing participation rates among eligible enrollees?
3. Are certain **MMP** strategies or characteristics associated with higher enrollment levels and enrollment growth?

Methods. To address these questions, we analyzed participation and enrollment trends in the 11 FAI capitated model demonstrations over the course of each state’s program and examined

¹ In 2017, 10 states operated 11 FAI demonstrations. New York has two demonstrations – the Fully Integrated Duals Advantage (FIDA) demonstration serves dually eligible beneficiaries generally, and the Fully Integrated Duals Advantage for individuals with intellectual and/or developmental disabilities (FIDA-IDD) demonstration serves dually eligible beneficiaries with intellectual and/or developmental disabilities (I/DD), specifically.

changes in each MMP's enrollment. We analyzed and compared state enrollment policies, states' and MMPs' prior experience with managed care and integrated care programs for dually eligible beneficiaries, state Medicaid managed long-term services and supports (LTSS) program features, and other MMP characteristics. We also conducted semi-structured interviews with state officials in the 10 demonstration states and with senior executives from 15 MMPs with higher levels of enrollment and retention relative to other MMPs. Interview topics covered a broad range of factors that potentially influenced beneficiary enrollment and retention, including but not limited to: whether and how passive enrollment was conducted; staggered enrollment and use of enrollment brokers; official communications with beneficiaries; outreach and marketing; engagement with community-based organizations and other stakeholders; provider education and engagement; state/health plan collaboration; and MMP model of care/care coordination.

To determine which factors were associated with higher or lower enrollment levels, we conducted a temporal analysis to determine whether a major change in state policy or strategy was followed by a marked change in enrollment. We also looked for patterns between beneficiary participation rates and various types of state policies and MMP characteristics. We conducted a structured analysis to code and organize interview comments into common themes. To rate the influence of program elements on participation rates and enrollment, we classified influential factors as (1) primary, if they emerged from both quantitative and qualitative analyses, or were identified by at least 15 of 25 interview respondents, and (2) secondary, if identified by 5 to 14 interview respondents.

Key findings

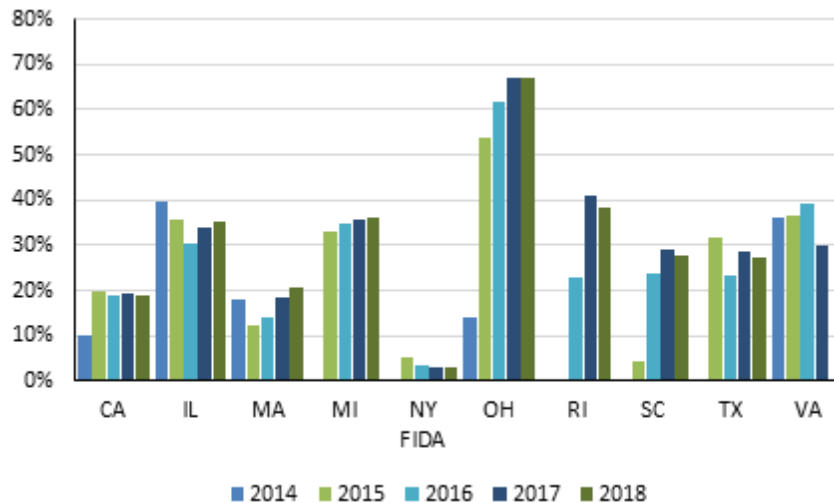
Beneficiary Participation Rates. Over the course of the demonstration, participation rates in four states – Ohio, Rhode Island, Virginia, and Michigan – have tended to fall at or above the 75th percentile among all states' beneficiary participation rates. Participation rates in three states – Illinois, South Carolina, and Texas – have generally fallen near the median, while those in California, New York, and Massachusetts have tended to fall at or below the 25th percentile range. Changes in participation rates over the course of each state's demonstration also varied across states (Figure ES.1). Six states showed small, but relatively consistent growth in participation rates over the course of the demonstrations (Massachusetts, Michigan, Ohio, Rhode Island, South Carolina, and Virginia). The other four states' participation rates have remained relatively constant or fluctuated from year to year (California, Illinois, New York, and Texas).

Major Factors Affecting Enrollment. The study findings indicate that dually eligible beneficiaries are more likely to enroll, and remain enrolled, in integrated Medicare-Medicaid plans when the process of enrolling is easy, the benefits of doing so are tangibly and quickly demonstrated, and integrated care plans are cast as a preferred option over non-integrated care arrangements.

Based on results from both quantitative and qualitative analyses, we found 13 factors to be associated with enrollment (Table ES.1). Seven program elements were associated with higher enrollment levels, five with lower enrollment levels, and one varies depending on the type of respondent – state or MMP. Four of the 13 factors are primary – those identified as important in both quantitative and qualitative analyses, or cited as having an important influence by at least 15

of the 25 interview respondents. Nine of the 13 factors are secondary, cited as having an important influence by 5 to 14 interview respondents.

Figure ES.1 - FAI Eligible Beneficiary Participation Rate by State, 2014-2018



Source: Mathematica analysis, using state-reported FAI eligibility estimates, 2018.

Note: The New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration is excluded from this figure because unlike the other states, New York allowed only voluntary enrollment for the target group.

Table ES.1 - Major Factors Affecting Enrollment in FAI Capitated Model Demonstrations

Higher Enrollment	Lower Enrollment
Primary	
Passive enrollment Alignment of FAI demonstration and MLTSS program features Positive beneficiary relationships with care coordinators and use of specific care coordination techniques (early 'welcome' calls, and face-to-face visits)	Insufficient LTSS provider support and engagement with MMPs
Secondary	
Medicaid 'deeming' policies, when allowed by the state Collaboration with established, trusted community-based organizations Strong provider networks Emphasis on certain outreach messages	Beneficiaries' ability to enroll in, disenroll from, or change MMPs at any time Influence from primary care providers, specialists, and hospitals (in some states) Systems and data exchange issues (in some states) Complexity of content in beneficiary enrollment notices
State use of an independent, third party enrollment broker – viewed by state officials as increasing enrollment, but by MMPs as lowering enrollment	

Source: Mathematica analysis

Notes: FAI = Financial Alignment Initiative; MMP = Medicare-Medicaid Plan; MLTSS = Managed long-term services and supports

Primary factors. Although many factors play a role in the number of eligible beneficiaries who enroll in the demonstration or in individual MMPs, this study found that states and health plans that adopted the following policies and strategies had higher participation rates or absolute numbers of dually eligible beneficiaries enrolled in FAI capitated model demonstration plans:

- **Passively enrolling beneficiaries into integrated MMPs** - Automatically enrolling beneficiaries into an MMP, and then giving them the ability to opt-out, was viewed as very helpful. That said, passive enrollment by itself may be insufficient to increase enrollment. How passive enrollment is done – how often, with which dually eligible beneficiaries, and the numbers enrolled at any one time through staggered waves – may also affect the number of beneficiaries who enroll and remain enrolled in the program.
- **Aligning key design features of state managed long-term services and supports (MLTSS) programs and FAI demonstrations**, including the eligible populations, areas of operation, and participating plans, makes it easier for the state, health plans, and community agencies to conduct targeted outreach about the benefits of choosing one integrated care plan to provide their Medicare and Medicaid benefits.
- Allowing MMP care coordinators to contact beneficiaries prior to passive enrollment and encouraging care coordinators to conduct face-to-face visits with new members as soon as possible helps to build trust with beneficiaries and gives MMPs a chance to explain – and show – the benefits of care coordination.
- **Engaging with LTSS providers and community-based organizations** makes it easier to attract, and serve, dually eligible beneficiaries in integrated care products.

Secondary factors. Four secondary factors were associated with higher rates of enrollment and retention: (1) Medicaid deeming policies, which allow MMPs to deem or consider beneficiaries as being enrolled during a short ‘grace period’ when they are seeking to regain Medicaid eligibility; (2) collaboration with trusted community-based organizations, which boosts health plans’ credibility and trust with beneficiaries, providers, and other stakeholders; (3) adequate provider networks, which make it more likely that eligible beneficiaries’ current providers will be in the plan’s network, avoiding the need for enrollees to change providers; and (4) emphasis on certain outreach messages, such as no beneficiary cost-sharing, extra benefits, care coordination, and using one insurance card that covers all health benefits, instead of multiple cards.

Secondary factors that were associated with lower enrollment include: (1) allowing dually eligible beneficiaries to change enrollment at any time; (2) refusal by some hospitals, primary care providers, or specialists to participate in MMP networks; (3) systems and data exchange issues, which create confusion and unnecessary complexity for beneficiaries, plans, and providers; and (4) complex language and content in beneficiary passive enrollment notices. State payment policies and competitive market dynamics may also dampen MMP enrollment in certain situations, for example when health plans have a financial incentive to market alternative products to dually eligible beneficiaries.

Conclusions and issues for further consideration

Medicare and Medicaid have multiple and often conflicting requirements, benefits and plans, which makes the process of navigating these two programs extraordinarily complicated for dually eligible beneficiaries. Integrated Medicare-Medicaid plans, designed to coordinate the services covered by each program, can greatly simplify what is otherwise a complex process. But making the beneficiary experience simple can be complex.

This study found that dually eligible beneficiaries are more likely to enroll, and remain enrolled, in integrated Medicare-Medicaid plans when they are passively enrolled, the benefits are tangibly and quickly demonstrated, and integrated care plans are cast as a preferred option among many that are available. Although many factors affect enrollment, this study found that states and health plans that adopted the following policies and strategies saw higher rates of participation in the FAI capitated model demonstrations:

- Passively enrolling beneficiaries into integrated MMPs removes potential administrative barriers to enrolling, signals to beneficiaries that MMPs are the preferred plan, and can help to reduce opt-out and disenrollment rates when implemented in staggered waves by target group or region of the state.
- Aligning key design features of state MLTSS programs and FAI demonstrations, including the eligible populations, areas of operation, and participating plans, makes it easier for the state, health plans, and community agencies to conduct targeted outreach about the benefits of choosing one plan to provide their Medicare and Medicaid benefits.
- Allowing MMP care coordinators to contact beneficiaries prior to passive enrollment, and encouraging MMPs to conduct face-to-face visits with new members as soon as possible, helps to build trust with beneficiaries and gives MMPs a chance to explain – and show – the benefits of care coordination.
- Engaging with LTSS providers, including building on LTSS provider networks established by health plans for their Medicaid MLTSS products, and collaborating with community-based organizations makes it easier to enroll dually eligible beneficiaries in integrated care products.

The results of this study also point to several issues for further consideration involving the FAI demonstrations and policies both at the federal and state level. These issues include: the use of default enrollment, beneficiary enrollment notices, special enrollment periods, and the design of integrated care programs more broadly.

- **Should MMPs be allowed to use default enrollment in certain circumstances to address low participation rates?** Potential advantages of allowing states to make integrated MMPs the ‘default’ option for Medicaid beneficiaries when they first become dually eligible for Medicare include increased alignment of Medicare enrollment policies for dually eligible beneficiaries with Medicaid enrollment policies, which currently allow automatic enrollment subject to certain conditions. This policy could also be particularly useful in states or regions where aligned dual eligible special needs plans (D-SNPs) and MLTSS plans are not offered.

Potential disadvantages may be that any form of automatic enrollment could infringe on beneficiaries' ability to choose between traditional fee-for-service (FFS) Medicare and managed care. Default enrollment into MMPs could also create barriers to provider access if a beneficiary sees providers who are part of the Medicaid managed care (MMC) plan's network, but are not part of the MMP's network.

- **Could CMS further simplify beneficiary MMP enrollment notices to better inform beneficiaries about their options?** The study findings echo those of previous research that attributed beneficiary reluctance to join MMPs, in part, to complex program notices (Graham et al. 2018; MedPAC 2016; PerryUndem 2015; Ptaszek et al. 2017). While CMS and states have taken steps to simplify and improve these notices in the past, additional efforts could make them clearer, easier to understand, and more focused on the benefits of integrated care. However, since just a few years remain in most states' demonstrations, it may not be worthwhile to invest further effort to simplify the notices.
- **Should dually eligible beneficiaries enrolled in MMPs be allowed to change their Medicare plan at any time? Or, should their ability to change plans be limited, consistent with policies for all other Medicare and Medicaid enrollees?** Typically, dually eligible beneficiaries enrolled in managed care plans for Medicaid benefits may only change their Medicaid plan once a year. In the past, dually eligible beneficiaries have been able to change their Medicare health coverage at any time. Starting in January 2019, dually eligible beneficiaries will only be allowed to change their Medicare health plan once a quarter. However, states operating FAI demonstrations were given the option to waive this enrollment period restriction for MMP enrollment and disenrollment in 2019, and all demonstration states have chosen to do so. This means MMP enrollees will be the only group of Medicare or Medicaid beneficiaries who can change plans at any time.

Limiting MMP beneficiaries' ability to change plans, or allowing them to do so on a less frequent basis, could increase enrollment in integrated care plans. As several interview respondents noted, the ability to change plans at any time increases beneficiary churn and inhibits MMPs' ability to coordinate care effectively. On the other hand, proponents argue that the ability to change MMP plans at any time is necessary to preserve access to care for an especially vulnerable population. When a dually eligible beneficiary enrolled in an MMP is prescribed a new medication or needs to see a new provider who is not part of a particular plan's network, that beneficiary may benefit from being able to switch into a plan that offers the coverage they need whenever they like.
- **To what extent can states align MLTSS and integrated care program features?** Study findings suggest that states operating or developing Medicaid MLTSS programs with key design features that are aligned with FAI demonstrations lead to higher demonstration participation rates. These features include eligible populations, geographic areas covered, and participating health plans. Alignment of these elements across the two programs could simplify beneficiary marketing and make differences in plans clearer to beneficiaries. On the other hand, complete alignment may not be possible, particularly in states with longstanding MLTSS programs.

- **What would be the effect on enrollment of states adopting Medicaid eligibility deeming policies?** To increase retention in integrated care plans and maintain continuity of care, several states have adopted Medicaid eligibility deeming policies to permit certain dually eligible beneficiaries to remain enrolled during temporary lapses in Medicaid coverage. These policies allow managed care plans to provide a grace period for re-enrollment. However, deeming policies can be burdensome for states and plans to administer. They also represent a financial risk to plans, which may not be fully compensated for services provided during the lapse in Medicaid coverage.
- **How can states ensure that provider networks are adequate in integrated care programs?** Because this study found that LTSS providers play a critical role in influencing dually eligible beneficiaries' decisions about health coverage, states that wish to increase enrollment in a new integrated care program may need to foster collaboration among health plans and LTSS providers. Specific approaches to this collaboration would probably vary by state and even by region within a state, but an effective strategy would likely need to bridge gaps in knowledge and experience by each group.
- **What is the state's role in encouraging enrollment into fully integrated plans?** In most states, dually eligible beneficiaries have multiple options for receiving Medicare and Medicaid benefits, including integrated, partially integrated, and non-integrated plans.² When states operate an FAI demonstration program, and also contract with D-SNPs that provide *less than* fully integrated care, states may wish to consider whether to encourage enrollment in the most integrated care plans and appropriate ways to do so. For example, states have flexibility to define Medicaid contract terms and rules for D-SNPs that foster greater integration and encourage beneficiaries to enroll in integrated care plans, rather than non-integrated arrangements.³

² Fully integrated plan options for dually eligible beneficiaries include MMPs, Programs of All Inclusive Care for the Elderly (PACE) programs, and Fully Integrated D-SNPs (FIDE SNPs). Partially integrated plan options include D-SNPs that are partially aligned with state MMC or MLTSS plans, and non-integrated options include FFS Medicare and Medicaid, standalone MA plans, or D-SNPs that are not aligned with MMC or MLTSS plans.

³ For example, states can specify which regions of the state D-SNPs must cover to align with MLTSS plans operating in those regions, require D-SNPs to operate a companion MLTSS program (and vice versa), and allow D-SNPs to enroll only beneficiaries who are also enrolled in the companion MLTSS plan through the same parent company (Weir Lakhmani and Kruse 2018; Verdier et al. 2016).

This page has been left blank for double-sided copying.

I. INTRODUCTION

Individuals who are dually eligible for Medicare and Medicaid have low incomes, are age 65 or older or are under age 65, and have disabilities or chronic illnesses. They frequently have multiple chronic health conditions, functional limitations, and complex health care needs. As a result, dually eligible beneficiaries account for a disproportionate share of spending in both Medicare and Medicaid. While dually eligible beneficiaries comprise 15 percent of all Medicaid beneficiaries and 20 percent of all Medicare beneficiaries, they accounted for 32 percent of Medicaid spending and 34 percent of Medicare spending in 2013 (MACPAC and MedPAC 2018).

In 2011, CMS launched the Financial Alignment Initiative (FAI) demonstration to test models of coordinated care for reducing the cost of care and improving health outcomes for the dually eligible population. Through the FAI capitated model, 10 states and CMS contract with integrated Medicare-Medicaid plans (MMPs), which are responsible for coordinating Medicare and Medicaid benefits and providing care management for enrollees.⁴ Only full-benefit dually eligible beneficiaries⁵ are eligible to enroll in MMPs, and each state can specify additional eligibility requirements, such as age and residence in certain regions within the state.⁶ Enrollment in FAI demonstrations is voluntary in all states, and dually eligible beneficiaries may choose to enroll in, disenroll from, or change plans at any time.⁷

Since the FAI program began in 2013, total program enrollment has been lower than anticipated (Grabowski et al. 2017). By September 2016, about 30 percent of eligible individuals were enrolled in MMPs (MedPAC 2016). However, individual beneficiary participation rates – the share of eligible beneficiaries enrolled in MMPs – have varied significantly across states, ranging from about 4 percent in New York to more than 65 percent in Ohio (MedPAC 2016). In addition, some MMPs have been more effective than others in maintaining or increasing enrollment over time (Integrated Care Resource Center (ICRC) 2018). For example, 10 health

⁴ CMS has also tested a managed fee-for-service (MFFS) FAI demonstration model in Colorado, and is currently testing an MFFS model in Washington and an administrative alignment model in Minnesota. This study was limited to 11 capitated model demonstrations in 10 states (New York has two capitated FAI demonstrations).

⁵ The term “full-benefit dually eligible beneficiaries” refers to individuals who have Medicare and full Medicaid benefits. Individuals who are only eligible for Medicare premium and/or cost-sharing assistance are referred to as “partial benefit dually eligible beneficiaries.” For more information about these two categories of dually eligible beneficiaries, see the 2018 MedPAC-MACPAC *Data Book on Beneficiaries Dually Eligible for Medicare and Medicaid*, p. 10-12, available at: <https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/>

⁶ For example, Massachusetts limits its program to adults younger than 65, while South Carolina restricts enrollment to adults age 65 and older. Eight states limit the program to certain regions. See Appendix B for a list of the populations included and excluded from each state’s demonstration.

⁷ The Medicare Special Enrollment Period (SEP) that allows dually eligible beneficiaries to make coverage changes is currently a monthly SEP, which allows this population to change plans at any time. This SEP will become quarterly in 2019, but FAI demonstration states are allowed to retain monthly MMP enrollment rights in 2019, and all have chosen to do so.

plan sponsors of the 43 participating in the capitated model demonstrations in March 2016 accounted for 70 percent of FAI enrollment at that time (MedPAC 2016).

Previous studies have explored the factors that contribute to beneficiary enrollment and retention. For example, some studies examined the effect of passive enrollment on beneficiary participation in the early years of the FAI demonstration.⁸ These studies found that passive enrollment produced large spikes in initial enrollment, but opt-out rates were relatively high (Grabowski et al 2017; MACPAC 2016). Although these studies reported opt-out rates that varied widely across states, they could only speculate on the reasons why and recommended further research to understand the causes of such variation. A survey of dually eligible beneficiaries in California found that the primary reasons beneficiaries gave for opting out of the FAI demonstration in that state included “wanting to continue seeing a provider who was not part of the [MMP] provider network, concerns that [the MMP] would not cover specific services or benefits they needed, being content and satisfied with their FFS Medicare, and finding the program complicated and hard to understand” (Graham et al. 2016). Focus groups with beneficiaries found that beneficiary reluctance to join (or remain enrolled in) MMPs was due in part to complex program notices (Graham et al. 2018; MedPAC 2016; PerryUndem 2015).

Although these studies helped to explain why enrollment in the FAI capitated model demonstrations has been lower than expected, they focused on a subset of demonstration states, were conducted in early implementation stages, or sought answers from small or select groups of beneficiaries.

This study was designed to gain additional insight and understanding of the factors that affect FAI demonstration enrollment, and address some limitations of previous studies, by examining the experience of all 10 FAI capitated model demonstration states over the life of each state’s demonstration, soliciting views from state officials and MMP representatives, and considering a broader set of factors that might affect enrollment. It sought to determine which program elements, state policies and MMP characteristics or strategies accounted for variation in participation rates and enrollment trends across states. The study began in April 2018, when all state FAI demonstrations had been in operation for at least three years and as many as six years. It focused on three key questions:

1. Which states and MMPs have been the most effective in enrolling eligible beneficiaries to date and increasing participation rates over time?
2. Which **state** policies and strategies have been most (and least) effective in increasing participation rates?
3. Are certain **MMP** strategies or characteristics associated with higher enrollment levels and enrollment growth?

⁸ Passive enrollment automatically assigns beneficiaries to a managed care plan; beneficiaries can then opt-out if they prefer another plan or coverage arrangement. Although passive enrollment is commonly used in state Medicaid programs that mandate enrollment in managed care, the use of passive enrollment in Medicare has been much more limited, for example, to assign dually eligible beneficiaries into Medicare Part D plans.

Following the introduction, Section II of this report describes the data and methods used to investigate these questions. Section III presents key findings from the quantitative and qualitative analyses. Section IV identifies and explains the policies, program elements, or other factors associated with higher enrollment and retention levels. Section V identifies and explains state policies and other factors associated with lower enrollment and retention, as well as demonstration design features that lead to either higher or lower enrollment depending on the views of different stakeholders, or in certain state or market conditions. Section VI offers conclusions based in the study findings, as well as questions for consideration by federal and state policymakers.

This page has been left blank for double-sided copying.

II. DATA AND METHODS

We conducted this study using three sets of data; sources are cited in Appendix A. First, we collected enrollment data for the 11 FAI capitated model demonstrations since the start of each state's demonstration, and calculated participation rates (enrollment as a share of eligibles) over the course of each state's program. We also analyzed changes over time in each MMP's enrollment, and compared enrollment growth and retention rates among MMPs operating in each state. Second, we collected and analyzed state demonstration enrollment policies described in demonstration three-way contracts among CMS, states, and MMPs; enrollment guidance issued by states; and other publicly available information from state and CMS websites. We also extracted information on states' and MMPs' prior experience with managed care and integrating care for dually eligible populations, state managed LTSS program features, and other information about MMPs. Third, we conducted semi-structured interviews with state officials in the 10 demonstration states and with senior managers from 15 MMPs with higher levels of enrollment and retention relative to other MMPs. During the interviews, we asked respondents to identify which policies or strategies influenced beneficiary enrollment and retention, and to explain how they did so, either positively or negatively.

To analyze which factors were associated with higher or lower enrollment levels, and their degree of influence, we used a mixed-method approach combining the results of three quantitative analyses and the qualitative interview themes. Quantitative analyses consisted of (1) a temporal analysis to determine whether a major change in state policy or strategy was followed by a marked change in enrollment; (2) assessing whether certain types of state enrollment policies or MMP characteristics were more common in states with higher or lower participation rates; and (3) examining state and MMP respondents' ratings indicating the degree to which they thought eight program elements promoted or hindered enrollment on a scale of 1-5.⁹ For the qualitative analysis, after completing interviews with representatives from all 10 FAI demonstration states, and the 15 MMPs, two reviewers conducted a structured analysis to code and organize interview comments into common themes, followed by meetings with the entire project team to identify the most frequent themes and connections among related topics.

We calculated rating scale averages for all 25 respondents, as well as states ($n = 10$)¹⁰ and MMPs ($n = 15$) separately, and examined the frequency of each response among all respondents. Results showed a small range of variance in average ratings, and questionable validity, due to discrepancies between the ratings and comments made during interviews. Consequently, we did not use the ratings to rank the influence of program elements on enrollment in a numeric scoring system.

⁹ In the rating scale, 1 = "strongly hindered," 2 = "slightly hindered," 3 = "no effect," 4 = "slightly promoted," and 5 = "strongly promoted". The eight elements included: passive enrollment; enrollment processes; communications with beneficiaries; outreach and marketing; stakeholder/partner engagement; provider education and engagement; state/health plan collaboration; and model of care/care coordination. The rating scale also included an "other" category.

¹⁰ One state did not complete a rating scale.

To rate the influence of various program factors on FAI participation rates and MMP enrollment, we classified them into two groups, primary or secondary, based on the following criteria:

- **Primary factors** are those identified as important in both quantitative and qualitative analyses, or with at least 15 of 25 interview respondents citing them as having an important influence on enrollment.
- **Secondary factors** are those identified only in the qualitative analyses and cited as having an important influence on enrollment by at least 5 and less than 15 interview respondents.

III. MAJOR FINDINGS

At the time this study was conducted in 2018, all 11 state FAI capitated model demonstrations had been in operation for almost three years – long enough to have overcome initial implementation hurdles and to distinguish patterns across state programs and MMPs in enrollment and participation rates among eligible beneficiaries. By examining variation across all states in key program design elements and enrollment policies, and across MMPs in enrollment and retention strategies, this study sought to identify the factors that contribute to different levels of enrollment. Below we summarize major findings on the study’s three main research questions.

A. Beneficiary participation rates

Participation rates are the percentage of enrollees among all beneficiaries who are eligible for the demonstration. Using the data and methods described above, we calculated estimated annual beneficiary participation rates for each state, using the most recent data available from each state program as the denominator – the estimated number of beneficiaries eligible for each program (Table III.1).

Table III.1 - FAI eligible beneficiary participation rates by state, 2014-2018

State	2014	2015	2016	2017	2018
California	10%	20%	19%	19%	19%
Illinois	40%	35%	30%	34%	35%
Massachusetts	18%	12%	14%	18%	21%
Michigan	NA	33%	35%	36%	36%
New York (FIDA demonstration)	NA	5%	4%	3%	3%
New York (FIDA-IDD demonstration)	NA	NA	2%	4%	5%
Ohio	14%	54%	62%	67%	67%
Rhode Island	NA	NA	23%	41%	38%
South Carolina	NA	4%	24%	29%	28%
Texas	NA	32%	23%	29%	27%
Virginia	36%	37%	39%	30%	NA
Range (lowest-highest)	10-40%	4-54%	2-62%	3-67%	3-67%
25th percentile	14%	12%	17%	19%	19%
Median (50th percentile)	18%	32%	23%	29%	28%
75th percentile	36%	35%	32%	35%	36%

Source: Mathematica analysis of FAI capitated model demonstration enrollment data (CMS, 2014-2018), based on estimated number of FAI eligible beneficiaries (denominator), reported by state officials.

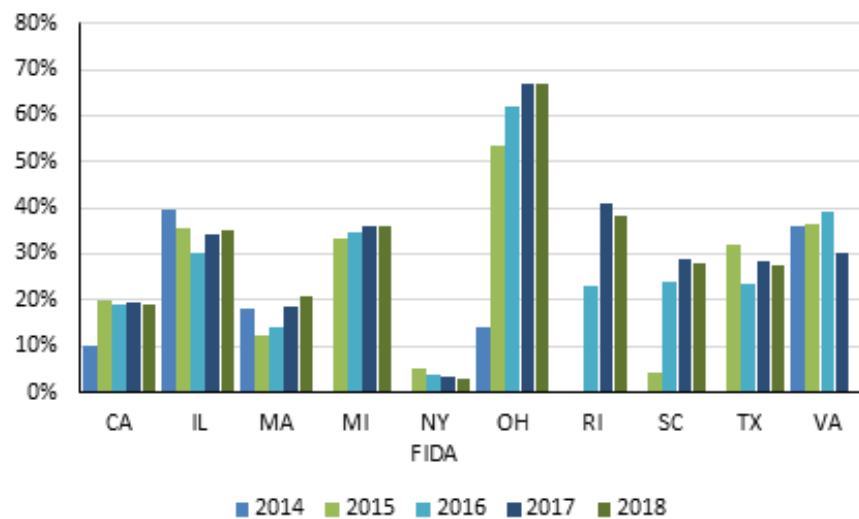
Notes: Table cells are gray and contain “NA” in years when that state’s demonstration was not active.

As of July 2018, the average participation rate across all states was about 27 percent, but ranged from a low of 3-5 percent in New York’s two programs to a high of 67-82 percent in Ohio. The distribution in participation rates across states in 2018 is similar to the range in all program years, except the first year (2014), before the programs in New York and Ohio began. Participation rates in four states – Ohio, Rhode Island, Virginia, and Michigan – have tended to fall at or above the 75th percentile among all states’ participation rates. Participation rates in three states – Illinois, South Carolina, and Texas – have generally fallen near the median, while those in California, New York, and Massachusetts have tended to fall at or below the 25th percentile.

Changes in participation rates over the course of each state’s demonstration also varied across the 10 states (Figure III.1). Six states showed small, but relatively consistent growth in participation rates over the course of the demonstrations (Massachusetts, Michigan, Ohio, Rhode Island, South Carolina, and Virginia).¹¹ The other four states’ participation rates have remained relatively constant or fluctuated from year to year (California, Illinois, New York, and Texas).

Although we present New York’s Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) participation rate in Table III.1, we excluded it from Figure III.1 and from several of our analyses of the relationship between participation rates and state enrollment policies because its enrollment experience is not comparable to other states. Unlike all other demonstrations, the state only allowed voluntary enrollment of the target population – individuals with intellectual or developmental disabilities – into the FIDA-IDD demonstration because the integrated care model represented a significant departure from the long-standing care delivery system that served these beneficiaries and their families. Voluntary enrollment gave state officials greater ability to engage in intensive stakeholder consultation, and to closely monitor program implementation, MMP operations, and quality metrics, and assure beneficiary rights.

Figure III.1 - FAI eligible beneficiary participation rates by state, 2014-2018



Source: Mathematica analysis, using state-reported FAI eligibility estimates, 2018.

Note: The New York FIDA-IDD demonstration is excluded from this figure because its participation rate is not comparable to those of other states; the state allowed only voluntary enrollment for the target group.

B. Key factors affecting enrollment

Based on results from both quantitative and qualitative analyses, we found 13 factors to be associated with enrollment (Table III.2). Seven program elements or factors were associated with higher enrollment, five with lower enrollment, and there was one on which opinion was divided, depending on the type of respondent (state or MMP).

¹¹ Virginia’s participation rate dropped in 2017 after it announced the termination of the demonstration.

Four of the 13 factors are labeled as primary because they were identified as important in both quantitative and qualitative analyses, or with at least 15 of the 25 interview respondents citing them as having an important influence on enrollment. Nine of the 13 factors are labeled as secondary, cited as important by 5 to 14 interview respondents.

In addition, each of these factors can affect enrollment in myriad ways, and the circumstances under which they exert a positive or negative effect are often complex. Findings from the quantitative analyses and interviews with state officials and MMP managers provide in-depth insights into how each program element affects enrollment, as described in detail in the next two sections of the report.

Table III.2 - Major factors affecting enrollment in FAI capitated model demonstrations

	Primary/ Secondary Factor	Result from quantitative analyses?	Result from qualitative analyses?	# of interview respondents (states/MMPs) citing the factor as influential
Factors associated with higher enrollment				
Passive enrollment	Primary	Yes	Yes	20
Alignment of FAI demonstration and MLTSS program features	Primary	Yes	Yes	6
Positive beneficiary relationships with care coordinators and use of specific care coordination techniques (early 'welcome' calls, and face-to-face visits)	Primary	No	Yes	15
Medicaid 'deeming' policies, when allowed by the state	Secondary	No	Yes	9
Collaboration with established, trusted community-based organizations	Secondary	No	Yes	7
Strong provider networks	Secondary	No	Yes	5
Emphasis on certain outreach messages	Secondary	No	Yes	5-6/message
Factors associated with lower enrollment				
Insufficient LTSS provider support and engagement with MMPs	Primary	No	Yes	15
Beneficiaries' ability to enroll in, disenroll from, or change MMPs at any time	Secondary	No	Yes	9
Influence from acute care providers - primary care providers, specialists, hospitals (in some states)	Secondary	No	Yes	8
Systems and data exchange issues (in some states)	Secondary	No	Yes	8
Complexity of content in beneficiary passive enrollment notices	Secondary	No	Yes	8
Factors influencing enrollment, with the direction (higher or lower) varying by respondent type				
State use of an independent, third party enrollment broker (opinions divided by state and MMP respondents)	Secondary	No	Yes	11

Source: Mathematica

Notes: Primary factors are those identified as important in both quantitative and qualitative analyses, or in the qualitative analysis if at least 15 of the 25 interview respondents citing them as having an important influence. Secondary factors are those that emerged from the qualitative analysis only, cited as important by 5 to 14 interview respondents.

FAI = Financial Alignment Initiative; MMP = Medicare-Medicaid Plan; MLTSS = Managed long-term services and supports

This page has been left blank for double-sided copying.

IV. FACTORS ASSOCIATED WITH HIGHER ENROLLMENT

This section presents key findings regarding the factors that help to increase participation by eligible beneficiaries and explains how they increase enrollment and retention. Three program elements are primary: (1) passive enrollment; (2) alignment of key FAI demonstration and MLTSS program design features, including the populations eligible to enroll, the geographic areas covered and participating health plans; and (3) positive beneficiary relationships with health plan care coordinators and use of specific care coordination techniques, which reduce opt-out rates among passively enrolled beneficiaries, and lessen disenrollment over time. This section also discusses the influence of four secondary factors.

A. Passive enrollment

Passive enrollment emerged in both quantitative and qualitative analyses as a key factor associated with higher rates of enrollment into states' demonstrations. Once passively enrolled, beneficiaries are more likely to remain with the MMP than opt out or transfer to another plan, although rates of opt-outs and transfers vary widely across states and MMPs.

The temporal analysis showed a clear association between states' use of passive enrollment and MMP enrollment growth. In all states that used passive enrollment (only the New York FIDA-IDD demonstration did not, as noted above), enrollment typically spiked for most MMPs during or immediately after the implementation of a passive enrollment 'wave.' The enrollment trend in Texas (Figure IV.1) illustrates this relationship; enrollment timeline charts for all 10 demonstration states can be found in Appendix C. In some states, enrollment dips slightly after these growth spurts; however, MMP enrollment levels did not typically revert to those before passive enrollment – they usually remained higher than they were previously.

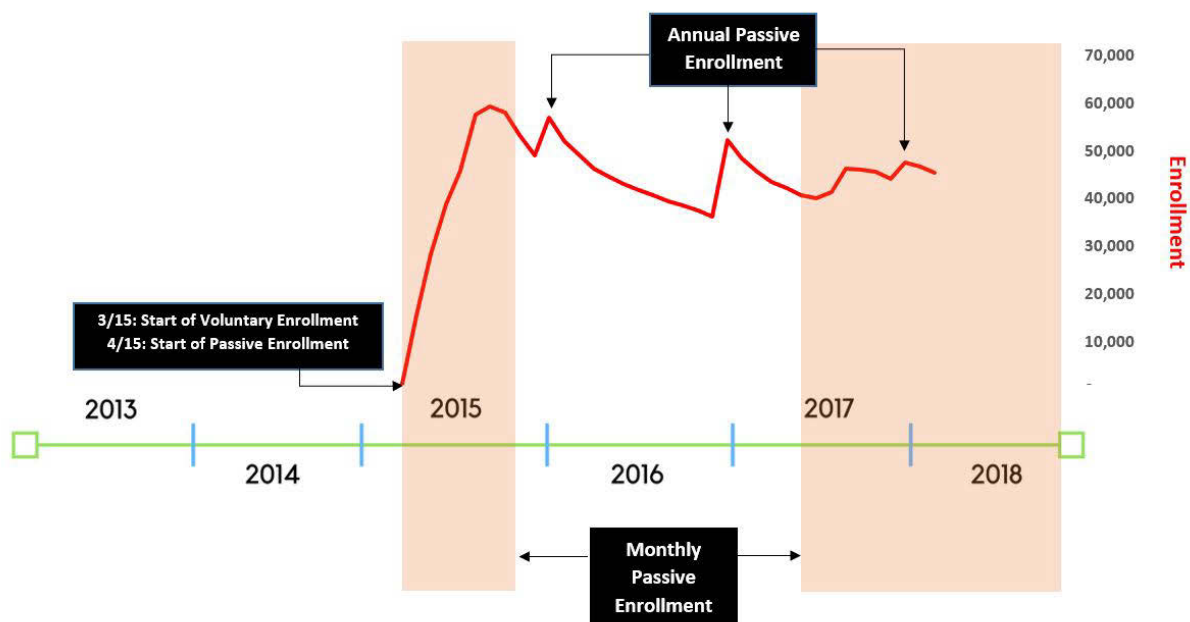
The majority of interview respondents (20 of 25; 9 states, and 11 health plans) said passive enrollment had a strong effect on demonstration participation rates. One state official called it the “single largest factor in bolstering enrollment,” and another noted that upwards of 60 percent of enrollment resulted from the state's use of passive enrollment. While the majority of interviewees felt that the use of passive enrollment had a positive impact, a few mentioned that its rollout was “messy” or challenging, diminishing its effectiveness. Only one health plan said that passive enrollment inhibited enrollment because beneficiaries did not like being told “where to go.”

When we analyzed specific state enrollment policies, we found that states with higher participation rates were also more likely to allow passive enrollment of Medicare Advantage (MA) plan members into MMPs offered by the same parent company. Illinois, Michigan, Ohio, Texas, and Virginia adopted this policy, and with

The New York FIDA-IDD demonstration, which specifically serves dually eligible beneficiaries with developmental disabilities, is the only capitated model FAI demonstration that has never used passive enrollment. Representatives from the New York state Office of Persons with Developmental Disabilities (the agency responsible for implementing the FIDA-IDD demonstration) stated, “OPWDD did not pursue passive enrollment, nor is mandatory enrollment part of our project scheme. As our population represents a complex population and a provider realm that heretofore has remained outside of managed care, our direction has been to employ carefully measured steps to implement the Demonstration. Our agency is based in individual need and choice, [so] a voluntary model was our only path to begin the longer journey to overall care coordination and management.”

the exception of Texas, each of these states have had participation rates at or above the 75th percentile among demonstration states, which in most years was 35 percent or higher.¹² In other words, maximizing the use of passive enrollment with dually eligible beneficiaries who already chose to enroll in a managed care plan increases participation rates in integrated MMPs. In states that do not passively enroll MA plan members (California, Massachusetts, New York, Rhode Island, and South Carolina), those beneficiaries may voluntarily enroll in an MMP if they are otherwise eligible for the demonstration, but the MMP is not the default option. In 2016, approximately 29 percent of full benefit dually eligible beneficiaries nationally were enrolled in an MA plan for at least part of the year (CMS, 2017), suggesting an opportunity to extend passive enrollment to a sizable number of these dually eligible beneficiaries in states which have not already adopted such a policy.

Figure IV.1 – Texas MMP enrollment timeline



Sources: Mathematica analysis of MMP enrollment data from *CMS Monthly Enrollment by Contract reports, 2013-2018*, available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/Monthly-Enrollment-by-Contract.html>; Data for Texas timeline of enrollment dates and policy changes are drawn from interviews with representatives from Texas, the Texas demonstration webpage, available at <https://hhs.texas.gov/services/health/medicaid-chip/programs/dual-eligible-project-mmp#letters-for-people-who-received-medicare-and-medicaid-who-can-choose-to-enroll-in-a-star-plus-medicare-medicaid-plan>, and Department of Health & Human Services and CMS FAI demonstration webpage for Texas, available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Texas.html>.

Interview respondents in two states and two MMPs also said that policies prohibiting the use of passive enrollment with certain populations inhibited enrollment. They believed that the exclusion from passive enrollment of two groups in particular depressed the numbers of people

¹² Rhode Island is the only state with a high participation rate which has not utilized passive enrollment with MA plan members, but this is because their sole MMP does not offer an MA plan.

eligible for the demonstration who ever enrolled: (1) MA members in a plan whose parent company does *not* offer an MMP and (2) beneficiaries who previously opted out of the demonstration.

Interviewees thought beneficiaries who previously opted out could be returned to the passive enrollment pool in subsequent years of the program if the MMPs proved their ability to comply with all contract requirements and achieved high quality ratings. These interviewees noted that the demonstrations had matured since their inception and MMPs had expanded provider networks, making the program a better option for beneficiaries than they may have been originally. Similarly, one MMP mentioned that previous regulations denying the use of passive enrollment in counties with only one MMP decreased enrollment, and that their state’s reversal of this policy has now helped to increase enrollment in the demonstration.

“Allowing passive enrollment to occur helped the members to get to understand the benefits of [the demonstration], of having someone manage both of your benefit packages and help you navigate through the complexity of the [Medicare-Medicaid] health care system.”

-- MMP Representative

Although passive enrollment was viewed as a primary factor that served to increase enrollment, it may not be sufficient by itself. How passive enrollment is done – how often, with which dually eligible beneficiaries, and the numbers enrolled at any one time – can play an important role in reducing the number of people who opt-out and increasing the number of people who remain enrolled over time. For example, several interviewees noted the benefit of staggering passive enrollment into ‘waves,’ which enrolls eligible beneficiaries residing in different geographic areas at different times. This practice limits the volume of new enrollees entering the program at once, giving health plans more time to communicate with providers and key stakeholders in each region. Some interviewees noted that capping the number of beneficiaries enrolled in each wave can help to prevent MMPs or the state enrollment broker from becoming overwhelmed with new enrollees.

Another way to stagger enrollment is to target particular populations with each passive enrollment wave. One state said this approach helped them strategically time and tailor marketing efforts to each target group. One MMP mentioned that targeting patients of particular provider groups in passive enrollment waves has helped to stabilize the opt-out rate. Another MMP noted that their state’s decision to defer the most complex populations of eligible beneficiaries to the last wave of passive enrollment allowed MMPs to gain experience serving less complex populations, which helped to increase retention.

B. Alignment of key design features of FAI demonstrations with state managed long term services and supports (MLTSS) programs

When we compared beneficiary participation rates to state policies and MMP characteristics, we found a clear relationship between participation rates and the alignment of key structural features of FAI demonstrations and MLTSS programs. We assessed alignment across the two programs by comparing key design features – eligible populations, geographic areas covered, and participating health plans – across FAI demonstrations and MLTSS programs in states operating an MLTSS program at the same time as the FAI demonstration (Figure IV.2).

Ohio, which has the highest participation rate among all states (52 to 82 percent, depending on the year and data source), is the only state whose mandatory MLTSS program and FAI demonstration are fully aligned across all of these dimensions. In Rhode Island, whose demonstration participation rate is among the top three states, the populations served by the two programs are mostly aligned,¹³ the service areas are identical, and it contracts with a single MMP in the demonstration, which is also the sole participating plan in the state's MLTSS program. This makes it easy for members in one product line to transfer to another to receive integrated benefits, without having to switch plans.

When a state's demonstration and mandatory MLTSS program populations are fully aligned on these dimensions, everyone who is eligible for the demonstration will either be enrolled in an MMP or an MLTSS plan, and everyone eligible for MLTSS is eligible for the demonstration. This makes it easier for the state and participating MMPs to effectively market the demonstration to MLTSS enrollees and help them understand the benefits of enrolling in the fully integrated demonstration. Similarly, when all participating MMPs have a companion MLTSS plan in the same service area, those plans can actively market their MMP product to their existing MLTSS members. Notably, in addition to fully aligning other aspects of the state's FAI demonstration and MLTSS program, Ohio also uses a single program name (MyCare) for both programs, which further simplifies program marketing for beneficiaries.

In contrast, when key program dimensions are *not* fully aligned, marketing becomes more complicated. For example, in unaligned states, the state and the MMPs cannot effectively market the demonstration to *all* MLTSS members; they must first determine which MLTSS beneficiaries actually qualify for the demonstration, and target their outreach and marketing to those beneficiaries. Additionally, if certain MLTSS plans do not offer a companion MMP in the same service area, those MLTSS plans have no financial incentive to market the demonstration to their MLTSS members because they would lose membership.

Both Ohio and Rhode Island rolled out their MLTSS program shortly before the demonstration, then passively enrolled MLTSS enrollees into the MMP. Interview respondents said this resulted in higher rates of enrollment because beneficiaries were given a chance to experience managed care through the MLTSS program first, then provided the opportunity to experience enhanced benefits and more coordinated care through the demonstration.

Although previous studies have suggested that managed care plans experienced with integrated Medicare and Medicaid programs would be better positioned to implement such programs and attract new enrollees (MACPAC 2016, Table 2; Weiser and Gold 2015), our analyses showed no clear patterns of association between beneficiary participation rates and MMP prior experience with Dual Eligible Special Needs Plans (D-SNPs), MA, or MLTSS plans in the demonstration states. Nor does state experience with MLTSS program operations and oversight confer any particular advantage; we did not find an obvious relationship between participation rates and operating an MLTSS program – whether mandatory or voluntary – prior to the start of the FAI demonstration. (See Appendices G and H for tables of state and MMP

¹³ Rhode Island allows enrollment of dually eligible beneficiaries and Medicaid-only beneficiaries into their MLTSS program. All dually eligible beneficiaries enrolled in the MLTSS program are also eligible for the state's FAI demonstration.

prior experience.) In addition, there was no association between participation rates and MA market penetration rates.

Figure IV.2 - Alignment of key program features between states' FAI demonstrations and MLTSS programs

	OH	CA	IL	MA	MI	NY	RI	TX
Same program name for Demonstration and MLTSS?	✓	✗	✗	✗	✗	✗	○ ^d	✗
Rolled out Demonstration and MLTSS simultaneously?	✓ ^a	✓ ^b	✗	✗	✗	✗	✗	✗
Eligible populations are identical?	✓	○	✓	✗	○	○	○	○
Participating counties identical for both programs?	✓	✓	○ ^c	○	○	○	✓	○
Same health plans offer MMP and MLTSS plans in each Demonstration county?	✓	○	○ ^c	○	✗	○	✓	✓ ^e

✓ = Elements completely aligned

○ = Elements overlap, but not completely aligned

✗ = Elements completely different

Notes: This table includes FAI demonstration states whose MLTSS programs have run concurrently with the demonstration. Virginia is excluded because its MLTSS program began as the state's FAI demonstration ended.

^a Ohio rolled out passive enrollment for MLTSS and voluntary enrollment for their demonstration simultaneously (5/1/2014), then rolled out passive enrollment for the demonstration 8 months later (1/1/2015).

^b California began rolling out passive enrollment for both MLTSS and their demonstration on 4/1/2014, but rollout of passive enrollment for MLTSS and demonstration populations was not simultaneous in every county. In some counties, MLTSS was rolled out prior to the demonstration, and rollout for particular sub-populations was staggered in most counties.

^c Between July 1, 2016 and December 31, 2017, Illinois operated an MLTSS program in six of the 15 FAI demonstration counties. During that time, each demonstration MMP operating in those counties also offered an MLTSS plan. (The demonstration MMP operating in the remaining nine counties did not operate an MLTSS plan because the MLTSS program was not yet operational in those counties.) Beginning January 1, 2018, Illinois planned to expand their MLTSS program statewide and embed it into their comprehensive MMC program, HealthChoice Illinois. The statewide expansion of MLTSS is currently delayed, but the awarding of HealthChoice contracts led to some misalignment between the health plans offering demonstration MMPs and those providing MLTSS.

^d Rhode Island has used corresponding names to refer to their FAI demonstration and MLTSS program and the health plans involved. Both programs are part of what is known as the state's "Integrated Care Initiative" (ICI) – the rollout of the MLTSS program was known as "Phase 1" of the ICI, and the rollout of the FAI demonstration was referred to as "Phase 2" of the ICI. In some contexts, though, Rhode Island has used an additional name for their MLTSS program – Rhody Health Options. Because the state utilizes a single health plan for delivery of both programs (Neighborhood Health Plan of Rhode Island), the plans have similar names - the MMP is called "Neighborhood Health INTEGRITY" and the MLTSS plan is referred to as "Neighborhood Health UNITY."

^e In Texas, STAR+PLUS MLTSS plans all offer MMPs in the same county in all but one of the state's six demonstration counties. The exception is Tarrant County, where Cigna-HealthSpring has an MLTSS plan, but no MMP.

C. Positive beneficiary relationships with care coordinators

A majority of respondents – 5 states and 10 MMPs – described high quality care coordination and early, frequent, and face-to-face contact between MMP care coordinators and

beneficiaries as a key factor contributing to fewer people opting out and higher retention. Such contacts helps to foster positive relationships between beneficiaries and MMP care coordinators, which reduces opt-outs and increases the likelihood that beneficiaries remain enrolled in the plan.

Several respondents noted that the majority of people who opt-out and disenroll from MMPs tend to do so before or shortly after beneficiaries' initial enrollment, before they have experienced the benefits of care coordination. According to several MMP respondents, state

"We saw early on that if you can have a couple of successful member touches within the first two to three months of a member's enrollment with our plan, the chances of them opting out are lessened."

-- MMP Representative

policies allowing MMP care coordinators to conduct early outreach to passive enrollees, such as welcome calls and outreach to conduct health risk assessments prior to the beneficiary's enrollment effective date,¹⁴ gives MMPs a chance to explain the benefits of integrated care. Interviewees also explained that care coordinators' use of face-to-face meetings with beneficiaries are also particularly useful because they create positive relationships with beneficiaries and build trust.

D. Secondary factors associated with higher enrollment

Four other program policies and MMP strategies played a secondary role in initial enrollment or ongoing retention in MMPs, according to interview respondents.

1. Medicaid deeming policies

Several states and MMPs found deeming results in higher MMP enrollee retention. Medicaid deeming policies allow MMPs to deem or consider beneficiaries as being enrolled, even if they lose Medicaid eligibility, typically due to lack of timely response during an annual Medicaid eligibility redetermination process. States who utilize deeming policies allow MMPs to continue the individual's enrollment for a specified period of time – usually two to three months – to provide a 'grace period' to regain Medicaid eligibility. Six states (including all three states who currently use deeming policies) and three MMPs said that deeming helped to increase MMP retention because it prevents enrollment 'churn' (beneficiaries cycling in and out of health plans) and allows plans to maintain continuity of care with members. For example, interview respondents from two MMPs reported retaining about 64 percent and 65 percent, respectively, of individuals who entered the deeming period.

However, deeming policies can be difficult for states to implement and require commitment from MMPs. For example, to implement deeming, states' Medicaid data systems must be

"I think the plans are doing a really good job with the deeming – keeping on top of the members' eligibility and going the extra mile to help them with their paperwork submissions, and working with the local caseworker to try to get that submitted – that's been huge for retention. Deeming and ongoing passive enrollment have been the two big [drivers of enrollment/retention]."

-- State Official

¹⁴ MMPs typically may not conduct outreach with passive enrollees prior to their enrollment effective date, unless the demonstration state specifically allows them to do so. As of September 2018, 7 of the 10 operational capitated FAI demonstrations allow their MMPs to conduct outreach with passive enrollees prior to their effective date.

programmed to flag beneficiaries in deemed status and track their eligibility status on a monthly basis for federal financial reporting. In addition, MMPs must be willing to accept financial risk by continuing to pay for the beneficiary's covered services during the period when a deemed beneficiary is trying to re-establish Medicaid eligibility. Although some MMPs are willing to accept this financial risk in the interest of maintaining continuity of care for their members, interview respondents in a few states said they did not adopt deeming policies because MMPs in their states did not want to take on such risk.¹⁵ Even when MMPs support the policy, helping MMP members maintain ongoing Medicaid eligibility can be time-consuming. One MMP said it requires a tremendous amount of outreach. Another MMP explained that the risk associated with deeming is lower for certain groups than others. For example, dually eligible beneficiaries age 65 and older tend to have more stable income and assets that increase the likelihood they will regain Medicaid eligibility. Dually eligible beneficiaries under age 65 tend to have more volatility in income or assets, which poses a greater risk to continued Medicaid eligibility.

2. Collaboration with established, trusted community-based organizations (CBOs)

Seven MMPs said that their efforts to collaborate with trusted CBOs, such as Area Agencies on Aging, senior centers, independent living centers, legal aid groups, and churches, have helped to increase enrollment in the demonstration by boosting the health plans' credibility and trust with beneficiaries, providers, and other key community stakeholders. One MMP believed that a particular CBO's outreach to beneficiaries about the demonstration under a separate contract with the state encouraged enrollment because the entity was viewed by beneficiaries as a trusted, independent third party.

"Finding key relationships, community partners that have strong history and a real trust level with dual eligible members brings up the credibility of a health plan."

--MMP Representative

3. Strong provider networks

Several respondents discussed the importance to enrollment of MMPs having sufficiently broad provider networks, which make it more likely that eligible beneficiaries' current providers will be in the plan's network, avoiding the need for enrollees to change providers. Some of the MMPs said that they drew from existing provider networks in their other product lines when launching their MMPs.

4. Emphasis on certain outreach messages

When asked if particular outreach messages or techniques encouraged beneficiaries to enroll in their FAI demonstrations, state and MMP interviewees shared several examples, which were often indicated during beneficiary focus groups or other consumer engagement methods. In some cases, interviewees stated that one or more of these program elements were cited by beneficiaries during the enrollment process as reasons for enrollment or re-enrollment in the demonstration. While some messages were cited as helpful by a few respondents, the following were mentioned as valuable by at least five respondents:

¹⁵ In a state that did not implement a deeming policy, a respondent said that if they were to do so, they would specify a narrow set of reasons to which it would apply to avoid putting MMPs at financial risk in situations where beneficiaries were unlikely to regain Medicaid eligibility.

- **\$0 copays** – the lack of beneficiary cost-sharing in MMPs
- **Extra benefits**, such as dental, transportation, and over-the-counter health product allowances
- **Care coordination**, integrated care team, holistic approach
- **One card/one plan** – use of a single insurance card for all health benefits, instead of multiple cards when a beneficiary utilizes FFS Medicare and Medicaid, or an MA plan paired with Medicaid.

"We were shocked that the one thing across the board, across the state that the members absolutely loved – so we started emphasizing it more and more when we became aware of that... when they really understood they didn't have to use separate Medicare, Medicaid, [Medicare Advantage] cards... That was the thing they talked about the most. That came up consistently in evaluations, in focus groups – one card."

--State Official

V. FACTORS ASSOCIATED WITH LOWER ENROLLMENT

This section presents key findings regarding factors associated with lower participation rates by eligible beneficiaries. One program element, albeit with several dimensions, emerged as the primary factor that decreased enrollment: insufficient support from, and engagement with, providers of long-term services and supports (LTSS). Four additional factors inhibited enrollment, though their effect was less prevalent and are therefore described as secondary influences. This section also discusses states' use of an independent enrollment broker, which was viewed by state officials as facilitating enrollment, but by MMPs as inhibiting enrollment. Finally, this section describes the way in which payment policy and competitive market dynamics can affect MMP enrollment in certain situations, sometimes markedly so.

A. Insufficient LTSS provider support and engagement with MMPs

Tensions between MMPs and LTSS providers, including nursing facilities and home and community based service (HCBS) providers whose patients and clients are eligible to participate in the FAI demonstration, was the most frequently discussed factor inhibiting enrollment. These tensions resulted partly from MMPs' lack of experience contracting with LTSS providers in the demonstration state and partly from LTSS providers' lack of experience contracting with managed care. For example, MMPs with little or no experience contracting with LTSS providers in the state had a steep learning curve working with LTSS providers and faced more challenges creating provider networks. Simultaneously, LTSS providers with little or no experience working with managed care plans were unfamiliar with contracting and provider credentialing, concerned about timely service authorizations, and worried about getting adequate reimbursement and timely payment. As a result, some LTSS providers refused to join MMP networks, or actively encouraged clients not to enroll or to disenroll from the demonstration.

"There definitely were providers who encouraged members to opt out of the program. They would say, 'Oh, it's not mandatory, you can just get out of it, just stay with fee-for-service.' So, there definitely was that discussion among providers, especially if they weren't contracted with one of the MCOs participating in the program, or if they were having some claims payment issues. Providers were encouraging people to opt out [rather] than to join the program."

--MMP Representative

"Those [HCBS] waiver members get a lot of influence from their waiver case manager and their LTSS providers, particularly their personal care attendants and others who, in many cases, become an extension of the family. And if they didn't really understand this demonstration, it caused a lot of beneficiary confusion, so [we held] a series of regional town hall meetings with these waiver case managers. Once we did that, we immediately saw less attrition of our waiver members because we brought them to the table and really engaged with them, and they learned early on that managed care is nothing to fear and that we can actually partner and team with them to provide even greater care to clients/members to better engage people in their care. And I think we've made tremendous strides in stressing these relationships with that population.

What we've done most recently, which wasn't done early on, is to strike that same level of engagement with our nursing facilities. And to be quite frank, a lot of the nursing facilities in [our state] were steadfast against [the demonstration], and some of them still remain that way today. They saw the demonstration as a threat to their business. We don't necessarily agree. I think with the right partnership structures, it can be a win-win situation as we try to keep people out of nursing facilities for long-term care, but enable them to receive more sub-acute care through them directly from the community, avoiding those costly hospital intermediaries.... I think now that we're having those crucial conversations, things are really getting better and there's less opposition from the nursing homes."

--MMP Representative

Some MMPs described steps they took to engage nursing facilities and HCBS providers, such as conducting educational outreach events with providers prior to demonstration launch, meeting with LTSS trade associations regularly during the early phases of the demonstration to answer questions and identify and remedy provider concerns, and providing extensive, one-on-one training with HCBS providers to help them understand and navigate managed care billing processes. Several of these MMPs took such steps based on their own experience or awareness of challenges in other demonstration states. Over time, most managed care plans made concerted efforts to reach out to, and collaborate with, LTSS providers, which MMP representatives said helped to reduce LTSS providers' fears and concerns about managed care and foster cooperation in encouraging patients to enroll in the demonstration. However, several interviewees said there is still work to be done in this area.

B. Secondary factors associated with lower enrollment

1. Beneficiaries' ability to enroll in, disenroll from, or change MMPs at any time

Long-standing Medicare policy allows all dually eligible beneficiaries, including those eligible for the FAI demonstration and those who are not, to make coverage changes at any time and as many times as they wish, known as a "continuous special enrollment period (SEP)."¹⁶ Several respondents said that this policy increased opt-out rates and decreased retention in the FAI demonstrations. For example, even if they were passively enrolled in an MMP, many beneficiaries chose to opt out of the program before they had a chance to experience it, often based on advice from LTSS providers and case managers, marketing by other types of health plans, and influence from insurance brokers. In addition, third-party insurance brokers can earn commissions from non-MMP plans, while MMPs are prohibited from doing so.¹⁷ Several MMPs said that insurance brokers often market non-MMP plans to MMP-eligible beneficiaries (or in some cases, beneficiaries already enrolled in MMPs) because of these commissions, which decreased enrollment into MMPs.

"One thing that I think impedes enrollment is the ease with which clients can opt out.... The ability to opt out so easily really does make a big difference in our ability to maintain our enrollment and keep people in a continuum of care. They can opt out and then change their mind.... I can't tell you the number of times I've seen people who've been in one plan, and then they opt out, and sometimes they call back and change their mind 2-3 times within the same month. So that ability to get in and out easily makes a huge difference in our enrollment numbers."

--State Official

¹⁶ According to federal Medicare rules, 42 CFR 423.38(c)(4), dually eligible beneficiaries can enroll and disenroll from Medicare Advantage or other managed care plans at any time. However, effective January 1, 2019, this will change from a continuous SEP for dually eligible beneficiaries to a quarterly SEP.

¹⁷ While MMPs are typically allowed to use their own agents to market MMP products, the majority of states with capitated model FAI demonstrations do not allow MMPs to compensate third-party insurance brokers. See Appendix F for details regarding which states allow the use of third-party brokers, and in what circumstances.

2. Influence from acute, primary care and specialty providers

Several respondents said that in some states, hospitals, primary care providers, and specialists inhibited beneficiary enrollment in MMPs. In some cases, providers refused to contract with, or participate in, MMP networks, and beneficiaries who wanted to continue seeing these providers were unwilling to make changes to their primary providers to join the MMP. In other cases, acute care providers actively encouraged beneficiaries to opt out of the program. For example, in one state, interviewees knew of providers that served particular cultural/ethnic communities encouraging beneficiaries in those communities to opt out of the demonstration. In another state, providers involved in Medicare Accountable Care Organizations (ACOs) have been reluctant to join MMP networks due to financial disincentives. MMP respondents in two states said that after analyzing data on beneficiary opt-outs, they identified specific providers or provider groups serving beneficiaries with high opt-out rates and conduct targeted outreach to those providers, which increased demonstration enrollment.

“...It’s very hard to change people’s health-seeking behavior when they are vulnerable and sick. If they have long-standing relationships with a provider, they don’t want to change, and they don’t really see why life could be better for them.”

--State Official

3. Systems and data exchange issues

Identifying and enrolling dually eligible beneficiaries into FAI demonstrations requires the exchange of data files among CMS, states, and MMPs. Systems and/or data exchange issues inhibited demonstration enrollment, according to several respondents, by creating confusion and unnecessary complexity for beneficiaries, plans, and providers during the enrollment process. For example, one state reported that they experienced significant difficulties in the early phases of the demonstration with ensuring that beneficiaries were enrolled in both Medicare and Medicaid, and were therefore eligible for the demonstration. The state cited several instances where beneficiary eligibility information stored in the state’s data system was inconsistent with eligibility information stored in the CMS Medicare Advantage and Prescription Drug (MARx) data system. As a result, the state had to manually resolve thousands of eligibility discrepancies.¹⁸ Another state said that complex enrollment-related issues arose with their launch of a new state eligibility system, and two states and one MMP said that long lags in state receipt of Medicare eligibility data caused delays in demonstration enrollment. In one of these two states, lag time in state access to Medicare eligibility data led to beneficiaries being enrolled in MMC plans initially, then being passively enrolled into the demonstration a couple of months later, which was confusing for beneficiaries.

4. Complex beneficiary enrollment notices

CMS requires states to send enrollment notices to beneficiaries who will be passively enrolled in the demonstration in each state, and provides states with templates for such notices. Complex language and content in these notices

“[The letters] are hard to understand, and I don’t know if we had any members who truly got it. When they did come to our meetings regarding enrollment, they were quite frightened in many cases.”

--MMP Representative

¹⁸ This state reported that in one demonstration region, the state had data discrepancies with the CMS MARx system for 4,000 of the 10,000 beneficiaries eligible for the demonstration in that region.

have decreased enrollment, several respondents said, because they make it difficult for beneficiaries to understand the program and the benefits of enrolling. Several interviewees noted that attempts were made to simplify notices, but some noted that CMS notification templates are still fairly rigid, and states have not been able to implement as many changes to the notices as they would like.

"We worked a long time on CMS notices because there are 20-30 specific notices that the state is responsible for, and I found that to slightly hinder the process because they are very confusing notices and there was very little leeway for us to make any changes to them. We worked with a lot of advocates to try to simplify the language, make it a lot easier for potential beneficiaries to understand, and we really weren't able to make many of those modifications. So as a program, nationwide, I think that is a limitation. We still hear this a lot from our consumer advisory board – that the notices they're getting are really confusing, and they're always the templates that come from CMS."

--State Official

C. State use of an independent, third party enrollment broker

All demonstration states, except Rhode Island, contract with an independent enrollment broker to handle enrollment processes, including issuing enrollment notices, counseling beneficiaries about their health plan options, helping them enroll in the plan of their choice, conducting passive enrollment using intelligent assignment algorithms, and managing official enrollment transactions between CMS, the state, and each plan. This means that health plans, with some exceptions,¹⁹ 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. In Rhode Island, state agency staff carry out these functions.

Unlike other program elements, for which state and MMP perspectives mostly aligned with regard to whether the element increases or decreases enrollment, views were divided on the way in which enrollment brokers affect enrollment.

- **Four state interviewees felt that use of an enrollment broker increased demonstration enrollment** because it augmented state capacity to handle the volume of calls and enrollment transactions required, conducted outreach, and/or served as a neutral/unbiased entity that beneficiaries could trust for assistance with choosing an appropriate MMP.
- **Seven MMP interviewees felt that state use of an enrollment broker decreased demonstration enrollment** because they lacked the necessary education/knowledge to properly assist beneficiaries with their demonstration options, lacked enough time to spend counseling beneficiaries, had lengthy and/or duplicative conversations with beneficiaries

¹⁹ California and New York allow health plans to initiate enrollment transactions on behalf of eligible beneficiaries in certain cases. 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 Medicaid 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." According to several MMP respondents, these policies, which enable MMPs to enroll members without going through enrollment brokers, increased enrollment into the MMP.

that led to beneficiary confusion and/or consumer ‘fatigue,’ and added an extra layer of complexity to the enrollment process.

Different state and MMP perceptions of the influence of enrollment brokers may be attributed to differences in Medicare and Medicaid enrollment processes. For example, state Medicaid agencies are used to contracting with enrollment brokers to assist all Medicaid beneficiaries, including those who are dually eligible, with enrollment in MMC plans. MMPs, on the other hand, are more accustomed to Medicare, where plans handle their own marketing and enrollment. In addition, MMPs may not be aware of state capacity challenges that state respondents said made it difficult for them to provide enrollment assistance without the use of an enrollment broker. States also may feel that the benefits of using an enrollment broker outweigh the drawbacks described by MMPs, or they may simply be less aware of or sensitive to those views.

“Prior to streamlined enrollment, a plan would talk with one of their [MLTSS plan] members and then would transfer them over to the [enrollment broker], and the [enrollment broker] would go ahead and ask the same questions you asked by phone, and through their script process or sometimes their lack of training, depending on who you got, they sometimes undid the enrollment. ...We couldn’t figure out sometimes why they got rejected. We would talk to the member, and they would say ‘yeah it’s ready to go,’ and then they would never get enrolled, and we didn’t know whether it was because they had a different conversation with this third party, or if it was related to eligibility.”

—MMP Representative

“I think [use of an enrollment broker] has promoted enrollment tremendously. The very basic reason is I don’t think we could have gotten it done on our own. Even if we had the human resources to do the call center and the mailings, I don’t believe our computer system is at the point where it could do the smart auto-assignment and run the algorithm that the Enrollment Broker is doing. So besides just physically handling the volume of work, I think the use of the Enrollment Broker has allowed us to enroll people in a better fashion and not just do it randomly or haphazardly to get them in a plan. It’s allowed us to do it in a more thoughtful way. It also gives us access to [the Enrollment Broker’s] Center for Health Literacy which has been extremely helpful in having our written information not only at the appropriate reading level, but also at a level of understandability. It has improved the materials that we could have come up with on our own tremendously and made them more user-friendly for the clients.”

—State Official

D. Role of competition and financial incentives in MMP enrollment

Dually eligible beneficiaries have multiple Medicare health coverage options, including traditional FFS Medicare and in most states, several types of managed care plans, such as MA plans, Medicare Advantage D-SNPs, fully integrated Dual Eligible Special Needs Plans (FIDE SNPs), Programs of All Inclusive Care for the Elderly (PACE), Chronic Condition Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs). In the 10 demonstration states, dually eligible beneficiaries also had the option to enroll in MMPs offered through the FAI demonstration.²⁰

²⁰ D-SNPs are a type of MA plan designed to serve dually eligible beneficiaries. In some states, D-SNP enrollment may be aligned with enrollment in an MMC plan through the same parent company, allowing for integration of benefits and care coordination across the two plans. FIDE SNPs are highly integrated D-SNPs that contract with state Medicaid departments to cover some or all Medicaid benefits, including behavioral health services and/or LTSS, in addition to covering Medicare benefits for their members. PACE programs provide integrated Medicare and Medicaid benefits and community supports for individuals who require a nursing facility level of care, but live in the community. For more information about how these integrated care models are alike or different, see Chapter 9 of the Medicare Payment Advisory Commission’s June 2018 Report to Congress (MedPAC 2018).

The existence of multiple health care coverage options provides a wide array of options for beneficiaries to choose from, and competition among them may drive quality improvements. But the presence of competing managed care products in FAI demonstration counties can also lead to lower MMP enrollment. In some cases, health plans, insurance brokers, or others who assist beneficiaries with enrollment choices may be driven by financial incentives that may or may not be consistent with the beneficiary's best interest, and may therefore try to convince beneficiaries to enroll in products that align with those objectives, and steer beneficiaries away from MMPs if financial incentives associated with other products are more attractive.

For example, in New York, interview respondents said that health plans found it more profitable to keep beneficiaries enrolled in their non-integrated Managed Long Term Care (MLTC) products, which only cover LTSS, rather than enrolling them in MMPs. If MLTC enrollees, who are required to enroll in such plans to receive LTSS, transferred to MMPs, the plans would lose money, because the state set lower Medicaid capitation rates for MMPs.²¹ Although the state later increased capitation rates to the MMPs, so they were higher than those paid to MLTC plans, the rate changes occurred too late to affect health plans' commitment to marketing their MMP products.

Dually eligible beneficiaries in New York also had the option to enroll in another type of integrated care plan – FIDE SNPs, which are linked to Medicaid Advantage Plans that cover Medicaid benefits. FIDE SNPs are eligible for frailty rate adjustments, while MMPs are not, and the state's Medicaid capitation rates for these FIDE SNPs were higher than the Medicaid portion of MMP rates during the initial phase of the demonstration. Therefore, plans offering both FIDE SNPs and MMPs had a financial incentive to maintain or encourage enrollment in the FIDE SNP product, rather than the MMP product (MedPAC 2018). Consequently, New York's low rate of beneficiary participation in the FAI demonstration may be offset by higher participation rates in this other type of integrated care plan.

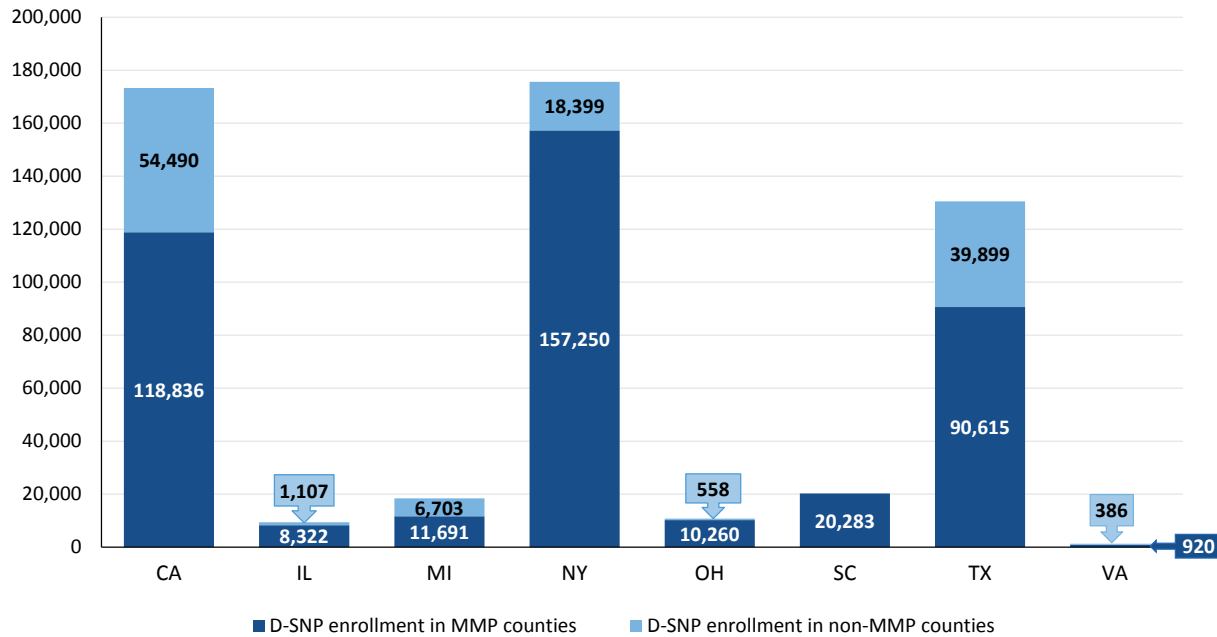
New York also has many D-SNPs operating in the same regions as the MMPs, most of which are not integrated with Medicaid benefits. The presence of these non-integrated D-SNPs intensifies product competition (see Appendix D for data on the number of D-SNP plans operating in MMP and non-MMP areas in New York and other FAI demonstration states). Figure V.1 shows D-SNP enrollment in eight FAI demonstration states, in MMP and non-MMP service areas, as of February 2015.²² At that time, California, New York, and Texas each had more than 10 D-SNPs operating in MMP counties and more than 50,000 D-SNP enrollees in those counties, with substantial enrollment in D-SNPs with no Medicaid integration. This competitive presence may have diluted MMP enrollment in these states, as well, particularly if D-SNP parent companies had incentives (financially or otherwise) to maintain those enrollees in

²¹ Medicaid capitation rates to MMPs were also subject to savings percentages applied to Medicare and Medicaid rates under the demonstration.

²² We used February 2015 data because it represents a point in time when all state FAI demonstrations were in operation, and most were in early implementation stages when efforts to enroll beneficiaries into MMPs were most active.

D-SNPs, instead of moving them into MMPs.²³ Illinois, Michigan, Ohio, and South Carolina had far fewer competing D-SNP products and enrollees in the areas in which MMPs were available.

Figure V.1. D-SNP enrollment in FAI demonstration states, February 2015



Source: Mathematica analysis of data extracted from the February 2015 CMS SNP Comprehensive Report and the February 2015 CMS Monthly Enrollment by Contract/Plan/State/County Report, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/index.html>

Notes: This chart excludes Massachusetts and New York’s FIDA-IDD demonstration, because D-SNPs serve different populations than those eligible for the FAI demonstration, and Rhode Island, which did not have D-SNPs operating in the state.

²³ For example, in California, health plans offered competing plans with a substantial financial advantage over MMPs (MedPAC 2018). Chapter 9 of the MedPAC 2018 Report to Congress (pp. 270-276) also discusses the competitive environment in New York and Texas, and provides a detailed explanation of the rate setting processes used for D-SNPs and MMPs and the way in which they can create financial incentives for plans that dampen MMP enrollment.

This page has been left blank for double-sided copying.

VI. CONCLUSIONS

Medicare and Medicaid have multiple and often conflicting requirements, benefits, and plans, which makes the process of navigating them complicated for dually eligible beneficiaries. Integrated MMPs, designed to coordinate the benefits covered by each program, can simplify what is an otherwise complex process.

By examining the experience of all 11 FAI capitated model demonstrations over a longer period of time than previous studies, including the views of state officials and MMP representatives, and considering a broad set of factors that might affect enrollment, this study provides systematic evidence that supports and expands on the findings of previous research. This evidence is particularly relevant to states that are continuing to operate FAI demonstrations over the next two years, but may also be of interest to states using other integrated care models to serve dually eligible beneficiaries, particularly since federal law requires D-SNPs to become more fully integrated with Medicaid by 2021.²⁴

The study findings indicate that dually eligible beneficiaries are more likely to enroll, and remain enrolled, in integrated Medicare-Medicaid plans when they are passively enrolled, the benefits are tangibly and quickly demonstrated, and integrated care plans are cast as a preferred option among many that are available. Although many factors affect enrollment, this study found that states and health plans that adopted the following policies and strategies saw higher rates of participation in the FAI capitated model demonstrations:

- Passively enrolling beneficiaries into integrated MMPs removes potential administrative barriers to enrolling, signals to beneficiaries that MMPs are the preferred plan, and can help to reduce opt-out and disenrollment rates when implemented in staggered waves by target group or region of the state.
- Aligning key design features of state MLTSS programs and FAI demonstrations, including the eligible populations, areas of operation, and participating plans, makes it easier for the state, health plans, and community agencies to conduct targeted outreach about the benefits of choosing one plan to provide their Medicare and Medicaid benefits.
- Allowing MMP care coordinators to contact beneficiaries prior to passive enrollment, and encouraging MMPs to conduct face-to-face visits with new members as soon as possible, helps to build trust with beneficiaries and gives MMPs a chance to explain – and show – the benefits of care coordination.
- Engaging with LTSS providers, including building on LTSS provider networks established by health plans for their Medicaid MLTSS products, and collaborating with community-based organizations makes it easier to enroll dually eligible beneficiaries in integrated care products.

²⁴ The Bipartisan Budget Act of 2018 (P.L. 115-123) requires D-SNPs to coordinate Medicaid long-term services and supports, behavioral health services, or both, and meet additional integration requirements to be established by CMS.

Issues for further consideration

The results of this study point to several issues for further consideration around the FAI program, regarding policies both at the federal and state level. These issues include: the use of default enrollment, beneficiary enrollment notices, special enrollment periods, and the design of integrated care programs more broadly.

Should MMPs be allowed to use default enrollment in certain circumstances to address low participation rates? In this study, passive enrollment generally emerged as one of the primary factors associated with increased enrollment in the MMPs. Passively enrolling MA plan members into an MMP through the same parent company likely increases MMP enrollment and continuity of coverage. This practice is similar to the current CMS policy permitting health plans to automatically (default) enroll Medicaid-only beneficiaries in a managed care plan that covers their *Medicare* benefits when these beneficiaries (1) first become eligible for Medicare; (2) are currently enrolled in an MMC plan operated by the same parent company as the Medicare plan; and (3) will continue to remain enrolled in the MMC plan for their Medicaid benefits.²⁵

Potential advantages of allowing states to make integrated MMPs the ‘default’ option for Medicaid beneficiaries when they first become dually eligible for Medicare include increased alignment of Medicare enrollment policies for dually eligible beneficiaries with Medicaid enrollment policies, which currently allow automatic enrollment subject to certain conditions. This policy could also be particularly useful in states or regions where integrated D-SNP/MLTSS plans are not offered.

Potential disadvantages may be that any form of automatic enrollment could infringe on beneficiaries’ ability to choose between traditional FFS Medicare and managed care. Default enrollment into MMPs could also create barriers to provider access if a beneficiary sees providers who are part of the MMC plan’s network, but are not part of the MMP’s network.

Could CMS further simplify beneficiary MMP enrollment notices to better inform beneficiaries about their options? The study findings echo those of previous research that attributed beneficiary reluctance to join MMPs, in part, to complex program notices (Graham et al. 2018; MedPAC 2016; PerryUndem 2015; Ptaszek et al. 2017).

While CMS and states have taken steps to simplify and improve these notices in the past, additional efforts could make them clearer, easier to understand, and more focused on the benefits of integrated care. However, since just a few years remain in most states’ demonstrations, it may not be worthwhile to invest further effort to simplify the notices.

²⁵ CMS recently expanded the authority of D-SNPs to conduct this type of default enrollment under special circumstances, effective in the 2019 contract year. However, MMPs are not currently allowed to use default enrollment for Medicaid-only members of their MMC plans. According to 42 CFR 422.66(c)(2), D-SNPs may only use default enrollment if the state Medicaid agency gives explicit permission and if the D-SNP provides timely notice to beneficiaries and allows them to decline default enrollment up to the day before the effective date. For a complete list of requirements related to the use of default enrollment, see 42 CFR 422.66(c)(2) i-iv:

https://www.ecfr.gov/cgi-bin/text-idx?SID=f4cfd02e97b08c9c3422796c65a1de65&mc=true&node=se42.3.422_166&rgn=div8.

Should dually eligible beneficiaries be allowed to change their Medicare plan at any time using Medicare’s special enrollment periods or should their ability to change plans be limited, consistent with policies for non-dually eligible Medicare enrollees, to once per year? At the time this report was written in October 2018, dually eligible beneficiaries could change their Medicare health plan at any time, using a continuous SEP policy. In contrast, Medicare-only beneficiaries can change plans just once a year during open enrollment season, and states can mandate enrollment of Medicaid-only beneficiaries into managed care plans, allowing them to change plans only once in a 12-month period or for specified reasons (“for cause”), as defined by 42 CFR §438.56(d)(2). Starting in 2019, all dually eligible beneficiaries will be allowed to change plans once each quarter (CMS 2018).²⁶ States operating FAI demonstrations were given the option to use the new quarterly SEP for 2019, or waive it. As of September 2018, all states with capitated FAI demonstration models waived it. States will again have the option to decide whether to apply or waive the new SEP requirements in 2020.

This study indicates that limiting MMP beneficiaries’ ability to change plans, or allowing them to do so on a less frequent basis, could increase enrollment in integrated care plans. As several interview respondents noted, the continuous SEP increases beneficiary churn and inhibits MMPs’ ability to coordinate care effectively.

On the other hand, proponents argue that the ability to change plans at any time is necessary to preserve access to care for an especially vulnerable population. When a dually eligible beneficiary is prescribed a new medication or needs to see a new provider who is not part of a particular plan’s network, that beneficiary can use the continuous SEP to switch into a plan that offers the coverage they need.

To what extent can states align MLTSS and integrated care program features? Study findings suggest that states operating or developing Medicaid MLTSS programs with key design features that are aligned with FAI demonstrations lead to higher demonstration participation rates. These features include eligible populations, geographic areas covered, and participating health plans.

Alignment of these elements across the two programs could simplify beneficiary marketing and make differences in plans clearer to beneficiaries. On the other hand, complete alignment may not be possible, particularly in states with longstanding MLTSS programs. For example, mature MLTSS programs commonly operate on a statewide basis and participating plans must offer coverage throughout the state, while MMPs may only operate in selected regions of the state. Additionally, an increasing number of state MLTSS programs mandate enrollment for people with any type of disability, including intellectual and developmental disabilities, while most FAI demonstrations exclude such populations.

²⁶ The final CMS rule also established additional SEPs for dually eligible and Medicare Part D Low Income Subsidy (LIS) eligible beneficiaries who have experienced a CMS or state-initiated plan enrollment. Dually eligible and LIS eligible beneficiaries also continue to have an SEP when they gain or lose Medicaid or LIS eligibility, and they may also utilize several other SEPs available to all Medicare beneficiaries who experience certain circumstances, such as a move, a change in health coverage, or other situations. For more information about Medicare SEPs, see <https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances-special-enrollment-periods>

What would be the effect on enrollment of states adopting Medicaid eligibility deeming policies? To increase retention in integrated care plans and maintain continuity of care, several states have adopted Medicaid eligibility deeming policies to permit certain dually eligible beneficiaries to remain enrolled during temporary lapses in Medicaid coverage.

These policies allow managed care plans to provide a grace period for re-enrollment. However, deeming policies can be burdensome for states and plans to administer. They also represent a financial risk to plans, which may not be fully compensated for services provided during the lapse in Medicaid coverage.

How can states ensure that provider networks are adequate in integrated care programs? Because this study found that LTSS providers play a critical role in influencing dually eligible beneficiaries' decisions about health coverage, states that wish to increase enrollment in a new integrated care program may need to foster collaboration among health plans and LTSS providers. Specific approaches to this collaboration would probably vary by state and even by region within a state, but an effective strategy would likely need to bridge gaps in knowledge and experience by each group.

What is the state's role in encouraging enrollment into fully integrated plans? As discussed in this report, dually eligible beneficiaries in most states have multiple options for receiving Medicare and Medicaid benefits, including integrated, partially integrated, and non-integrated plans.²⁷ As of September 2018, most states operating FAI demonstrations also contract with D-SNPs, which represent an alternative to MMPs for dually eligible beneficiaries. Depending on payment incentives, plans and third-party brokers may have incentives to steer beneficiaries to products other than MMPs. When states operate an FAI demonstration program, and also contract with D-SNPs that provide *less than* fully integrated care, states may wish to consider whether to encourage enrollment in the most integrated care plans and appropriate ways to do so. For example, states have flexibility to define the Medicaid contract terms and rules for D-SNPs that foster greater integration and encourage beneficiaries to enroll in integrated care plans, rather than non-integrated arrangements.²⁸ The landscape of plan options for dually eligible beneficiaries in each state may vary, and therefore require state-specific policy responses.

Study limitations

This study has some limitations that warrant caution in generalizing the findings to all states. Although the study findings suggest that in most FAI demonstration states, certain program

²⁷ Fully integrated plan options for dually eligible beneficiaries include MMPs, PACE programs, and Fully Integrated D-SNPs (FIDE SNPs). Partially integrated plan options include D-SNPs that are partially aligned with state MMC or MLTSS plans, and non-integrated options include FFS Medicare and Medicaid, standalone MA plans, or D-SNPs that are not aligned with MMC or MLTSS plans.

²⁸ For example, states can specify which regions of the state D-SNPs must cover to align with MLTSS plans operating in those regions, require D-SNPs to operate a companion MLTSS program (and vice versa), and allow D-SNPs to enroll only beneficiaries who are also enrolled in the companion MLTSS plan through the same parent company (Weir Lakhmani and Kruse 2018; Verdier et al. 2016).

elements play a major role in increasing or decreasing enrollment, some factors may have stronger effects in specific state and market situations than in others.

In addition, the premise of this study was that state enrollment policies, MMP strategies, and state program design features are the main drivers of participation rates. However, many factors outside of state policy and MMP control may have important effects on enrollment. This study did not examine all aspects of each state's health care market, Medicaid delivery and payment systems, political environment, and the degree of support or opposition by providers and beneficiary advocates, which may have affected enrollment directly or indirectly.

The study conducted interviews with state officials in all 10 demonstration states and a purposive sample of MMPs – those with higher enrollment or greater enrollment growth than other MMPs – because of their in-depth knowledge about FAI enrollment policies and practices. However, since we did not interview other stakeholders, such as beneficiaries or beneficiary advocates, less effective MMPs, and federal program staff, the study results may have been different had we solicited the views of these additional stakeholders about the influence of various factors on enrollment.

Finally, although demonstration participation rates are an important indicator of program effectiveness, they are not the only or most meaningful indicator of program impact. Other outcomes, such as beneficiary satisfaction, increased quality of care, and reduction in costs or cost growth, are equally or more important. Results from forthcoming impact evaluations of each state's demonstration, which aim to examine these outcomes, will provide a more comprehensive picture of the value of this integrated care model.

This page has been left blank for double-sided copying.

REFERENCES

- Centers for Medicare & Medicaid Services (CMS). “Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program.” Final Rule. Federal Register, vol. 83, no. 73, April 16, 2018. <https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare>
- Centers for Medicare & Medicaid Services (CMS). “Managed Care Enrollment Trends among Medicare-Medicaid Beneficiaries and Medicare-only Beneficiaries, 2006 through 2016.” Data Analysis Brief. CMS, November 2017. Available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ManagedCareEnrollmentTrends2006-2016Data.pdf>
- Grabowski, D.C., N.R. Joyce, T.G. McGuire, and R.G. Frank. “Passive Enrollment of Dual Eligible Beneficiaries into Medicare and Medicaid Managed Care Has Not Met Expectations.” *Health Affairs*, vol. 36, no. 5, 2017, pp. 846–854. Available at <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1082>
- Graham, C., P. Liu, and S. Kaye. “Evaluation of Cal MediConnect: Key Findings from a Survey with Beneficiaries.” The SCAN Foundation, August 2016. Available at http://www.thescanfoundation.org/sites/default/files/uc_duals_phonesurvey_2016.pdf
- Graham, C., H.C. Stewart, E. Kurtovich, and P. Liu. “Integration of Medicare and Medicaid for Dually Eligible Beneficiaries: A Focus Group Study Examining Beneficiaries’ Early Experiences in California’s Dual Financial Alignment Demonstration.” *Disability and Health Journal*, vol. 11, issue 1, January 2018, pp. 130-138. Available at <https://doi.org/10.1016/j.dhjo.2017.07.003>
- Integrated Care Resource Center (ICRC). “Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, July 2017–July 2018.” Technical Assistance Tool. ICRC, 2018. Available at <https://www.integratedcareresourcecenter.com/content/monthly-enrollment-medicare-medicaid-plans-plan-and-state-july-2017-july-2018>
- Kasten, J., D. Lipson, P. Saucier, and J. Libersky. “Who Enrolls in Medicaid Managed Care Programs that Cover Long-Term Services and Supports.” Medicaid 1115 Demonstrations Issue Brief, June 2017. Available at: <https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-ib1-508-mltss-enrollment.pdf>
- Lewis, E., S. Eiken, A. Amos, and P. Saucier. “The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2017 Update.” Report by Truven Health Analytics, January 29, 2018. Available at: <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>

- Libersky, J., C. Stepanczuk, R. Lester, K. Liao, and D. Lipson. “Medicaid Managed Long-Term Services and Supports: Themes from Site Visits to Five States.” Mathematica Policy Research Working Paper, March 2016. 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>
- Medicaid and CHIP Payment and Access Commission (MACPAC). “Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicare and Medicaid.” Washington, D.C.: MACPAC, January 2018. Available at <https://www.macpac.gov/publication/financial-alignment-initiative-for-beneficiaries-dually-eligible-for-medicare-and-medicare/>
- Medicaid and CHIP Payment and Access Commission (MACPAC). “Experiences with Financial Alignment Initiative Demonstration Projects in Three States: California, Massachusetts, and Ohio.” Washington, DC: MACPAC, 2015. <https://www.macpac.gov/publication/results-from-focus-groups-with-enrollees-in-the-financial-alignment-initiative-demonstration-in-california-massachusetts-and-ohio/>
- MedPAC. “Report to Congress: Medicare and the Health Care Delivery System.” Chapter 9, Managed Care Plans for Dual-Eligible Beneficiaries. Washington, D.C.: MedPAC, June 2018. Available at http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0
- MedPAC. “Report to Congress. Medicare and the Health Care Delivery System.” Chapter 9, Issues Affecting Dual-Eligible Beneficiaries: CMS’ Financial Alignment Demonstration and the Medicare Savings Programs. Washington, DC: MedPAC, June 2016. Available at <http://www.medpac.gov/docs/default-source/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0>
- MedPAC and MACPAC. “Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid.” Washington, DC: MedPAC and MACPAC, 2018. Available at <https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/>
- Ptaszek, A., A. Chepaitis, A.M. Greene, S. Hoover, G. Khatutsky, B. Lyda-McDonald, Q. Roberts, N. Thach, E. Gattine, and S. Holladay. “Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative.” RTI International, March 2017. Available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf>
- PerryUndem. “Experiences with Financial Alignment Initiative Demonstration Projects: Feedback from Beneficiaries in California, Massachusetts, and Ohio.” PerryUndem Research Communication, May 2015. <https://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf>

- Weir Lakhmani, E., and A. Kruse. “Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment.” Tip Sheet. Integrated Care Resource Center, April 2018. Available at https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Aligning_Enrollment.pdf
- Weiser, R., and M. Gold. “Demonstrations to Improve the Coordination of Medicare and Medicaid for Dually Eligible Beneficiaries: What Prior Experience Did Health Plans and States Have with Capitated Arrangements?” Washington, DC: Kaiser Family Foundation, April 2015.
- Verdier, J., and D. Chelminsky. “State and Health Plan Strategies to Grow Enrollment in Integrated Managed Care Plans for Dually Eligible Beneficiaries.” Technical Assistance Brief. Integrated Care Resource Center, June 2017. Available at https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Growing_Enrollment_in_Integrated_Managed_Care_Plans_FINAL_6-01-17.pdf
- Verdier, J., A. Kruse, R. Sweetland Lester, A.M. Philip, and D. Chelminsky. “State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options.” Technical Assistance Brief. Integrated Care Resource Center, November 2016. Available at https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues_Options.pdf

This page has been left blank for double-sided copying.

This page has been left blank for double-sided copying.

www.mathematica-mpr.com

**Improving public well-being by conducting high quality,
objective research and data collection**

PRINCETON, NJ ■ ANN ARBOR, MI ■ CAMBRIDGE, MA ■ CHICAGO, IL ■ OAKLAND, CA ■
SEATTLE, WA ■ TUCSON, AZ ■ WASHINGTON, DC ■ WOODLAWN, MD



Mathematica® is a registered trademark
of Mathematica Policy Research, Inc.