



LISTENING TO DUALY ELIGIBLE INDIVIDUALS:

Person-Centered Enrollment Strategies for Integrated Care

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EXECUTIVE SUMMARY

To improve care for dually eligible individuals while simultaneously reducing their health care costs, federal and state policymakers have increasingly relied on integrated care models – such as the Affordable Care Act’s Financial Alignment Initiative (FAI), Medicare Advantage fully-integrated Dual Eligible Special Needs Plans (FIDE SNPs) and/or the Program of All-Inclusive Care for the Elderly (PACE). However, enrollment in integrated care models has fallen drastically short of expectations. For example, the Centers for Medicare & Medicaid Services (CMS) anticipated enrolling between one and two million dually eligible individuals in the FAIs during the initial stages of implementation,¹ but only about 400,000 have enrolled.²

To better understand why enrollment in integrated care has been lower than expected, we launched a three-pronged research project aimed at understanding the perspectives of dually eligible individuals regarding whether integrated care plans, specifically Medicare-Medicaid plans offered through the FAI, meet their needs. In particular, our primary research questions were:

1. What factors are associated with enrollment in the FAI and which appear to be most important to dually eligible individuals?
2. What best practices could federal policymakers, state policymakers, integrated care plans and other stakeholders employ to increase participation in integrated products in a person-centered way?

Our research uncovered several major findings that addressed our first research question.

Major Findings:

- The main factors that are important to dually eligible individuals about the FAI, and that would therefore likely cause them to enroll or stay enrolled in the FAI, are: 1) the ability to continue seeing the providers they need to maintain their health; 2) the opportunity to make an informed decision after reviewing accessible material; 3) the opportunity to speak with a knowledgeable person about the FAI, and 4) the potential to receive additional or supplemental benefits.
- The limited networks of Medicare-Medicaid plans (MMPs) hinder the ability of dually eligible individuals to maintain access to their providers.
- The passive enrollment process hinders the ability of dually eligible individuals to review accessible materials, speak with a knowledgeable person and learn about the benefits offered by MMPs that are most important to them.

These findings led us to conclude that if policymakers want to improve enrollment in integrated care, they should improve the information dually eligible individuals receive about their integrated care options, both the type and amount of information as well as the way it is delivered. Additionally, they should increase and improve the ability of dually eligible individuals to maintain access to the providers they need to maintain their health. We therefore make several recommendations to address our second research question.

¹ David C. Grabowski, Nina R. Joyce, Thomas G. McGuire, and Richard G. Frank. Passive Enrollment of Dual-Eligible Beneficiaries Into Medicare and Medicaid Managed Care Has Not Met Expectations. *Health Affairs*. May 2017, p. 847. Available at: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1082>

² Integrated Care Resource Center. Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, April 2020-April 2021. April 2021. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/MMP_Enroll_by_State_April_2021.pdf

Recommendations:

- The federal government should enact policies to help dually eligible individuals maintain access to their providers, such as requiring: 1) states to evaluate opt-out rates due to provider access issues; 2) MMPs to address provider access issues before they can participate in ongoing passive enrollment, and 3) a one-year continuity of care period for managed care integrated care plans.
- The federal government should create a resource hub in which a dually eligible individual can receive clear, comprehensive information about their integrated care options and speak with a trusted expert.
- States should designate and train certain community-based organizations to serve as designated enrollment assister entities.
- The federal government should issue new content requirements and accessibility standards designed to improve the passive enrollment notice and other informational material for dually eligible individuals.
- States and health plans should market the benefits of integrated care plans that dually eligible individuals have identified as important to them.

Overall, if policymakers want dually eligible individuals to enroll in integrated care, they should design enrollment policies, communications materials, benefits packages and provider networks that are truly reflective of, and responsive to, the needs and preferences of this population. The best way to increase and improve enrollment in integrated care is to make sure it truly fits and meets the needs of the dually eligible population it serves.

INTRODUCTION

In 2019, there were over 12 million individuals who were dually eligible for Medicare and Medicaid – individuals with low incomes who are either 65 and older or younger individuals with long-term disabilities and/or complex health needs.³ The fact that Medicare and Medicaid cover different benefits (for example, Medicaid covers long-term services and supports while Medicare does not), creates fragmentation in the health care delivery system for dually eligible individuals resulting in challenges to efficient and effective care coordination.⁴ Additionally, dually eligible individuals tend to have greater care needs,⁵ and therefore, are more costly for Medicare and Medicaid to cover than individuals who are only eligible for one program.⁶ Furthermore, in this past year the impact of the COVID-19 pandemic has exacerbated many of these issues for dually eligible individuals. They were more likely to contract

³ Medicaid and CHIP Payment and Access Commission (MACPAC). June 2020 Report to Congress, Chapter 2: Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options. June 2020, p. 33. Available at: <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-2-Integrating-Care-for-Dually-Eligible-Beneficiaries-Policy-Issues-and-Options.pdf>

⁴ See footnote 1 at p. 846, available at: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1082>.

⁵ Congressional Budget Office. Dual Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies. June 2013. Available at: <https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308dualeligibles2.pdf>. This report finds that eligible individuals are more likely than other Medicare enrollees to have multiple chronic conditions, functional limitations so that they require assistance with activities of daily living, and a serious mental illness or substance use disorders.

⁶ See footnote 1, citing that Medicare spends twice as much per dual eligibility as it does per Medicare-only beneficiary. See also Debra Lipson, Laura Kimmey, Danielle Chelminsky, Caroline Margiotta, Alena Tourtellotte and Erin Weir Lakmani. Why Dually Eligible Beneficiaries Stay or Leave Integrated Care Plans. Mathematica. January 2021, p.1. Available at: [https://www.mathematica.org/our-publications-and-findings/publications/why-dually-eligible-beneficiaries-stay-or-leave-integrated-care-plans?utm_source=acoustic&utm_medium=email&utm_campaign=email&utm_content=Arnold%20Ventures%20Dually%20Eligible%20Beneficiaries%20Personalized%2002%2023%2021%20\(1\)](https://www.mathematica.org/our-publications-and-findings/publications/why-dually-eligible-beneficiaries-stay-or-leave-integrated-care-plans?utm_source=acoustic&utm_medium=email&utm_campaign=email&utm_content=Arnold%20Ventures%20Dually%20Eligible%20Beneficiaries%20Personalized%2002%2023%2021%20(1)), citing that dually eligible individuals account for about 33 percent of all Medicare and Medicaid spending but are only 20 percent and 15 percent of all enrollees in each program, respectively.

COVID-19 and experience worse health outcomes.⁷ Because they are at greater risk of having worse health outcomes, as well as at greater risk of experiencing fragmented, uncoordinated care, there has been increased attention in recent years on creating integrated care products for dually eligible individuals – more specifically, health plans that coordinate and deliver both Medicare and Medicaid benefits. Around a decade ago, only three states had integrated care models, but as of January 2020, more than one-third of states operated some form of integrated care model such as the Financial Alignment Initiative (FAI), the Medicare Advantage fully integrated Dual Eligible Special Needs Plan (FIDE SNPs) and/or the Program of All-Inclusive Care for the Elderly (PACE).⁸ The underlying premise of integrated care plans is that they offer a two-fold benefit – they can improve care for dually eligible individuals through better coordination and alignment between Medicare and Medicaid, and in doing so, lower costs for the federal and state governments.

However, despite these purported benefits and the fact that enrollment in integrated care models has increased nearly five-fold in the last ten years,⁹ total enrollment has still fallen drastically short of policymakers' expectations. For example, the Centers for Medicare & Medicaid Services (CMS) anticipated enrolling between one and two million dually eligible individuals in the FAIs during the initial stages of implementation,¹⁰ but only 400,000 enrolled.¹¹ As of December 2019, only 10 percent of dually eligible individuals were enrolled in any type of integrated care.¹²

STUDY OBJECTIVES

Previous research has analyzed the factors influencing enrollment in the FAIs and other integrated care options.¹³ However, this research has primarily focused on policy (such as passive enrollment) and administrative solutions (such as aligning the FAI with state Medicaid managed long-term services and supports programs or improving data sharing between Medicare and Medicaid) as ways for improving

⁷ Preliminary Medicare COVID-19 Data Snapshot: <https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>

⁸ Alexandra Kruse and Michelle Herman Soper. State Efforts to Integrate Care for Dually-Eligible Beneficiaries: 2020 Update. Center for Health Care Strategies. February 2020. Available at: https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries_022720.pdf

⁹ See above footnote.

¹⁰ See Grabowski et al., p. 846, available at: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1082>

¹¹ Integrated Care Resource Center. Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, April 2020-April 2021. April 2021. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/MMP_Enroll_by_State_April_2021.pdf

¹² See footnote 3 at p. 32, available at: <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-2-Integrating-Care-for-Dually-Eligible-Beneficiaries-Policy-Issues-and-Options.pdf>, citing Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. Medicare-Medicaid Coordination Office FY 2019 Report to Congress. February 2020. Available at: <https://www.cms.gov/files/document/mmco-report-congress.pdf>

¹³ Debra Lipson, Erin Weir Lahkmani, Alena Tourtellotte, and Danielle Chelminsky. The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries, Mathematica Policy Research. December 2018. Available at: <https://www.macpac.gov/wp-content/uploads/2019/01/Enrollment-in-Integrated-Care-Demonstrations-for-Dually-Eligible-Beneficiaries.pdf>. See also Debra Lipson et al. Why Dually Eligible Beneficiaries Stay or Leave Integrated Care Plans. Mathematica. January 2021. Available at: https://www.mathematica.org/our-publications-and-findings/publications/why-dually-eligible-beneficiaries-stay-or-leave-integrated-care-plans?utm_source=acoustic&utm_medium=email&utm_campaign=email&utm_content=Arnold%20Ventures%20Dually%20Eligible%20Beneficiaries%20Personalized%2002%2023%2021%201. See also Sarah Barth, Jon Blum, Elaine Henry, Narda Ipakchi and Sharon Silow-Carroll. Medicare-Medicaid Integration: Reflecting on Progress to Date and Charting the Path to Making Integrated Programs Available to all Dually-Eligible Beneficiaries, Brief #2. Health Management Associates. August 2020. Available at: https://www.healthmanagement.com/wp-content/uploads/HMA_Medicare-Medicaid-Integration-Brief-2.pdf. See also MACPAC. Report to Congress: Chapter 4: Establishing a Unified Program for Dually Eligible Beneficiaries: Design Considerations. March 2021. <https://www.macpac.gov/wp-content/uploads/2021/03/Chapter-4-Establishing-a-Unified-Program-for-Dually-Eligible-Beneficiaries-Design-Considerations.pdf>. See also Medicare Payment and Access Commission (MedPAC). June 2018 Report to the Congress, Medicare and the Health Care Delivery System. June 2018, Chapter 9. Available at: http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0.

enrollment. Importantly, none of the current research examines how to incorporate the perspectives of dually eligible individuals into integrated care enrollment policy, plan design and the development of communications best practices.¹⁴

RESEARCH QUESTIONS

To address this gap, our primary research questions included:

1. What factors are associated with enrollment in the FAI and which appear to be most important to dually eligible individuals? Specific key factors that we examined were:
 - What are the most critical pieces of plan design influencing decision-making?
 - Who are the trusted sources of information regarding possible enrollment in a plan?
 - How do dually eligible individuals understand the concept of “integration” and what are the implications on enrollment decisions?
 - What market conditions affect enrollment?
2. What best practices could federal policymakers, state policymakers, integrated care plans and other stakeholders employ to increase participation in integrated products in a person-centered way?

BACKGROUND

FAI Enrollment Policies

To answer our first research question, a significant portion of our analysis was spent on the different FAI enrollment policies used by each of the target states and the impact of these policies on a dually eligible individual’s ability to enroll in an integrated care plan that meets their needs. Below are descriptions of the two primary enrollment policies of the FAI.

1. Passive Enrollment

Passive enrollment means a dually eligible individual is automatically enrolled into the FAI, as well as into one of the Medicare-Medicaid plans administering the FAI in their region unless, before the effective enrollment date, they decide to opt out of the demonstration altogether. Prior to their passive enrollment, individuals typically receive a notice informing them about the process, the plan selected for them, and their rights and options regarding opting out, 60- and 30-days prior to their passive enrollment.¹⁵ In most FAI states, MMPs are also permitted to conduct “welcome calls” or other forms of outreach, in which they contact the enrollee prior to their passive enrollment to establish communication and to inform them about the plan and its benefits.¹⁶

¹⁴ Each FAI’s Memorandum of Understanding required an external evaluation, and each evaluation contained focus groups of FAI enrollees, as well as individuals who decided to opt out or disenroll.

¹⁵ Some states send a 90-day passive enrollment notice, such as California.

¹⁶ Debra Lipson et al. The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries. Mathematica Policy Research. December 2018, p. 16. Available at: <https://www.macpac.gov/wp-content/uploads/2019/01/Enrollment-in-Integrated-Care-Demonstrations-for-Dually-Eligible-Beneficiaries.pdf>

2. Voluntary Enrollment/Opt-in

In contrast to passive enrollment, voluntary or opt-in policies in the FAI allow individuals to proactively decide whether and when to enroll in the FAI, as well as which MMP they would like to enroll into, if more than one is offered in their county. In most FAI states, individuals and their authorized representatives are the only people who can request enrollment in the FAI on their behalf, and they must do so by contacting the state's FAI enrollment broker contractor.¹⁷ During the initial implementation of the FAIs, many states offered an initial opt-in period followed by periods of passive enrollment, either on a monthly or quarterly basis.

FAI Features of Four Target States

We decided to focus our research on the Financial Alignment Initiatives, with a specific examination of four states: California, Illinois, Massachusetts, and Ohio. These states were selected because each of their demonstrations had unique characteristics, and so we believed this diversity in FAI features would allow us to gain a comprehensive understanding of the enrollment experiences of dually eligible individuals. Below are brief summaries of the enrollment policies, market conditions and other unique features of each state's FAI.

California.

We selected California because the state's FAI, Cal MediConnect, stopped using passive enrollment in 2016 and exclusively uses the opt-in enrollment policy.¹⁸ On average, its opt-in rate has hovered around 20 percent.¹⁹ Additionally, the state allowed county-specific variations in enrollment policies, such as how and when passive enrollment was implemented.²⁰ We specifically focused our research on Los Angeles County, San Mateo County and the Inland Empire region (San Bernardino and Riverside counties) due to their demographic and geographic diversity, as well as differences in enrollment policies and market conditions.²¹ In addition to care coordination services required of all MMPs, the Cal MediConnect program offers new benefits to dually eligible individuals that they could not have received under Medicaid or Medicare alone, such as non-emergency transportation, vision coverage and flexible benefits called "Care Plan Options" to help enrollees live safely in their homes, such as home modifications like wheelchair ramps.²² Prior to the demonstration, all long-term services and supports (LTSS) were delivered through separate entities in each county (rather than uniformly through the state's Medicaid program), and therefore, the central coordination of medical services and LTSS was a core feature of the demonstration.²³ Lastly, we included California because it has a large number of Medicare Advantage plans and D-SNPs operating in the demonstration counties, and we wanted to evaluate the impact of large numbers of plan options on enrollment decisions. For example, Los Angeles County had 115 Medicare Advantage plan options offered in 2020 as well as 21 D-SNP plans.²⁴

¹⁷ When California transitioned to exclusively using opt-in enrollment, it also implemented "streamlined" enrollment, in which health plans can bypass the enrollment broker and process enrollment requests on behalf of individuals.

¹⁸ Edith G Walsh. Financial Alignment Initiative California Cal MediConnect: First Evaluation Report. RTI International. November 2018, p. ES-7. Available at: <https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf>

¹⁹ See footnote 16 at xi, Figure ES-1, FAI Eligible Beneficiary Participation Rate by State, 2014-2018. See also above footnote, citing that during its last month of passive enrollment, Cal MediConnect had an average opt out of 50 percent. The average opt out rates varied widely between counties, with San Mateo County reporting a 10 percent opt out rate and Los Angeles County reporting a 58 percent rate.

²⁰ For example, San Mateo County passively enrolled all dually eligible individuals at the beginning of the demonstration, while individuals in the six other demonstration counties first had an opt in period, followed by passive enrollment. See footnote 17 at p. 34-5.

²¹ Los Angeles County in particular is highly demographically diverse. In 2015, the state's analysis of individuals who opted out found that the opt-out rate of individuals who spoke languages other than English was as high as 94 percent, particularly among speakers of Farsi, Armenian, Hebrew and Russian. See footnote 17 at p. ES-6.

²² See footnote 18 at p. 7.

²³ See footnote 18 at p. ES-2.

²⁴ 2021 MA Landscape Source Files containing up-to-date data as of October 15, 2020. Available at: <https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin>. 2021 SNP Landscape Source Files containing up-to-date data as of October 15, 2020. Available at: <https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin>

Illinois

We selected Illinois because the state chose two regions for its FAI, entitled the Medicare-Medicaid Alignment Initiative – the Greater Chicago region (made up of six counties) and the Central Illinois region (made up of 15 counties), and we felt the urban versus rural geographies of those regions respectively would offer interesting comparisons.²⁵ The state uses monthly passive enrollment,²⁶ and its average enrollment rate throughout the demonstration has hovered between 30-40 percent.²⁷ In addition, all dually eligible individuals in the state received their Medicaid benefits through a fee-for-service delivery system prior to the demonstration, and therefore the transition to managed care was a new experience for these individuals.²⁸ Illinois decided to implement a managed long-term services and supports (MLTSS) program in 2016, but similar to California, the state had no prior experience with MLTSS prior to the demonstration.²⁹ Lastly, all Medicare D-SNPs stopped operating in the state in 2017, and the state does not offer a Program of All-Inclusive Care for the Elderly.³⁰ Therefore, the MMAI is the only integrated care option available to individuals.

Massachusetts

We selected Massachusetts because its FAI, One Care, is unique in that it only serves adults ages 21-64.³¹ One Care uses quarterly passive enrollment³², and throughout the demonstration, enrollment has averaged between 20-25 percent.³³ The One Care program offers several new benefits that dually eligible individuals would not have been able to receive under Medicaid or Medicare alone, including diversionary behavioral health services, new community-based supports such as peer support and respite care, and expanded dental and durable medical equipment (DME) benefits.³⁴ While each demonstration county has Medicare D-SNP plans operating in it, in contrast to California, the largest number of plan options available in any county is eight.³⁵

Ohio

We selected Ohio because its FAI, MyCare Ohio, is unique in that when the state implemented the FAI program, it simultaneously implemented a mandatory Medicaid managed care program (including a MLTSS program) and used the same “MyCare Ohio” name for both programs.³⁶ All dually eligible individuals who were eligible for the FAI were required to enroll in MyCare for their Medicaid benefits,

²⁵ Edith G Walsh. Financial Alignment Initiative Illinois Medicare-Medicaid Alignment Initiative: First Evaluation Report. RTI International. November 2018, p. 5. Available at: <https://innovation.cms.gov/Files/reports/fai-il-firstevalrpt.pdf>

²⁶ See footnote 16. Appendix E: Enrollment Policies and Process in Capitated Model FAI Demonstration States. July 2018. Available at: <https://www.macpac.gov/wp-content/uploads/2019/01/APPENDICES-Enrollment-in-Integrated-Care-Demonstrations-for-Dually-Eligible-Beneficiaries.pdf>

²⁷ See footnote 16 at p. xi, Figure ES-1. FAI Eligible Beneficiary Participation Rate by State, 2014-2018.

²⁸ See footnote 25 at p. ES-2.

²⁹ See footnote 25 at p. ES-2.

³⁰ See footnote 25 at p. 7.

³¹ Edith G. Walsh. Financial Alignment Initiative Massachusetts One Care: Third Evaluation Report. RTI International. April 2019, p. ES-1. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MAEvalReportDY3042019.pdf>. The state allows individuals who turn 65 while enrolled in One Care to remain in the program, however.

³² See footnote 16.

³³ See footnote 16 at p. xi, Figure ES-1. FAI Eligible Beneficiary Participation Rate by State, 2014-2018.

³⁴ Edith G Walsh. Financial Alignment Initiative Annual Report: One Care: MassHealth Plus Medicare, First Annual Report. RTI International. September 2016, Appendix E. Available at: <https://www.mass.gov/doc/one-care-evaluation-report-demonstration-year-1-3/download>

³⁵ 2021 SNP Landscape Source Files containing up-to-date data as of October 15, 2020. Available at: <https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin>

³⁶ Molly O’Malley Watts. Early Insights from Ohio’s Demonstration to Integrate and Align Financing for Dual Eligible Beneficiaries. Kaiser Family Foundation. May 2015. Available at: <https://files.kff.org/attachment/issue-brief-early-insights-from-ohios-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries>

and therefore they can only opt out of receiving their Medicare benefits through the program.³⁷ The state also decided to fully align its MLTSS program and FAI, including the populations who were eligible, the counties where the programs were available, and the plans participating in both programs.³⁸ All of these factors have been viewed as contributing to Ohio having the highest average enrollment rate of any FAI state.³⁹ MyCare Ohio uses monthly passive enrollment.⁴⁰ Lastly, each of the MMPs also operates a Medicare Advantage plan, and multiple Medicare D-SNPs operate in each of the demonstration counties,⁴¹ with 11 options available in one county.⁴²

The below table compares some of the major differences between the features of each FAI state of focus:

FAI State	Using passive enrollment?	Individuals 65 and over eligible?	New benefits offered?	Medicaid managed care in the state prior to the FAI?	Alignment with MLTSS program?
California	N	Y	Y	Y	N
Illinois	Y	Y	N	N	N
Massachusetts	Y	N	Y	Y	N
Ohio	Y	Y	N	Y	Y

DATA COLLECTION AND METHODOLOGY

We collected information for our study in three ways: (1) a document and literature review (2) consumer data and (3) enrollment stakeholder data. We also convened an Advisory Committee to help guide us in our analysis and the development of our recommendations. Below are more details on each of these components:

Document and Literature Review

The document review examined each state FAI’s Memorandum of Understanding and three-way contract. We also reviewed federal and state enrollment and marketing guidance documents, state enrollment dashboards, and state FAI evaluation reports. We collected documents from a variety of sources, including federal and state websites, consumer advocacy organizations, our project advisory committee, and enrollment stakeholders. Lastly, we searched the available peer-reviewed literature and gray literature on enrollment practices, issues and approaches in integrated care programs.

Consumer Data: Focus Groups and Interviews

The Center contracted with the Institute for Community Health⁴³ (ICH) to conduct and analyze the information collected from focus groups and from one-on-one interviews with dually eligible individuals in all four states.⁴⁴ Participants comprised a mix of individuals, both those who were currently enrolled

³⁷ Edith G Walsh. Financial Alignment Initiative MyCare Ohio: First Evaluation Report. RTI International. November 2018, p.27. Available at: <https://innovation.cms.gov/files/reports/fai-oh-firstevalrpt.pdf>

³⁸ See footnote 15 at p. 15, Table IV.2. Alignment of Key Program Features Between States’ FAI Demonstrations and MLTSS Programs.

³⁹ See footnote 15 at p. 7, stating that 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 to a high of 67-82 percent in Ohio.

⁴⁰ See footnote 26.

⁴¹ See footnote 37 at p. 13.

⁴² 2021 SNP Landscape Source Files containing up-to-date data as of October 15, 2020. Available at: <https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin>

⁴³ Institute for Community Health website: www.icommunityhealth.org

⁴⁴ The dually eligible individuals who participated in the focus groups and interview will hereafter be referred to as “participants” and the information from the focus groups and interviews with dually eligible individuals will be referred to as “consumer data.”

and those eligible, but not enrolled in the FAI. Of those who were enrolled, some had been passively enrolled and others had proactively opted into the FAI. Of those who were not enrolled, some had decided to opt out and others had never been selected for passive enrollment. A small number of caregivers for dually eligible family members participated alongside the family members they care for in two states. In total, ICH conducted nine focus groups and 36 interviews with a total of 76 individuals. The interviews were completed between September and December 2020. Due to the COVID-19 pandemic, all focus groups and interviews took place virtually via Zoom teleconferencing sessions or telephone calls. Participants were recruited through consumer advocacy organizations and health plans and were provided a gift card for their participation. Table 1 below shows a breakdown of participants by state, enrollment status and demographic information.

The focus groups and individual interviews with dually eligible individuals explored their experiences and perspectives around the enrollment process. Key areas of exploration included: the reasons and circumstances surrounding the participants' enrollment experience; how decisions were made around enrollment; experiences in integrated plans; participants' priorities for plans; their opinions regarding common enrollment strategies (passive enrollment vs. voluntary), and how the enrollment process might have been improved or changed.

Two factors may have affected the recruitment (i.e., the individuals who agreed to participate) and content of the conversations. First, hosting the focus groups and interviews virtually may have increased accessibility by not requiring individuals to commit time and resources traveling to a physical location; it also allowed researchers to be more flexible with appointment times and rescheduling. On the other hand, remote focus groups and interviews have hindered participation for individuals with internet or technology access barriers. Second, when talking to individuals about their experiences with enrollment, they were often asked to remember details of interactions that occurred several years prior. Accuracy of recall can be challenging over that amount of time. Therefore, our reporting pertains to individuals' memories and impressions rather than on accurate details of their enrollment situations. A second challenge with recall-based studies is the difficulty of remembering a lack of awareness. It is often unclear whether an individual was not aware of enrollment at the time of enrollment, which may have been several years in the past, or whether they simply do not recall this part of the experience at the time of the interview. Nevertheless, memories and impressions are valuable in helping us understand consumers' subjective experience of enrollment.

Table 1. Focus group and interview participants by state, enrollment status and eligibility

	CA	IL	MA	OH	Total
Total number of participants	36	12	13	15	76
Enrollment Status					
Enrolled	17	7	12	13	49
Not enrolled	19	5	1	2	27
Type of enrollment					
Passively Enrolled	1	1	0	12	14
Opted In	16	6	12	1	35
Opted Out	4	5	1	2	12
Never Enrolled	15	0	0	0	15
First dually eligible due to					
Disability or health condition	23	7	13	13	56
Age 65+	10	4	0	0	14
Unknown	3	1	0	2	6

	CA	IL	MA	OH	Total
Consumer or caregiver					
Consumer	32	12	12	12	70
Caregiver	4	0	0	2	6
Language of interview/focus group participant					
English	29	12	12	15	68
Spanish	7	0	1	0	8

Enrollment Stakeholder Data

We completed 36 key informant interviews with enrollment stakeholders between June and December 2020: 13 with national experts and 28 with experts from the four FAI states. Enrollment stakeholders included: a mix of federal and state officials; national health policy experts and researchers; national and state health plan leadership; health care advocates; providers; ombudsman programs; State Health Insurance Assistance Program (SHIP) counselors; and community-based organizations. Stakeholders were asked about their perspectives on successes and challenges with enrollment in the FAI, which factors they viewed as influencing enrollment and recommendations for best practices.

Advisory Committee

The Center also selected an advisory committee for the project that was comprised of a former CMS official, a former state Medicaid official, a health plan membership organization and consumer health advocacy organizations.⁴⁵ The Advisory Committee convened several times over the course of the project and provided guidance on enrollment factors to consider and analyze when conducting each of the three research components. The Advisory Committee provided important contextual information for interpreting a number of our findings, as well as insights on understanding the relative importance of certain findings.

MAJOR FINDINGS

Research Question 1: What factors are associated with enrollment in the FAI and which appear to be most important to dually eligible individuals?

The three components of our research revealed that four aspects of MMPs are important to dually eligible individuals:

1. The ability to continue seeing the providers they need to maintain their health

The most significant factor affecting an individual’s decision to enroll or opt out of the FAI was the ability to continue seeing providers they are currently working with to manage their chronic conditions, long-term care and/or health and social needs – with 60 out of 76 participants emphasizing its importance. Several participants shared that they were initially interested in or willing to be passively enrolled in the FAI, but opted out once they determined they could no longer see one or more of the providers they needed to maintain their health and well-being. In particular, specialists (such as podiatrists, psychiatrists and surgeons), behavioral health providers, and long-term services and supports (LTSS) providers were cited as the types of providers who were not within the MMPs’

⁴⁵ Advisory Committee members include: 1) Christine Aguiar Lynch, Vice President of Medicare and Managed Long-Term Services and Supports, Association for Community Affiliated Plans; 2) Kevin Prindiville, Executive Director, Justice in Aging; 3) Melanie Bella, Chief of New Business and Policy, Cityblock Health and former director of the Centers for Medicare & Medicaid Services’ Medicare-Medicaid Coordination Office; 4) RoAnne Chaney, former executive director, Michigan Disability Rights Coalition; 5) Robert Master, former CEO, Commonwealth Care Alliance and 6) Tom Betlach, Partner, Speire Healthcare Strategies.

network but with whom important relationships had been established. Overall, many participants, particularly individuals with disabilities and others who have a complex care team, viewed limited provider networks as a plan design feature that would seriously jeopardize their health and well-being, and, therefore, concluded the FAI was not a viable option for them. The literature⁴⁶ and enrollment stakeholders⁴⁷ confirmed the importance to dually eligible individuals of being able to see their preferred providers.

2. The opportunity to make an informed decision after reviewing accessible resources

A common theme among participants who reported a positive enrollment experience was that they felt they had received a sufficient amount of information about the enrollment process and plan they ultimately selected (or were passively enrolled into), prior to actually being enrolled. Helpful resources were described as materials and resources that were accessible (i.e., clear, easy to understand and accommodating to individuals with different abilities) and that contained benefit information and provider network information. For example, some participants remembered reviewing their passive enrollment notice and finding it helpful when these notices contained information to help compare plan options, such as a chart containing all of the different MMPs and the benefits offered by each. Other participants mentioned looking at health plan website information or contacting health plans prior to their enrollment to confirm whether their provider was in-network. Our literature review confirmed that multiple opportunities to learn about the FAI increase the likelihood that a dually eligible individual will feel informed enough make a decision.⁴⁸

3. The opportunity to speak with a knowledgeable person about the FAI

Dually eligible individuals were also more likely to enroll in the FAI if they learned about it from an individual who they viewed as knowledgeable about the subject matter and/or had their best interests in mind – someone viewed as a trusted source of information. The trusted sources most often cited were family members, friends, individuals within the disability advocacy community, case workers/ social workers and providers. These individuals were viewed as trusted because they had a prior, established relationship with the participant.

However, an important conundrum brought to light by the consumer data is that the people who dually eligible individuals view as trusted are not the individuals who are most knowledgeable about the FAIs. Conversely, the people who are most knowledgeable about the FAIs, such as health plan staff members, are not viewed by dually eligible individuals as trustworthy sources. Overall, several participants shared that despite receiving helpful information from individuals in their lives who they viewed as trusted, or from health plan representatives, they still wished there was a person who was both truly knowledgeable about the FAI *and* trustworthy (i.e., someone not affiliated with a health plan) – a trained expert they could speak with to learn more about their options.

4. The potential to receive additional or supplemental benefits

Dually eligible individuals were also more likely to enroll or stay enrolled in the FAI if they perceived it as providing them with a tangible benefit that they could not get under their current coverage. For participants, benefits that were tangible to them were reduced cost-sharing, particularly for copayments for prescription drugs, as well as covered services that were previously not covered or minimally covered under Medicaid and/or Medicare alone, such as dental, vision, transportation and

⁴⁶ See footnote 15, stating that strong provider networks were a “secondary factor” affecting higher enrollment in the FAIs, available at: <https://www.macpac.gov/wp-content/uploads/2019/01/Enrollment-in-Integrated-Care-Demonstrations-for-Dually-Eligible-Beneficiaries.pdf>

⁴⁷ Quote from a key informant interviewee who works as a direct service provider: “I have to say more people who are passively enrolled in it are staying with it if they can find the providers that they’re accustomed to as well as specialists they’re interested in. Those are the biggest things. If they don’t have the specialist in any of the plans, they’re not going to want to stay with it.”

⁴⁸ See footnote 16, quoting an MMP representative as saying, “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.”

durable medical equipment. Our enrollment stakeholders also confirmed that the idea of receiving a benefit or service that Medicaid or Medicare alone did not fully cover was also an influential factor in the enrollment decision.⁴⁹

Enrollment Strategies Must Address All Four Factors to Be Effective

When we reviewed all of the above four factors together, the clearest theme that emerged was that dually eligible individuals want to have enough information, including information about the plan's provider network, to be able to determine whether the plan truly meets their needs. Dually eligible individuals feel they are best positioned to make an informed choice once they have received accessible, comprehensive materials and are able to ask questions to and speak with a person who is knowledgeable about the FAI and trustworthy to them. While making this type of information accessible and delivering it in a way that is preferable to dually eligible individuals is necessary, information alone is not sufficient to allow them to feel that enrolling into integrated care is the best choice for them. The benefits and design features of integrated care plans must also include what is most important to dually eligible individuals. Overall, all four factors identified above must be incorporated into integrated care enrollment policies and plan designs in order for them to truly meet dually eligible individuals' needs.

FAI Enrollment Issues Encountered by Dually Eligible Individuals

The major findings are reflective of five key areas of concern for dually eligible individuals when it comes to enrolling in an FAI plan:

1. The limited networks of integrated care plans hinder access to needed providers

Both participants and enrollment stakeholders shared that the primary reason individuals opted out of the FAI was that their provider was not in the managed care network. MMPs have limited provider networks, based on both the types of providers considered "in-network" as well as geographic limitations on the networks, and many participants felt that they had to opt out of the FAI after learning that certain providers and specialists were not in-network. For many participants in the focus groups and consumer interviews, their primary concern was not just existing relationships with primary care providers, but access to critical specialists that they currently see or may need in the future to manage their complex health and social needs. This need to maintain access to a wide array of specialists in order to stay healthy was particularly emphasized by some individuals with disabilities, and was frequently raised by this population as a substantial reason why the FAI plans were not an option for them. Focus group participants in the formal FAI evaluations also mentioned that the primary reasons they opted out were because they wanted to maintain access to providers they were currently working with who were not in the plan's network.⁵⁰ The evaluations also revealed that while some states collected data on that number of individuals who decide to opt out or disenroll from the FAI and their reasons for doing so, this type of data collection is not required of states.⁵¹

Support for integrated care was also impacted by a dually eligible individual's prior experience with or length of enrollment in Medicaid, as well as their experience with managed care. Generally, individuals

⁴⁹ Key informant interview with a former FAI enrollee who stated they enrolled because the FAI would allow them to see a therapist who "would not be available, probably even through commercial insurance," and because they felt the FAI allowed them to receive better coverage of out-of-network providers than through Medicaid or Medicare alone. "I would say essentially that was the sole reason at the time that I knew this was what I had to do, because I knew I had medical needs and providers I needed to see that would not be covered elsewhere."

⁵⁰ See footnote 31 at p. 31. See footnote 18 at p. 43.

⁵¹ None of the three-way contracts in any of our four target states require the reporting or assessment of opt out rates. Ohio's three-way contract contains the strongest language regarding the monitoring of opt outs, stating that "CMS and the ODM will monitor Enrollments, disenrollments and Opt Out requests for both evaluation purposes and for compliance with applicable marketing and Enrollment laws, regulations and CMS policies, for the purposes of identifying any inappropriate or illegal marketing practices. some states voluntarily collect and report opt out/disenrollment data. See MyCare three-way contract at p. 32, available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OHContract.pdf#page=32>

in our focus groups under 65 years of age seemed to be more familiar with Medicaid coverage, and seemed to have more experience navigating the health care system as a dually eligible individual compared to people who turned 65 and then became dually eligible (perhaps because individuals under 65 must receive Social Security Disability Insurance for 24 months before being eligible for Medicare, and therefore they are likely to become eligible for and enroll in Medicaid before being enrolled in Medicare). The comfort level with Medicaid of some focus group individuals 65 and older was lower than dually eligible individuals younger than 65. In particular, individuals 65 and older were concerned their Medicare fee-for-service providers would not or did not accept Medicaid. Additionally, some individuals who were in the Medicare fee-for-service system prior to being enrolled in the FAI reported that joining a MMP decreased their access to Medicare providers.

2. Dually eligible individuals do not have sufficient information in a format that aids them in making an informed enrollment decision

The document review, consumer data and enrollment stakeholder interviews all indicated many dually eligible individuals feel they do not receive enough information about the FAI prior to being passively enrolled. The document review revealed that mailed passive enrollment notices are typically the only communication enrollees receive prior to their passive enrollment. The federal Medicare-Medicaid marketing guidance actually prohibits Medicare-Medicaid plans from contacting individuals prior to their enrollment effective date through phone or text⁵², unless the state grants permission to the MMPs to do so. While most demonstration states allow MMPs to conduct welcome calls, the passive enrollment notices are the only *required* communication to dually eligible individuals prior to their passive enrollment. Having the passive enrollment notice serve as the only way dually eligible individuals find out about the FAI is problematic for several reasons, described in more detail below. For participants who remembered receiving the passive enrollment notice, some described it as confusing and hard-to-understand. Lastly, the majority of participants shared that their preferred way to receive information was to speak with a person about it, rather than receive written information through the mail.

Most participants shared they did not remember receiving the passive enrollment notice, and found out about the FAI after they were enrolled in it.

“For myself, my wife and I turned 65 this year. And prior to turning 65, we were under Medicaid. So, when we turned 65, we were switching to Medicare. We had made some calls to Medicare, just the toll-free number, and we happened to be in a conversation with the Medicare agent and all of a sudden, the Medicare agent indicated, ‘Well, you guys are automatically enrolled in [the FAI].’ And we said, ‘Well, what’s that?’ And she really couldn’t give us a good answer. And so, we opted out. To this day, I honestly still don’t understand the difference between turning MMAI on or off. I just figured off, maybe I’ll get some more paperwork or something, but I really don’t know what [the FAI] really does for people.”

— *Focus group participant*

⁵² See 42 CFR 422.2268, 42 CFR 423.2268. Medicare Communications and Marketing Guidance CY2019. Available at: <https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines>. All four of the FAI states we researched allow MMPs to conduct welcome calls but prohibit contact with prospective enrollees through email. For example, California’s marketing guidance explains, “plans may use reasonable efforts to contact current non-MMP enrollees who are eligible for MMP enrollment to provide information about their MMP products. Calls with questions about other Medicare program options should be warm-transferred to 1-800-MEDICARE or to the Health Insurance Counseling and Advocacy Program for information and assistance.” See also Section 40.3 - Marketing Through Telephonic Contact, Final Contract Year 2020 Marketing Guidance for California Medicare-Medicaid Plans. April 2019. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CAMarketingGuidanceCY202008292019.pdf>. The Illinois, Massachusetts and Ohio 2020 Marketing Guidances all provide the same text, except they direct plans to warm transfer enrollees to “1-800-MEDICARE or to the State Health Insurance Assistance Program for information and assistance.”

Our research confirmed that not only do dually eligible individuals feel they do not receive enough information about the FAI, but enrollment stakeholders shared that dually eligible individuals also receive an overwhelming amount of marketing mailings from Medicare Advantage plans.⁵³ In particular, several factors contribute to an environment in which dually eligible individuals receive too little information about the FAI and too much information about non-integrated (or not fully integrated) options such as Medicare Advantage plans, D-SNPs, or D-SNP look-alikes.⁵⁴ One interviewee explained FAI enrollment is at a disadvantage compared to other Medicare plans because MMPs do not market themselves in the same way Medicare Advantage plans do (and overall, the Medicaid program does not advertise itself in the same way the Medicare program does). This may lead dually eligible individuals to believe non-integrated options are their only or best option. Others noted insurance agents and brokers can receive commissions for Medicare Advantage enrollments, but not for MMP enrollments, which may also contribute to an environment in which individuals are more likely to receive information about non-integrated products and less likely to receive information about the MMP. This lack of symmetry in information makes it hard for dually eligible individuals to fully understand their integrated care options, which in turn, undermines well-informed decision-making. Moreover, as mentioned above, because the passive enrollment notice is the only proactive communication dually eligible individuals receive about integrated care, it often cannot “cut through the noise” of the large amounts of advertising about non-integrated care.

3. The passive enrollment process does not sufficiently inform dually eligible individuals that their health coverage is changing, which can then lead to disruptions in care that cause them to opt out

Overall, a strong theme from the focus group and interview participants is that they place significant value in making their own decisions about enrollment, rooted in a concrete understanding about whether a particular plan will meet their needs. The majority of focus group participants did not support a policy in which a person or entity other than themselves could make a health coverage enrollment decision on their behalf. For some individuals, the passive enrollment process prevented them from finding out that their health coverage was about to change, and therefore they were not always able to determine whether or how the change would impact them until after it had taken place, sometimes not until they visited a provider or pharmacy and were told they could not be seen or their prescription could not be filled. Several participants shared alarming stories about not being able to access needed providers and medications as a result of passive enrollment:

Quotes from focus group participants:

“It was a completely inappropriate fit. I could not see the doctor I wanted to see and it was aggressively preemptive and didn't serve my needs at all and caused an enormous amount of headache to get disenrolled from. Who could know better than yourself which plan you want?”

⁵³ Quote from a national health policy expert: “It’s a tricky universe to navigate, [Medicare Advantage plans] can do mass marketing in your area. So, you could very well be getting some sort of flyer in the mail or a postcard or you could be seeing a TV ad or somebody could come to your senior center and give a presentation to everybody at the senior center including duals and non-duals.”

⁵⁴ D-SNP lookalikes are Medicare Advantage plans that are aggressively marketed to dually eligible individuals even though they don’t integrate or coordinate any Medicaid benefits and have no obligations to comply with any federal rules regarding offering integrated care plans to dually eligible individuals. Instead, they typically offer a premium for Part D, a high Part D deductible and the highest out-of-pocket limit on part A and B services allowed by the federal government. They generally offer supplemental benefits that are not fully covered by Medicare or Medicaid, such as dental, vision or transportation and are generally marketed to dually eligible individuals because this population is protected from paying out-of-pocket costs themselves due to participation in programs like the Medicare Savings Program and Low-Income Subsidy Program.

Quotes from focus group participants (continued):

“I did feel like I had a choice. It was just that I had to free myself from somebody who made that choice for me and that was complicated and difficult. I did have to go, for I think it was two months, without medications because of it.”

“The same thing with medication. It was a delay, a hold up and everything until everything got situated because you would go to the pharmacy and then you're not in the system and then when you bring them the card, it was just a real... It wasn't good, I'll put it that way. It was just like backwards and forwards, backwards and forwards. For the people that are on medication and they really need the medication, to even hold off two to three days, sometimes even four to five, that was very difficult.”

In contrast, some enrollment stakeholders, primarily government officials and health plan members⁵⁵, viewed passive enrollment as a critical tool to ensure the FAIs had enough individuals enrolled to succeed and be financially viable. Our document review confirmed that monthly passive enrollment, particularly when combined with mandatory enrollment in the FAI for some or all Medicaid benefits, increased enrollment in the FAI in two of the target states.⁵⁶ In contrast, however, California decided to no longer use passive enrollment in 2016 due to the large amount of confusion it caused dually eligible individuals and the fact that certain counties had opt-out rates of 50 percent or higher.⁵⁷

Many enrollment stakeholder interviewees from consumer advocacy organizations⁵⁸ and direct service organizations, however, confirmed the views of the majority of dually eligible individuals we spoke with – that passive enrollment prevents individuals from having the opportunity to learn about the FAI and whether and how it might impact their care needs before being enrolled, which can then lead to disruptions in care. Specifically, these interviewees felt that passive enrollment fails to provide some of the factors dually eligible individuals identified as needing to make an informed decision. For example, by only mailing written material to individuals, the passive enrollment notice fails to provide individuals with information in the manner they'd most prefer to receive it – i.e., directly from a knowledgeable, trustworthy person. Furthermore, many individuals may not receive or open their mail, due to inaccurate contact information, housing instability issues, privacy or confidentiality issues (such as for survivors of domestic violence), or simply from throwing away or not opening mail they do not anticipate receiving. Even if and when individuals open their passive enrollment notice and read it, they may find it confusing given the length, the technical and complex language, their potential lack of familiarity with the subject matter and sender, and the fact that the notice may not be written in their primary language. Therefore,

⁵⁵ Quote from a health plan staff member: “To be passively enrolled is to say, ‘I got a notice and did nothing about it.’ So, what I like about the passive approach is it shines a spotlight on the people who I think need the most attention, and it allows us an opportunity to bridge that gap and show the members “Hey, we're here. We care. We want to help. If you want our help, we're willing to help. If you don't, it's okay. No pressure. And so, what I like about passive enrollment is it does pick up members who may not otherwise understand that they'd be eligible for this program, and it secures their future needs so that, if and when that member does have an urgent or an emergent situation, they're already taken care of whether they realize it or not, from whether they choose to engage with us or not.”

⁵⁶ As mentioned previously in the report, Ohio's use of mandatory MyCare Ohio enrollment for Medicaid has been thought to have contributed to high enrollment throughout the state. In Illinois, the implementation of mandatory enrollment in MLTSS in July 2016, combined with monthly passive enrollment, helped stabilize enrollment in 2016. See footnote 24 at p. 21.

⁵⁷ See footnote 18 at p. ES-7.

⁵⁸ Quote from a consumer advocate: “It does seem like people, when they're passively enrolled, a good number of them find out after the fact. They don't read their mail because they get so much of it. So, when they find out they've been passively enrolled, they're very angry about it and they don't really have a desire to stay with the plan that they've been enrolled in or even check out another plan because they feel like... This is a quote I get often, ‘Why did this happen to me? What did I do to have this happen?’ They feel like they've done something wrong and that's why they've been enrolled in a managed care plan and they don't necessarily want to stay with that plan or any other because they're very upset.”

the passive enrollment process also prevents individuals, as well as their authorized representatives such as caregivers and legal guardians, from being able to review accessible materials and learn about the additional and supplemental benefits that the MMP they are being passively enrolled into offers. Overall, passive enrollment process fails to provide individuals with the opportunity to learn about the features of the FAI that are most important to them, and to learn about those features in the way they would most prefer, which is what they ultimately need to be able to make an informed decision.

4. There is no single entity adequately resourced to counsel dually eligible individuals about all of their integrated care options

As mentioned above, many participants expressed a desire to speak with a trustworthy, knowledgeable expert about their integrated care options, but felt that this type of person was not available to them. For example, many participants shared that they had trusted information sources they turned to, such as friends and family or their providers, but they also shared that these trusted sources often had limited information about their health plan options or the details of FAI plans. In contrast, while health plan staff members certainly have substantial information about their plan, their main motivation for offering this information to dually eligible individuals is to market their product, rather than provide comprehensive, impartial options counseling.

Our key informant interviews, as well as document and literature reviews, confirmed there is not a single designated entity or organization that is adequately resourced to provide information, counseling, and enrollment assistance about integrated care options. For example, the State Health Insurance Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs) receive funding from CMS to provide choice counseling, conduct outreach and provide education and assistance about the FAI. However, these programs are not trained to provide information and counseling about all integrated care options, which is the best way for someone to determine whether integrated care is right for them and if so, which type of integrated care and which integrated care plan is best for them. Additionally, each state FAI has its own ombudsman program, but these programs are intended to only serve individuals who are currently enrolled in the FAI, rather than eligible individuals who need assistance with enrolling.

Quotes from participants on wanting to speak with a trustworthy expert:

“A letter only says so much, and sometimes letters can be confusing, so it’s always best to have a conversation over the phone with a human who’s very knowledgeable, and who is professional, who really knows the program inside and out, and who can answer any question...and that didn’t happen.”

“It wasn’t an easy process and I wish there was a dual eligible guru somewhere that you could call. That would have been great, but that person doesn’t exist.”

“There wasn’t really a go-to person for figuring this stuff out, and there still really isn’t.”

5. What dually eligible individuals view as the benefits of integrated care are not well known to the individuals designing integrated care plans

Our research uncovered notable differences among stakeholders about the benefits of integration. For example, enrollment stakeholders such as government officials and national health policy experts in our key informant interviews mentioned care coordination as the main benefit of integrated care, or as the main difference between integrated care and non-integrated care. However, for dually eligible individuals, access to a new type of provider they were unfamiliar with, such as a care coordinator, was not nearly as important to them as being able to maintain access to the providers with whom they already had relationships and/or may need to use to manage their health conditions.

As mentioned above, our consumer data identified the following as benefits of integrated care: 1) cost-sharing, such as not having to pay copayments for prescriptions; 2) access to supplemental or additional benefits; and 3) having one insurance card instead of two. Surprisingly, however, enrollment stakeholders who were interviewed and the reviewed literature seldom mentioned the same benefits dually eligible individuals stated were important to them – nor did they describe integration or the benefits of integration in the way that resonates with the concerns of dually eligible individuals. This finding suggests that when policymakers and health plans are designing benefits packages and other features of integrated care plans, they should be careful to include features that dually eligible say are important to them.

Research Question 2: What best practices could federal and state policymakers and health plans employ to increase participation in integrated care in a person-centered way?

Dually eligible individuals need a significant amount of information and a sufficient opportunity to digest that information to ensure an integrated plan is the right option for them. After analyzing what is truly important to dually eligible individuals and examining the reasons why enrollment policies are not fully addressing their priorities, we now offer several recommendations for ways policymakers could better incorporate what is most important to dually eligible individuals into enrollment policies and practices so that they can be more person-centered.

Table 2 below shows how each recommendation corresponds to a key enrollment factor and problem for dually eligible individuals.

Table 2. Person-Centered Enrollment Recommendations Based on Findings

Key Enrollment Factor for Dually Eligible Individuals	Recommendation
The ability to continue seeing the providers they need to maintain their health	The federal government should enact policies to help dually eligible individuals maintain access to their providers, such as requiring: 1) state to evaluate opt out rates due to provider access issues 2) MMPs to address provider access issues before they can participate in ongoing passive enrollment, and 3) a one-year continuity of care period for managed care integrated care plans.
The opportunity to make an informed decision after reviewing accessible resources	The federal government should establish a resource hub, in consultation with states, which gives clear, comprehensive information to dually eligible individuals about their options and connects individuals to a trained expert.
	The federal government should require all outreach and education materials, including passive enrollment notices, to be available in the primary languages spoken in the demonstration counties, as well as contain the contact information for the resource hub.
The opportunity to speak with a knowledgeable person	State Medicaid agencies should designate and train certain community-based organizations to be integrated care enrollment assistance entities.
The potential to receive additional or supplemental benefits	States and health plans should use messaging that incorporates the benefits of integrated care that dually eligible individuals have identified as important to them.

Recommendation 1: The federal government should enact policies to help dually eligible individuals maintain access to their providers, such as requiring: 1) states to evaluate opt-out rates due to provider access issues; 2) MMPs to address provider access issues before they can participate in ongoing passive enrollment, and 3) a one-year continuity of care period for integrated care plans so dually eligible individuals can maintain access to all of the providers they need to have the full scope of their complex health and social needs met

As mentioned above, the ability to continue seeing the providers they need to address the full scope of their health and social needs was perhaps the most important factor to dually eligible individuals when deciding whether to enroll or stay enrolled. Focus group participants in the formal FAI evaluations mentioned that the primary reasons they opted out were because they wanted to maintain access to providers they were currently working with who were not in the plan's network.⁵⁹ The evaluations also revealed that while some states collected data on that number of individuals who decide to opt out or disenroll from the FAI and their reasons for doing so, this type of data collection is not required of states.⁶⁰ Therefore, we recommend the federal government require states to collect data on the reasons why individuals decided to opt out or disenroll from the FAI. Additionally, because providers are commonly viewed as a trusted source of information by dually eligible individuals, states should conduct ongoing outreach to providers as well as early outreach when any new integrated care products are introduced. Early outreach and education can influence both provider decisions to stay in-network and provider conversations with potential enrollees.

Collecting and reporting opt-out data can better help states determine whether individuals are opting out because they did not know enough about the FAI to determine whether they wanted to enroll, or whether they knew that enrolling in the FAI would mean losing access to a provider or benefit they currently have. If opt outs are occurring because of the latter, states and health plans can then use the data to identify gaps in provider networks and work to develop more robust networks that better meet the full scope of health and social needs of dually eligible individuals. Additionally, states can use this data to assess if there are any trends in provider access issues, such as particular plans experiencing high disenrollment rates due to their networks or particular providers that dually eligible individuals are having trouble accessing. States could also use this data to assess whether additional enrollment policies or protections need to be put in place to increase access to providers and ensure better access to care, such as stronger network adequacy or network management rules, or changes to intelligent assignment procedures. If a high number of opt out requests due to provider access issues are attributable to a particular plan, states should impose corrective action plans on these MMPs requiring them to improve their networks, and prohibit these plans from qualifying from ongoing passive enrollment unless and until they improve their provider network according to the terms of the corrective action plan.

In addition, we recommend the federal government offer a one-year continuity of care period to allow individuals the opportunity to continue seeing existing out-of-network providers after initially enrolling in an MMP. Many states only require MMPs to use a 90-day continuity of care policy,⁶¹ however, some enrollment stakeholders shared that the 90-day period of time was an insufficient amount of time to protect against care disruptions, particularly for individuals who were unaware they had been passively enrolled.⁶² A one-year continuity of care period may help prevent issues of care disruption after passive enrollment has taken place and give an adequate amount of time to make any necessary course

⁵⁹ See footnote 31 at p. 31. See footnote 18 at p. 43.

⁶⁰ None of the three-way contracts in any of our four target states require the reporting or assessment of opt out rates. Ohio's three-way contract contains the strongest language regarding the monitoring of opt outs, stating that "CMS and the ODM will monitor Enrollments, disenrollments and Opt Out requests for both evaluation purposes and for compliance with applicable marketing and Enrollment laws, regulations and CMS policies, for the purposes of identifying any inappropriate or illegal marketing practices. some states voluntarily collect and report opt out/disenrollment data." See MyCare three-way contract at p. 32, available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OHContract.pdf#page=32>

⁶¹ As of August 2016, California uses a one-year continuity of care period for Medicaid and Medicare providers. See footnote 14, available at: <https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf>

⁶² Quote from a direct service provider: "I just had a family member who was passively enrolled into [the FAI], has real complex care needs, significant PCA hours, but they only gave her a 90-day authorization... it was very, very, very concerning to that family to be passively enrolled into [the FAI] and then that fear that 90-day authorization was not going to cover what they were really going to need down the road."

corrections. A combination of robust data collection noted above with a one-year continuity of care period can potentially alleviate provider access issues as well as help integrated care plans better meet the needs of dually eligible individuals.

Recommendation 2: The federal government should establish a resource hub, in consultation with states, which gives clear, comprehensive information to dually eligible individuals about their options and connects individuals to a trained expert

To support dually eligible individuals' informed decision-making, we recommend the federal government establish a resource hub that includes an interactive website and toll-free hotline in which individuals, their caregivers and other trusted sources can learn about integrated care, its benefits and the available plan options. The hub should offer information in ways that take into account the accessibility needs and preferences of this population. For example, the hub should offer written resources in languages other than English, in accessible font sizes and in alternative text formats. Additionally, a toll-free telephone number should be made available, similar to 1-800-MEDICARE, for dually eligible individuals who do not regularly use the Internet.

Currently, some tools are available to learn about integrated care and compare options, such as MyCareMyChoice.org, but there is no federally resourced and managed "one-stop-shop" location where dually eligible individuals can learn about what integrated care is and how and why it may benefit them, as well as enable them to compare options and enroll in coverage. For example, an ideal resource hub would help dually eligible individuals learn about which integrated care option might be best for them based on their health needs, such as the "Find My Care" feature of MyCareMyChoice.org.⁶³ The hub would also allow dually eligible individuals to compare plan options available to them in their region and enroll directly in coverage, such as the Medicare plan finder on Medicare.gov.⁶⁴ Additionally, the hub would also provide a hotline individuals can call so they can speak with or be referred to a knowledgeable, trustworthy expert on integrated care (more details on who can serve as the trusted expert below). Overall, we recommend the creation of a resource hub that builds on and combines evaluated elements of the tools that are currently available to help dually eligible individuals learn about their integrated care options.

Recommendation 3: State Medicaid agencies should designate and train certain community-based organizations to be integrated care enrollment assistance entities

In conjunction with the above recommendation, states should contract with community-based or direct-service organizations to provide enrollment assistance and options counseling to dually eligible individuals about *all* integrated care options available in a state, so that dually eligible individuals can not only receive this type of information in the first place (especially when offered in conjunction with the hub), but also in the way they would most prefer. To determine which organization in a state should be a dedicated enrollment assister, we recommend states conduct assessments of local entities (e.g., through a formal request for information or proposal process) that work most closely with dually eligible individuals. These entities might include advocacy organizations (such as disability rights organizations and advocates serving low-income older adults), state-based entities (such as SHIP programs, FAI ombudsman programs, long-term care ombudsman programs, Aging and Disability Resource Centers, independent living centers, Area Agencies on Aging, etc.), community-based organizations and service providers (such as senior centers), and others that may be providing information, services and other

⁶³ The MyCareMyChoice tool, through funding from the Administration for Community Living, is being expanded to three additional states, more information available at: <https://acl.gov/news-and-events/announcements/national-center-benefits-outreach-and-enrollment-awarded>. There will be an evaluation of the tool in all of the three expanded states. The tool is available at <https://www.mycaremychoice.org/en/find-my-care>.

⁶⁴ Medicare Plan Finder. Available at: <https://www.medicare.gov/plan-compare/#/?lang=en&year=2021>

supports to dually eligible individuals. Once the entity is selected, the federal government should provide a national, uniform training and certification program for these entities, as well as ongoing training and technical assistance to ensure there is uniformity and consistency in how the service is being provided.⁶⁵

Although designating an organization as an enrollment assistance entity will create a knowledgeable expert, it does not automatically mean dually eligible individuals will view the entity as “trustworthy”. Therefore, the federal government should also provide additional funding to help conduct outreach and public education about the enrollment assister entities and its services, to help build that trust over time. The enrollment assistance entity should also be required to and receive adequate funding to provide information and counseling in all of the prevalent or threshold languages spoken in a state. Lastly, the enrollment assistance entity should be funded to meet and partner with other key stakeholders that interact with dual eligibles such as, the state SHIP program, Aging and Disability Resource Centers, Long-term Care ombudsman program and/or FAI ombudsman (if the enrollment assister ends up being an entity separate from these) so the different entities can learn from one another on ongoing basis.

Recommendation 4: The federal government should require and provide funding to states for all outreach and education materials, including passive enrollment notices, to be printed in all accessible language formats (including primary languages, Braille, large print, alternative texts) used in the demonstration counties as well as contain the contact information for the resource hub/enrollment assister

We recommend the federal government implement policies to make all enrollment notices more clear and consumer-friendly. Specifically, to make the enrollment process more equitable for all dually eligible individuals, we recommend the federal government require states to print and disseminate all written materials in all threshold languages, rather than only providing taglines in non-English languages informing individuals about how they can access translated materials or interpreter services. Our document review revealed that California reported disproportionately high opt-out rates of individuals whose primary language was not English – for example, in Los Angeles County, individuals who identified as speakers of Farsi, Armenian, Hebrew and Russian opted out at rates ranging from 82-94 percent.⁶⁶ Currently, the state-specific marketing guidelines for all four target states require MMPs to make translations of “vital”⁶⁷ materials available in “threshold” or “prevalent” languages spoken in each state, typically defined as languages spoken by five percent or more of the population within an MMPs service area,⁶⁸ but states are viewed as “making this material available” so long as MMPs have a process

⁶⁵ There is also a role for philanthropy to play in cultivating the development of an enrollment assister entity for integrated care, such as by funding the development of other trainings, materials and technical assistance opportunities for the enrollment assister entity. Philanthropy can also play a role in convening a forum for current community-based organizations who provide integrated care enrollment assistance in order to share information, learn from one another, and for these entities to provide feedback to states, health plans and the federal government on enrollment in integrated care.

⁶⁶ See footnote 18 at p. 41.

⁶⁷ Section 30.3 on the 2019 Medicare Communications and Marketing Guidelines. September 2018. Available at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY2019-Medicare-Communications-and-Marketing-Guidelines_Updated-090518.pdf

⁶⁸ Illinois, Massachusetts and Ohio use the “prevalent” standard, defined as “Spanish and any language that is the primary language of five (5) percent or more of households of Medicaid managed care enrollees in the plan’s service area.” See Section 30.3 of the Final Contract Year 2020 Marketing Guidance for Illinois Medicare-Medicaid Plans. August 2019. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/ILMarketingGuidanceCY202008222019.pdf>. See also Section 30.3 of the Final Contract Year 2020 Marketing Guidance for Massachusetts Medicare-Medicaid Plans. August 2019. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MAMarketingGuidanceCY202008232019.pdf>. See also Section 30.3 of the Final Contract Year 2020 Marketing Guidance for Ohio Medicare-Medicaid Plans. August 2019. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/OHMarketingGuidanceCY202008292019.pdf>. California, in contrast, requires that “translated written informing materials must be provided to all monolingual or limited English proficiency members that speak the languages identified for the Department of Health Care Services for the managed care plan’s service area.” Available at: <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2017/APL17-011.pdf>

through which enrollees can request these materials,⁶⁹ and operate a call center that offers interpreter services.⁷⁰ As discussed above, providing information about passive enrollment only through the mail is already ineffective and insufficient for many reasons discussed above. Therefore, requiring individuals to call a phone number to be able to understand the content of the notice adds an additionally unfair, ineffective barrier.

MMPs were also previously required to comply with provisions of Section 1557 of the Affordable Care Act regarding providing a tagline in threshold languages informing individuals about the availability of interpreter and translator services in their primary language on certain communications materials.⁷¹ However, due to recent policy changes regarding Section 1557, the Medicare-Medicaid Coordination Office released a memo in August 2020 stating that MMPs were no longer required to comply with the sections of marketing guidelines referencing Section 1557.⁷² We therefore request that MMCO reverse this policy and re-institute previous requirements.

Additionally, we recommend the federal government collect data on the languages spoken by and communications methods (such as Braille, alternative text formats such as digital readers, large fonts, etc.) used by dually eligible individuals at the time they are identified for passive enrollment so that states can be sure to send individuals materials in their primary language. We also recommend the federal government conduct ongoing evaluations on whether notices and other written materials are truly accessible to dually eligible individuals, and use these findings to determine whether and when states should receive approval to tailor the content of written materials. If states receive approval to alter their passive enrollment notice or other written materials in some way, they should be required to conduct a certain amount of public education about the change before sending revised materials directly to dually eligible individuals. For example, states should be required to test notices, host multiple meetings with and send multiple communications to stakeholders about the changes so that there are multiple opportunities to learn about the change, ask questions and provide feedback.

Lastly, the federal government should require states to make information about the resource hub and enrollment assister entity available on all communications, particularly the passive enrollment notice. Currently, the contact information for the FAI ombudsman program and FAI choice counselor (whether a SHIP, ADRC or other organization) is listed towards the bottom of the passive enrollment notice. We recommend moving this information closer to the beginning of the notice so that individuals are more easily informed that there are trained experts available to provide enrollment assistance. Overall, while improving the content of written materials is certainly an important step in improving and increasing the opportunities for dually eligible individuals to learn about integrated care, it is not sufficient for several reasons discussed above, namely that dually eligible individuals prefer to receive information and counseling regarding their health coverage options from a person, rather than written material. Therefore, we believe that providing contact information for an enrollment assister organization more prominently on the notice, in addition to printing and sending all written content in threshold languages other than English to the dually eligible individuals who speak them, are two of the more person-centered changes that could be made to written materials for dually eligible individuals.

⁶⁹ See above footnote.

⁷⁰ Medicare Communications and Marketing Guidelines. September 2018. Available At: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY2019-Medicare-Communications-and-Marketing-Guidelines_Updated-090518.pdf

⁷¹ See footnote 68.

⁷² State-Specific Marketing Guidance and Model Materials for Medicare-Medicaid Plans and Minnesota Senior Health Options Plans for Contract Year 2021. August 2020. Available at: <https://www.cms.gov/files/document/mmpmshomembermaterialsmktgguidancememocy2021.pdf>

Recommendation 5: States and health plans should use messaging that incorporates the benefits of integrated care that dually eligible individuals have identified as important to them

We recommend that states and health plans promote the benefits of integrated care that dually eligible individuals identified as important to them through our consumer data, specifically: 1) cost-sharing information 2) access to supplemental or additional benefits, and 3) having one insurance card instead of two. When states, health plans and the enrollment assister entity communicate with dually eligible individuals, they should be sure to mention these benefits rather than what stakeholders and policymakers think may be the true benefits or appeal of “integration.” For example, when health plan staff members conduct “welcome calls” to individuals who are about to be passively enrolled into their plan, or when the designated enrollment assister conducts outreach to dually eligible individuals, they should be sure to highlight – as applicable – the ability to continue to seeing their providers and the potential to receive additional or supplemental benefits, two key person-centered factors influencing enrollment. These elements of integrated care should also be emphasized in materials communicating with dually eligible individuals, which will ultimately make them more effective.

CONCLUSION

An enrollment model in which dually eligible individuals have access to sufficient information that allows them to choose an integrated care plan that will meet their needs, and are provided with the opportunity to speak with a knowledgeable, trustworthy expert prior to their enrollment, would substantially improve the current enrollment strategies for integrated care by making them more person-centered. Overall, if policymakers want dually eligible individuals to enroll in integrated care, they should design enrollment policies, communications materials, benefits packages and provider networks that are truly reflective of and responsive to the needs and preferences of dually eligible individuals.

APPENDIX 1

Person-Centered Enrollment Strategies for Integrated Care Key Informant Interview Guide

Template Introduction:

Hi,

Thank you for taking the time to speak with me today. [provide name, role, and some background if interviewee is new to you and to the Center].

I would like to share some background about the project with you and then go into some of the questions that I have for you today. Does that sound ok? [wait for any response, clarifying questions]

The purpose of our project is to identify successful strategies to support enrollment in integrated products serving dually-eligible individuals, particularly in the Financial Alignment Demonstration. We want to hear your perspectives on things that have worked well and as well as challenges that may have made it less likely for consumers to enroll in integrated products or to stay enrolled.

We are primarily focusing on experiences in CA, IL, MA, OH [for national stakeholders: “but if you are aware of important examples/experiences from other states we would also be interested in learning about those”]. In addition to key informant interviews like this we are also doing consumer focus groups and a document review.

The final product of this project will be a white paper and toolkit with recommendations for outreach, education and enrollment in plans and programs serving Medicare-Medicaid enrollees. We will be sure to share the final report and toolkit with you.

Do you have any questions about the project?

This interview should last no more than one hour. We do not intend to attribute comments to specific individuals. We may quote you, but if we use your name or give information that may be used to identify you (your role, for example), we will check back with you first. If there is anything that you would like to share but not have it be attributed to you, please let us know, and we will respect your wishes. You will have a chance to see the final report before it is released.

I would also like to record this interview for notetaking purposes. Do I have your permission to record this interview?

Do you have any questions for me before we begin?

Domain	Key Questions	
	National Stakeholders	State Stakeholders
Warm up/ introductory questions	<p>How have you been involved with the Financial Alignment Demonstration?</p> <p>How have you been engaged specifically around issues of enrollment and uptake in the Demonstration?</p>	<p>What is your role within the organization?</p> <p>How long have you been involved with the Financial Alignment Demonstration?</p> <p>What specific aspects of your work connect to enrollment? [Directly or indirectly]</p>
Enrollment Policies Key areas: <ul style="list-style-type: none"> • Voluntary vs. passive enrollment • Phased enrollment • Opt-out opportunities • Medicaid deeming (this can be probed in the conversation depending on if the state had a deeming policy in place) 	<p>What factors were considered when developing the various enrollment policies in the demonstration? What feedback would you hear from states and health plans? [question geared towards federal officials and some policy experts]</p> <p>Were there any policies that you observed in the Demonstration related to enrollment that were particularly beneficial/not beneficial?</p> <p><i>Optional question, if there is time:</i> Can you talk about the trends you see in enrollment policies in different integrated programs and how they compare to the policies in place for the demonstration? [question geared towards researchers and policy experts]</p>	<p>Tell us about the key enrollment-related policies in your state’s demonstration.</p> <p>From your perspective, what was the impact of enrollment policies in beneficiary participation/experience in the demonstration? [ask about each of the key areas, as appropriate]</p> <p><i>Prompt if needed:</i> Were there any policies that you observed related to enrollment that were particularly beneficial/not beneficial?</p> <p>What was your experience with/ observation of the impact of passive enrollment on beneficiary retention?</p> <p><i>Prompt if needed:</i> Were there features of the passive enrollment policy that made it more or less successful? [question in particular for state officials and health plans]</p> <p>To your knowledge, did you observe any particular patterns that emerged from those who opted-out versus opted-in?</p> <p>What other enrollment policies were important in your state? (for example, in IL—ask about MIPAA)</p> <p><i>[for state officials and health plans in CA and OH]</i> How did the rollout of simultaneous MLTSS programs impact enrollment?</p>

Domain	Key Questions	
	National Stakeholders	State Stakeholders
<p>Enrollment Brokers</p> <p>Key areas:</p> <ul style="list-style-type: none"> • Quality of broker-provided services • Availability and consistency of information • Accessibility of broker-provided services, including language access • Quality of broker training in engagement of the target populations 	<p>How did enrollment brokers impact program uptake? [could probe federal officials, particularly at ACL, what they would hear from states and if there were any common themes]</p>	<p>What role did enrollment brokers play in the enrollment process in your state? [enrollment broker such as Maximus]</p> <p>How did enrollment brokers impact program uptake? [important question for state officials, in particular]</p>
<p>Beneficiary Communications</p> <p>Key areas:</p> <ul style="list-style-type: none"> • Beneficiary notices, messaging, outreach by states • Marketing and outreach strategies by health plans 	<p>What best practices have you observed over the course of the program across the demonstrations when it came to communicating with beneficiaries? What challenges were faced? What was surprising? Not surprising?</p>	<p>What best practices have emerged over the course of the program when it came to communicating with beneficiaries? What challenges were faced? What was surprising? Not surprising?</p> <p>Are there unique marketing strategies either you employed or are aware of that influenced beneficiary enrollment/retention/experience? [question more for health plans and states]</p> <p>Can you share your outreach and education strategies used for beneficiaries? For providers?</p>
<p>Managed Care Environment</p> <p>Key areas:</p> <ul style="list-style-type: none"> • Perception of managed care • Penetration of other integrated products and managed care generally • Role of insurance brokers 	<p>How do the presence of other integrated care programs (e.g. D-SNPs, Medicaid Managed LTSS) impact enrollment and retention into the demonstrations?</p> <p>What role did insurance brokers play in influencing beneficiaries' decisions to enroll in an integrated product?</p>	<p>Help us understand the managed care environment in your state. How common are Medicaid and Medicare managed care products? How is managed care perceived?</p> <p>How do the presence of other integrated care programs (e.g. D-SNPs, Medicaid Managed LTSS) in your state impact enrollment and retention into the demonstrations? How were beneficiaries educated/aware of the various integrated programs?</p> <p>What role did insurance brokers play in influencing beneficiaries' decisions to enroll in an integrated product? [probe about look alike D-SNP plans]</p>

Domain	Key Questions	
	National Stakeholders	State Stakeholders
<p>Medicare-Medicaid Plan Factors</p> <p>Key areas:</p> <ul style="list-style-type: none"> Options available in demonstration regions Provider networks/provider buy-in Prior plan experience, particularly in long-term services and supports Plan benefits Plan approach to engaging consumers Frontline provider relationship with beneficiary 	<p>One could imagine that there are lots of different characteristics of plans that might make beneficiaries more or less likely to enroll, including things like plan reputation, networks, approach to engaging consumers. Which characteristics do you think are most important when it comes to beneficiaries' decisions to enroll or not to enroll with a plan?</p> <p>There are also features that are outside of the control of plans, such as the benefits offered in the demonstration. Were there features that you saw that made enrollment more or less attractive for beneficiaries?</p> <p>How would you design the plan requirements and responsibilities differently today given your experience to date?</p>	<p>One could imagine that there are lots of different characteristics of plans that might make beneficiaries more or less likely to enroll, including things like plan reputation, networks, approach to engaging consumers. Which characteristics do you think are most important when it comes to beneficiaries' decisions to enroll or not to enroll with a plan?</p> <p>There are also features that are outside of the control of plans, such as the benefits offered in the demonstration. Were there features that you saw that made enrollment more or less attractive for beneficiaries?</p> <p>How would you design the program differently today given your experience to date? What are the factors that would influence beneficiary participation and improve beneficiary experience?</p>
<p>Beneficiary Attitudes and Health Factors</p> <p>Key areas:</p> <ul style="list-style-type: none"> Health and functional status Attitudes toward managed care Relationship with providers 	<p>Across the demonstrations, are there factors that you believe played a role in enrollment and retention? [probe key areas]</p>	<p>In your state, did you see any differences in enrollment patterns between different beneficiary demographic groups (i.e. over/under 65, LTSS users, etc.) or by health status or other factors?</p>
<p>General Questions for national and state stakeholders</p>	<p>Are there factors that you think are important that we did not talk about today?</p> <p>What are the factors that you think are most important for us to explore in our focus groups with beneficiaries?</p> <p>Are there other best practices/emerging practices related to consumer experience with enrollment that you have not yet mentioned? These could be from the demonstrations or from experiences with other integrated products.</p> <p>Who else should we speak with?</p>	<p>Are there factors that you think are important that we did not talk about today?</p> <p>What are the factors that you think are most important for us to explore in our focus groups with beneficiaries? Do you have any burning questions that you'd like to have answered?</p> <p>Are there other best practices/emerging practices related to consumer experience with enrollment that you have not yet mentioned? These could be from the demonstrations or from experiences with other integrated products.</p> <p>Who else should we speak with?</p>

Thank you for taking the time to answer our questions. We appreciate your perspective. As I said in the beginning, we do not intend to attribute comments to specific individuals. We may quote you, but if we use your name or give information that may be used to identify you (your role, for example), we will check back with you first. If there is anything that you would like to share but not have it be attributed to you, please let us know, and we will respect your wishes. You will have a chance to see the final report before it is released.

If you have any follow up questions or comments, please feel free to reach out me.

APPENDIX 2

Person-Centered Enrollment Strategies for Integrated Care Focus Group Moderator's Guide

KEY

- Bold text indicates questions that are ONLY for groups in which participants are enrolled in the pilot / demo programs.
- Blue text indicates alternative questions for groups in which participants are not enrolled in the pilot programs.
- Further subdivisions within the text are indicated for opt-in versus opt-out states.

INTRODUCTION

Hello, thank you all for being here today! My name is [Name] and I'm going to be moderating today's conversation. My colleague, [Name], is also here to help and will be taking notes, and my colleague, [Name], will be handling any tech issues that arise. I'm a researcher hired by Community Catalyst, working with [host organization], to speak with individuals with both Medicare and Medicaid in your state to better understand your experiences with the combined Medicare/Medicaid health insurance, like **[State Specific Program Name]** health plan. The information we learn today will help us design health plan enrollment to be more person-centered. This focus group will take no longer than an hour and a half.

You've all been invited to participate today because you are enrolled in [State Specific Program Name] health plan for your health care.

You've all been invited to participate today because you are all eligible to participate in the [State Specific Program Name] health plan, but are not enrolled.

We will be conducting approximately 12 focus groups in the states of Massachusetts, Ohio, California and Illinois with up to 144 participants.

We want to understand what these plans look like from your perspective, which means there are no right or wrong answers to our questions. We just want to know what you think about your experience with the plan.

Before we get started, I want to share some information and guidelines about this discussion.

Your participation in this focus group is completely voluntary. You can end your participation in the focus group at any time, and you are free to decline to answer any question you don't feel comfortable answering. To respect the privacy of your fellow participants, please do not repeat what is said in the focus group to others. Additionally, your participation in this research is confidential. This means that any information we collect as part of this project will not be published or shared in a way that means anyone could identify you. We are recording this focus group so we have an accurate record of what will be discussed, but it will not be shared with anyone outside of our project team.

We'll be discussing the following topics:

- Making decisions about health and health insurance plans
- What information we've heard about health insurance plans
- Times when we've switched plans, and the things we've been thinking about
- Things that are important to us about health plans
- Any suggestions for improvements you may have about health plans

Following the focus group, you will each receive a \$125 gift card, to compensate you for taking the time to speak with us today. Whatever you share with us today will in no way impact your health care services. We do not anticipate any risks to you for participating in this project, nor any direct benefits to you other than the gift card. Does anyone have any questions? [pause] Do you consent to participate today? [pause] Thank you very much.

Domain	Question
Warm up / Ice breaker	1. We're going to start with a fun question to get to know each other a little. We're going to go around and ask each of you to introduce yourself and share one thing that made you smile in the past week. I'll start.
<p>What messages people have heard about the demonstration and integration, and from whom/where?</p> <p>Note: this intro text is a normalizing statement, to help people know that this isn't a quiz, and it's both okay and helpful for us to understand if they don't know something.</p>	<p>We're interested in understanding the ways that the [State demonstration plan] has been successful in getting information out to the public. I know you receive a lot of information from a variety of sources, and so it's possible you know certain information but don't remember exactly how you learned it. That's totally fine. It's helpful to us to understand whatever you can recall about your enrollment experience.</p> <p>2. Thinking back to when you first learned about [state demonstration plan], what did you understand about how this program was different from your existing health insurance program?</p> <p><i>[If it hasn't already come up]</i> [State Specific Program Name] health plan allows you to get Medicare + Medicaid benefits together in one plan. What does that mean to you?</p> <p>Probe: How did you learn about the program? How did you get information about the program? How easy was it to find information about the program? Do you remember receiving notices?</p> <p>3. When you were making your enrollment decision, if you had questions, who would you turn to for advice and information?</p> <p><i>If needed, probe:</i> If you had questions about [state demonstration plan], were you able to get them answered before joining?</p>
Before integration	<p>4A. As a reminder, you are all here because you are right now enrolled in [State Specific Program Name] health plan. I will have some questions for you about that in a while, but I first want to ask you about BEFORE you were enrolled in this plan. Before [State Specific Program Name] health plan, can you tell me about the health program you previously used, and how you feel that worked?</p> <p>4B. As a reminder, you're here because you are eligible for [State Specific Program Name] health plan that combines Medicare/Medicaid, but have opted-out. I want to ask you some questions now about what it is like to use two separate plans for your health care coverage. How do you feel that works?</p>

<p>Before integration (continued)</p>	<p>Probe: What types of difficulties have you had with having Medicaid and Medicare benefits from separate from each other?</p> <p><i>If needed, probe:</i> For example, did you ever have a situation where :</p> <ul style="list-style-type: none"> • the two plans [state specific Medicare and Medicaid program names] didn't seem to be talking to each other? • you were trying to get coverage for a service, but one plan told you to talk to the other one, back and forth? • it took longer to receive a service or see a specialist because you had to go through two plans to get it approved? <p>Probe: What types of advantages have you seen by having those benefits separate from each other?</p> <p><i>If needed, probe:</i> For example, did you ever have a situation here:</p> <ul style="list-style-type: none"> • There was a doctor or other health provider you could only access through Medicare, or vice versa?
<p>Enrollment policy</p> <p>How did consumers perceive the choice of enrollment? What were the perceived alternatives, if any?</p> <p>10. Who made the choice, and was it perceived as a choice?</p> <p>11. How much did people consider alternatives? What worries were taken into account?</p> <p>This set of questions is customized for particular circumstances:</p> <ol style="list-style-type: none"> people who opted in; people who chose not to opt-in (or weren't aware of the choice); people who were passively enrolled and opted out; people who were passively enrolled and stayed in (or weren't aware of the choice). 	<p>I have some questions now about the enrollment process, and making switches to health plans. We are interested in understanding what people remember about recent switches. It's totally normal that sometimes switches get made to health plans and people don't always understand or remember them. I'm just interested in learning from you about what parts you remember or knew about.</p> <p>5A. (Opted in) In your state, there was recently [state specific time frame] an option to enroll in the [State Specific Program Name] health plan, and you enrolled. Can you talk about what you remember about how that switch happened?</p> <p><i>If needed, probe:</i> How did you first learn about it? Who made the decision? How much do you feel like you made a choice?</p> <p>5B. (Didn't opt in) In your state, there was recently [state specific time frame] an option to enroll in the [State Specific Program Name] health plan, and you did not enroll. Can you talk about how much you were aware of that option?</p> <p><i>If needed, probe:</i> How did you first learn about it? How much do you feel like you made a choice to not enroll?</p> <p>5C. (Opted out) In your state, [state specific time frame], people who were eligible for [State Specific Program Name] health plan were automatically enrolled, including you. There was then an option to switch back out of the health plan, and you did that. Can you talk about what you remember about how that switch happened?</p> <p><i>If needed, probe:</i> How did you first learn about it? Who made the decision? How much do you feel like you made a choice to opt out?</p>

<p>Enrollment policy (continued)</p>	<p>5d. (Didn't opt out) In your state, [state specific time frame], people who were eligible for [State Specific Program Name] health plan were automatically enrolled, including you. There was then an option to switch back out of the health plan, and you did not do that. Can you talk about what you remember about that switch? How much were you aware that you could have switched out again?</p> <p><i>If needed, probe:</i> How did you first learn about it? Who made the decision? How much do you feel like you made a choice to stay in?</p> <p>6A. (Opted in) <i>If applicable:</i> So a number of you were not aware of the switch in the moment. That's really helpful for us to understand, thank you! For those of you who were aware...</p> <p>[all] Could you talk about your understandings of the most important reasons for why the switch was made? <i>If needed, probe:</i> How much did you consider other choices? What were those other choices? What was the most important factor in making the decision? What worries did you have about the new plan? <i>If needed, probe:</i> How confident do you feel in the choice of enrolling?</p> <p>6B. (Didn't opt in) <i>If applicable:</i> So a number of you were not aware of the option to switch in the moment. That's really helpful for us to understand, thank you! For those of you who were aware...</p> <p>[all] Could you talk about your understandings of the most important reasons for why your plan was not switched? <i>If needed, probe:</i> How much did you consider switching? What was the most important factor in making the decision not to switch? What worries did you have about the new plan? <i>If needed, probe:</i> How confident do you feel in the choice of not enrolling?</p> <p>6C. (Opted out) <i>If applicable:</i> So a number of you were not aware of the switch in the moment. That's really helpful for us to understand, thank you! For those of you who were aware...</p> <p>[all] Could you talk about your understandings of the most important reasons for why the switch out of the plan was made? <i>If needed, probe:</i> How much did you consider remaining in the plan? What was the most important factor in making the decision to switch out of the plan? What worries did you have about the new plan? <i>If needed, probe:</i> How confident do you feel in the choice of switching out of [state specific program name] health plan?</p> <p>6D. (Didn't opt out) <i>If applicable:</i> So a number of you were not aware of the option to switch out of the plan in the moment. That's really helpful for us to understand, thank you! For those of you who were aware...</p> <p>[all] Could you talk about your understandings of the most important reasons for why you remained enrolled in the plan? <i>If needed, probe:</i> How much did you consider switching out again? What was the most important factor in making the decision to remain in? What worries did you have about the new plan? <i>If needed, probe:</i> How confident do you feel in the choice of enrolling?</p>
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<p>What do people feel about opt-in vs passive enrollment and opt-out?</p> <p>This set of questions is customized for particular circumstances:</p> <ul style="list-style-type: none"> a) people who opted in; b) people who chose not to opt-in (or weren't aware of the choice); c) people who were passively enrolled and opted out; d) people who were passively enrolled and stayed in (or weren't aware of the choice). 	<p>7A. So as we were saying, In your state, [State Specific Program Name] health plan allows you to make a decision whether to enroll in it, and you're here because you enrolled. In other states, there are plans that automatically enroll people who are eligible. If they don't want to be in it, they have to actively opt-out. What do you feel about people being automatically enrolled?</p> <p>7B. So as we were saying, in your state, [State Specific program name] health plan allows you to opt in, and you're here because you did not do that. In other states, there are plans that automatically enroll people who are eligible. If they don't want to be in it, they have to actively opt-out. What do you feel about people being automatically enrolled?</p> <p>7C. So, as we were saying, in your state, [State Specific program name] health plan automatically enrolls people who are eligible, and then people can take themselves out if they want to. You're here because you took yourself out. In other states, however, people are not automatically enrolled – they have to actively opt in to the plan. What do you feel about people being automatically enrolled, versus having to opt in?</p> <p>7D. So as we were saying, in your state, [State Specific program name] health plan automatically enrolls people who are eligible, and then people can take themselves out if they want to. You're here because you were automatically enrolled and are still in the plan. What do you feel about people being automatically enrolled, versus having to opt in?</p>
<p>What program design and delivery of care feature matters the most to consumers?</p>	<p>8. Thinking about what you want from a health insurance plan, (not your specific doctors or providers), what are the most important things that make you feel satisfied or unsatisfied with a plan?</p> <p><i>If needed, prompt:</i> These might be things like...</p> <ul style="list-style-type: none"> • My experience with a care coordinator or other representative of a plan; • How my plan communicates with me (such as by phone, text, email or direct mail) • being able to see my doctors (or a specific doctor); • other benefits such as vision, drug coverage, mental health and dental; • other health supports like in-home services; coverage for a specific treatment (such as a type of therapy or a particular drug); • the plan's customer service • Help with transition to new services, providers or coverage

Experience in the plan	<p>9. [For people enrolled only] Now that you are in the plan, can you talk about what your experience has been?</p> <p><i>If needed, probe: Did you have to switch doctors?</i></p> <p>10. If you've had questions about your plan, what did you do to try and get answers? How was that experience?</p> <p>11. Compared to before you were in this plan, when the plans were separate, how much is it easier or harder to get your needs met? <i>If needed, probe: For example, how much is it easier or harder to:</i></p> <ul style="list-style-type: none"> • Get questions answered? • Have problems solved? • Get appointments? • Access specialists? • Access interpreters if needed? • Access care coordinators? <p><i>If needed, probe: How does it compare to before in terms of</i></p> <ul style="list-style-type: none"> • Wait times? • Overall quality of care? • Cost?
Improvements	<p>12. We would love to hear your thoughts about ways to improve the system:</p> <p>What would need to change to make your coverage easier to use?</p> <p>How can we better communicate about enrollment to consumers?</p> <p>What other improvements do you think would be helpful?</p> <p>How could your health plan better support your community?</p>
Wrap-up	<p>13. Is there anything else you feel I should know that you haven't gotten a chance to say?</p>

Thank you very much for your participation!



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