The Dual Eligible Demonstration Projects: The Passive Enrollment Challenge

Introduction

In addition to the health coverage expansions and insurance market reforms contained in the Affordable Care Act (ACA), the law also launched many experiments aimed at changing the delivery and financing of health care. In particular, the law created the Center for Medicare and Medicaid Innovation (CMMI)[1] which is charged with testing "innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP…while preserving or enhancing the quality of care furnished."[2] One of CMMI's key target populations is those who are eligible for both Medicare and Medicaid benefits ("dual eligibles"). Dual eligibles represent one of the most medically vulnerable and costliest populations within both of those public programs.

Working together with another office created by the ACA, the Medicare-Medicaid Coordination Office (MMCO), CMMI is actively developing ways to restructure the delivery and financing of care for dual eligibles. These efforts are driven by two factors. First, the care many receive is uncoordinated, duplicative, and, as a result, often ineffective in terms of meeting individual needs. Second, state and federal budget pressures are compelling officials to search for better, more efficient ways to administer these essential public programs. In essence, CMMI and MMCO seek to achieve the highly-touted "Triple Aim" for dual eligibles: better health, better health care, and lower per capita costs.

In July 2011, CMMI created the Financial Alignment Demonstration under which states could use two financial models as the basis for a proposed demonstration project aimed at integrating care for dual eligibles.[3] One of the models uses a fully capitated approach in which the Center for Medicare and Medicaid Services (CMS), the state Medicaid program, and participating managed care plans enter into a three-way contract that will pay the plans a blended Medicare/Medicaid rate for each enrolled dual eligible out of which the plans will provide seamless, integrated coverage of all Medicare and Medicaid benefits and services. Of the twenty-four states with active proposals before CMS, seventeen states proposed using the capitated model. To date, two of those states—Massachusetts and Ohio—have completed negotiations with CMS, though a number of other states are known to be in active negotiations.[4] The demonstration projects are set to begin as early as April 2013.

While many stakeholders support the goals of the demonstration projects, there are significant concerns with the demonstration project designs.[5] One particular concern centers on the enrollment process. CMS explicitly permitted states to use passive enrollment. Passive enrollment means the dually eligible individual is automatically enrolled in an integrated care plan chosen by the state Medicaid agency *unless* —before the effective enrollment date—s/he

chooses to enroll in a specific plan or elects to remain in original Medicare.[6] This approach, which many states already use in their Medicaid program, is a departure for Medicare, which to date, has allowed beneficiaries to voluntarily opt-in—but has never passively enrolled them—into managed care plans.

This issue brief discusses the passive enrollment issue, the concerns for affected beneficiaries, the existence of viable alternatives to passive enrollment that might achieve the same goals and policy options that might mitigate beneficiary concerns. Although the demonstration design process is well underway, there are many design elements left to be decided. As the gateway to this new mode of care delivery and financing, the enrollment process will be pivotal to its success or failure.

Background

There are many excellent resources on the distribution and demographics of the dual eligible population, but we focus here on the ones relevant to the demonstration projects.

Only "full" dual eligibles will be targeted for demonstration enrollment. All 9.1 million of the dual eligibles in the country today are Medicare beneficiaries by virtue of the fact that they are either age 65 or older, *or* they are under age 65 and have a significant permanent disability. About two-thirds of duals are 65 or older, and the remaining third are under age 65. Low-income Medicare beneficiaries may also qualify for Medicaid benefits depending on state eligibility requirements, but the level of Medicaid benefit depends on the individual's income. The lowest-income individuals – about 7 million of the 9 million total – are eligible for full Medicaid benefits, which include such things as long-term care and some social and other supportive services not covered by Medicare. These individuals are *full* dual eligibles,[7] of which approximately 3 million live in states that have developed demonstration projects. [8]

Participating states can decide which segments of their dual eligible populations they want to include in their demonstration project. CMS will, for example, permit states to target all dual eligibles within the state, or they may choose to include only a subset, e.g. only the duals that are under or over age 65, only duals residing in a specific region of the state, only duals in long-term care, etc. It is anticipated that among the participating states, eligibility will range from about 20,000 dual eligibles in Wisconsin to 560,000 in California.[9] [10]

Dual eligibles are a diverse population in terms of need for—and use of —medical and non-medical services, but as a group they are poorer and sicker than Medicare and Medicaid beneficiaries who are not dually eligible. Population characteristics that may be relevant to the passive enrollment issue include the following:

- More than 60 percent have a mental or cognitive impairment.
- More than 20 percent need assistance with two or more activities of daily living (ADL) or instrumental activities of daily living (IADL).[11]

There is broad agreement among all stakeholders that these two groups in particular pose unique care delivery, management and social support challenges. At the same time though, it should be noted that as is the case for health spending generally, a relatively small group of dual eligibles—about 20 percent—account for nearly 60percent of spending on dual eligibles. In other words, a small group of dual eligibles use a lot of services, and others use relatively few.[12]

Very few dual eligibles are enrolled in health plans that integrate Medicaid and Medicare services and financing. Taken together, the Medicare and Medicaid programs provide a continuum of care and services that are, in theory at least, ideal to meet the needs of most dual eligibles. The problem, though, is that in addition to covering different benefits, the two programs have separate financing sources, medical necessity criteria, enrollment pathways, and administration. This has meant that dual eligibles often are required to navigate the health system on their own, with little coordination of, or accountability for, their care.

Up until now there has been little systematic effort to blend Medicare and Medicaid. The Program of All Inclusive Care for the Elderly (PACE), which became fully operational in 1990, represents the earliest integrated care experiment, but its enrollment is limited by eligibility requirements and program design. There are a handful of other small "legacy" integrated care plans[13] that resulted from extensive state/federal waiver negotiations, but as with PACE, enrollment is relatively small. In 2003, amendments to the Medicare law allowed for an expansion of Medicare Advantage – the Medicare managed care program – to include Special Needs Plans (SNPs). These SNPs are permitted to limit their enrollment to dual eligibles, institutionalized beneficiaries, or beneficiaries with specific types of chronic illnesses—e.g. diabetes, chronic obstructive pulmonary disease, etc. They are also now required to contract with state Medicaid programs to ensure better coordination across the spectrum of benefits and services. Again though, even this "enhanced" SNP model is essentially untried at the scale anticipated for the demonstrations.

A recent paper from the Kaiser Family Foundation examined studies of existing integrated care models and concluded, "generating modest net Medicare savings and better outcomes for dually eligible beneficiaries is possible, but will require tailoring, targeting and monitoring."[14]

The passive enrollment rationale

Government officials and health plan stakeholders believe the success of integrated care plan demonstrations depends, in large part, on maximizing dual enrollment as quickly as possible, and they view passive enrollment as the most workable approach for achieving this. Critical mass in these plans is perceived as necessary for four reasons:[15]

- **Savings:** Rapid scaling up is essential to produce near-term savings for both the Medicare and Medicaid programs. Savings are anticipated from better care coordination, and diversion from more costly care settings (e.g. acute care hospitals) to less intensive, community-based service provision.

- **Infrastructure:** High-volume enrollment (and the premium dollars it brings) is essential so health plans can invest in the infrastructure necessary to support the full spectrum of

benefits and a robust care coordination function, and also be able to exercise sufficient buying power in the marketplace so they can control costs and ensure a broad provider network.

- **Equitable Distribution:** Passive enrollment is necessary to ensure the highest-need dual eligibles are distributed equitably across health plans.

- **Evaluation:** Large-scale participation in integrated care plans is necessary so there can be a meaningful evaluation of the approach since the demonstration has only a three-year authorization.

It is not clear any of these rationales justify the use of passive enrollment, particularly for a population known to suffer from greater-than-average cognitive or mental impairments. And, in fact, experience has shown the approach has been highly problematic for this population in the past.

For example, in 2011, California instituted mandatory Medicaid managed care for its entire Medicaid-eligible population including seniors and persons with disabilities. Of the 240,000 affected individuals, 60percent had to be passively enrolled. A report on the transition identified a number of issues that could well be mirrored in the demonstration project enrollment process. Those issues, which were raised by a broad spectrum of stakeholders including consumer advocates, health plans, primary and specialty care providers, and human services agencies include, among others, insufficient outreach, complicated written materials, limited individual counseling, and the inability of health plans and providers to respond to beneficiary questions.[16]

Similarly, there were serious passive enrollment challenges in the transition of dual eligible beneficiaries' prescription drug coverage from Medicaid to Medicare Part D in 2006. Some 6 million dual eligibles, who previously had been receiving prescription drug coverage through Medicaid, were randomly enrolled in Part D plans. Many found some or all of their drugs were not covered by their new plan and/or their usual pharmacy sources were no longer available. Perhaps even more important, there turned out to be a substantial dollar difference between a randomly chosen plan and the lowest-cost plan.[17]

A better way

The Financial Alignment Initiative's goals could be achieved through the use of a voluntary, opt-in process that would allow the demonstration projects to grow at a rate that matches the capacities and competencies of the plans.

The best way to ensure robust enrollment in the demonstrations is to offer robust benefits and high quality health plans that are attractive to consumers because they meet consumer needs in ways the current system does not. For example, a plan that offers a member a trusted point person who knows them and helps them navigate the system, allows them to continue relationships with existing trusted providers and connects them with the supportive services they need to pursue their personal goals will be an attractive option for many dual eligibles.

But also key to a successful voluntary enrollment effort is a robust collaboration among state, advocates, health plans and providers. Together, these stakeholders can create a well-resourced marketing, outreach, education, and enrollment effort that offers beneficiaries a variety of good options and credibly makes the case that integrated care will be an improvement over the status quo. This will require attention to a number of critical details, including:

- The form and content of all state/CMS approved marketing materials must be both linguistically appropriate and adequate to inform individuals of their options and of available consumer assistance resources that can help them determine whether participation makes sense for them and, if so, select the plan that best meets their individualized needs.

- The state should contract with trusted community-based organizations, including local health and human services organizations that already work with the target populations, long-standing providers and peer supports, to conduct individualized choice counseling.

- The state should partner with advocacy organizations to train providers about how to talk about the demonstration with patients for whom it might be appropriate.

If the outreach and education are accurate, "high touch" and personalized, and if the messengers are appropriate ones, then substantial voluntary enrollment will follow and the "critical mass" imperative will be satisfied in a much more sustainable way.

Recommendations for mitigating passive enrollment concerns

If states do opt for passive enrollment, or if voluntary enrollment fails to yield adequate enrollment into plans that have satisfied key quality measures, they should consider using a mixture of possible alternatives. First, states could employ a hybrid approach and use voluntary enrollment in some geographic areas while using passive enrollment in others. This approach would permit a valid comparison among the two groups.

Second, states could begin with a six-to-nine month voluntary enrollment period before beginning passive enrollment.[18] Following this voluntary enrollment period, states could phase in passive enrollment, but only into plans passing readiness reviews demonstrating they have both the capacity and the competency to care for dual eligibles.[19] States could phase in enrollment in six-month increments, beginning with those who have less complex needs—for example, those requiring no LTSS—and then adding, as plans demonstrate readiness to take on new, and more complex, enrollees. This approach would enable health plans to identify and correct systems issues before the frailest duals are enrolled. A phased-in approach would also increase the chance that the required health assessment and the resulting care plan are thoughtful and meaningful.

In any passive enrollment scenario, states should adopt a set of strong consumer protections:

- The form and content of all notices must be adequate to inform individuals of their rights, including the right to opt-out of the project. It also should inform them of the timing of the process, and of available consumer assistance resources. Given the predominance of

cognitive limitations and frailty; low education level; and language barriers among the dual eligible population, the notices must be clear, accessible, and culturally and linguistically appropriate. The information must be addressed through a number of mediums and forums—such as letters, websites, meetings, and phone calls—all of which should be calculated to reach the target population. Once notified, beneficiaries must be given at least 90 days to make a choice among integrated care entities. And, states should contract with a variety of trusted community-based organizations, including those beyond Aging and Disability Resource Centers (ADRCs) and State Health Insurance Programs (SHIPs), to conduct choice counseling.[20]

- States must contract with a neutral entity to facilitate enrollment and provide comprehensive, accessible and culturally competent consumer assistance both pre- and post-enrollment. Using an independent third party will address the adverse selection concerns because it will not "steer" passive enrollees to a particular health plan solely because of health status or anticipated service needs. States must allocate sufficient resources to enrollment assistance and monitoring.

- Passive enrollment must be accomplished through an "intelligent assignment" process. This means that an explicit effort must be made to understand the beneficiary's current provider relationships as well as any LTSS needs. The plan selected for the beneficiary would be one that preserves existing provider relationships to the extent possible, and offers the services or supports that best meet the individual's needs, preferences and goals.

- There must be generous continuity of care and other transitional protections and supports. Given the magnitude of the undertaking, it is unlikely that beneficiaries—passively enrolled or not—will experience a completely seamless transition, so there must be contingency measures in place to facilitate transfers of care.[21] In particular, plans should maintain an open network provider system to contract with providers not currently in the network, and offer "single-case agreements" that allow members to continue seeing their existing provider while being reimbursed by the health delivery system, without arbitrary limits on their duration.

- Beneficiaries must be allowed to opt-out of the demonstration at any time, without being subject to a lock-in period.[22]

- Each state should create a demonstration oversight body or council that would monitor the demonstration's ongoing operations and those of the participating health plans. This body would have the authority to ask for and receive reports on relevant topics such as quality of care and financial performance. If systemic problems were identified, the oversight body could be empowered to demand corrective actions and to use other strategies such as the media and/or litigation.

Conclusion

As with most innovations, CMS' Financial Alignment Demonstrations offer both great opportunity and great risk. The appeal of passive enrollment is compelling as a mechanism for accelerating the adoption of an approach to care delivery and financing that could be a "win-win" all around. At the same time though, it will be employed with a population for whom there is very little margin of error where access to care is concerned. Given these risks and the overall lack of experience among plans in serving dual eligibles through an integrated approach, we conclude it would be preferable to launch these demonstration projects using a fully voluntary enrollment approach. However, in the event states continue to pursue the use of passive enrollment, it would seem that with adoption of the above recommendations—some of which are already being adopted by states that have finalized their Memorandum of Understanding with CMS—and with close monitoring of the roll-out, the potential benefits of the demonstration may in fact outweigh the risks.

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[1] CMMI is an office within the Center for Medicare and Medicaid Services (CMS).
[2] 42 U.S.C. 1315a.
[3] CMS Letter to State Medicaid Directors regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees (July 8, 2011) http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf
[4] A third state, Washington, has finalized a Memorandum of Understanding with CMS for its managed fee-for-service demonstration project.
[5] See, e.g., July 18, 2012 national organization sign-on letter to MMCO Director Melanie Bella, http://www.ncpssm.org/Portals/0/pdf/dual-eligible-demonstrations.pdf; June 27, 2012 sign-on letter to HHS Secretary Katheleen Sebelius http://www.communitycatalyst.org/doc_store/publications/Sebelius_duals_demo_projects_savings_letter_July2012.pdf.
[6] To date, the overwhelming majority of participating states have indicated they intend to use passive enrollment. See http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/Proposed-Enrollment-052412.pdf.
[7] The approximately 2 million low-income Medicare beneficiaries who are not poor enough to qualify for full Medicaid benefits nevertheless are eligible for Medicaid payment of their Medicare Part B premiums, as well as co-insurance amounts, but not for the other Medicaid benefits and services. These so-called "partial duals" are not eligible for participation in the integrated care demonstrations.
[8] Correspondence from the Medicare Payment Advisory Commission to Marilyn Tavenner, Acting Administrator of the Centers for Medicare and Medicaid Services dated July 11, 2012. http://www.medpac.gov/documents/07112012_MedPAC_Comment_CMS_demos_states_integratedcare_dualeligibles.pdf.
[9] All state proposals are available on the CMS Financial Alignment Initiative webpage. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.
[10] Presentation of Margaret Tatar, Medi-Cal Managed Care Division, Department of Health Care Services, National Academy for State Health Policy, Annual Conference, October 15, 2012. http://www.nashpconference.org/wp-content/uploads/2012/presentations/Arnquist.Duals.Precon.California.pdf

[11] ADLs refer to self-care activities such as feeding, bathing and dressing. IADLs refer to activities that allow a person to live independently in the community and include activities like housework, taking medications and managing money.

[12] *The Diversity of Dual Eligible Beneficiaries: An Examination of Services and Spending for People Eligible for Both Medicaid and Medicare,* Kaiser Family Foundation, April 2012. http://www.kff.org/medicaid/upload/7895-02.pdf.

[13] The three programs are Massachusetts' Senior Care Options Program, Minnesota Senior Health Options and the Wisconsin Partnership Program.

[14] See *Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence*, Randall Brown and David R. Mann. Kaiser Family Foundation http://www.kff.org/medicare/upload/8353.pdf.

[15] See e.g. *What's Best Enrollment Process for Dual Eligibles?,* California Healthline, January 12, 2012, http://www.californiahealthline.org/think-tank/2012/whats-best-enrollment-process-for-dual-eligibles.aspx; *Reform-Based Initiatives on Dual Eligibles Take Shape, Offering Big Potential for Plans*, Vol. 2 Issue 36 (November 21,2011). http://aishealth.com/archive/nref112111-02.

[16] *A First Look: Mandatory Enrollment of Medi-Cal's Seniors and People with Disabilities into Managed Care*, the California HealthCare Foundation, August 2012. http://www.chcf.org/~/media/MEDIApercent20LIBRARYpercent20Files/PDF/F/PDFpercent20FirstLookMandatoryEnrollmentSPD.pdf.

[17] *The Role of Beneficiary-centered Assignment for Medicare Part D*, a report prepared by Georgetown University for the Medicare Payment Advisory Commission, May 8, 2007. http://www.medpac.gov/documents/june07_bene_centered_assignment_contractor.pdf.

[18] Massachusetts and Ohio, the two states with approved demonstration projects using the capitated financing model, are each using a voluntary enrollment period, but they vary in terms of type and length. Massachusetts will begin a three-month voluntary enrollment period in July 2013, with two passive enrollment periods starting in October 2013 and January 2014. See http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/related-information.html. Ohio's voluntary enrollment period is only one month starting in September 2013, with passive enrollment occurring in October, November and December 2013, by demonstration region. See https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OHMOU.pdf.

[19] In January 2013, CMS issued guidance to plans interested in participating in 2014 capitated demonstration projects which prohibits low-performing plans from receiving passive enrollment. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2014_PlanGuidance01092013.pdf.

[20] In August 2012, CMS made funding available to states for the purposes of contracting with SHIPs and ADRCs for options counseling. See http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4437&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

[21] Some excellent resources have been developed by the National Health Law Program and the National Senior Citizens Law Center. See e.g. http://www.healthlaw.org/images/stories/2012_04_NHeLP_Hold_Harmless_Passive_Enrollment.pdf and http://www.nsclc.org/wp-content/uploads/2011/07/Final-Issue-Brief-2.pdf

[22] CMS has stated its intention to require states that adopt passive enrollment to allow individuals to opt out of their assigned plan on a monthly basis and return to original Medicare. This approach has been adopted by Massachusetts and Ohio. See https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OHMOU.pdf (Ohio) and https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf (Massachusetts).