HEALTH MANAGEMENT ASSOCIATES

ISSUE BRIEF #1

Medicare-Medicaid Integration: Integrated Model Enrollment Rates Show Majority of Medicare-Medicaid Dual Eligible Population Not Enrolled

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APRIL 2020

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*This issue brief presents an analysis of enrollment in integrated programs for the Medicare-Medicaid Full Benefit Dual Eligible (FBDE)[i] population between calendar years (CY) 2014 and 2019. While FBDE enrollment in integrated programs nearly quadrupled over the past five years, increasing from 179,600 to 665,700 persons, the number of people enrolled in an integrated program never rose above one in 10 FBDE people. Current integration program options do not extend to the vast majority of the FBDE population, resulting in inequity. Among the FBDE population with the option to enroll in an integrated program, many have chosen to opt out or disenroll. These findings raise important questions***: How does public policy equitably advance access to integrated programs to all FBDE people throughout the country? Are current federal and state policy and regulatory frameworks adequate to extend access of integrated programs to all FBDE people? Are new or different frameworks needed to make integrated care available to all of them? Further, how can the federal government and states create integrated program options that are less confusing and disruptive so that more people enroll in integrated programs?*

This issue brief was produced under a grant from Arnold Ventures.

KEY FINDINGS

Our analysis of enrollment numbers in integrated programs produced the following key findings:

1. **There were no integrated programs available in fifteen states including the District of Columbia for FBDE people in 2019**. Thirty-six states made available at least one integrated program to FBDE people. Nine of these states are participating in the capitated Financial Alignment Initiative (FAI) demonstrations.

2. **While enrollment in integrated program options has grown significantly during the past five years, only one in 10 FBDE people are enrolled in an integrated program**. From 2014 to 2019, FBDE enrollment in integrated care nearly quadrupled from 179,600 to 665,700 and grew by nearly 500,000.

3. **Sixty-six percent of the enrollment growth in integrated programs over the last five years was in the capitated FAI demonstration**. Many of these programs have ended or are winding down, leading to considerable uncertainty about the future number of FBDE people enrolled in integrated programs.

4. **Despite the enrollment growth due to the capitated FAI demonstrations, almost seven in 10 FBDE people living in states where the demonstration was available were not eligible to enroll in the program—even among people who were eligible, many people**

opted out of the program. FBDE enrollment in the capitated FAI demonstrations was further dampened by the high number of people opting out of or disenrolling from the capitated FAI demonstrations. Estimates of the number of people electing to opt out of the capitated FAI demonstrations have not been reported consistently across these demonstrations. State-based reports, however, suggest opt-out rates as high as 50 percent.[ii]

5. **The percent of total FBDE people enrolled in integrated programs varies greatly by state in which integrated programs exist**. Percent of total FDBE population enrolled ranges from less than 1 percent in Indiana to a high of 40 percent in Rhode Island.

There are multiple reasons that contribute to the lack of availability of Medicare-Medicaid integrated program options nationwide and limited enrollment in places where it exists today. The result is that millions of people are not enrolled in whole-person, integrated program options – this reality is inefficient, and worse yet, inequitable.

INTRODUCTION

In 2019, 7.7 million people in the United States were eligible for full benefits under Medicare and individual state Medicaid programs.[iii] This group is called the Full Benefit Dual Eligible (FBDE) population. Their ability to access coverage that integrates these two programs varies significantly across the country. Based upon an analysis of CMS enrollment data for years 2014 and 2019 for three integrated programs which are the focus of this analytical brief, only 665,700 FBDE people are enrolled in an integrated program, or less than one in 10.

FBDE Population

The FBDE population is comprised of individuals with complex chronic conditions and disabilities and high social service needs. This population needs and uses a full range of Medicare and/or Medicaid services and supports including medical, behavioral health, and long-term services and supports (LTSS), as well as social services. Under the current Medicare and Medicare programs, the majority of individuals receive care from multiple providers and across multiple settings of care with little to no care coordination across delivery systems.[iv] The current programs are not structured to address the person-centered needs of this population in an integrated manner, unless they are enrolled in an integrated program. These integrated programs, however, have limited geographic scope, program eligibility, and enrollment as pointed out in this issue brief.

Federal and state policy makers have long considered new ways to ensure that the FBDE population has access to integrated Medicare and Medicaid program benefits and services. Efforts to bring the two programs together accelerated after the enactment of the Affordable Care Act (ACA) in 2010, when federal and state administrators received new authorities to

develop and test new programs of integration. These new programs have made a substantial contribution towards understanding the needs of the FBDE population and the key goals of integration for this population. Nearly a decade after the ACA, however, low enrollment in integrated programs among the FBDE population persists.

MEDICARE-MEDICAID INTEGRATED PROGRAMS

The Centers for Medicare and Medicaid Services (CMS) defines an integrated program as one that provides the full array of Medicare and Medicaid benefits through a single delivery and financing system in order to provide quality care for dually eligible enrollees, improve care coordination, and reduce administrative burdens.[v]

Under the current federal and state policy framework, there are four types of Medicare-Medicaid integrated programs, which are listed below. The first three programs are the subject of this brief.

1. **Medicare-Medicaid Financial Alignment Initiative (FAI) Demonstrations.** Today, 10 states participate with CMS in demonstration programs that provide integrated care. There are two models:

    - ***Capitated*:** Benefits are provided by a single managed care entity that receives funding from both Medicare and Medicaid. (9 states – California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas.)[vi]
    - ***Managed Fee-for-Service*:** CMS and a state enter into an agreement through which the state is eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicare and Medicaid. (1 state – Washington.)

2. **Program of All-Inclusive Care for the Elderly (PACE).** Under capitated payments, PACE provides all Medicare and Medicaid services primarily in an adult day health center (supplemented by in-home and referral services in accordance with individual needs) to certain frail, elderly people age 55 and older still living in the community. (31 states – Alabama, Arkansas, California, Colorado, Delaware, Florida, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin, and Wyoming.)

3. **Medicare Advantage Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)** Dual Eligible Special Needs Plans (D-SNPS) with FIDE SNP designation provide Medicare benefits and Medicaid benefits, consistent with state policy, by a single health plan entity. (11 states – Arizona, California, Florida, Idaho, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania, Tennessee, Wisconsin.)

4. **Medicaid Managed Long-Term Service and Supports Program (MLTSS) managed care organizations and aligned D-SNPs (MLTSS+D-SNP).** Some states require managed care organizations (MCOs) that administer MLTSS to operate "aligned" or "companion" D-SNPs with dual integration requirements in state Medicaid agency contracts (SMACs). D-SNPs must follow these requirements to operate in a state. (10 states – Arizona, Hawaii, Idaho, New Mexico, Massachusetts, Minnesota, Pennsylvania, Tennessee, Texas, Virginia.) States are increasingly expressing interest in and moving to the MLTSS+D-SNP model (for example, California has expressed interest; Texas is establishing this model in geographic areas not covered by the capitated FAI demonstration; Virginia ended its capitated FAI demonstration and moved to this model). This issue brief does not count individuals in aligned MLTSS+D-SNP plans in our enrollment estimates, because of the risk of over counting.[vii]

Issue Brief Analysis of FBDE Enrollment Levels

Our analysis of FBDE enrollment levels for 2014 and 2019 is limited to the number of FBDE people enrolled in the following three integrated programs: (1) capitated FAI demonstrations; (2) PACE programs; and (3) FIDE SNPs. FBDE people enrolled in MLTSS+D-SNP models are excluded from our analysis to avoid an overcount of enrollees in companion or aligned MLTSS MCOs and D-SNPs. As a result, our count of FBDE enrollment levels in integrated programs are undercounted.[viii] (See Appendix A. Methodology and Key Data Sources Used to Count the FBDE Population)

ENROLLMENT IN MEDICARE-MEDICAID INTEGRATED PROGRAMS

The percent of the FBDE population enrolled in integrated programs increased from 2.5 percent in 2014 to 8.6 percent in 2019 or by 6.1 percentage points (Table 1). **The majority of the enrollment growth occurred in the capitated FAI demonstrations, which accounted for 66 percent of the overall enrollment growth in integrated programs, with FIDE SNPs accounting for 30 percent and PACE 4 percent of the growth.** The enrollment trend for integrated programs has been positive over the past five years. Unfortunately, the impact of the capitated FAI demonstration may be short-lived, since several states have already ended or plan to terminate their capitated FAI demonstrations. Table 1 also shows that the absolute growth in FBDE enrollment in integrated programs between 2014 and 2019 was nearly equal to the absolute growth in the total FBDE population. (The growth was 486,100 and 441,900, respectively.) Despite

the enrollment gains in integrated programs, the percent of the FBDE population enrolled in an integrated program remained below 10 percent from 2014 to 2019. The number of unenrolled FBDEs remained approximately 7.1 million as the overall size of the FBDEs increased between 2014-2019.

Table 1. Total FBDE Enrollment in Integrated Programs, 2014-2019

FBDE Enrollment in Integrated Programs, 2014-2019							
Calendar Year (CY)	**Capitated FAI**	**PACE**	**FIDE SNP**	**FBDE Enrollment**	**Total FBDE Population**	**Total Enrollment Rate**	**FBDE Unenrolled**
CY 2014	62,700	28,800	88,100	179,600	7,300,000	2.5%	7,120,400
CY 2019	381,200	49,100	235,400	665,700	7,741,900	8.6%	7,076,200
Growth CY 2014-2019	**318,500**	**20,300**	**147,300**	**486,100**	**441,900**	*6.1%*	**(44,200)**
Share of Growth	**66%**	**4%**	**30%**	**100%**			

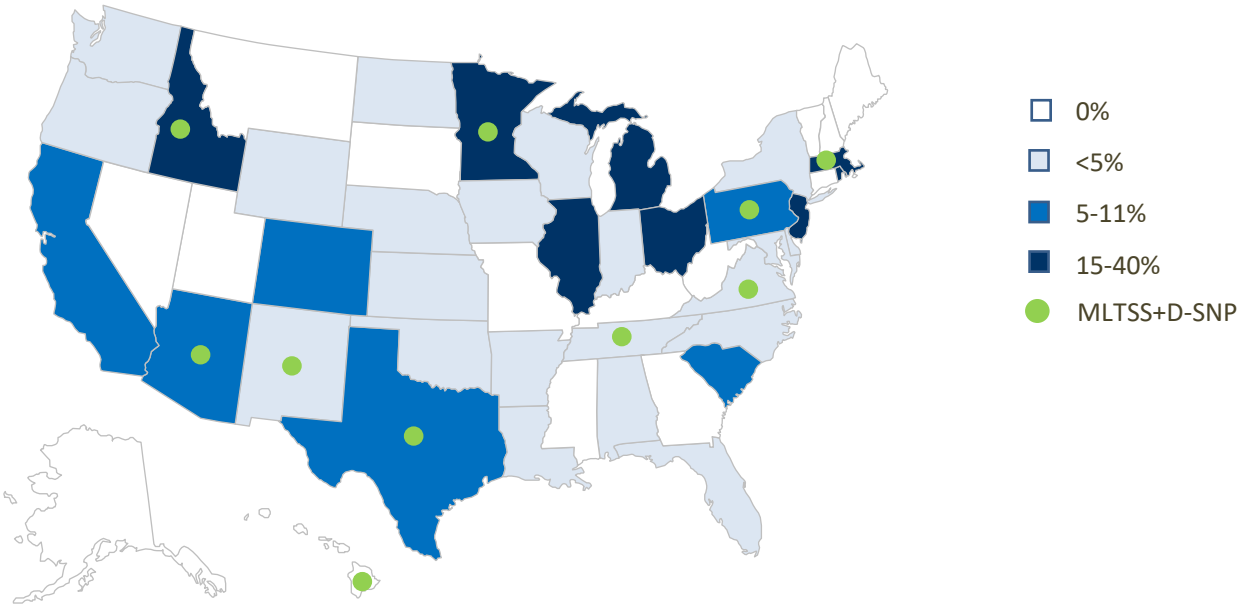
GREAT VARIATION IN ENROLLMENT AND ACCESS TO INTEGRATED PROGRAMS

FBDE individuals do not have access to integrated programs in 15 states including the District of Columbia. Across the 36 states with at least one integrated program, enrollment rates among the FBDE population range from below 1 percent to as high as 40 percent. These numbers underscore the significant variation across states in enrollment in and access to integrated programs.

States in which all three integrated programs operate do not necessarily have the highest rates of enrollment of their FBDE population. For example, California and New York have all three programs, yet the enrollment rates were 9.5 and 3.5 percent respectively. This reflects that access alone does not address the challenge of achieving higher enrollment rates in integrated programs.

Finally, states that have only the PACE program have the lowest rates of enrollment. There are 16 states that are counted as having only the PACE program, with total enrollment of 13,000 and an overall enrollment rate of 1 percent.

Figure 1. FBDE Enrollment Ranges in Integrated Programs in 2019



Source: HMA analysis, based upon data from CMS.

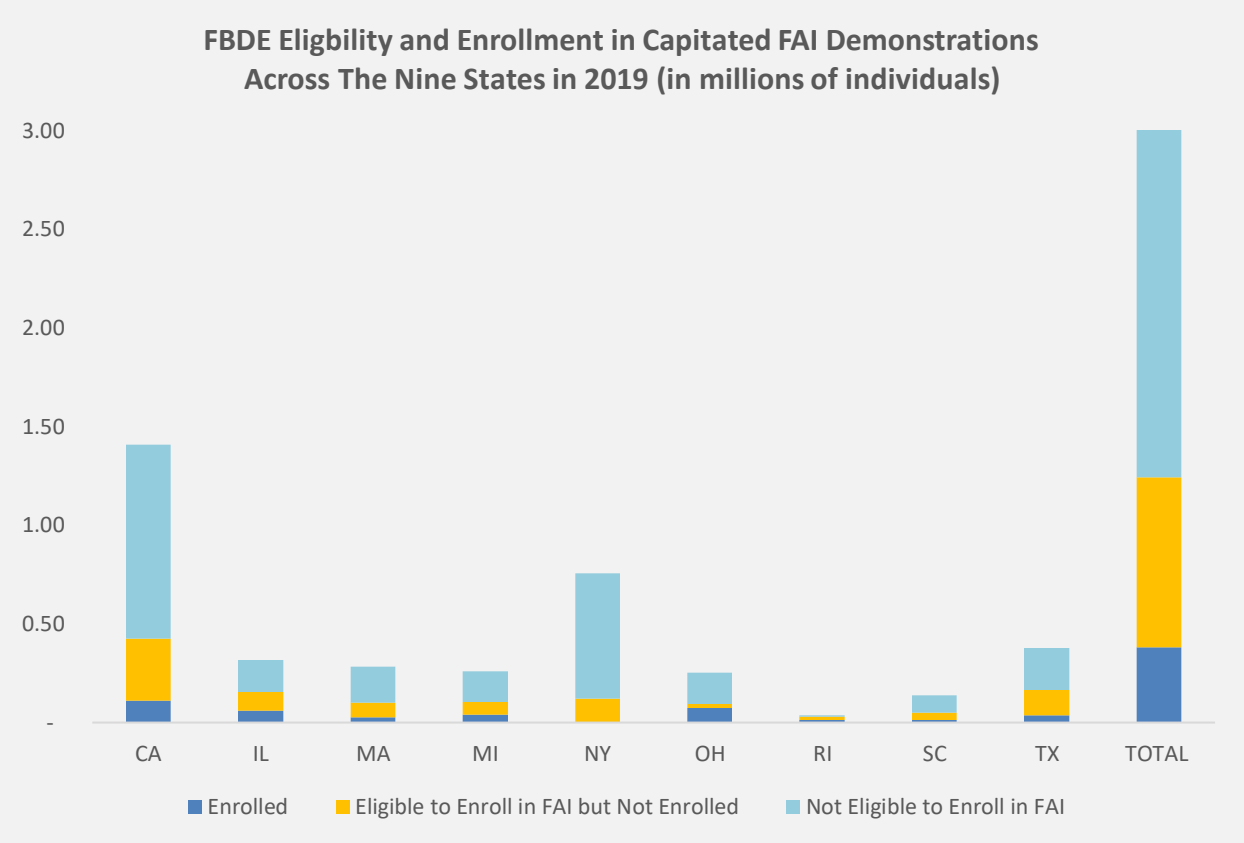
Deep Dive: Capitated Financial Alignment Initiatives

The capitated FAI demonstration was the most significant driver of enrollment growth over the five years examined, accounting for 66 percent of enrollment growth.

Nine states currently participate in the capitated FAI demonstrations: California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas. There are 3.8 million FBDE people living in these states alone, representing close to half of all FBDE individuals in the country. However, the population that was eligible to participate in the demonstration was much smaller—only 1 out of 3 FBDE people were eligible to take part in the demonstrations across these nine states. This is because many participating states did not make the demonstration available statewide and some states limited enrollment to certain populations.

Enrollment in capitated FAI demonstrations varied by state. Ohio had the highest enrollment rate at 80 percent while New York had the lowest at 3 percent. New York experienced very high opt-out rates from its two capitated FAI demonstrations.

Figure 2: FBDE Eligibility and Enrollment in Capitated FAI Demonstrations in 2019



Source: HMA analysis, based upon data from CMS and MACPAC.

CMS reopened its call for states to apply to participate in the FAI demonstration, including the capitated FAI demonstration, but as of March 2020, no state has elected to move forward.[ix] The enrollment gains made under this model are likely in jeopardy. It is not clear how many states will continue their capitated FAI demonstrations. Some states, such as California, have already announced plans to no longer participate, and intend to shift to a MLTSS+D-SNP program to advance integration. New York has already ended one of its two capitated FAI demonstrations and the second will end December 31, 2020.

Key Facts: Program of All-Inclusive Care for the Elderly (PACE)

Today, 31 states have a PACE program, with total enrollment of 49,100. From 2014 to 2019, PACE enrollment nearly doubled, increasing from 28,800 FBDE people to 49,100. Nearly 75 percent of PACE enrollment is concentrated in eight states, with an average state enrollment of 4,300 enrollees. The remaining enrollment is spread across the 23 states, with an average state enrollment of 525. Given the size and scale of PACE programs across the states, even future rapid expansion of their availability and enrollment will have very little impact on the percent of total FBDE individuals enrolled in fully integrated programs nationally.

PACE History

PACE is the longest established and considered by CMS to be the most fully integrated program operating in the United States. PACE was first authorized as a Medicare demonstration program in the mid-1980s and made permanent in 1997, under the Balanced Budget Act of 1997. PACE programs are limited to only those FBDE people who require a nursing home level of need. Non-profit or for-profit organizations may offer PACE programs. Programs may be limited in enrollment by the size and capacity of the organization, state-imposed enrollment caps, and the design of the program whereby eligible FBDE people decide to enroll.

Key Facts: FIDE SNPs

Today, 11 states have FIDE SNPs with total enrollment of 235,400 enrollees. Massachusetts, Minnesota and New Jersey have relatively high numbers of FBDE people enrolled in these plans. Recently, Congress and CMS have enacted new laws and issued new regulations to promote greater availability of FIDE SNPS. To date, however, it is unclear whether the private market for these plans will expand and increase enrollment levels.

APPENDIX A.
METHODOLOGY AND KEY DATA SOURCES USED TO COUNT THE FBDE POPULATION

Key Data Sources

For this issue brief, HMA relied upon three sources of data to estimate total enrollment in integrated plans.

1. **Medicare Advantage Enrollment Data.** This data source is published monthly by CMS.[x] Data for 2014 was anchored to the June 2014 report. Data for 2019 was anchored to the December 2019 report. For the state of Pennsylvania, however, data for January 2020 was used to capture enrollment in the new FIDE SNP program. This data source was used to summarize enrollment counts in the capitated FAI demonstrations, PACE, and FIDE SNP programs. This data served as the numerator to calculate enrollment rates in integrated programs by state.

2. **The Medicare-Medicaid Coordination Office Data.**[xi] This data source provided the total number of FBDE individuals by state. The March 2019 report served as the source of data for 2014 and 2019. This data was accessed February 2020 and served as the denominator to calculate enrollment rates in integrated programs by state.

3. **MACPAC Data.** This data source provided the total FBDE people eligible to enroll in the capitated FAI demonstrations. The data served as the denominator to calculate enrollment rates for the capitated FAI demonstrations. The numbers used in this issue brief were published by MACPAC in December 2017.

Exclusion of the MLTSS+D-SNP Programs in Counts of Enrollees

Enrollment in MLTSS+D-SNP programs was not included in estimates of total FBDE enrollment in integrated programs because data for FBDE people enrolled in MLTSS+D-SNP integrated plans are not sufficiently detailed and standardized. A March 2020 GAO report provides January 2019 enrollment of FBDE people in the same parent company's Medicaid MLTSS plan and D-SNP plan. GAO's count of enrollment at the parent level includes enrollment in D-SNPs that operate in states that *may not* require the same level of integration between Medicare and Medicaid as those states that require Medicaid MCOs to operate a D-SNP with additional requirements for integration in SMACs. In these states with SMAC requirements, plans are referred to as "aligned" or "companion plans." Additionally, CMS monthly default enrollment reports do not track people who opt out within 90 days of enrollment as allowed by federal regulation. To avoid an overcount of the number of FBDE people enrolled in truly integrated programs, HMA chose to exclude these enrollment numbers.[xii]

APPENDIX B.
STATE-LEVEL DATA ON ENROLLMENT IN INTEGRATED PROGRAMS

#	State	Capitated FAI Demonstration	PACE	FIDE SNP	MLTSS+ DSNP	FBDE Enrollment	Total FBDE Population	FBDE Enrollment Rate	FBDE Unenrolled
1	Alabama	-	200	-	-	200	85,300	0.2%	85,100
2	Alaska	-	-	-	-	-	16,900	-	16,900
3	Arizona	-	-	11,900	Yes	11,900	169,500	7.0%	157,600
4	Arkansas	-	300	-	-	300	67,100	0.4%	66,800
5	California	112,400	7,500	13,800	-	133,700	1,410,100	9.5%	1,276,400
6	Colorado	-	4,400	-	-	4,400	83,000	5.3%	78,600
7	Connecticut	-	-	-	-	-	70,600	-	70,600
8	Delaware	-	300	-	-	300	14,100	2.1%	13,800
9	DC			-	-	-	22,300	-	22,300
10	Florida	-	2,200	400	-	2,600	397,200	0.7%	394,600
11	Georgia	-	-	-	-	-	148,900	-	148,900
12	Hawaii	-	-	-	Yes	-	35,100	-	35,100
13	Idaho	-	-	7,600	Yes	7,600	27,900	27.2%	20,300
14	Illinois	59,200	-	-	-	59,200	315,900	18.7%	256,700
15	Indiana	-	500	-	-	500	138,500	0.0%	138,000
16	Iowa	-	600	-	-	600	64,900	0.9%	64,300
17	Kansas	-	500	-	-	500	37,900	1.3%	37,400
18	Kentucky	-	-	-	-	-	92,800	-	92,800
19	Louisiana	-	500	-	-	500	125,900	0.4%	125,400
20	Maine	-	-	-	-	-	51,500	-	51,500
21	Maryland	-	200	-	-	200	84,900	0.2%	84,700
22	Massachusetts	25,300	4,700	57,900	Yes	87,900	282,400	31.1%	194,500
23	Michigan	39,400	3,200	-	-	42,600	260,500	16.4%	217,900
24	Minnesota	-	-	41,100	Yes	41,100	122,100	33.7%	81,000
25	Mississippi	-	-	-	-	-	76,700	-	76,700
26	Missouri	-	-	-	-	-	136,300	-	136,300
27	Montana	-	-	-	-	-	17,300	-	17,300
28	Nebraska	-	200	-	-	200	35,700	0.6%	35,500
29	Nevada	-	-	-	-	-	30,500	-	30,500
30	New Hampshire	-	-	-	-	-	20,900	-	20,900
31	New Jersey	-	1,100	50,200	-	51,300	193,800	26.5%	142,500
32	New Mexico	-	400	-	Yes	400	65,300	0.6%	64,900
33	New York	4,000	5,200	17,600	-	26,800	755,800	3.5%	729,000
34	North Carolina	-	2,100	-	-	2,100	249,600	0.8%	247,500
35	North Dakota	-	200	-	-	200	10,700	1.9%	10,500

#	State	Capitated FAI Demonstration	PACE	FIDE SNP	MLTSS+ DSNP	FBDE Enrollment	Total FBDE Population	FBDE Enrollment Rate	FBDE Unenrolled
36	Ohio	74,600	500	-	-	75,100	253,000	29.7%	177,900
37	Oklahoma	-	500	-	-	500	94,000	0.5%	93,500
38	Oregon	-	1,400	-	-	1,400	81,300	1.7%	79,900
39	Pennsylvania	-	7,000	30,500	Yes	37,500	375,700	10.0%	338,200
40	Rhode Island	14,100	400	-	-	14,500	36,900	39.3%	22,400
41	South Carolina	14,300	500	-	-	14,800	136,900	10.8%	122,100
42	South Dakota	-	-	-	-	-	12,300	-	12,300
43	Tennessee	-	300	1,500	Yes	1,800	141,700	1.3%	139,900
44	Texas	37,900	1,200	-	Yes	39,100	378,700	10.3%	339,600
45	Utah	-	-	-	-	-	32,100	-	32,100
46	Vermont	-	-	-	-	-	19,700	-	19,700
47	Virginia	-	1,300	-	Yes	1,300	128,700	1.0%	127,400
48	Washington	-	900	-	-	900	132,600	0.7%	131,700
49	West Virginia	-	-	-	-	-	45,400	-	45,400
50	Wisconsin	-	600	2,900	-	3,500	147,000	2.4%	143,500
51	Wyoming	-	200	-	-	200	8,000	2.5%	7,800
	Total	**381,200**	**49,100**	**235,400**	**-**	**665,700**	**7,741,900**	**8.6%**	**7,076,200**
	States	**9**	**31**	**11**	**11**				
	Average State Enrollment	**42,356**	**1,584**	**21,400**					

Source: HMA analysis, based upon data from CMS.

APPENDIX C.
ENROLLMENT IN THE CAPITATED FAI DEMONSTRATIONS

FBDE Eligibility and Enrollment in the Capitated FAI Demonstrations										
		Population Numbers					Calculations			
#	State	*Total FBDE Population*	Not Eligible to Enroll in FAI	Eligible to Enroll in FAI	FAI Enrolled	Eligible to Enroll in FAI but Not Enrolled	% Not Eligible to Enroll in FAI	% Eligible to Enroll in FAI	% FAI Enrolled (Based on FAI Eligible Population)	% FAI Enrolled (Based on Total FBDE Population)
1	California	*1,410,100*	986,100	424,000	112,400	311,600	70%	30%	27%	8%
2	Illinois	*315,900*	161,900	154,000	59,200	94,800	51%	49%	38%	19%
3	Massachusetts	*282,400*	181,400	101,000	25,300	75,700	64%	36%	25%	9%
4	Michigan	*260,500*	155,500	105,000	39,400	65,600	60%	40%	38%	15%
5	New York	*755,800*	635,800	120,000	4,000	116,000	84%	16%	3%	1%
6	Ohio	*253,000*	160,000	93,000	74,600	18,400	63%	37%	80%	29%
7	Rhode Island	*36,900*	6,900	30,000	14,100	15,900	19%	81%	47%	38%
8	South Carolina	*136,900*	86,900	50,000	14,300	35,700	63%	37%	29%	10%
9	Texas	*378,700*	213,700	165,000	37,900	127,100	56%	44%	23%	10%
	Total	**3,830,200**	**2,588,200**	**1,242,000**	**381,200**	**860,800**	**68%**	**32%**	**31%**	**10%**

Source: HMA analysis, based upon data from CMS.

[i] Over 12 million people nationwide are dually eligible for Medicare and Medicaid. Some qualify for full Medicaid benefits, referred to as full benefit dually eligible (FBDE) individuals. Others solely qualify for assistance with payment of Medicare premiums, and in some cases, Medicare cost sharing, referred to as partial benefit dually eligible individuals.

[ii] "Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare," Medicaid and CHIP Payment and Access Commission, (January 2018), https://www.macpac.gov/publication/financial-alignment-initiative-for-beneficiaries-dually-eligible-for-medicaid-and-medicare/.

[iii] In 2019, nearly 8 million people in the United States were eligible to receive access to full benefits under Medicare and individual state Medicaid programs on the basis of their income and/or disability status. The Centers for Medicare and Medicaid (CMS), Medicare and Medicaid Coordination Office (MMCO), People Dually Eligible for Medicare and Medicaid, Fact Sheet, March 2019.

[iv] Most receive primary and acute care medical services through Medicare fee-for-service (FFS) or a Medicare Advantage (MA) plan, while obtaining personal care services, adult day services and other home and community-based services (HCBS) from different Medicaid health plans and providers.

[v] "Integrating Care," Centers for Medicare & Medicaid Services, accessed 2020, https://www.medicaid.gov/medicaid/long-term-servicessupports/integrating-care/index.html.

[vi] New York ended one of two capitated FAI demonstrations and is ending its second demonstration by the end of 2020. California announced it is ending its capitated FAI demonstration and implementing a MLTSS+D-SNP model.

[vii] Virginia intends to move to a FIDE SNP model.

[viii] According to a March 2020 GAO report, in January 2019 386,000 FBDE people were enrolled in a Medicaid MCO and a D-SNP offered by the same or related companies. "Medicare and Medicaid: Alignment of Managed Care Plans for Dual Eligible Beneficiaries," U.S. Government Accountability Office, Report to congressional committees, (March 2020), https://www.gao.gov/assets/710/705347.pdf.

[ix] As of July 2019, Washington's managed fee-for-service FAI demonstration had 20,300 FBDE individuals enrolled and as of December 2018, had 131,700 FBDE individuals in the state. "Financial Alignment Initiative," Medicaid and CHIP Payment and Access Commission, accessed 2020, https://www.macpac.gov/subtopic/financial-alignment-initiative/. This enrollment was not included in the overall analysis and does not have an impact on the brief findings.

[x] "Medicare Advantage/Part D Contract and Enrollment Data," Centers for Medicare & Medicaid Services, accessed 2020, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.

[xi] "MMCO Statistical & Analytic Reports," Centers for Medicare & Medicaid Services, accessed 2020, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.

[xii] U.S. Government Accountability Office, "Medicare."