

Report on Early Implementation of Demonstrations under the Financial Alignment Initiative

Prepared for

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Executive Summary

This report provides a preliminary update on the status of selected evaluation and implementation activities for the seven demonstrations implemented as of May 1, 2014, as part of the Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative to test integrated care and financing models for Medicare-Medicaid enrollees. Implementing these demonstrations is complex and challenging, requiring integration of multiple systems and sometimes conflicting Medicare and Medicaid policies, as well as major investments of time and resources by the States, Medicare-Medicaid Plans (MMPs), and CMS. This report describes the range of activities and early experiences in implementing these demonstrations during the first 6 months of operations in each demonstration State, and includes information about specific successes and challenges encountered in aligning Medicare and Medicaid systems and policies.

The report covers integrated delivery systems, enrollment, care coordination models, beneficiary safeguards, and stakeholder engagement; and identifies issues on which the evaluation team will focus in the future. The Minnesota Demonstration to Align Medicare and Medicaid Administrative Processes is described separately at the end of the report because of its unique demonstration structure. Information for this report was collected from site visit interviews with States, beneficiary advocates, CMS staff, and various other demonstration stakeholders, including MMPs; quarterly data submitted by each State; quarterly meetings with State demonstration representatives; any available reports from States' internal evaluation activities; and State-specific documentation (e.g., websites, three-way contracts, final demonstration agreements, Memoranda of Understanding).

1. Introduction

The Medicare-Medicaid Coordination Office (MMCO) and Innovation Center at the Centers for Medicare & Medicaid Services (CMS) created the Financial Alignment Initiative to test integrated care and financing models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models integrating medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees, with the expectation that integrated delivery models would address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits.

Under the Financial Alignment Initiative, CMS made two financial alignment models available to States: (1) a capitated model in which health plans coordinate the full range of health care services, and (2) a managed fee-for-service (MFFS) model in which States are eligible to benefit financially from savings resulting from initiatives that improve quality and reduce costs. As of

December 2015, nine participating States are implementing capitated model demonstrations, whereas two are implementing MFFS model demonstrations.¹ Minnesota is also implementing a demonstration focused on administrative changes to better align the Medicare and Medicaid operational components of the existing Minnesota Senior Health Options (MSHO) program. CMS continues to work with a small number of additional States on the demonstration designs.

Developing each demonstration's design was a complex process negotiated by CMS and each State. Before implementation of each demonstration, CMS and the respective State entered into a joint Memorandum of Understanding (MOU) that laid out the parameters of the demonstration and CMS's and the State's activities in preparation for implementation. Demonstrations operating capitated models then established three-way contracts among CMS, the State, and MMPs. The three-way contract builds on the MOU's provisions to specify detailed operational and technical MMP requirements and to spell out the joint oversight roles of CMS and the State.

States participating in managed fee-for-service model demonstrations also enter into MOUs with CMS, but instead of integrating financing through a blended capitated payment outlined in the three-way contract, the Medicare and Medicaid programs continue to separately finance distinct services through direct FFS payments to providers. The MFFS model demonstrations do not alter payment, prior authorization or provider networks available under FFS Medicare and Medicaid. Managed fee-for-service model demonstrations are established through an MFFS Final Demonstration Agreement, a two-way agreement between CMS and the State that also builds on the provisions of the MOU in detailing the demonstration's terms and conditions.

CMS contracted with RTI International to monitor demonstration implementation, evaluate the impact of the demonstration on the beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstrations' impact on a range of outcomes for the eligible population as a whole and for special populations (e.g., people with mental illness and/or substance use disorders, LTSS users). To achieve these goals, RTI is collecting qualitative and quantitative data from States each quarter; analyzing Medicare and Medicaid enrollment and claims data as available; conducting site visits, beneficiary focus groups, and interviews; and reviewing relevant findings from any beneficiary surveys conducted by other entities.

This report provides a preliminary update on the status of selected evaluation and implementation activities for the seven demonstrations implemented as of May 1, 2014 (shown in *Table 1*). Implementing these demonstrations is complex and challenging. It requires integrating multiple systems and sometimes conflicting Medicare and Medicaid policies, and major investments of time and resources by the States and CMS. As implementation of the demonstrations proceeds, differences in Medicare and Medicaid policies and processes continue to emerge and to be resolved. This report describes the range of activities and experience during the first 6 months of implementing these demonstrations and includes information about specific successes and challenges encountered in aligning Medicare and Medicaid systems and policies.

¹ Two additional states will begin implementing capitated model demonstrations in 2016: Rhode Island and New York (FIDA-IDD).

The report covers integrated delivery systems, enrollment, care coordination models, beneficiary safeguards, and stakeholder engagement; and identifies issues on which the evaluation team will focus in the future. Information was collected from site visit interviews, quarterly data submitted by each State, and State-specific documentation (e.g., three-way contracts, final demonstration agreements, MOUs) and captures experiences in the first 6 months of implementation. This report does not include quantitative analysis of quality, utilization, or cost measures because of limited data availability for all demonstrations in the report. Individual demonstration-specific annual reports are forthcoming. Additional information about the demonstrations is available at www.cms.gov,² and on individual State websites.

Table 1.
Overview of demonstrations covered in this report

State	Demonstration name	Implementation date	Eligible population and geographic areas	Type of model
California	Cal MediConnect	April 1, 2014	Aged 21 or older, in 7 counties in southern California and around the Bay Area	Capitated
Illinois	Illinois Medicare-Medicaid Alignment Initiative	March 1, 2014	Aged 21 or older, in 21 counties in Greater Chicago and Central Illinois	Capitated
Massachusetts	One Care	October 1, 2013	Aged 21-64* in 9 of 14 counties in Massachusetts**	Capitated
Minnesota	Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience	September 13, 2013	Aged 65 or older, statewide	Other
Ohio	MyCare Ohio	May 1, 2014	Aged 18 or older, in 28 counties (7 regions of 3 to 5 counties each, including major urban centers)	Capitated
Virginia	Virginia Commonwealth Coordinated Care	April 1, 2014	Aged 21 or older, in 104 localities: Central Virginia, Tidewater Northern Virginia, Roanoke, and Western/Charlottesville	Capitated
Washington	Washington Health Homes MFSS	July 1, 2013	All ages, statewide except for 2 counties (Snohomish and King)	MFSS

MFSS = managed fee for service.

* The Massachusetts demonstration targets individuals ages 21-64 at the time of enrollment, and allows people to remain in their MMP when they turn 65 as long as they maintain demonstration eligibility.

** Includes eight full counties and one partial county.

² <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

2. Integrating Medicare and Medicaid Systems

A primary goal of the demonstrations under the Financial Alignment Initiative is to integrate services provided to Medicare-Medicaid enrollees and streamline their health care experience. In order to accomplish this integration, it is necessary for States, CMS, the MMPs, and care coordination entities to integrate service systems and address differences in Medicare and Medicaid policies, administration and oversight.

In States with a capitated model demonstration, the State and CMS contracted with MMPs to deliver integrated primary, acute, and LTSS services. MMPs in Illinois, Massachusetts, Ohio, and Virginia are responsible for providing and integrating behavioral health and substance use services directly or through a subcontract arrangement, whereas in California, these services are coordinated by the MMPs, but they continue to be provided by well-established, county-based agencies that have a history of collaboration with MMPs in the State.

As of August 2014, 29 MMPs had entered into three-way contracts with States and CMS, and about 60 percent of those plans were for-profit, national chains. Three-quarters of the MMPs had previous Medicaid managed care experience, and nearly all had experience operating a Dual Eligible Special Needs Plan (D-SNP), Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), or another type of Medicare Advantage plan, before launching their demonstration product.³ MMP representatives reported to the evaluation team that their prior experience with Medicaid managed care and with operating an integrated program such as a D-SNP was a distinct advantage in preparation for developing their MMP.

In the Washington State MFFS demonstration, health homes are responsible for organizing enhanced integration of primary, acute, behavioral, and LTSS services for Medicare-Medicaid enrollees. The State defines health homes as the central point for directing person-centered care for high-cost, high-risk enrollees. Although the State's existing delivery systems for services are unchanged, health homes serve as the bridge for integrating care across these existing delivery systems.

Integrating Services

In capitated model demonstrations, the overall goal of the MMPs is the integration of Medicare and Medicaid services to create a seamless model and align incentives across the delivery systems. Rather than navigating two separate systems of care—each with different providers and sometimes conflicting benefits and policies—beneficiaries in the capitated model demonstrations now can use one card to obtain all needed services. Their care coordinator, in conjunction with their multidisciplinary care team, which includes at a minimum, their primary care provider,

³ D-SNPs and FIDE SNPs are types of Medicare Advantage plans, along with HMOs and PPOs. D-SNPs and FIDE SNPs provide more integrated care than these other types of Medicare Advantage plans or Medicare fee for service and are required to offer a coordinated Medicare and Medicaid benefits package.

specialists, and long-term services and supports (LTSS) providers, is tasked with ensuring that enrollees receive comprehensive, person-centered care. To accomplish system integration, States, CMS, the MMPs, and care coordination entities had to integrate service systems, and address differences in Medicare and Medicaid policies, administration and oversight. One of the key success factors was the degree to which the MMP was able to integrate organizations that provide LTSS services billable under Medicaid.

Of the MMPs interviewed during site visits in the first 6 months of implementation, those with experience working with LTSS providers, for example, in MMPs holding a Medicaid managed care contract that includes LTSS, reported a relatively easy transition to integrating LTSS with primary care. MMP representatives said that their prior experience of working with older adults, younger people with disabilities, or people with chronic conditions was a strong motivation for participating in the demonstration and that ongoing engagement of members, combined with a person-centered approach to care coordination and care management, is critical to the demonstration's long-term success and its ability to improve outcomes for individuals.

Other MMPs reported that working with LTSS was entirely new to them. Unfamiliar with LTSS operational functions, such as utilization management, they discovered that some activities of the LTSS agencies overlapped with their own. Thus, they were taking steps to educate themselves to reconcile and streamline activities, such as conducting assessments, coordinating care, and providing optional or flexible benefits. Optional or flexible benefits are services such as home modifications, including ramps or grab bars, Meals on Wheels, or similar services not otherwise available to an individual beneficiary through local agencies or other means. A key feature of these initiatives is that MMPs may authorize and fund these discretionary services from their capitated payments to help enrollees remain in the community; this flexibility is thought to enable MMPs to better serve participants wishing to continue living independently in their communities and to prevent inpatient hospital and/or institutional visits.

Some additional challenges in integrating delivery of services arose in capitated model demonstrations because many providers, including nursing facilities, had little experience with managed care. In some States, these entities were reluctant to partner with MMPs, citing prior authorization and billing procedures as stumbling blocks. Nursing facility representatives in particular reported wanting more direct engagement with State officials and MMPs regarding concerns with payment rates, reimbursement for Medicare bad debt payments, and the impact of MMPs' prior authorization requirements on their authority to treat and bill for services provided to resident enrollees. An example of an administrative problem between MMPs and community-based providers concerned independent home care workers in Ohio. These workers were accustomed to submitting handwritten notices of work performed under Medicaid to a billing agent who converted the work notices to standardized claims. When the agent discontinued contracts with independent providers, the home care workers did not know how to submit claims, resulting in nonpayment to thousands of home care workers and subsequently jeopardizing enrollees' access to needed services. When MMPs learned of the problem, they dispatched

employees, ranging from a CEO to claims-processing staff, to provide one-on-one claims training for these providers.

MMPs used different methods to address challenges they encountered with LTSS contracting and relationship building. Some clinics and practices co-located primary care providers with LTSS and behavioral health providers to improve coordination.

In some States, early in the demonstration, MMPs began what some called “an unprecedented level of cooperation” among plans. Despite being competitors, these MMPs saw the virtue of working together to anticipate problems related to LTSS contracting and to share solutions to similar issues. For example, in Virginia, the three MMPs

- hired an independent attorney to work through antitrust issues;
- created common responses to providers who were new to managed care, so that the providers would not have to learn three different versions;
- designed similar authorization forms (e.g., for behavioral health); and
- met with providers and separately with beneficiaries to explain differences among MMPs, rather than conducting separate meetings with each MMP and having providers and beneficiaries try to figure out differences among the MMPs.

In some demonstrations, when challenges initially emerged, some MMPs reached out to other demonstration MMPs to discuss solutions to common operational and contracting problems. This information sharing led to the formation of collaborative work groups among multiple MMPs and LTSS providers.

MMP/LTSS provider work groups meet frequently in some States to focus on streamlining MMP/LTSS-related processes. In the early months, the work groups initially focused on billing issues, later they continued to meet to address other emerging issues. These collaborations have spun off separate subgroups to address other topics of mutual concern, such as home care and hospice. In regions in which plan and LTSS provider collaborative relationships had previously existed, work groups discussed approaches to integration of services and administrative processes that would be required under the demonstration, further expanding these relationships. State representatives and subject matter advocates are invited to participate in these work groups; however, the focus is on MMPs and LTSS providers.

Although the MFFS demonstration in Washington State was not introducing a new method for delivering services, State officials indicated that using health homes as a platform for integrating care had been challenging at times. They cited the need to reconcile various policies, such as eligibility criteria and enrollment policies, grounded either in health homes or the demonstration. Particularly problematic was the length of time it took for approval of its submitted health home State Plan Amendments, which affected initial enrollment processes and other demonstration start-up activities. Yet, the State noted that because State funds were unavailable to support

intensive care coordination services, the enhanced Federal financial participation available through the Medicaid health home initiative made the development of the demonstration care coordination delivery system possible.

Integrating Medicare and Medicaid Policies, Administration, and Oversight

During the site visits, all State officials commented on the overall complexity of integrating Medicare and Medicaid and the multifaceted aspects of their demonstrations, noting the need to keep ahead of equally important, concurrent processes. To enable beneficiaries to participate in the demonstrations, Medicare and State Medicaid enrollment systems must be integrated, a complex task requiring substantial technical modifications to State information systems. Care coordination systems need to be developed to manage the full range of Medicare and Medicaid benefits. New management structures must be established to oversee and reconcile the often conflicting administrative processes of the two programs to ensure that new delivery systems comply with the complex and varied standards of the Medicaid and Medicare programs; to develop and administer reporting systems that meet the requirements of the two programs; and to mesh the distinct Medicare and Medicaid quality management and measurement processes of the two programs. Beneficiary materials that integrate information about enrollment and Medicare and Medicaid benefits must be developed. MMPs must administer integrated grievance and appeals systems, submit Medicare and Medicaid encounter data in the format required by CMS and, in some States, an additional State-specific format, and develop systems to process claims for each program. A significant level of effort has been and continues to be required for demonstrations to align all of these complex Medicare and Medicaid administrative processes in a manner that is invisible to enrollees.

Interviewees in capitated model demonstration States noted the importance of the role of the joint CMS-State Contract Management Team (CMT) in addressing ongoing issues related to the integration of Medicare and Medicaid policies and processes. The CMT is responsible for day-to-day monitoring of the MMPs, including monitoring plans' compliance with the three-way contract; reviewing performance and enrollment data; reviewing and responding to beneficiary complaints; reviewing reports from the ombudsman; reviewing marketing materials; and reviewing grievance and appeal data.

Each CMT includes representatives from the State Medicaid agency, the Medicare and Medicaid groups in the CMS Regional Offices, and the Medicare-Medicaid Coordination Office (MMCO) State lead, all of whom are authorized to represent their respective agencies in administering the three-way contract. The CMT for each demonstration meets on a regular basis, with additional meetings held on an as-needed basis. Core CMT members from both the State and CMS bring in additional staff with specific area expertise (e.g., State home and community-based services [HCBS] waiver experts or enrollment team members) as needed. As part of its contract monitoring responsibilities, the CMT holds conference calls on a regular basis with MMPs

collectively and individually. CMS and State staff concur in their view that the CMT has been a very successful vehicle for joint oversight of MMP performance.

The CMT is also the vehicle for resolving any differences in Medicare-Medicaid policies and procedures that may arise during the demonstrations' implementation. State staff bring to the CMT extensive familiarity with Medicaid program rules and the design of LTSS and behavioral health delivery systems. CMS Medicare regional staff bring a deep knowledge of Medicare policy and operations. Some State officials noted that having more in-depth knowledge of Medicare administrative and operational policies would have been beneficial as they continued to work with CMS to resolve areas of misalignment between the Medicare and Medicaid programs.

Each State's demonstration team officials serve many key functions related to the implementation of the demonstrations, which include the following:

- MMP management and oversight: demonstration staff work with individual MMPs and multiple State departments and programs that are touched by the demonstration, in addition to working with internal finance and legal services;
- enrollment: demonstration staff manage their enrollment and eligibility information systems; they work closely with enrollment brokers and systems vendors to ensure that their demonstration is meeting Medicare requirements and that enrollment systems properly integrate with Medicare enrollment systems;
- stakeholder engagement: all State teams routinely engage a wide range of stakeholders such as beneficiary advocacy organizations, providers, and MMPs, on project implementation issues, in a variety of ways including webinars, websites, stakeholder calls, and face-to face meetings;
- quality management: State quality monitoring staff, working with the CMT, develop, collect, and analyze MMPs' reports on quality standards that were developed by CMS and each State, and develop quality improvement initiatives to address areas of weak performance; and
- data collection and measurement: States extract data from their Medicaid Management Information Systems (MMIS), and other systems, to comply with Financial Alignment Initiative reporting requirements.

Early Findings on Integrating Systems

State and CMS representatives for the capitated model demonstrations presented in this report are working closely in CMTs to find solutions to improve Medicare and Medicaid integration. Each State has its own distinct issues, but some common early findings are discussed below.

- According to State officials, addressing the nuts and bolts of aligning the Medicare and Medicaid program policies, procedures, and systems has been more time consuming than they expected. Some States reported that they did not anticipate the extensive financial investments they would be required to make prior to implementation to modify their management information systems to conform to those of CMS.
- MMPs vary in their experience with LTSS and with LTSS providers, creating challenges to integrating services and to administering LTSS benefits.
- States often use enrollment lock-in periods in implementing Medicaid managed care, as does the Medicare Advantage program for Medicare-only enrollees who are not also eligible for Medicaid. Some States would have liked enrollment lock-in periods for the MMPs. However, CMS determined in the demonstration design that enrollment lock-in for the Medicare benefit would be the same as for Medicare-Medicaid enrollees in Medicare Advantage and PACE, to preserve beneficiaries' freedom to choose how they receive their Medicare services and to change MMPs on a monthly basis.
- Other specific areas of Medicare and Medicaid program misalignment noted by State officials include beneficiary materials, differing MMP compliance processes, rate-setting processes, and grievances and appeals processes (see *Beneficiary Safeguards and Protections* section). However, State officials more often reported in broad terms that a multitude of small and medium-sized areas of Medicare-Medicaid program operational misalignment are pervasive throughout the demonstration. State officials expressed the opinion that for a broad range of day-to-day operational policies and procedures where the Medicare and Medicaid programs differ, they have had limited ability to tailor administrative provisions to align with State policies and little choice but to accept Medicare processes. As implementation of the demonstration has proceeded, additional areas of Medicare-Medicaid program misalignment have surfaced, which are being referred to the CMT for discussion among CMS and State staff.
- The MMPs interviewed by the evaluation team reported that within the first 6 months they had invested heavily to ensure success, hired management and data analytic staff, tailored data collection and medical record systems, created member materials and websites, and learned new reporting and compliance requirements.

3. Enrollment

This section describes the status of enrollment across six demonstrations in their first two quarters of operation (California, Illinois, Massachusetts, Ohio, Virginia, and Washington). Enrollment data for Minnesota are not included because the Minnesota demonstration is focused on aligning Medicare and Medicaid administrative functions for its Minnesota Senior Health

Options Program (MSHO), which has been operating in its current form for 9 years and has sustained its target enrollment level. The section also provides information on achievements and challenges that demonstrations have faced with enrollment during the first two demonstration quarters.

Enrollment Figures and Methods

Beneficiaries can enroll in the demonstrations by opting in (actively making a choice to enroll and, in capitated model demonstrations, selecting an MMP), or through passive enrollment in which the State enrolls the beneficiary in an MMP, with the opportunity to opt out (in capitated model demonstrations), or auto-assigns them to health homes (in the Washington State managed fee-for-service [MFFS] demonstration). Beneficiaries also have the opportunity to opt out of the demonstration prior to passive enrollment or to disenroll later. The capitated model demonstrations generally provided an opt-in enrollment period before implementing passive enrollment. Demonstrations varied in the length of their opt-in only periods, and how soon they implemented passive enrollment sometimes varied by county.

States used assignment algorithms to assign beneficiaries to MMPs as part of the passive enrollment process for capitated model demonstrations. At least three States tried to limit disruption in care by attempting to enroll beneficiaries in MMPs associated with plans beneficiaries had been enrolled in previously or by matching them with MMPs that included the beneficiaries' current providers in the MMPs' networks. Some States also used intelligent assignment algorithms to prioritize passive enrollment of specific target populations. For example, Massachusetts used an algorithm to passively enroll beneficiaries with lower health care needs into the demonstration first, whereas Washington focused on enrolling its highest-need beneficiaries first, and Illinois enrolled its LTSS users last.

In aggregate, the six demonstrations enrolled fewer beneficiaries than the States initially anticipated in the first 6 months of operations, for a variety of reasons. Opt-out rates were higher than anticipated, and the lack of good contact information for beneficiaries led to lower enrollment in some States. In some service areas fewer MMPs ultimately participated in the demonstration than had been anticipated, resulting in more limited demonstration capacity and limiting States' ability to implement passive enrollment, which requires having at least two plans available to each beneficiary. States also purposefully staggered the enrollment process to allow more time for MMP readiness and acknowledging limits to MMP capacity (in capitated model demonstrations), or health home capacity (in Washington State), to ensure time for sending enrollment notices to beneficiaries, and to allow enrollment system testing and refinements. Some States also phased in enrollment by geographic region or special population. The States included in this report reported several reasons that a subset of beneficiaries opted out of the demonstration before passive enrollment took effect, including satisfaction with the care they were receiving outside of the demonstration; beneficiaries' providers' not having contracted with the MMPs or encouraging beneficiaries not to enroll; and general confusion about the demonstration.

While some MMPs and States had initially expected and desired higher enrollments, to maximize the potential impact of the demonstrations, the lower initial enrollment rates allowed States, MMPs, health homes and providers to identify and address initial demonstration challenges, such as finding, engaging and assessing their members (see *Section 4, Care Coordination*). Demonstration enrollment began to increase in subsequent quarters.

Table 2 presents the total number of beneficiaries eligible for the demonstrations in the first two quarters in each State, as well as enrollment data through the second quarter of implementation as reported by these demonstration States. Enrollment ranged from 2,036 in demonstration health homes in Washington (13 percent of eligible beneficiaries) to 46,793 in Illinois MMPs (32 percent of all eligible beneficiaries). The data presented also includes estimates of the number of those passively enrolled. To some extent the variation in total enrollment reflects how soon each State implemented passive enrollment, which was the source of most demonstration enrollment. The Massachusetts and Virginia demonstrations include some counties with only one MMP and hence were excluded from passive enrollment, and some rural areas in California were excluded from passive enrollment because there was only one MMP in those zip codes.

Table 2.
Eligibility and enrollment by State, as of end of second demonstration quarter¹

Category	CA	IL	MA	OH	VA	WA
Total number of beneficiaries eligible to enroll in demonstration	431,000	148,458	93,928	95,431	70,502	16,176
Beneficiaries enrolled in the demonstration at the end of 2nd quarter	44,804	46,793	9,704	14,957	20,507	2,036
Total passively enrolled ²	--	41,162	4,171	N/A	20,728	2,109
Percentage of eligibles enrolled at the end of the 2 nd quarter	~10% ³	32%	10%	16%	29%	13%

N/A = not applicable; -- = not available at the time of this report.

¹ For additional detail and context, please refer to the individual State evaluation design reports at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.

² The total passively enrolled population may be higher than the currently enrolled population because of disenrollments during the first two quarters.

³ Approximation due to multiple sources of data.

NOTE: Although the time period reported is 6 months, the calendar months are not the same across demonstrations because each State has a different start date.

SOURCES: California: Estimate provided by Centers for Medicare & Services and SDRS, 2nd quarter, 2014; Illinois: SDRS, 2nd quarter, 2014; Massachusetts: SDRS, 2nd quarter, 2014; Ohio: SDRS 2nd quarter, 2015; Virginia: SDRS, 2nd quarter, 2014; Washington: SDRS, 2nd quarter, 2013.

Even though the Washington State MFFS demonstration provides services through the traditional fee-for-service Medicare and Medicaid programs and does not affect beneficiaries' choice of providers or limit availability of services, beneficiaries have the option to opt out of the

demonstration. Beneficiaries are auto-assigned to a health home to coordinate their services, and they may choose not to use or engage with that health home. Their Medicare and Medicaid services are not disrupted if they decide not to engage with the health home.

Beneficiaries in both capitated and MFFS demonstrations also may disenroll at any point during the demonstration, generally effective the first day of the subsequent month. Although not presented here, the number of beneficiaries disenrolling from the demonstrations included in this report has been minimal through March 31, 2015.

Medicare-Medicaid Plan Enrollment

Table 3 shows the percentage of beneficiaries enrolled in each MMP in each capitated model demonstration. MMP data reported by a CMS contractor reflecting demonstration data at the end of the sites' first 6 months (with the exception of Illinois, which reflects data at the end of the first 5 months) showed that 8 (of 10) MMPs in California were operational: 3 plans enrolled between 17 percent and 20 percent each of demonstration enrollees, with the remaining beneficiaries divided among the 5 plans. Illinois also had 8 MMPs: 1 plan enrolled slightly more than 20 percent of demonstration enrollees, and 5 plans enrolled from 10 percent to 17 percent each. Two of the 3 MMPs dominated the market in Massachusetts, with 66 percent and 26 percent of demonstration enrollees, whereas 1 MMP of 5 in Ohio dominated the market with 44 percent of beneficiaries enrolled. In Virginia, 3 MMPs had enrollment ranging from 20 percent to 42 percent each. Variation in enrollment across plans within a State reflects various factors including the geographic area covered by an MMP, the result of the intelligent assignment algorithms, MMP capacity, and prior enrollment in an MMP's existing Medicaid managed care plan.

Mandatory Medicaid Managed Care

Some demonstration States have mandatory Medicaid managed care (i.e., require their Medicare-Medicaid enrollees to enroll in Medicaid managed care for their Medicaid services, whether or not they enroll in an MMP). Medicare-Medicaid enrollees in California who live in the demonstration areas are required to enroll in managed care plans for their Medicaid benefits unless they are otherwise excluded, even if they opt out or disenroll from the demonstration. In Ohio, beneficiaries who opt out or disenroll from the demonstration continue to receive Medicaid services through a MyCare Ohio managed care plan. Enrollment in Medicaid managed care will be mandatory for beneficiaries receiving LTSS in Illinois; implementation is tentatively planned for early 2016.

Table 3.
MMP enrollment by capitated model demonstration at the end of the first 6 months¹

CA: MMP	CA: Enrollment	IL: MMP	IL: Enrollment	MA: MMP	MA: Enrollment	OH: MMP	OH: Enrollment	VA: MMP	VA: Enrollment
Blue Cross Partnership of California	8%	Aetna Better Health of Illinois	15%	Commonwealth Care Alliance	66%	Aetna, Inc.	15%	HealthKeepers	39%
Care1st	12%	Health Alliance Medical Plans	10%	Fallon Total Care	26%	CareSource Management Group Co.	44%	Humana Health Plan	38%
Community Health Group	7%	Health Care Service Corporation	21%	Tufts Health Plan - Network Health	8%	Centene Corporation	13%	Virginia Premier Health Plan	23%
Health Net	20%	HealthSpring	17%			Molina Healthcare, Inc.	13%		
Health Plan of San Mateo	6%	Humana Health Plan	16%			UnitedHealth Group	16%		
Inland Empire Health Plan	17%	IlliniCare Health Plan	2%						
LA Care	10%	Meridian Health Plan of Illinois	14%						
Molina Healthcare	21%	Molina Healthcare of Illinois	7%						
Cal Optima	N/A								
Santa Clara Family Health	N/A								

N/A = not applicable: these MMPs were not operational during the first 6 months of the demonstration.

¹ Illinois is an exception: data are as of August 2014, which is 5 months of enrollment. Data for month 6 were not available.

NOTES: Empty cells indicate that there are no data. Some percentages do not total 100 because of rounding.

SOURCES: NORC at the University of Chicago: Executive Summary—California September Monthly Report (enrollment data as of 10/31/14).. Baltimore, MD: Centers for Medicare & Medicaid Services, 2014; NORC at the University of Chicago: Executive Summary—Illinois August Monthly Report (enrollment data as of 8/29/14). Baltimore, MD: Centers for Medicare & Medicaid Services, 2014. NORC at the University of Chicago: Executive Summary – Massachusetts April Monthly and Quarter 1 Report (enrollment data as of March 2014). Baltimore, MD: Centers for Medicare & Medicaid Services, 2014. NORC at the University of Chicago: Ohio October Monthly and Quarter 3 Quarterly Report (enrollment data as of 11/28/14). Baltimore, MD: Centers for Medicare & Medicaid Services, 2014. NORC at the University of Chicago: Executive Summary—Virginia September Monthly Report and Quarter 2 Report (enrollment data as of 10/31/14). Baltimore: Centers for Medicare & Medicaid Services, 2014.

Early Findings on Enrollment

Even though enrollments began more slowly than initially planned, the demonstrations have successfully enrolled thousands of beneficiaries during their first two quarters of operations. During that time, a number of early lessons emerged about the enrollment process and how to better reach and enroll beneficiaries:

- In most demonstrations highlighted here, passive enrollment was very important to building enrollments. As evidenced by Table 2, where data are available, the States enrolled many, if not the vast majority, of eligible beneficiaries through passive enrollment (Massachusetts is an exception). However, these demonstrations encountered challenges with passive enrollment. Despite efforts to accommodate plan capacity such as staggering enrollment, MMPs needed to handle the influx of many enrollees at one time. Also, passively enrolled individuals might not have been familiar with how the demonstration or managed care worked, so MMPs needed to educate them.
- Multiple strategies need to be employed by States and MMPs to locate beneficiaries for enrollment in the demonstrations. Finding eligible beneficiaries was a challenge voiced by key informants interviewed by the evaluation team. State systems often had incorrect or outdated contact information, making it difficult or impossible to get required passive enrollment notices to beneficiaries. To ease this challenge, one State, Virginia, asked local Department of Social Services offices to assist with locating eligible beneficiaries whose information packets had been returned in the mail.
- MMPs also indicated that their staff spent an inordinate amount of time trying to locate enrollees in order to complete initial health assessments and introduce enrollees to the benefits of the demonstration. MMPs used creative efforts to locate beneficiaries, including contacting providers and visiting places where beneficiaries may be, such as dialysis centers, day centers, and soup kitchens. Some MMPs contracted with commercial vendors for phone and address tracking, and others reviewed pharmacy data to look for more up-to-date contact information.
 - Notices developed for the demonstration were confusing, and there were many of them. Coordinating information sent by multiple sources about the demonstration might have reduced confusion among beneficiaries. Various entities, including the State and enrollment brokers, sent a wide range of demonstration information to beneficiaries prior to enrollment, which many stakeholders considered excessive.
 - Enrollment notices were revised after the first few months of implementation in California to incorporate feedback from consumer testing and advocate input.
 - Massachusetts began sharing enrollment notices with a consumer-led stakeholder committee for review.

- Virginia has convened focus groups to provide feedback on its materials.
 - CMS and States have applied this learning in the later-implementing demonstrations as well: Rhode Island and New York have already shared early drafts of their enrollment notices with consumer advocacy groups, and CMS is sharing them with national groups.
 - In addition to consumer testing of enrollment notices, CMS has tested a number of model beneficiary communications that are sent by plans, which are applicable across the State demonstrations. CMS is also undertaking a second round of testing this year
- Once enrolled, beneficiaries received information from their new MMP and beneficiaries also received disenrollment notices from their existing Part D plan (PDP), and from their previous Medicare Advantage plan, if they had one. These notices may have been particularly confusing to passively enrolled beneficiaries. Although the effective disenrollment dates were aligned with the demonstration effective enrollment dates, in some cases the PDP disenrollment notices arrived before the demonstration enrollment materials, creating confusion. In response:
 - Massachusetts worked with CMS, the demonstration’s Customer Service Center (CSC), and the State Health Insurance Assistance Program (SHIP) to educate customer service representatives and SHIP counselors about the demonstration’s interface with Part D to help answer enrollees’ questions. Massachusetts also developed information about the demonstration and prescription drug changes that was included in subsequent mailings to members.
 - An MMP in Virginia drafted a simplified informational pamphlet about the demonstration to include in mailings to make the information more consumer friendly and demonstration specific.
 - CMS developed revised PDP disenrollment notices specific to Medicare-Medicaid enrollees who were included in passive enrollment into an MMP. These notices replaced the previous PDP disenrollment notices that were sent to all Medicare beneficiaries, including Medicare-Medicaid enrollees. The new notices explain that the recipients are receiving the PDP disenrollment notice because of passive enrollment into an MMP, and provide contact information for beneficiaries to call with questions or to learn more about their options.
 - Although disenrollments have been low, some States reported that unrestricted beneficiary choice sometimes resulted in beneficiaries’ changing enrollment decisions multiple times during a month. With enrollments and disenrollments taking effect at the start of the following month, some enrollment changes were processed before a more recent pending change request from the same beneficiary. Thus, some enrollees received duplicate and conflicting enrollment packets from different MMPs. In addition, States reported that processing numerous change requests from a subset of beneficiaries depleted demonstration resources.

- Many States and MMPs reported technological challenges to enrollment. Additional time and a platform for end-to-end testing before launch of the demonstration might have helped identify and resolve computer system issues that required last-minute changes and manual workarounds. Transferring and syncing data across multiple systems (e.g., Federal, State, and MMP) caused discrepancies in enrollment information and delays in enrollment. In particular, States cited challenges in reconciling their enrollment systems with those of CMS.
- Despite outreach efforts and the use of intelligent assignment algorithms, interviewees reported that some enrollees were unaware of their MMP enrollment and its implications until arriving at a pharmacy or doctor's office that was out of network (e.g., when a provider denied service saying it was not in the MMP network).

4. Care Coordination

Care coordination is a centerpiece of all demonstrations under the Financial Alignment Initiative and is considered the primary vehicle for achieving improved outcomes through comprehensive risk assessments and health action plans, person-centered planning, and navigation assistance to access services.

Care coordination and care management are not new functions. Before these demonstrations, most States provided care coordination for a subset of dually-eligible individuals (e.g., people receiving home and community-based services [HCBS] waiver services) or in association with a narrower set of services (e.g., behavioral health or long-term services and supports [LTSS]). The demonstrations provide the opportunity to create a single point of contact for all care coordination services; expand the number of people getting the service; broaden the scope of the services being managed (e.g., medical, behavioral health, LTSS), and provide for cross-disciplinary care teams.

The entities conducting care coordination and care management vary across the demonstrations and the MMPs. Except as described below, the three-way contracts allow the MMPs to develop their own care coordination strategies and processes. MMPs can provide care coordination either internally or contract for the services. In Massachusetts and Ohio, the States have leveraged existing relationships with community-based organizations and required the use of some of the care management infrastructures available through area agencies on aging, independent living centers, mental health recovery centers, and health homes. In addition to a care coordinator role on each member's care team, Massachusetts also required the MMPs to contract with community-based organizations and offer an additional long-term supports (LTS) coordinator to all enrollees. The LTS Coordinator role was designed to bring independent long term services and supports and behavioral health expertise to members' care teams. Enrollees must be offered a choice of at least two LTS Coordinators, and MMPs are required to contract with at least one independent living center in each area, and to offer an LTS Coordinator from the State's Aging

Service Access Points (ASAPs) to enrollees age 60 and older. Similarly, in Ohio, the MyCare Ohio plans must contract with Area Agencies on Aging for waiver service coordination for enrollees aged 60 or older, and may also contract with other service coordination entities. In Washington, many of the area agencies on aging serve as care coordination organizations and provide care coordination services under the demonstration. In Illinois, MMPs are also responsible for providing care management for nursing facility residents by employing clinicians who specialize in care management for nursing facility residents known as SNFists.

Care coordination functions generally include an assessment of an individual's medical, physical, and other social support needs, development of a personalized plan of care/action plan, monitoring and clinical management of people with complex care needs, and helping beneficiaries locate and obtain needed services. These functions are performed as part of an integrated care team that includes primary care providers, specialists, behavioral health providers, LTSS providers, and the beneficiary.

All demonstrations require that some form of a risk assessment be conducted within specified time frames, which usually vary by the level of risk or care need. For example, Ohio requires assessments to be completed within 15 days of enrollment for those in the most intensive group and within 75 days for those assigned to a lower level/monitoring tier. California requires that assessments be completed within 45 days for those in its highest risk category and 90 days for all others. States identified the assessment content areas with CMS input, but in most instances did not require the use of a standardized tool across MMPs, instead each MMP developed its own requirements. In addition to a comprehensive assessment, Massachusetts requires MMPs to complete the standardized Minimum Data Set–Home Care (MDS-HC) for confirmation of high LTSS or high behavioral health rating category assignment within 90 or 180 days, depending on the rating category. Plans had difficulty meeting these requirements due to the volume of initial assessments needed in the first months compounded by problems locating their enrollees.

In addition, States used various methods to further stratify beneficiaries by categories of risk, including claims-based algorithms and other care-need criteria (e.g., residing in a nursing facility or receiving HCBS waiver services). States used these risk stratifications in several ways: to develop payment levels, to allocate care coordination resources, to determine the time frames for conducting assessments and reassessments, and to develop care plans.

Early Findings on Care Coordination

During the first 6 months of implementation, MMPs interviewed by the evaluation team were still refining their work flow and workloads, and developing the information systems needed to support care coordination. Some were contracting with outside vendors to conduct initial assessments and develop plans of care. States invested substantial resources to provide training for care coordinators, and there is anecdotal evidence of enrollees' benefiting from care coordination services.

- Several States identified the need to provide specialized training for care coordinators on their enhanced roles and responsibilities and on the needs of the special populations.
 - Washington provided extensive statewide training covering the information and skills needed for the care coordinators, including an overview of program philosophy, motivational interviewing, enhanced care coordination functions, and use of the State information (Predictive Risk Intelligence system, or PRISM) system.
 - Massachusetts developed a training video, targeted to the demonstration care coordinators and the LTS coordinators, on the distinct roles and responsibilities of the LTS coordinator.
 - California used grant funds from the Administration for Community Living (ACL) to develop a special training program for care coordinators focused on Alzheimer’s disease, because about a quarter of its enrollees were thought to be diagnosed with or potentially have Alzheimer’s disease.

In many demonstrations, implementation of the full array and/or volume of care management services was slower than anticipated due to a number of start-up issues that required focus and attention.

Waves of passive enrollment require plans to find, engage and assess a large number of new enrollees in a short period of time. Plans reported great difficulty staffing to meet the demands of these peak enrollment periods especially during early implementation. As a result many MMPs and health homes were not always able to adhere to the required timelines for assessment and care plan completion. States and CMS worked with the MMPs to clarify the minimum required protocols for reaching out to members (e.g., number of phone calls/attempts) and the data reporting requirements associated with assessments, refusals, and inability to locate people.

- State officials and stakeholders reported that the roles and responsibilities of the care coordinator were at times overlapping and confused with the roles and responsibilities of other case managers in the system; although in Washington, the health home coordinators were viewed as complementing the role of the case manager embedded in the specific delivery system, who was unable to comprehensively address the full range of an individual’s needs.
 - In Virginia, stakeholders reported that the role of the care managers and LTSS providers seemed to be blurred. LTSS providers in that State were concerned that the care managers might be eliminating their jobs.
 - In California, many agencies serving the target population (e.g., community-based organizations and county-based mental health and substance abuse agencies) had their own care coordination and comprehensive processes. The boundaries and

possible redundancies in having different types of care coordinators had not been entirely worked out within the first 6 months.

- In Massachusetts, work was focused on ensuring that enrollees understood the purpose of the care coordinator and were offered access to a newly created Independent Living and LTSS (LTS) coordinator.
- The lack of trained care coordinators was also a common challenge during the early implementation phase.
 - In Ohio, MMPs had difficulty hiring enough trained staff to meet the required assessment schedule. One way that MMPs were able to staff quickly was by hiring care coordinators from other community-based agencies, thus reducing the capacity of the community organizations.
 - In Illinois, State and MMP officials reported difficulty hiring and maintaining care coordinators, especially in the Chicago area. One MMP indicated that competition for case managers was high due in part to the number of health plans in the area and the State’s care coordination staffing requirements.
 - In Massachusetts, the community-based organizations were hesitant to fully staff with LTS coordinators because of uncertainty about their case-load volumes.
- The information and data management systems to support centralized enrollee records was also identified as a key area of focus for development and improvement. During the first 6 months of implementation, these systems were in the early stages of development and use for most of the States and the MMPs highlighted in this report.
 - In Ohio, MMPs were having difficulty meeting the requirements to create a centralized enrollee record accessible by the entire team.
 - In California, each MMP has a different care coordination management system with no integration with the State- or county-based systems. MMPs generally adapted current systems for use in the demonstration and reported on their intentions to expand electronic medical records (EMR) and other systems to include a wide range of medical and LTSS assessment and other information.
 - Some, but not all MMPs, have central electronic records. For those that do, not all team members have access to the records. In Massachusetts, MMPs reported they had developed systems to share assessment and other case note information with the community-based organizations.
- Self-reported stories of those benefiting from the coordination of medical and LTSS are emerging:
 - Massachusetts produced several video vignettes to illustrate how care coordinators can help members live independently, stay healthy and access

transportation and other services. One story illustrated how the care coordinator connected the member to Meals on Wheels, a doctor close to home, phone services, and visiting nursing services. Other video vignettes showed how care coordinators have set up transportation services, facilitated access to dental services and coordinated care with primary care and specialty physicians.⁴

- In Virginia, success stories from the field, reported as part of routine stakeholder updates, provide examples of how care coordinators are improving the health and quality of life of members. In one example, a care coordinator was able to identify gaps in primary care, arrange transportation to a local provider, divert the member from otherwise using the emergency room, and address long-standing issues of pain. In other instances, care coordinators conducting in-home visits have identified unmet needs, addressed caregiver burden, arranged access to food delivery that would accommodate a diabetic diet, helped to resolve unmanaged pain, and facilitated the approval of increased hours of personal care.⁵ Similar stories were provided as part of focus groups and ongoing evaluative observations that illustrated how care managers advocated for enrollees, provided clear explanations of benefits, and helped members access needed and, in some cases, new services, such as a wheelchair, dental services, and eyeglasses.⁶

5. Beneficiary Safeguards and Protections

Although the demonstrations under the Financial Alignment Initiative are widely seen as an opportunity to improve the coordination of services and thus promote better outcomes for Medicare-Medicaid enrollees, many stakeholders caution that these innovations, combined with the goal of achieving savings, come with potential beneficiary risks. This section reviews specific areas of risk, the protections that CMS and States have incorporated into the design of the demonstrations, and initial observations about how these protections are working.

Passive Enrollment Protections

CMS permits Medicare beneficiaries to be passively enrolled into the demonstrations under certain circumstances. Multiple safeguards were put into place to maximize beneficiary awareness and choice under passive enrollment. These safeguards included advance notification allowing beneficiaries to opt out prior to enrollment, assignment to MMPs whose networks include providers with whom there was an established relationship whenever possible, the option to disenroll at any time, and the restriction that passive enrollment apply only in areas where

⁴ <http://www.mass.gov/eohhs/consumer/insurance/one-care/one-care-videos.html>. As obtained on April 8, 2015.

⁵ Stakeholder updates July–November 2014; http://www.dmas.virginia.gov/Content_pgs/altc-stkhld.aspx. As obtained on April 9, 2015.

⁶ PowerPoint presentation entitled Review of Commonwealth Coordinated Care Beneficiary Focus Groups (CY 2014) by Craver, G., Lee, M., and Broughton, S. March 23, 2015; PowerPoint entitled Review of Commonwealth Coordinated Care (CCC) Coordination Observations (CY 2014) by Craver, G. January 26, 2015; http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx. As obtained on April 8, 2015.

there were two or more MMPs, with limited exceptions including areas designated as “rural” or, in the case of two counties in California, exempt under federal regulations.⁷ (See section on *Enrollment*.)

Enrollment Assistance

All demonstrations developed programs to help beneficiaries make decisions about whether to enroll or which plan to enroll in. Many of these programs are supported through CMS funding opportunities open to all demonstration States, such as the funding opportunity to support options counseling through the State Health Insurance Programs (SHIP) and Aging and Disability Resource Centers (ADRC). States chose different models and have had varying success in the early months of implementation. Here are a few examples:

- All capitated model demonstrations included in this report used an outside enrollment broker. California reported higher-than-expected call volumes during the initial enrollment period. As a result, beneficiaries reported to stakeholder and advocacy groups that inaccurate and inadequate information was provided. Illinois, however, found that a carefully planned phased-in enrollment strategy helped the State enroll one-third of its target population by the second quarter of implementation. Massachusetts and California relied heavily on advocacy organizations, in addition to its enrollment broker, to provide enrollment assistance to its beneficiaries. Massachusetts and California also convened focus groups to assess beneficiary reaction to enrollment materials and convened work groups to advise the State on how to make materials more understandable. California, Illinois, Massachusetts, and Ohio use the same enrollment broker for the demonstration as for their traditional Medicaid Managed Care program.
- In California, Illinois, Massachusetts, Virginia, and Washington, options counseling was made available through SHIP/ADRC grant funds provided by CMS. California and Virginia used the State’s insurance counseling assistance/advocacy program in addition to an enrollment broker to assist beneficiaries.

Ombuds Program

All demonstrations highlighted in this report, except for Minnesota, applied for and received Federal funding to support the development of an ombuds program specifically for the demonstration. In addition, CMS funded an Ombudsman Technical Assistance Program for the demonstrations under the Financial Alignment Initiative to make information and resources available to State ombuds programs and to facilitate an exchange of ideas and best practices across programs.

⁷ Orange and San Mateo counties are organized as County Organized Health Systems (COHS) and are exempt from Federal requirements that beneficiaries be given a choice of at least two plans in a region (Section 4701 of the BBA of 1997 and implemented in 42CFR 438.52).

Differences across these demonstrations primarily center on the entity serving as the ombuds program and the authority of that entity. At the urging of their stakeholders, California, Illinois, and Massachusetts all required that the ombuds program be an independent entity. Virginia and Ohio, however, augmented the scope of existing State ombuds programs, one serving long-term and home care recipients (Ohio) and the other serving residents in nursing facilities and assisted living facilities (Virginia). In Illinois, the ombuds program for the demonstration is independent of the Medicaid agency and is part of the existing Long-Term Services and Supports (LTSS) ombuds program, which is housed in the Department of Aging and serves both LTSS institutional residents and home and community-based services (HCBS) waiver participants.

Activities conducted by the ombuds program varied but generally included outreach, advocacy, complaint resolution, and, to a lesser degree, options counseling. Stakeholders interviewed by the evaluation generally spoke highly of the ombuds programs although they were often slow to get started. In Illinois, a combination of factors seemed to have delayed their timely start-up: a longer than expected application process; lower than expected funding levels that hampered their ability to hire both the regional and central office staff; delay in CMS training on use of the HPMS system for entering complaints; and more time required to conduct staff training because of a lack of familiarity with community-based beneficiaries. In California, the ombuds program expanded its tasks beyond complaints and advocacy to include options counseling after it was inundated with calls on basic questions about the demonstration. It requested and received additional training on all aspects of the California demonstration from the National Senior Citizens Law Center (now Justice in Aging) to provide staff attorneys with comprehensive information. Training was critical during early implementation to broaden knowledge about managed care and the demonstration. The Massachusetts ombuds program indicated its preference that ombuds programs also be given the legal authority to represent beneficiaries in appeal hearings. Despite these early challenges, there was widespread expectation that the ombuds programs will play a critical role in most of the demonstrations.

Continuity of Care

To ensure that demonstration enrollment did not disrupt beneficiary care plans and receipt of existing services, all capitated model demonstrations have instituted continuity of care provisions for an interval of time or until a new plan of care using in-network providers can be developed. Because the Washington managed fee-for-service model demonstration does not limit beneficiaries to specific provider networks, this provision is not relevant to that demonstration. Under the continuity of care provision, a beneficiary enrolled in the demonstration may, for a period of time, continue to see providers (including those outside the MMP network) and receive services that were authorized before enrollment. California and Virginia have the longest continuity of care provision at 6 months (for California, this is for Medicare-only services); there is also a 12-month continuity of care for Medicaid services in California. Continuity of care requirements in Ohio vary from 90 to 365 days, based on type of service, beneficiary risk level, and other criteria. State officials and MMPs in Virginia reported that some providers, such as nursing facilities, did not initially use the provision and denied services because of provider

concerns about payment rates even though pre-demonstration rates applied during the continuity of care period. The continuity of care provision in the Illinois and Massachusetts demonstrations extends until assessments and plans of care are completed.

Complaints, Grievances, and Appeals

The right to be heard on issues of dissatisfaction and to have recourse when resolutions are not favorable is a core protection for beneficiaries. CMS and States have negotiated key components of complaint systems to ensure that the terms of an integrated grievance and appeals system allow for the Medicaid or Medicare standard more favorable to beneficiaries to prevail.

Under capitated model demonstrations, complaints must be tracked and entered into the CMS Complaint Tracking Module (CTM). These include complaints received by 1-800-Medicare, State agencies, and ombuds programs. MMPs do not enter complaints into the CTM but are required in all demonstrations to submit monthly reports on the nature and resolution of complaints they receive directly. During the first 6 months of implementation, there was some confusion as to what constituted a complaint and who had responsibility for entering complaints in the CTM. For example, Massachusetts found that some MMPs did not document complaints that were resolved at the time that they were first made. The Massachusetts ombuds program staff was trained in the use of the CTM after it launched, and reports complaints via the CMT. California, Massachusetts, and Ohio advocate a “no wrong door” approach to complaints, an effort that, although desirable, requires coordination to ensure that there is a comprehensive record of all complaints and that efforts are not duplicated. States reported during site visits that early complaints have been largely related to enrollment issues (e.g., beneficiaries did not know they were enrolled), provider networks (e.g., beneficiary provider not part of MMP’s network, insufficient number of specialists in the network), and formulary (e.g., particular medications not covered).

States, ombuds programs, and MMPs reported that there were limited appeals during the first 6 months, presumably because continuity of care provisions remained in effect for many beneficiaries during the first 6 months of implementation.

The evaluation team found a few variations in how States operate their appeals process, although all provisions have the same or greater protection than the Medicare standard outside of the demonstration⁸—but not necessarily greater than the Medicaid standard. Most differences pertain to the path for resolving an appeal. In the case of capitated model demonstrations, the MMP is the first level of review for an appeal, though in some states beneficiaries can file an appeal directly with the state fair hearing agency for Medicaid services. The other similarity across capitated model demonstrations pertains to Medicare service appeals that are not resolved by the MMP in the beneficiary’s favor. In such cases, the second level of Medicare appeals is the

⁸ Medicare standards governing appeals can be found in the Medicare Managed Care Manual, Chapter 13 and 42 C.F.R for managed care and 42 CFR Part 405, Subpart I (for fee-for-service). Medicaid standards for governing appeals can be found at 42 CFR Part 431, Subpart E (general provision, including fee-for-service) and 42 CFR Part 438, Subpart F (for managed care).

Independent Review Entity (IRE). Massachusetts and Ohio use the state fair hearing agency for Medicaid-related appeals. In the case of appeals that overlap between Medicare and Medicaid, these States allow the beneficiary to send appeals to the state fair hearing agency in addition to having an automatic review by the IRE. The finding most favorable to the beneficiary applies. In both states, the beneficiary has the option of sending an appeal that overlaps between Medicare and Medicaid to state fair hearing agency at the same time that the appeal is forwarded automatically to the Medicare IRE.

Beneficiary Focus Groups and Surveys

States and CMS have placed strong emphasis on soliciting beneficiary feedback during the design and implementation of the demonstration to help ensure that their initiatives are responsive to their needs. All demonstrations presented in this report have conducted or plan to conduct focus groups or surveys with enrolled beneficiaries. Before implementation, Ohio developed a questionnaire for prospective enrollees to identify needs and areas of improvement over their current system. In the first 6 months of implementation, Massachusetts conducted a focus group with beneficiaries who opted in to One Care (i.e., self-selected a MMP) and another with beneficiaries who opted out of the demonstration. These focus groups found that self-selected enrollees were more likely than the opt-out group to have confirmed their provider's participation in the MMP and to have seen value in care coordination services, no copays for medications, and better dental coverage. Similar results were found in an enrollee survey administered in Massachusetts. In addition, Massachusetts administered a survey to three groups (self-select; opt out; no action) to examine enrollee perceptions during the early enrollment period. Findings found marked differences among the groups with respect to their understanding of marketing materials and their willingness to seek enrollment assistance. Findings from focus groups and surveys were used in Massachusetts to refine communication and outreach materials. Researchers from the University of California San Francisco (UCSF) and Berkeley are working with California demonstration project staff to conduct a large telephone survey and 15 focus groups with funding from the SCAN Foundation. Early results from the focus groups will provide State staff with insight regarding beneficiaries who opted out or disenrolled from the demonstration.

Accountability and Transparency

Because the Financial Alignment Initiative is creating major service delivery reform for Medicare and Medicaid, particularly in capitated model demonstrations, demonstrations are under close scrutiny by Federal and State policy makers, providers, and other stakeholders. States were required under the demonstration to engage the public in meaningful ways during the design, implementation, and monitoring of these initiatives. States have established councils, committees, work groups, and websites—all with the intent to ensure an open and transparent process for decision making (see section on *Stakeholder Engagement*). Quality metrics are being used to assess and track progress and to make midcourse corrections when intended outcomes are not achieved. Many States and their stakeholders reported to the evaluation that

this level of transparency and accountability are without parallel and serve as the most important safeguard and protection under the demonstration.

Early Findings on Beneficiary Safeguards and Protections

States and CMS have placed high priority on implementing beneficiary protections as part of the demonstrations. Federal funds advanced State efforts to establish or expand enrollee assistance and ombuds programs. Although beneficiary feedback from surveys and focus groups in a few States have helped to refine these efforts, there has been limited experience in most demonstrations to conclusively determine the effectiveness of established safeguards.

- The formal role of brokers, options counselors, SHIP and ADRC advisors as well as the informal role of advocacy organizations were critical to building awareness among beneficiaries about their enrollment options. States relied on feedback from advocates and beneficiaries to help shape their enrollment strategies and to make corrections.
- CMS funding allowed all States to develop new ombuds programs for the demonstrations or to enhance the role of existing programs. Early efforts focused on selecting entities best positioned to serve this role and ensuring that the ombuds program had sufficient training on managed care and the demonstration.
- The continuity of care provision provided an important transition for beneficiaries although its enforcement in Virginia was challenged by out-of-network nursing facility providers.
- CMS's Complaint Tracking Module (CTM) serves as a tracking tool and repository for complaints received by States, ombuds programs, and Medicare. Complaints received and resolved by MMPs are separately reported to States and CMS.
- States that convened beneficiary focus groups used results to clarify demonstration design, such as the role of the LTS Coordinator in MA, and to make marketing materials easier to understand. In addition to focus groups that will be conducted by the RTI evaluation team, all States plan surveys and/or focus groups to assess demonstration performance from the beneficiary perspective.

6. Stakeholder Engagement

The States participating in the Financial Alignment Initiative are required to engage stakeholders throughout demonstration design and implementation. These stakeholders include Medicare-Medicaid enrollees and their families or caregivers; beneficiary and provider advocacy groups; providers (including clinicians, practices, and institutions); long-term services and supports

(LTSS) providers; the Medicare-Medicaid plans; and State government, including related agencies and legislators.

Effective stakeholder engagement allows State officials to better understand the specific interests, needs, experiences, and concerns of affected groups, and, to the extent possible, address them through policy, design, implementation, outreach, and education. The States have used a wide range of strategies and invested substantial resources in engaging stakeholders and considering their input in demonstration design and implementation, and stakeholders have played multiple roles in shaping the demonstrations, ranging from active resistance to active participation.

Many stakeholders see the demonstrations as an opportunity to provide comprehensive care coordination and services to a complex population that historically had limited access to care management. They also see the demonstrations as a chance to provide flexibility and new benefits that are more responsive to individual care needs. However, it was reported during site visits in some States that some stakeholders may have had negative experiences with similar prior initiatives (e.g., transitioning long-term care populations into managed care). There was also concern that beneficiaries and providers may be confused or overwhelmed because they are participating in a concurrent State initiative—for example, mandatory Medicaid managed care, Money Follows the Person, or establishment of health homes.

Strategies for Engaging Stakeholders

Within this context, the demonstration States are employing a variety of strategies to engage stakeholders in the design and implementation of their demonstrations. Although the scope and type of stakeholder engagement activities differ among the States included in this report, many are conducting the same types of activities for beneficiaries, advocacy groups, and providers. These activities include:

- hosting public forums
- conducting regular or as-needed meetings
- conducting webinars
- conducting focus groups, surveys, or key informant interviews
- convening multi-stakeholder advisory boards or work groups
- posting demonstration materials on State websites
- participating on panels at stakeholder meetings
- distributing information at events such as health fairs or conventions

As required by the three-way contracts, MMPs are also independently obtaining enrollee and community stakeholder input through activities, including beneficiary advisory committees and enrollee satisfaction surveys.

Some States are also using innovative strategies to engage stakeholders. For example, some States have conducted multiple day-long informational forums for providers and beneficiaries. Virginia holds quarterly meetings with stakeholders as well as weekly calls with provider groups, and MMPs are required to participate in these activities. They have found that having regular meetings with MMPs present facilitates communication among demonstration staff, MMP staff, and stakeholders of both demonstration-wide and MMP-specific information. Virginia also leveraged technical assistance that it received from the Center for Health Care Strategies through a State leader's participation in the Robert Wood Johnson Foundation's Medicaid Leadership Institute to develop a communications strategy for its demonstration. Massachusetts developed a public awareness toolkit and a consumer/provider outreach toolkit. Ohio used a Request for Information (RFI) to solicit recommendations and identify existing best practices in integrated care from numerous stakeholder groups, and incorporated the responses received through the RFI into its initial concept paper for the demonstration. With the help of a regional LTSS rebalancing task force and the State's Association of Area Agencies on Aging, Ohio also distributed a questionnaire during the demonstration design process to Medicare-Medicaid enrollees and Medicaid waiver participants to gain insight into the existing service delivery system and identify needs and areas for improvement. The State received nearly 700 responses. After facing initial challenges with generating enough potential beneficiary focus group participants, Washington succeeded by soliciting local agencies to convene beneficiaries. Washington also ensured that its engagement process included consultation with American Indian/Alaska Native tribal organizations to engage tribal clinics in participating in the demonstration.

Early Findings on Stakeholder Engagement

The States have used a variety of strategies and resources to engage stakeholders during the first 6 months of implementing their demonstrations. Early findings from these efforts include the following:

- In many instances, States see stakeholders as key partners in the States' design and implementation efforts. The States have sometimes been able to adapt their plans or approaches, or provide additional resources to stakeholders, in response to stakeholder feedback.
 - In California, stakeholders requested a description of the planning process for sending notices to beneficiaries; they later received a comprehensive list of steps and timelines indicating when notices would be sent to specific groups. This allowed stakeholders to educate beneficiary groups before they received the notices. Also, after enrollment forms proved to be confusing in the beginning

months of California's demonstration, CMS and the State organized extensive testing with beneficiaries and redesigned the forms for later enrollment phases.

- In Massachusetts, stakeholder input informed the development and modifications of member materials and improvements in outreach strategies to certain underserved communities.
- Some States (e.g., California, Illinois, Massachusetts) sought stakeholder input on priorities for demonstration quality measures and considered this input in developing their final set of metrics.
- Illinois developed new processes for consultation with related State agencies that oversee affected Medicaid waiver programs that included weekly meetings during the design phase to ensure that agency needs and expertise were taken into account in planning and implementation.
- Massachusetts and Virginia in particular have committed significant resources to supporting stakeholder engagement and have been praised by stakeholders for their efforts throughout the design and implementation phases. Stakeholders in both of these States spoke highly of the States' commitment to transparency during their stakeholder engagement processes, and the leadership demonstrated by sponsoring agencies to convene stakeholders for input.
 - Massachusetts created a consumer-chaired demonstration Implementation Council that meets regularly to discuss implementation policy as part of a comprehensive strategy that engages beneficiaries, advocates, related agencies, MMPs, and providers to continually inform program design. Stakeholders praised Massachusetts's approach as unprecedented and as a model for other States.
 - Virginia's weekly calendar for stakeholder engagement activities is extensive, including a variety of periodic meetings and calls designed to update interested communities and receive feedback. Stakeholders also lauded Virginia for these efforts, and State staff and leadership expressed enthusiasm for and commitment to these activities.
- Some States that have faced opposition from key stakeholders attributed this opposition to a lack of sufficient engagement with specific stakeholder groups.
 - Illinois has been facing challenges with provider participation that officials suggested might be due to a lack of clear understanding among providers about the program and a dearth of direct outreach and education to providers, by the State, and by CMS. Although State officials admitted that more State engagement efforts were needed, they also suggested that many providers serving Medicare-Medicaid enrollees see themselves primarily as Medicare providers and therefore may require more direct education and outreach from CMS and the MMPs about the demonstration.

- After Virginia encountered resistance from nursing facilities, State demonstration staff worked closely with the leader of a nursing facility association to convene additional discussions with the nursing facilities to address their concerns and solicit buy-in.

7. Minnesota Demonstration to Align Medicare and Medicaid Administrative Processes

To further explore ways to better align Medicare and Medicaid operational policies, CMS and Minnesota are conducting a demonstration that uses the existing Minnesota Senior Health Options Program (MSHO) as a platform for implementing administrative program alignment activities. Minnesota is working with CMS to strengthen the alignment of Medicare and Medicaid administrative policies within MSHO, an integrated program that is built on Medicare Special Needs Plans (SNPs) and Medicaid managed care organizations.

The Minnesota demonstration (1) authorizes a set of administrative activities designed to better align Medicare and Medicaid policies and processes; and (2) formalizes certain informal agreements between CMS and Minnesota that allowed flexibility for MSHO administration because of the program's integrated nature. Targets of the demonstration's administrative alignment activities include State input into Medicare policies and procedures for network adequacy assessments and model of care standards; coordination of Medicare and Medicaid Quality Improvement Plans; and collaboration between CMS and the State on administration of a single Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Examples of informal agreements formalized through the demonstration include Medicare-Medicaid integrated enrollment systems, claims adjudication, and grievance and appeals systems.

The results of the Minnesota demonstration are likely to provide lessons for CMS and for other States that are seeking to integrate care for Medicare-Medicaid enrollees through the existing authorities of Medicare SNPs and Medicaid managed care organizations.

8. Next Steps for the Evaluation

The evaluation team will continue a wide range of data collection and analysis activities to monitor and evaluate demonstration implementation and outcomes. These activities include collecting information on a quarterly basis from each State through the online State Data Reporting System, quarterly calls with State demonstration staff, annual site visits to interview a range of stakeholders, beneficiary focus groups, and data analyses using Medicare and Medicaid enrollment, claims and encounter data, and the Nursing Home Minimum Data Set. RTI will also review Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, State evaluation activities, results of the State-conducted surveys and other reports, as well as

grievance and appeals data, and will track Medicare-Medicaid Plan (MMP) quality rating reports. In addition to the seven demonstrations highlighted in this report, five demonstrations have been implemented in other States between September 1, 2014, and March 1, 2015. CMS continues to work with a small number of States on their demonstration designs. The evaluation team will produce three annual reports for each demonstration, and an annual cross-State report. These reports will contain greater detail about the demonstrations and their experiences and will be posted on the CMS website.

The principal focus of the evaluation will be at the State level. CMS has engaged an operations support contractor to monitor fulfillment of certain demonstration requirements outlined in the Memoranda of Understanding (MOUs), three-way contracts, and final demonstration agreements, including MMP-level monitoring in capitated model States. RTI will integrate that information into the evaluation as appropriate.

In addition to monitoring demonstration implementation, the evaluation will also examine the experiences of beneficiaries, their families, and caregivers to assess how closely the demonstrations meet the goal of designing person-centered care delivery models. RTI will solicit direct feedback from beneficiaries through focus groups to gain insight into how the initiative affects them. RTI will also conduct additional key stakeholder interviews to better understand the level of beneficiary engagement with the demonstration, its perceived impact on beneficiary outcomes, and any unintended consequences. RTI will conduct interviews with members of beneficiary groups whose stakeholders are served by a State's demonstration, such as members of consumer advisory groups, beneficiary rights advocates, and public guardian groups. Finally, RTI will incorporate other data collected from States, such as results from State-funded focus groups, reports, and other materials developed by States.

A detailed quantitative evaluation of quality of care, utilization and access, and cost will also be conducted as data become available. Different analytic approaches are required for managed fee-for-service (MFFS) model States versus capitated model States in terms of data requirements, analytic issues, and outcome variables, which are detailed in the evaluation design reports available at www.cms.gov.⁹ For MFFS model demonstrations, Medicare and Medicaid claims from CMS will allow examination of utilization and cost of acute and long-term care services as well as key quality of care measures. Because of delays in the availability of Medicaid data, the evaluation will focus on Medicare services initially. For capitated model demonstrations, MMPs will report Medicare and Medicaid encounters to CMS, and these data will be made available to the evaluation. As of March 2015, a few, but not all, MMPs have begun to submit these encounters to CMS. As these data become available, the evaluation will proceed with quantitative analyses of medical care, LTSS, and behavioral health utilization trends, access to care, and quality of services.

⁹ Evaluation design reports are available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.

While Medicaid data, in general, are delayed, the evaluation is able to readily analyze the Nursing Home Minimum Data Set Version 3.0 (MDS 3.0) to determine utilizations patterns, characteristics of facility residents at admission, and quality of care in nursing facilities. With these data, the evaluation will be able to track LTSS rebalancing efforts in the demonstrations, and quality of nursing facility care. As Medicaid and encounter data become available, RTI will also start tracking State Plan personal care utilization, the balance of HCBS and facility use, and transitions across community and institutional settings.

Finally, RTI will work with CMS to identify high-priority, policy-relevant populations to analyze for each demonstration being sure to bring in State, MCO and stakeholder perspectives as well. Possible special populations of interest, subject to sufficient sample size and other considerations, may include racial and ethnic groups, people living in rural or inner-city areas, younger people with disabilities, people aged 65 or older, people with behavioral health needs, people with developmental disabilities, users of LTSS, and high-cost beneficiaries.

9. Conclusion

CMS developed the Financial Alignment Initiative to test models with States to better align the financing of the Medicare and Medicaid programs and to integrate primary, acute, behavioral health and long-term services and supports for dually eligible beneficiaries. Achievement of these goals, especially under capitated models, requires an unprecedented effort to integrate and adapt systems, policies, and procedures that govern the administration and management of these distinct and complex programs.

This report provided insight on the early implementation experience of the six demonstrations that began as of May 1, 2014 (excluding the Minnesota demonstration, which uses an administrative simplification model and was not included in the majority of this report). Through site visits and monitoring activities, the RTI evaluation team obtained the perspectives of CMS, the States, their partners, and stakeholders in designing and operating new service delivery and payment models as well as the experience of beneficiaries and their advocates.

Although the models and features of the demonstrations in this report differ, the evaluation team found several notable similarities:

- Three-way contracts have been negotiated for capitated model demonstrations between CMS, States and MMPs that establish the care delivery model; provider network, access and quality standards; beneficiary protections; data submission requirements; and payment arrangements.
- State officials have gone through significant efforts to work through the numerous and cumbersome redesign of eligibility, enrollment and data systems to effectively interface with Medicare.

- In capitated model demonstrations, joint State and CMS Contract Management Teams have been established and convene on a weekly and ad hoc basis to oversee and resolve administrative and operational issues in addition to care delivery and enrollee-specific concerns.
- Between 10 and 32 percent of eligible beneficiaries were enrolled in the demonstrations during initial months of operation (including both those who opted in and those who were passively enrolled). States had to overcome challenges in finding beneficiaries and persuading others of the benefits of an integrated service model.
- Significant investments have been made in training care coordinators, providers, and MMPs on the special needs of Medicare-Medicaid enrollees and the value and approaches for coordinating care across services and settings.
- Through funds provided by CMS, States have established or enhanced enrollment assistance and ombuds programs to advocate for and support beneficiaries in ways that facilitate informed and impartial decision making and problem resolution.
- Stakeholders are actively engaged and committed to ensuring that the demonstrations are transparent and responsive to the needs of beneficiaries.
- States reported that the upfront time and resource commitment required to implement the demonstrations far exceeded their estimations. Officials noted that they were unaware of many Medicare requirements, such as the Medicare information technology systems requirements and Medicare quality compliance rules that were applicable to the demonstration. Reconciling differences between Medicare and Medicaid operations consumed significant resources by the States and their care partners. It is unclear at this point whether the time and resource commitments will diminish as the demonstrations mature or if these efforts are inherent to coordinating Medicare, a national standardized program, with Medicaid, a State-specific program with unique features.