



**CHCS** Center for  
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## **ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons**

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Prepared for the Association for Community Affiliated Plans by the  
Center for Health Care Strategies

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## I. Executive Summary

More than 10 million Americans are dually eligible for Medicare and Medicaid. This population includes many of the poorest, sickest, and costliest beneficiaries in both programs. Due to program misalignments, however, these beneficiaries often receive fragmented, uncoordinated care. In 2011, the Centers for Medicare & Medicaid Services (CMS) launched the Financial Alignment Initiative to test new models to integrate Medicare and Medicaid—referred to as financial alignment demonstrations or “demonstrations” in each state in which they operate. Through these demonstrations, CMS and states can contract with Medicare-Medicaid Plans (MMPs), which are responsible for managing the full range of covered services for dually eligible beneficiaries.

This report examines the experiences of 14 MMPs that are members of the Association for Community Affiliated Plans (ACAP) and managing demonstrations. On behalf of ACAP, the Center for Health Care Strategies (CHCS) interviewed these plans to identify innovations advanced under the demonstrations, as well as lessons for integrating care for dually eligible individuals. Following is a summary of findings from these interviews that may inform efforts to improve Medicare and Medicaid integration and alignment.

### Medicare-Medicaid Plan Innovations in Aligning Care

The interviews with ACAP MMPs identified innovations designed to better coordinate and integrate care for dually eligible beneficiaries. Innovations discussed in this report are grouped around key themes:

- **Support individuals in the community by addressing housing and other social determinants of health, and reducing institutional care.** To promote members’ independence and maximize their ability to reside in the setting of their choice, ACAP MMPs focused on reducing the need for institutional care and worked with states and community-based organizations to secure stable housing for members. In particular, ACAP MMPs sought to address social determinants of health to prevent at-risk individuals from further medical and/or functional decline that would require admission to a nursing facility, and to identify individuals already residing in nursing facilities who might be able to transition to community living. ACAP MMPs also leveraged flexibilities within their contracts to fund housing-related services and supports.
- **Coordinate care delivery across various providers and services.** The demonstrations align Medicare and Medicaid providers, systems, and benefits under one system of care. ACAP MMPs described the critical role of care coordinators and interdisciplinary care teams (ICTs) in improving care management. Specific approaches undertaken by MMPs to improve care management include: (1) enhancing discharge/transition planning; (2) implementing telehealth solutions; and (3) building relationships with community-based organizations.
- **Identify unmet needs.** Many dually eligible beneficiaries have complex needs that have historically gone unmet, often due to their inability to access services and the lack of coordination across Medicare and Medicaid providers. ACAP MMPs are using the

opportunity as integrated health plans to increase access to appropriate behavioral health services, improve care management for medically frail individuals in the home, provide supplemental benefits including dental care, and meet members' social needs.

- **Engage providers across the continuum of care.** ACAP MMPs emphasized that obtaining provider buy-in and ensuring that providers are well-integrated into the care management process are critical for the development of robust health plan networks and longer-term MMP viability. Long-term services and supports (LTSS) providers – both institutional and home- and community-based (HCBS) providers – often had limited experience with managed care and many MMPs tailored training and outreach to engage these providers and partnered with provider associations to provide education regarding the demonstration.
- **Coordinate physical and behavioral health.** Nationally, more than 40 percent of dually eligible beneficiaries have a mental health condition.<sup>1</sup> ACAP MMPs sought to improve coordination across mental health, substance use disorder, and physical health services by: (1) promoting interdisciplinary collaboration across physical and behavioral health providers; (2) developing electronic information sharing and management solutions; and (3) leveraging community connections to provide person-centered, recovery-focused care.
- **Explore alternative payment models to improve value and accountability.** Combining Medicare and Medicaid funding streams increases incentives for plans to develop value-based payment (VBP) arrangements that reward providers for outcomes because MMPs manage the full range of services that can impact beneficiary outcomes. VBP initiatives implemented by ACAP MMPs include: (1) linking a portion of provider payments to quality outcomes; (2) establishing incentives for primary care providers (PCP) to engage in care coordination for complex patients; and (3) using gain-sharing arrangements with providers.

## Key Lessons

ACAP MMPs agreed that the financial alignment demonstrations offer significant promise for improving health care quality and effectiveness for dually eligible beneficiaries. Their overarching lesson is that a policy and operational undertaking of this magnitude takes time and requires unparalleled effort to develop structures, policies, and procedures to improve care. Specific lessons include:

- Investing in relationships with states and providers – before, during, and following program implementation – is essential to program success;
- Implementing extensive care management activities requires significant time and resources from both plans and providers;
- Coordinating physical and behavioral health services necessitates that MMPs focus on promoting collaboration and information sharing across primary care and specialty behavioral health settings; and
- Simplifying and fine-tuning administrative and related processes are key to demonstration success, but this takes time.

Highlighting the efforts of ACAP MMPs and examining their experiences in the demonstrations may be useful to CMS, states, health plans, Congress, and other stakeholders as they evaluate the Financial Alignment Initiative and consider integration options for dually eligible individuals.

## II. Introduction

The more than 10 million individuals dually eligible for Medicare and Medicaid are among the most vulnerable and highest-need populations in the nation's health care system. These individuals often face a combination of poverty, co-existing chronic physical and behavioral health conditions, cognitive disabilities, and social isolation. Given their high needs and resulting high service utilization, they account for a disproportionate share of both Medicare and Medicaid expenditures. In 2011, the federal and state governments spent more than \$294 billion on care for dually eligible individuals.<sup>2</sup>

Medicaid and Medicare are separate programs with distinct providers, administrative processes, and benefits that often do not align. For dually eligible individuals, Medicare is the primary payer for hospitals, physician and post-acute care services, and prescription drugs. State Medicaid programs provide financial assistance with Medicare premiums and cost sharing, as well as additional benefits not covered by Medicare, such as some behavioral health services and long-term services and supports (LTSS). Dually eligible individuals receiving services in these separate delivery systems regularly face: (1) uncoordinated services; (2) poor provider communication; and (3) differing policies regarding reimbursement, beneficiary protections, covered benefits, and enrollment. As a result, their care is often fragmented or episodic, resulting in poor health outcomes, cost-shifting, and avoidable spending. Given dually eligible beneficiaries' complex needs and high service use and costs, improving integration and coordination of their care is a shared priority for states, health plans, and the federal government.

This report focuses on a key federal-state partnership to integrate care for dually eligible individuals, the Financial Alignment Initiative (referred to as financial alignment demonstrations in each state in which they operate and noted hereafter as "demonstrations"), and the experiences of 14 participating health plans that are members of the Association for Community Affiliated Plans (ACAP). On behalf of ACAP, the Center for Health Care Strategies (CHCS) interviewed these plans to explore their early successes, challenges, and lessons from their experiences in the demonstration. This report:

1. Provides background information about the demonstrations and the states and health plans that operate them;
2. Documents health plan innovations that advance integration across Medicare and Medicaid; and
3. Identifies several lessons from the early phases of the demonstration that may be valuable to the Centers for Medicare & Medicaid Services (CMS), states, health plans, Congress, and other health system stakeholders.

Highlighting innovations by ACAP health plans participating in these demonstrations and examining plan efforts to improve care for dually eligible individuals may help other health plans design and implement their own integrated care programs to serve this population.

### III. The Financial Alignment Initiative

In 2010, the Affordable Care Act led to the establishment of the Medicare-Medicaid Coordination Office in the Centers for Medicare & Medicaid Services (CMS), creating heretofore largely unavailable opportunities to improve care for individuals who are dually eligible for Medicare and Medicaid. In 2011, the Medicare-Medicaid Coordination Office announced a new initiative to test models that better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health and LTSS for dually eligible individuals.<sup>3</sup>

The Financial Alignment Initiative granted states Medicare and Medicaid waiver authority to pursue two types of demonstration models: capitated or managed fee-for-service (MFFS). In the capitated model, the state, CMS, and a Medicare-Medicaid Plan (MMP) enter into a three-way contract, under which the MMP provides comprehensive coverage for all Medicare Part A, B, and D and Medicaid services, and aligned administrative functions (such as enrollment, marketing, reporting, etc.). MMPs receive a blended Medicare and Medicaid prospective payment, and the demonstrations are jointly administered and monitored by CMS and the states. As of June 2016, nine states (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia) that have implemented capitated model demonstrations, have enrolled more than 370,000 individuals.<sup>4</sup> Rhode Island, the final state to implement, has begun voluntary enrollment and expects to grow enrollment throughout 2016.

Under the MFFS model, states sign an agreement with CMS to manage an enhanced fee-for-service program that integrates primary, acute, behavioral health and LTSS for Medicare-Medicaid enrollees. States receive a retrospective performance payment if they achieve a set level of Medicare savings. MFFS models may leverage existing state infrastructure such as Medicaid health homes, accountable care organizations, and other related programs. Colorado and Washington have implemented MFFS model demonstrations.<sup>5,6</sup>

Table 1 provides an overview of the 13 financial alignment demonstrations operating across 12 states, including the key characteristics of the eligible population and geographic areas served.

In addition to states with capitated and MFFS model financial alignment demonstrations, Minnesota has implemented an alternative demonstration to improve beneficiary experience and administrative alignment in its existing Minnesota Senior Health Options program.<sup>7</sup> The demonstration builds on Minnesota's Medicare Advantage dual eligible special needs plan (D-SNP)-based delivery system, and focuses on improving beneficiary experience by furthering Medicare and Medicaid administrative alignment.

**Table 1. Financial Alignment Demonstrations<sup>8</sup>**

State	Demonstration	Implementation Date	Eligible Medicare-Medicaid Population	Geographic Area Served	Participating MMPs (as of June 2016)	Enrollment (as of June 2016)
<i>Capitated Model</i>						
California	Cal MediConnect	April 1, 2014	Age 21 or older	7 counties in southern California and around the Bay Area	Anthem Blue Cross, <b>CalOptima</b> , CareMore, Care1st, <b>Community Health Group of San Diego</b> , Health Net, <b>Health Plan of San Mateo</b> , <b>Inland Empire Health Plan</b> , L.A. Care <b>Health Plan</b> , Molina, <b>Santa Clara Family Health Plan</b>	122,905
Illinois	Medicare-Medicaid Alignment Initiative	March 1, 2014	Age 21 or older	21 counties in greater Chicago and central Illinois	Aetna, BlueCross BlueShield, Cigna, Humana, IlliniCare, Meridian, Molina	48,468
Massachusetts	One Care	October 1, 2013	Age 21-64*	9 counties**	<b>Commonwealth Care Alliance</b> , Tufts Health Plan	13,106
Michigan	MI Health Link	March 1, 2015	Age 21 or older	25 counties in the Upper Peninsula, southwest Michigan, Wayne County, and Macomb County	Aetna, AmeriHealth, Fidelis, HAP Midwest, Meridian, Molina, Upper Peninsula Health Plan	40,884
New York	Fully Integrated Duals Advantage	January 1, 2015	Age 21 or older who require particular types of LTSS	8 counties	Aetna, AgeWell, AlphaCare, CenterLight, Centers Plan for Healthy Living, <b>Elderplan</b> , Elderserve Health, Fidelis, <b>GuildNet</b> , HealthFirst, Independence Care System, MetroPlus, North Shore-LIJ, Senior Whole Health of New York, <b>VillageCareMAX</b> , <b>VNS Choice</b> , WellCare	5,516
	Fully Integrated Duals Advantage: Intellectual/	April 1, 2016	Age 21 or older with intellectual	9 counties	Partners Health Plan	206



State	Demonstration	Implementation Date	Eligible Medicare-Medicaid Population	Geographic Area Served	Participating MMPs (as of June 2016)	Enrollment (as of June 2016)
	Developmental Disabilities		or developmental disabilities			
Ohio	MyCare Ohio	May 1, 2014	Age 18 or older	28 counties in 7 regions	Aetna, Buckeye, CareSource, Molina, United	62,981
Rhode Island	Medicare-Medicaid Alignment Integrated Care Initiative Demonstration	June 1, 2016	Age 21 or older	Statewide	<b>Neighborhood Health Plan of Rhode Island</b>	N/A***
South Carolina	Healthy Connections Prime	February 1, 2015	Age 65 or older who reside community at the time of enrollment	Statewide	Absolute, Advicare, First Choice, Molina	5,614
Texas	Dual Eligible Integrated Care Demonstration Project	March 1, 2015	Age 21 or older, who qualify for Supplemental Security Income or Medicaid HCBS	6 counties	Amerigroup, Cigna-HealthSpring, Molina, Superior, United	42,924
Virginia	Commonwealth Coordinated Care	April 1, 2014	Age 21 or older	104 localities in central Virginia, Tidewater, Northern Virginia, Roanoke, and western Virginia/Charlottesville	Anthem, Humana, <b>Virginia Premier Health Plan</b>	27,768
<b><i>Managed Fee-for-Service Model</i></b>						
Colorado	Financial Alignment Demonstration	September 1, 2014	Age 21 or older	Statewide	N/A	24,860

<b>State</b>	<b>Demonstration</b>	<b>Implementation Date</b>	<b>Eligible Medicare-Medicaid Population</b>	<b>Geographic Area Served</b>	<b>Participating MMPs (as of June 2016)</b>	<b>Enrollment (as of June 2016)</b>
Washington	Health Homes MFSS	July 1, 2013	All ages	Statewide except for 2 counties (Snohomish and King)	N/A	20,179

\* Only individuals ages 21-64 at the time of enrollment are eligible, but beneficiaries may remain enrolled in their MMP once they turn 65 as long as they maintain dually eligible status.

\*\* Includes eight full counties and one partial county.

\*\*\* Rhode Island began enrollment in its demonstration on June 1, 2016. Enrollment data is not yet available.

## Other Approaches to Integrating Care for Dually Eligible Individuals

The federally-driven Financial Alignment Initiative is not the only effort to integrate care for dually eligible individuals. States are also exploring other approaches, listed below. The feasibility of using these different approaches varies across states and regions, depending on the penetration of managed care in both Medicaid and Medicare, the sophistication of integrated health systems, the state's capacity to oversee these programs, and the degree of consumer and provider stakeholder engagement and support.<sup>9</sup>

- **Dual Eligible Special Needs Plans (D-SNPs)** are a type of Medicare Advantage plan that contracts with both state Medicaid agencies and CMS to provide a coordinated benefit package for dually eligible enrollees. While D-SNPs can provide more integrated care, D-SNP contracts do not require comprehensive blending of Medicare and Medicaid benefits, funding or aligned program administration.
- **Program of All-inclusive Care for the Elderly (PACE)** is a provider-based model that offers comprehensive medical and social services to frail, community-dwelling individuals age 55 and older, most of whom are Medicare-Medicaid enrollees. PACE organizations are Medicare providers, and states may provide PACE services to Medicaid beneficiaries as a state plan option.
- **Accountable Care Organizations (ACOs)** make providers financially accountable for the health of the population they serve. States are creating Medicaid ACOs that, in addition to primary and acute medical care, may also be responsible for behavioral health, LTSS, prescription medications, and even social services. However, to effectively serve Medicare-Medicaid enrollees, ACOs must operate across both the Medicare and Medicaid programs.

In addition to these existing platforms, ACAP proposed a new option in 2011: **Very Integrated Plans (VIPs)**.<sup>10</sup> Though currently not an existing program, VIPs offer the potential for distinct programs featuring a fully-integrated, capitated model of care outside of the Financial Alignment Initiative that states could implement via their Medicaid State Plan.<sup>11</sup> States would contract with managed care organizations (MCOs) to provide care for dually eligible beneficiaries, while CMS would set standards for strong patient protections in the areas of participant rights, eligibility, application procedures, administrative requirements, services, payment, quality assurance, and marketing guidelines.

## Mechanisms for Financial Alignment

The three-way contracts between states, CMS, and MMPs provide a significant opportunity to align financing, benefits, and incentives across the Medicare and Medicaid programs for health plans, providers, and the individuals enrolled in the demonstrations. In most states and plans, the demonstrations provide the first opportunity to bring together Medicare-covered benefits with Medicaid-covered behavioral health, LTSS and other wrap-around services under one entity. In addition to providing an integrated set of Medicare and Medicaid services, MMPs receive a capitated payment jointly set by CMS and states, which blends Medicare and Medicaid funds at the health plan level. The demonstrations also provide an opportunity for Medicare and Medicaid

to share in savings that may be achieved through these new integrated programs. State-specific savings percentages for each year were established by CMS and states prior to launching the demonstrations, based on prospective modeling of potential savings.<sup>12</sup> Aggregate savings targets were created to capture potential Medicare and Medicaid savings resulting from improved care management, administrative efficiencies, and changes in service utilization.

Over the course of the demonstrations, CMS, states, and MMPs have agreed to a number of financing changes. For example, the savings percentage targets were lowered in some states after the demonstrations were underway to: (a) account for early MMP experiences; and (b) encourage continued investment in plan innovations that have the potential to transform care for this vulnerable population. In addition, after a careful review of its risk-adjustment methodology, CMS decided to adjust Medicare payments to MMPs. In an October 28, 2015 memo, CMS stated that the CMS-Hierarchical Condition Category (HCC) risk adjustment model under-predicts the costs for full benefit dual eligible enrollees.<sup>13</sup> This directly impacts MMPs since only full benefit dually eligible individuals are enrolled in the demonstrations. As a result of these findings, CMS announced that Medicare Part A and B payments to MMPs would be adjusted in 2016 to better align payments with fee-for-service costs.<sup>14</sup> These changes to demonstration financing recognize that transforming care in complex health systems takes time and that adequate financing is central to ensure the demonstrations have the ability to effectively care for enrollees.

## IV. Methods

Of ACAP's 56 member health plans, 14 are MMPs (noted hereafter as "ACAP MMPs"), all of which were interviewed for this report. Interviews sought to identify key successes, planned and implemented innovations, and lessons across six focus areas:

1. Supporting individuals in the community by addressing housing and other social determinants of health, and reducing institutional care;
2. Coordinating care delivery across various providers and services;
3. Identifying unmet needs;
4. Engaging providers across the continuum of care;
5. Coordinating physical and behavioral health; and
6. Exploring alternative payment models to incentivize improved access to and delivery of care.

Interviewees for each plan included between two and eight staff members who represented a broad range of subject matter expertise and perspectives across six states. Interviewees included executive leadership, medical directors, and directors of care management, finance, provider relations, and government affairs, as well as other key staff that varied by plan. All interviews were conducted telephonically with follow-up questions submitted via email. ACAP MMPs were asked to provide member vignettes that highlighted experiences with demonstration program features.<sup>15</sup> Interviews were completed over a five-week period, ending in April 2016.

## V. Description of ACAP MMPs

The 56 ACAP health plans are all not-for-profit, community-affiliated, mission-driven plans. All primarily serve members who are enrolled in public or state-sponsored coverage programs, such as Medicaid, Medicare, CHIP or other state-only subsidized programs. The MMPs serve both urban and rural populations across the country. Table 2 lists the ACAP MMPs along with their states of operation and current demonstration enrollment.

**Table 2. ACAP MMPs**

ACAP MMP	State	Current MMP Enrollment (June 2016) <sup>16</sup>
CalOptima*	California	19,224
CareSource	Ohio	16,263
Commonwealth Care Alliance	Massachusetts	9,987
Community Health Group of San Diego	California	4,823
Elderplan/Homefirst	New York	293
GuildNet	New York	849
Health Plan of San Mateo*	California	9,424
Inland Empire Health Plan	California	21,835
L.A. Care	California	12,819
Neighborhood Health Plan of Rhode Island	Rhode Island	0**
Santa Clara Family Health Plan	California	8,203
VillageCareMAX	New York	24
Virginia Premier Health Plan	Virginia	5,859
VNSNY CHOICE Health Plan	New York	1,990

\* California MMPs began serving dually eligible beneficiaries in their Medicaid managed care plans (Medi-Cal Plans) in 2011, although enrollees continued to receive most LTSS through the Medi-Cal fee-for-service system. Only CalOptima and Health Plan of San Mateo had experience coordinating LTSS services for these individuals prior to California's demonstration launch.

\*\* Rhode Island's demonstration enrollment data is not yet available.

ACAP MMPs are operating in six states (California, Massachusetts, New York, Ohio, Rhode Island, and Virginia). Collectively, the ACAP MMPs enroll close to 30 percent of all the dually eligible individuals participating in the capitated model demonstrations.<sup>17</sup> The ACAP MMPs have a wide range of enrollment. For example, Inland Empire Health Plan (California) has enrolled more than 20,000 people, while Neighborhood Health Plan of Rhode Island has just begun demonstration enrollment.

All but one of the ACAP MMPs had prior experience operating a D-SNP and/or a Medicaid managed long-term services and supports (MLTSS) plan.<sup>18</sup> Prior plan experience serving dually eligible beneficiaries in capitated Medicare and Medicaid arrangements, particularly via D-SNP or MLTSS plans, provides a foundation for implementing the demonstrations by ensuring familiarity with beneficiaries' complex medical and social needs as well as a level of comfort working with states and non-medical providers that serve Medicaid populations.<sup>19</sup> Given that most ACAP MMPs have experience with this population, they are well-positioned to compare

experiences and outcomes between the demonstrations and less integrated systems, and provide insight into the value of integrated care programs.

In the sections that follow, this report describes the findings of the interviews with ACAP MMPs. Note that when the report refers to MMP members, these are dually eligible individuals who have enrolled in capitated model demonstrations through the MMPs.

## VI. Analysis of Plan Innovations

Several key themes emerged from the interviews regarding ACAP MMPs’ experiences with the financial alignment demonstrations that highlight the value of better coordinated, more integrated care for dually eligible beneficiaries. Through the demonstrations, ACAP MMPs have implemented or expanded on efforts to: (1) support individuals in the community by addressing housing and other social determinants of health, and reducing institutional care; (2) coordinate care delivery across various providers and services; (3) identify unmet needs; (4) engage providers across the continuum of care; (5) coordinate physical and behavioral health; and (6) explore alternative payment models to incentivize improved access to and delivery of care. Table 3 provides a snapshot of ACAP MMPs’ innovations in these areas. Following are more detailed descriptions of the innovations, including examples of their impact on demonstration enrollees.

**Table 3. Innovative Program Approaches**

Focus Area	Innovative Approaches and Program Features
Supporting Individuals in the Community	Reducing the need for institutional care
	Securing stable housing and addressing social determinants of health
Improving Care Coordination	Enhancing transition planning
	Offering telehealth solutions
	Partnering with key community organizations
Identifying Unmet Needs	Creating new services and settings
	Tailoring and redefining existing services
Engaging Providers	Targeting outreach to nursing facilities
	Partnering with HCBS providers and associations
Coordinating Behavioral and Physical Health	Promoting interdisciplinary collaboration
	Developing electronic information sharing and management solutions
	Leveraging community connections
Exploring Alternative Payment Models	Exploring broad value-based payment (VBP) efforts
	Tailoring VBP approaches to different providers

### A. Supporting Individuals in the Community

One of the goals of the financial alignment demonstrations is to deliver person-centered care that promotes beneficiaries’ independence and respects their right to reside in the setting of their choice to the greatest extent possible. This is an important goal for the dually eligible population, more than 40 percent of whom require LTSS and about one-third reside in institutions.<sup>20,21</sup>

However, managing complex medical conditions and providing LTSS in the community can be challenging when individuals lack adequate housing or are homeless. Access to stable housing is a key social determinant of health and the lack of it can increase the need for acute health services.<sup>22</sup> While nearly all homeless individuals are eligible for Medicaid in states that expanded Medicaid under the Affordable Care Act, Medicaid funds cannot be used to pay for housing directly.<sup>23</sup>

ACAP MMPs have undertaken initiatives to prevent at-risk individuals from further medical and/or functional decline that would require admission to a nursing or other inpatient facility, and to identify individuals already residing in nursing facilities who might be able to transition back to community living. Because Medicaid funds cannot be used for housing, ACAP MMPs have leveraged flexibilities within their contracts to fund housing-related services and supports. These innovations have allowed ACAP MMPs to support demonstration efforts to shift LTSS utilization to community settings and divert individuals from institutional care when possible.

### ***1. Reducing the Need for Institutional Care***

ACAP MMPs use a variety of interventions to reduce the need for institutional care. The level of integration provided by the financial alignment demonstrations is a key factor in a plan's ability to reduce the need for institutional care. As one plan noted, bringing all LTSS under one entity allowed for a "bird's eye view" of all services available, which was not possible under the state's fee-for-service system. This allowed the MMP to understand where additional services were needed to support the full continuum of community-based care. For example, Inland Empire Health Plan in California recently partnered with Landmark Health, a provider of in-home medical care, for its members with five or more chronic conditions. This initiative seeks to divert emergency department (ED) visits, prevent hospital readmissions, and extend individuals' ability to remain in their homes. Each enrolled member is assigned a Landmark provider (e.g., physician, nurse practitioner, or physician's assistant) who: (1) meets in-person with the member monthly; (2) tracks the individual's medical conditions; and (3) supports the members' other providers by helping with planned medical treatments. Landmark providers, available for house calls 24/7, develop a care plan in collaboration with the member's other providers, and work with the member's PCP to ensure that the care plan is carried out. Also, social workers may visit members at home to identify wrap-around services to help members stay at home. Landmark's expanded network of providers and related services has been very valuable in supporting some of the plan's most complex need members.

A number of ACAP MMPs are also exploring ways to help members who reside in institutional settings return to community living. Community Health Group of San Diego contracts with a vendor that uses hospitalist physicians to provide enhanced care management for a subset of its members in skilled nursing facilities. The physicians assess members and track their care to ensure continuity and appropriateness of interventions. Based on the physician's assessment and the member's preference, a member may be identified for transition into a community setting. Community Health Group of San Diego noted some challenges implementing the model in nursing facilities with limited managed care experience, but still believes that the intervention is promising and is currently evaluating the results.

Neighborhood Health Plan of Rhode Island's enhanced MLTSS care management model includes a multidisciplinary team that is deployed into the community to help members to access community services and reduce reliance on both hospital and institutional care. The plan credits this model with an 11 percent reduction in ED visits among the entire MLTSS enrollee population. Neighborhood Health Plan also employs several other interventions to ensure members can reside in their homes. Through regular home visits, care managers were able to identify and resolve major issues such as: (1) helping a member and her caregiver repair her wheelchair; (2) working with a member to establish the appropriate level of home care services to reduce the frequency of hospital admissions and emergency department visits; and (3) working with a housing complex that had previously refused to make home modifications and repairs so that a member could continue to reside there. These efforts will remain in place for its recently launched MMP product, and the plan expects to see similar results for newly enrolled dually eligible beneficiaries.

## ***2. Securing Stable Housing and Addressing Social Determinants of Health***

A lack of affordable housing is especially problematic for dually eligible beneficiaries, given their low incomes and high rates of comorbidities, disabilities, and behavioral health issues.<sup>24</sup> CMS, states, and plans recognize the connection between housing instability and increased hospitalizations and costs among dually eligible beneficiaries.<sup>25</sup> Although Medicaid funds cannot be used to pay directly for housing, recent CMS guidance outlined circumstances under which Medicaid can fund other housing-related services (e.g., assisting with applications; developing a housing support plan; providing tenancy services).<sup>26</sup> Additionally, MMPs may leverage opportunities like the Money Follows the Person Rebalancing Demonstration Grant program that is active in 43 states and the District of Columbia to support beneficiaries who reside in institutions or have insecure housing arrangements to transition to stable community-based settings.<sup>27</sup>

ACAP MMPs are working with states and community-based organizations to address their members' housing needs by: (1) developing pilot projects to transition members to stable housing arrangements; and (2) partnering with housing authorities and related agencies to identify housing options and to access housing-related databases.

In California, which has the highest rate of homelessness in the country, homeless individuals typically have an inpatient length of stay about four days longer than average, which results in significantly increased acute care costs.<sup>28,29</sup> In response, several ACAP MMPs are seeking to increase secure housing options for their members, which directly aligns with one of the state's policy goals outlined in its new 1115 waiver authority, the Medi-Cal 2020 Demonstration, approved on December 31, 2015.<sup>30</sup> The demonstration program offers opportunities for public and private entities to develop pilots or interventions to target individuals who are currently or are at risk of being homeless who have a demonstrated medical need for housing or supportive services.



Community Health Group of San Diego contracts with Project 25, a program that seeks to improve health outcomes and to reduce costs of care for homeless individuals. Project 25 helps to identify housing opportunities for a small, high-need subset of the plan's members, including dually eligible beneficiaries, and links them to preventive medical care, intensive care management, and round-the-clock case workers. Project 25, which began as a three-year pilot, has saved San Diego taxpayers more than \$2 million per year.<sup>31</sup> The Medi-Cal managed care plans in San Diego cover up to 40 percent of service costs for Project 25 clients, and the program receives additional funding from the Substance Abuse and Mental Health Services Administration.

In a new pilot program, L.A. Care Health Plan awarded a grant to the CSH (Corporation for Supportive Housing) to provide intensive case management services to its highest-need, highest-cost homeless members and link them to a large network of housing and social service resources to reduce readmission rates. This program meets a significant need: in Los Angeles County, the top 10 percent of highest-need homeless individuals account for 72 percent of homeless health care spending.<sup>32</sup> L.A. Care hopes that the two-year pilot program can be replicated to target its approximately 20,000 homeless Medi-Cal members.<sup>33</sup>

The Health Plan of San Mateo developed the Community Care Settings Pilot program to help members transition out of institutions to the community and avoid unnecessary institutionalizations.<sup>34</sup> Members receive intense case management, housing assistance services, and medical care. The plan partnered with a care management agency and a housing agency to create the pilot program, which also leverages the plan's relationships with other organizations in San Mateo County, including: affordable supportive housing providers; county agencies; hospital and nursing facility discharge planners and social workers; and a network of community Residential Care Facilities for the Elderly.<sup>35</sup> Health Plan of San Mateo uses various funding sources to operate the pilot, including a Money Follows the Person grant, state waiver programs, and the health plan's own reserves.<sup>36</sup>

#### **Community Health Group of San Diego's Partnership with Project 25**

Mike was struggling with health problems due to a serious accident on the job and severe depression after his wife passed away in 2011. At one point, he was on 26 different medications. In between frequent inpatient hospital stays, Mike was homeless. Through Project 25, Community Health Group of San Diego was able to connect Mike with affordable housing and case management. Now Mike lives in a small, one-bedroom apartment and has reduced his medications to 5-6 a day. Mike's 30-plus hospital admissions a year decreased drastically since he joined Project 25 and enrolled in Community Health Group of San Diego's Medicare-Medicaid Plan.

### **The Health Plan of San Mateo’s Community Care Settings Pilot**

Jim, age 58, is a dually eligible beneficiary who was admitted to a skilled nursing facility in September 2014 for rehabilitation after knee replacement surgery. He had a long history of homelessness and had no home to go to after discharge. Jim also had a history of alcohol abuse and had been to a residential alcohol and drug rehabilitation program. After evaluation by the Health Plan of San Mateo, he moved into a scattered site housing unit in March 2015 through the Community Care Settings Pilot. Jim has since returned to Alcoholics Anonymous, reconnected to behavioral health services, and is complying with psychiatric treatment. He has not had any relapses and has started riding his bike to regain his strength. His family visits with him regularly, and Jim reports that he loves his new home.

CalOptima and Inland Empire Health Plan recognized the need to develop a discharge plan that addresses housing instability and ongoing medical oversight for their high-need members. Both of these ACAP MMPs partnered with the Illumination Foundation, an organization that provides recuperative care (i.e., a combination of interim housing, integrated medical oversight, interdisciplinary case management, and targeted support to identify housing options) for homeless individuals in southern California. The Illumination Foundation found that providing recuperative care and connecting beneficiaries to housing has reduced hospital readmissions by 50 percent and lowered the daily cost of care by 90

percent for homeless members participating in the program.<sup>37</sup>

ACAP MMPs have also found value in partnering with state housing resources. VNSNY CHOICE Health Plan described a fruitful partnership with the New York City Housing Authority in which the plan’s interdisciplinary care teams (ICTs) collaborate with housing authority staff to support members transitioning out of hospitals or nursing facilities, changing housing settings, or requiring additional modifications such as moving to lower floors within apartment buildings to increase accessibility.

Developing partnerships to quickly identify members with housing needs is another area of focus for ACAP MMPs eager to improve care coordination. Medicaid does not consistently capture data on homelessness, so several MMPs have begun to access external housing-related databases – like the federal Department of Housing and Urban Development’s Homeless Management Information System<sup>38</sup> – to obtain timely information on the housing status of their members. L.A. Care Health Plan recently signed a memorandum of understanding with the Los Angeles Homeless Services Authority to access a database that identifies homeless individuals in Los Angeles County. This database also provides information on service needs and can help link members to appropriate housing providers.

## **B. Improving Care Coordination**

Shifting from a fragmented to a coordinated system of care by aligning Medicare and Medicaid providers, systems, and benefits is a major goal of the demonstrations and ACAP MMPs. Care coordinators and ICTs play a crucial role in ACAP MMPs’ efforts to achieve this goal. New or expanded roles for providers (e.g., PCPs, social workers, nurses, LTSS providers, and behavioral health providers) participating in ICTs offer opportunities for coordination. However, MMPs and

providers may be challenged to strike the right balance between sharing information across providers, requiring participation, and minimizing burden on providers' time and resources.

ACAP MMPs described innovative approaches to better manage members' care, including: (1) enhanced discharge/transition planning to reduce hospitalizations and/or emergency room visits; (2) telehealth solutions to support care management and access to care; and (3) relationships with community-based organizations to support care management.

### ***1. Enhancing Transition Planning***

Effective care coordination can help manage the complex care needs of dually eligible beneficiaries who have frequent transitions between their homes, hospitals, and nursing facility settings. This population also experiences frequent avoidable hospitalizations, particularly when individuals reside in a nursing facility setting.<sup>39</sup> For example, a recent study found that about 26 percent of all hospitalizations for dually eligible beneficiaries were potentially avoidable.<sup>40</sup> ACAP MMPs, including Inland Empire Health Plan, VillageCareMAX, Community Health Group of San Diego, and Neighborhood Health Plan of Rhode Island have developed new care management models and program features that provide enhanced support specifically for members who are discharged from hospitals or nursing facility settings.

VillageCareMAX promotes successful transitions by assigning members to a transitional care nurse for comprehensive care management on discharge from the hospital to community settings. The transitional care nurse educates members about following their care regimen,

collaborates as needed with other providers (e.g., pharmacists) involved in the member's care, and ensures that home care services and durable medical equipment and supplies are in place promptly upon discharge. The transitional care nurse will also check in with the member to ensure that necessary follow-up appointments were made, and assists them with scheduling if needed. Between 30 and 60 days post-discharge, the transitional care nurse contacts the member to assess whether additional care management or transition support is needed. Once the member is stable, ongoing care management responsibility shifts to the previously assigned MMP care manager.

#### **VillageCareMAX's Approach to Managing Transitions**

When Millie enrolled into New York's financial alignment demonstration in August 2015, she required maximum assistance for her activities of daily living and received 12 hours of personal care services (PCA) per day. Since her enrollment less than a year ago, Millie's care manager helped her navigate several care transitions by:

- Securing a respite stay in a skilled nursing facility when Millie's daughter had to go out of town;
- Moving Millie into her own apartment when her daughter could no longer care for her at night;
- Managing a temporary transfer to a skilled facility so her care manager could coordinate needed exterminator and cleaning services due to the apartment's poor condition.

Prior to discharge, VillageCareMAX assigned a transitional care nurse to work with Millie, her care manager, daughter, and providers to identify her ongoing needs and to coordinate services upon her return home. At this time, Millie remains safe in the community with a live-in PCA.

Community Health Group of San Diego developed a similar approach for its Multiple Admitters Project (MAP), which targets care management support and timely home health services to frequently hospitalized members with chronic conditions. When a MAP member is hospitalized, the plan's high-risk care manager begins working with hospital staff on transition planning and a specially selected home health vendor to establish services within 24 hours of discharge. In addition, the plan's psychosocial approach to post-discharge care management ensures a member's behavioral health and social support needs are coordinated alongside his or her clinical needs. Community Health Group of San Diego has found that having a high-risk care manager facilitate transitions helps to address all aspects of the member's return home, including coordinating with the home health agency, managing medications, and leveraging the ICT to address all member needs.

Inland Empire Health Plan partnered with Charter Healthcare Group, a home health/hospice agency, to provide transitional care services with the goal of supporting members safely in the community while reducing the frequency of ED visits and hospital readmissions. Charter locates high-risk members who have chronic medical conditions and/or comorbidities such as behavioral health conditions, and who have recently been released from a hospital or have frequent ED visits. Charter's clinical team, including a physician, nurse, and/or social worker, provides 24/7 care and meets members anywhere they feel comfortable (e.g., their home, or a hotel, restaurant, or park). In the care planning process, Charter's team outreaches to members' families and providers to ensure that members can reside in their setting of choice. Charter's clinical team meets weekly with the plan's various departments, including care management, behavioral health, utilization management, LTSS, and disabilities to discuss members currently enrolled in this transitional care program. Preliminary data show that the program diverted 20 ED visits in a one-week period for 167 members. This program has been recognized by the California Department of Health Care Services with the state's first Annual Innovation Award.<sup>41</sup>

## ***2. Offering Telehealth Solutions***

MMPs are using telehealth services (e.g., consultations via videoconferencing, transmissions of images or data, remote monitoring of health conditions, and consumer-focused digital devices and cell phone applications) to support care management efforts and increase access. These services can help dually eligible populations overcome some of the barriers they face in accessing care, such as: (1) having a disability that makes it challenging to get to a provider's office; (2) living in a remote or rural location; or (3) needing care from specialists, such as psychiatrists, who are in short supply.

Several ACAP MMPs, including CareSource, VillageCareMAX and Elderplan/Homefirst, have implemented telehealth pilots. Home care workers are given electronic tablets to gather health statistics and track medication administration and nutritional intake for plan members. VillageCareMAX is piloting the use of these tablets with approximately five percent of its members who are at high-risk for hospitalization. The home care workers track member data over time via the tablet, and if an indicator value is outside a desired range, an alert is sent to the plan to intervene and prevent adverse events.

The Health Plan of San Mateo launched a successful remote patient monitoring pilot that gives Wi-Fi enabled blood pressure cuffs to members with high blood pressure. The cuff tracks blood pressure, and members upload their results at local pharmacies and a federally qualified health center with which the plan has partnered. The data are then transferred to a cloud-based database so that providers can view the results and target medications accordingly. Members have been enthusiastic about using this technology, and all users have been able to keep blood pressure under control. The Health Plan of San Mateo plans to expand the telehealth program to more members and develop a similar telehealth initiative focused on monitoring glucose levels to support diabetes management.

ACAP MMPs are also exploring telehealth solutions to address provider access issues. Although L.A. Care's service area is predominately urban, it has a substantial number of members in outlying rural areas where there is a shortage of providers. L.A. Care is beginning a telehealth initiative that would bring nurses, nurse practitioners, or licensed nurse practitioners into these communities with laptops capable of supporting videoconferencing between members and physicians.

Other plans are working to increase access to specialists. For example, the general shortage of psychiatrists and other behavioral health providers, combined with reported resistance among some of these providers to serve the Medicaid population, creates access issues for beneficiaries who need these services.<sup>42</sup> Commonwealth Care Alliance completed a pilot program on tele-psychiatry, and plans to continue using videoconferencing capabilities to support care delivery for its members. Similarly, Inland Empire Health Plan decided to start its first telehealth initiative in psychiatry services to address this provider shortage.

The plans view telehealth as a promising tool to engage members in their care and address barriers to access such as geography and provider shortages. Over time, their experiences will help to inform broader telehealth initiatives for these and other populations.

### ***3. Partnering with Key Community Organizations***

To better coordinate care and serve their members, many of the ACAP MMPs are partnering with key community organizations (e.g., community health and mental health centers, retail stores, social service providers, and faith-based organizations) that connect with MMP members where they already seek health and social supports, as well as live, shop, and pray. ACAP MMPs are using these partnerships to better reach, educate, and target care management activities for their members.

Commonwealth Care Alliance developed relationships with Recovery Learning Communities (RLCs), consumer-operated centers that provide self-help/peer support, information and referral, advocacy and training activities for individuals with behavioral health conditions. The RLCs work collaboratively with mental health providers, human service agencies, and other community groups. The plan found that many of its members with behavioral health conditions were already aware of the support that RLCs offer, so it worked with the RLCs to develop new pathways to connect members to peer supports and other community-based services. For example, peer support staff from the local RLC run support groups at Commonwealth Care

Alliance's two crisis stabilization units [refer to [section VII.C](#)], so members already have connections to peer supports and better understand referral processes before they are discharged from these units. The plan also invested in training RLCs on managed care fundamentals (e.g., billing, clinical models and contracting), and it expects to see increasing value to its members due to this partnership.

Partnering with consumer-focused advocacy groups and other community-based organizations has enabled other ACAP MMPs to better train their health plan care managers. Elderplan/Homefirst partnered with the Center for Independence of the Disabled, a disability-focused consumer advocacy group to help the plan review nursing assessment protocols and conduct in-service training to increase the disability competence of their care management staff. Similarly, VillageCareMAX partnered with the Jewish Board of Family and Children's Services, a community-based organization that provides mental health, developmental disability, housing, and other services and supports in New York City, to develop targeted training for care management staff who would be serving many of VillageCareMAX's members.

### C. Identifying Unmet Needs

Many dually eligible beneficiaries have complex needs that have historically gone unmet, often due to the members' inability to access services and lack of communication and coordination between providers in the fragmented Medicare and Medicaid systems. ACAP MMPs have developed innovative approaches to identify and address member needs by leveraging the opportunities from the integrated benefit package in the demonstrations to establish new services and tailor existing ones. An MMP noted that by managing the full spectrum of hospital, nursing facility, post-acute care services, and HCBS services, MMPs have greater potential than ever before to provide whole-person care.

#### 1. *Creating New Services and Settings*

About 70 percent of Commonwealth Care Alliance's more than 10,000 dually eligible members enrolled in the demonstration have a behavioral health diagnosis.<sup>43</sup> The plan estimated that as many as 50 to 70 percent of members in inpatient acute psychiatric settings did not need that level of care, but there were not enough community-based beds to serve them. At the same time, however, many of these members require a more intensive level of services than outpatient therapy. To bridge this gap, the plan created two

#### **Commonwealth Care Alliance's Crisis Stabilization Units**

Jeremy is a 59-year-old male with a schizoaffective disorder. After an incident in the group home where he lived, his providers were concerned about his ability to live safely in the community and recommended his admission to a state hospital for a long-term stay. As an alternative, Commonwealth Care Alliance was able to offer Jim a spot in one of its crisis stabilization units (CSUs). In the therapeutic environment of the CSU, Jeremy's condition improved, and no further incidents have occurred.

When Jeremy first came to the CSU, the staff found that though he was a talented artist, Jeremy did not want to paint. However, a few months later he started painting again and recently won an art contest. Jeremy is living safely in the CSU community and says that it is "a haven of rest amongst the brutality of the streets." He reports the staff "is fantastic, they make me feel safe."

crisis stabilization units (CSUs) that accommodate members who need short-term intensive behavioral health and medical services. The CSUs – one located in a renovated house, the other in an unused hospital wing – are residential, therapeutic settings with services provided by care managers and nurse practitioners. Since the CSUs are run by the plan, there is continuous sharing of information, with services provided on-site. This approach has been cost effective; 86 percent of the individuals in CSUs are inpatient diversions, and the average length of stay in the CSUs is shorter (9.5 days) than the average, more expensive, stay in an inpatient behavioral health unit (11.2 days).

#### **CareSource’s Dental Care Benefits**

A CareSource care manager discovered that Cindy’s dentures no longer fit her correctly after an illness. Unable to chew properly, Cindy was eating a modified diet. The care manager checked with Cindy’s dentist, who informed her that the dentures could not be refit and that Cindy was not eligible for a new set for several years. The care manager collaborated with Cindy’s medical providers, long-term care providers, and dentist to document the illnesses that led to Cindy’s inability to wear the dentures and submit a new claim for dentures. The claim was approved and Cindy happily reported at a recent face-to-face meeting with the care manager that she had received the new dentures and was eating a regular diet, which was more nutritious and enjoyable. Cindy reports she has more self-confidence and is no longer ashamed to smile.

Several ACAP MMPs noted that states give plans the flexibility to authorize discretionary, supplemental services (e.g., additional home modifications or other adaptive technologies) that increases MMPs’ reach in addressing unmet needs. This flexibility can allow MMPs to support members’ ability to remain in the community. CareSource provided an example of pouring concrete to pave a member’s driveway so that the member could access transportation to get to his doctor appointments. In addition, MMPs also have flexibility to offer dental benefits. Medicare does not cover dental services, and although the majority of states offer some Medicaid dental services for adults, the benefits are not extensive and many states limit coverage for individuals over age 65.<sup>44</sup> This creates a

significant gap in care for dually eligible individuals. Ohio, like several other states, requires dental care coverage in the demonstrations.

## ***2. Tailoring and Redefining Existing Services***

ACAP MMPs described several examples of opportunities to work with service providers to better tailor services for high-need populations. For instance, the Health Plan of San Mateo partners closely with San Mateo County to provide focused care management services for its dually eligible members who meet medical frailty criteria and receive a certain number of personal care service hours, through California’s Coordinated Care Initiative In-Home Supportive Services (CCI-IHSS) program. The plan now has access to seven social workers to provide additional case management supports to high-risk members. The social workers, who have expertise in managing county-provided services and supports, are embedded onsite at the plan and use the same information system as the plan’s care managers. The plan has credited this partnership to improve its ability to expedite case manager services at appropriate levels to people who need them.

Some MMPs provided examples of program flexibilities that they adopted once they were able to identify pockets of unmet needs. VNSNY CHOICE Health Plan noted that before the demonstration, members' behavioral health needs were contracted out, and the plan did not have a mechanism to track if members were getting necessary services. However, members now have access to a full array of crisis and community behavioral health services through VNSNY CHOICE, and the plan's ability to facilitate and monitor access has been a valuable component to ensuring that these members get the services they need. Another plan waived a requirement that individuals had to commit to adult day health services to begin receiving services when it realized that some beneficiaries did not want to sign up before ensuring that was the right choice for them. The plan now allows for a trial period that has encouraged more people join. In another example, the Health Plan of San Mateo identified residents of nursing facilities who had behavioral health issues and wanted to transition out to the community. When the plan first tried to involve behavioral health providers in this process, the providers were hesitant because they reported that "we typically do not work with nursing facility residents." The plan worked with the nursing facility and behavioral health providers to recognize that this historical care pattern was a hindrance to members and to begin to address these members' preferences to live in the community.

**GuildNet's Recreational Therapists**

Elaine, age 80, has osteoarthritis, urinary incontinence, hypercholesterolemia, and glaucoma. She has been enrolled in New York's demonstration since October 2015. She has a home care personal care assistant five days a week and uses mobility aids, but her ability to independently manage her own care is hampered by anxiety and delusional episodes. Though she lives alone and has no family, she has declined ongoing support from her care manager.

GuildNet's recreational therapist identified resources to help Elaine maintain her independence and improve her quality of life. Due to her vision impairment, he arranged for a senior center to provide weekly in-home volunteers to read her mail to her. Elaine had been a composer, so the therapist gave her theater and concert information, including large-print schedules. At Elaine's request, the therapist also introduced her to an agency that will help her create an inventory for her book collection, use the internet, and access scribe services. With support from the therapist, Elaine has been able to better manage her needs and access recreational activities that she enjoys.

Unmet needs can be social in nature as well, and an important component of providing person-centered care is to support individuals' community ties and mitigate feelings of isolation and depression they might have been due to a disabling condition. GuildNet, for example, noted that opportunities to socialize and pursue extracurricular activities helps its members and can lead to better outcomes. The plan employs a full-time recreational therapist who works with care managers to link individuals to social supports based on their interests. GuildNet's MMP population includes a high proportion of individuals with visual impairments, and the plan noted that the therapist has been especially helpful in linking these members to enjoyable activities in

the community. These services are available to and benefit the plan's full membership within and outside of the demonstration. Similarly, GuildNet reported that it often pays for group activities that encourage socialization and arrange activities at local senior centers.



## **D. Engaging Providers**

Engaging and securing the support and participation of all types of providers (e.g., primary care physicians, hospitals, behavioral health providers, nursing facilities, and HCBS providers) has been a challenge across the financial alignment demonstrations. All ACAP MMPs emphasized that obtaining provider buy-in and integrating providers into the care management process are critical for development of robust health plan networks and longer-term MMP viability.

ACAP MMPs noted particular challenges with engaging both nursing facilities and HCBS providers who historically have limited experience with managed care in demonstration states. In addition to learning how to work within a managed care arrangement, providers also needed to understand how integrating Medicare and Medicaid services would impact their operations and their patients. All ACAP MMPs described the importance of collaboration with states, other MMPs, and various other stakeholders in engaging and training LTSS providers on care coordination and administrative processes. Many ACAP MMPs were successful in engaging nursing facilities and HCBS providers by: (1) tailoring outreach and training approaches; and (2) partnering with providers and provider associations.

### ***1. Targeted Outreach to Nursing Facilities***

CalOptima tailored its provider engagement efforts to address nursing facility concerns, build strong relationships between plan and facility staff, and ensure a smooth transition for residents enrolling in the plan. The plan conducted comprehensive outreach to each contracted nursing facility in Orange County, California, and provided targeted education to both attending physicians and residents' families to increase their understanding of the new program. Although eligible individuals were enrolled into Cal MediConnect by birth month in other demonstration areas, CalOptima used a facility-by-facility phased enrollment approach instead to enroll all eligible individuals within a particular facility at one time. This approach allowed the plan to send dedicated plan staff to each nursing facility as soon as enrollment materials were mailed. Plan staff explained the program to nursing facility leadership, including social workers, attending physicians, and nursing staff, and scheduled presentations as part of resident family council meetings to help them understand the benefits and implications of enrolling in the demonstration. The strategy successfully increased awareness of the benefits of the program and contributed to a lower opt-out rate among nursing facility residents in Orange County compared to other California demonstration counties.

To address and resolve early implementation issues with nursing facility industry partners, both CareSource and Community Health Group of San Diego worked with other MMPs in their states to develop and lead cross-plan workgroups. In Ohio, the dedicated forums for nursing facilities that CareSource engaged in created a streamlined process for nursing facilities to bring questions that could often be uniformly addressed across plans. The collaborative met regularly to discuss operational and programmatic issues and provided MMPs with opportunities to educate the providers about the demonstration.

The inclusion of custodial care in the Medicaid service package was new for all of the MMPs and nursing facility providers in San Diego, so a forum for developing relationships among them was welcomed. Community Health Group of San Diego collaborated with other San Diego health plans to create a workgroup focused on convening key leadership from the 128 San Diego nursing facilities and representatives from the nursing facility industry association. The workgroup was successful in building relationships and educating nursing facilities on how the health plans can assist with letters of agreement, authorizations, contracting, and supporting members.

## ***2. Partnering with HCBS Providers and Associations***

ACAP MMPs with prior experience working with HCBS providers through Medicaid managed care programs were well-positioned to leverage existing relationships and established processes when the demonstrations were launched, which supported HCBS providers with limited familiarity with managed care. A number of ACAP MMPs invested in new pathways to further engage essential HCBS providers by partnering with the relevant associations that represent them.

In New York, Elderplan/Homefirst partnered with an association for personal care attendants (PCAs) to share information about the value of the integrated benefit package with PCA providers. This association partnership helped Elderplan/Homefirst reach members and created a pathway to answer PCAs' questions about New York's demonstration. In California, In-Home Supportive Services (IHSS) is a county-administered program for PCA services with which MMPs are required to coordinate. To develop strong communication pathways, Santa Clara Family Health Plan partnered with its county IHSS program to develop a coordination guide on how plan and IHSS providers can work together to manage medical services and HCBS for members. Both the plan and the IHSS program also identified the need for a dedicated IHSS county contact to work with the plan on IHSS referrals and communication. This partnership has made a difference for members; for instance, the plan has seen improvements in turn-around times for IHSS applications and the coordination of IHSS home care assessments for plan members discharged from hospital settings.

Inland Empire Health Plan uses a more broad-based approach to engagement with community-based organizations. In 2006, it partnered with another plan (also now an MMP in San Bernardino County) and PossAbilities of Loma Linda University to form the Inland Empire Disabilities Collaborative. The collaborative brings together more than 900 service providers that serve people with disabilities and seniors for peer-to-peer networking. It advocates to help all collaborative members, including HCBS providers, better meet the needs of individuals with disabilities.<sup>45</sup> In recent years, Inland Empire Health Plan has encouraged the collaborative to educate service providers on the opportunities to improve care for dually eligible individuals with disabilities through California's financial alignment demonstration. Plan staff also benefit from participation in the collaborative by learning about community resources available to members with disabilities.

## E. Coordinating Behavioral and Physical Health

More than 40 percent of Medicare-Medicaid enrollees have a mental health condition.<sup>46</sup> Among Medicare beneficiaries, those with serious mental illness, such as major depression, bipolar disorder, and schizophrenia, are more than twice as likely to have three or more chronic, comorbid conditions.<sup>47</sup> Most dually eligible beneficiaries who need behavioral health services must navigate at least two layers of fragmentation in the health care system: (1) between physical and behavioral health systems of care; and (2) between the Medicare and Medicaid programs. Without the kind of integration happening in ACAP MMPs, there is little-to-no coordination across payers and providers for this very high-need population.

Managing all Medicare (the primary payer for most acute and primary behavioral health services, including hospital visits and psychiatrist/psychologist visits) and Medicaid (the payer for crucial “wraparound” services, rehabilitation, and HCBS) services under one plan allows MMPs to bridge the gaps in care in the current system. In addition to placing MMPs at risk for all Medicare and Medicaid services, several states require MMPs to report on performance measures that reflect shared accountability for physical and behavioral health services, such as evidence of written policies for coordinated care planning and information exchange, and reduction in ED visits for beneficiaries with serious mental illness or substance use disorders. In California, where specialty mental health services are still managed separately by the counties, MMPs and county mental health programs may earn incentive payments if they meet quality metrics that advance care coordination across the systems. The demonstrations provide vehicles for related reforms as well. For example, CareSource explained that post-demonstration launch, the State of Ohio and MMPs realized that some behavioral health providers were billing Medicaid for services provided to dually eligible beneficiaries when Medicare, as primary payer, should have been billed first for certain services. Several of these providers were not credentialed as Medicare providers. The state now requires that participating providers obtain Medicare provider numbers, which will streamline and improve the accuracy of payment for behavioral health services.

ACAP MMPs described several efforts to improve coordination across physical and behavioral health services, including: (1) access to ICTs with engaged, collaborative primary care and behavioral health providers; (2) data sharing and e-management mechanisms across providers to capture complete clinical profiles; and (3) person-centered, recovery-focused care with linkages to community supports.

### *1. Promoting Interdisciplinary Collaboration*

ICTs can help break down structural siloes between physical and mental health providers, who have different terminologies and approaches to treatment and recovery. Physical health providers tend to rely on medical models with set treatment parameters, in contrast to mental health’s recovery-oriented model that views outcomes on a continuum and relies more heavily on consumer-driven treatment decisions. Several MMPs noted that their ability to manage inpatient stays for psychiatric conditions along with community services to aid members post-discharge was extremely valuable for positive outcomes. Many ACAP MMPs agreed that ICTs facilitated meaningful communication – through at least weekly or monthly meetings – between physical

and behavioral providers about clinical and administrative processes and treatment decisions for individuals with comorbid conditions. Some MMPs reported that the demonstrations provided a vehicle to bring behavioral health providers into their care management activities for the first time.

Commonwealth Care Alliance reported that it internalized an integrated approach to care management—from plan leadership to members of the ICT. Although nurses or nurse practitioners typically lead ICT care coordination functions, Commonwealth Care Alliance members with behavioral health needs may request that behavioral health specialists take the lead role in coordinating care activities across all providers. Both physical and behavioral health providers are available at all times to all beneficiaries in all settings. For example, nurse practitioners conduct daily rounds at the plan’s mental health crisis stabilization units to address medical conditions and concerns.

One issue ACAP MMPs have not completely resolved with interdisciplinary care management is that members can still end up with several individuals coordinating different elements of their care. This can be confusing. L.A. Care Health Plan established weekly meetings between plan staff and county mental health providers, who are active members of the ICTs, to help facilitate referrals and other treatment decisions. During these weekly meetings, plan and county staff discuss individuals served by both systems and select one person on the ICT to serve as lead coordinator to streamline the care management process.

## ***2. Developing Electronic Information Sharing and Management Solutions***

Lack of access to data across the physical and behavioral health care systems is a key challenge for plans and providers in coordinating services. Given the high rates of ED visits, inpatient stays, prescription drug use, and comorbid chronic conditions among Medicare-Medicaid enrollees with behavioral health conditions, it is essential for MMPs to have real-time data across systems in order to: understand the full spectrum of members’ needs; manage their immediate care needs; target behavioral health interventions; and provide follow-up care coordination and transition support.

ACAP MMPs have developed new electronic platforms to facilitate such information sharing. L.A. Care Health Plan launched an electronic management platform to support PCPs who see individuals with behavioral health conditions. Through this platform, PCPs can contact behavioral health specialists via text or email to consult about treatment options in a primary care setting or make referrals for more intensive behavioral health treatment or community-based services. This system helps to promote physical and behavioral health coordination by supporting PCPs with the specialized knowledge they need to treat some behavioral health conditions in their offices, and it increases PCPs’ comfort level with referrals.

Inland Empire Health Plan uses a web-based system to facilitate communication and coordination among behavioral health providers, PCPs, and the plan’s behavioral health care managers about the full range of Medicare and Medicaid-covered behavioral health services. Behavioral health providers can access their patients’ health history (e.g., current medications, lab reports, and other relevant medical history) as well as send information about assessments

and care plans to the plan’s behavioral health care managers. In addition, the system allows PCPs to communicate with behavioral health providers and care managers, and view treatment plans. As reported by Inland Empire Health Plan in 2015, more than 70 percent of the plan’s PCPs have downloaded their patients’ behavioral health treatment plan.<sup>48</sup>

While ACAP MMPs are using electronic systems to promote information sharing, there are some challenges related to data exchange across separately managed systems, particularly philosophical differences among physical and mental health providers about data privacy and constraints imposed by federal and state privacy laws such as HIPAA and 42 CFR Part 2.<sup>49,50</sup> MMP interviewees stressed the importance of proactively addressing concerns about data privacy while balancing the need for data availability for effective care coordination. Several ACAP MMPs continue to make concerted efforts to educate members about safeguards in place to protect their information, as well as the value of sharing information across providers who need it to better manage and provide care. One plan noted that because it is accountable for all physical and behavioral health services, it has more leverage to compile all clinical information and share it appropriately with treating providers. Relatedly, Commonwealth Care Alliance noted that its clinical record has a feature to hide psychotherapy notes to ensure that only providers who need access to that information receive it.

### 3. *Leveraging Community Connections*

Ensuring access to community-based, behavioral health programs is another feature of a successful coordinated model. As required under the financial alignment demonstration in

**Virginia Premier Health Plan’s Enhanced Care Coordination**

Jenny is enrolled in Virginia Premier Health Plan’s Enhanced Care Coordination (ECC) Program. Although she regularly attended mental health therapy sessions at a Community Service Board, she did not have a medical doctor prior to enrolling in ECC. The ECC health plan care manager worked with the behavioral health care manager to identify Jenny’s needs and develop a plan of care. The health plan care manager helped Jenny set up an appointment with a primary care physician, who prescribed medication to address Jenny’s medical issues and ordered appropriate preventive testing, including a mammogram, colonoscopy, and blood work. At the Community Service Board, the psychiatrist reviewed Jenny’s blood work and increased her antipsychotic medication for escalating psychiatric symptoms. Subsequently, the health plan care manager followed up with Jenny and found improved outcomes for both her medical and psychiatric issues.

Virginia, Virginia Premier Health Plan is piloting an enhanced care management model with direct linkages to Community Service Boards (CSBs), which are local organizations that play a major role in serving individuals with behavioral health needs. The plan piloted an integrated care management program in which the plan care managers work closely with care management staff at the CSBs to link behavioral health and Medicare-covered medical services. When individuals receive counseling or other behavioral health services at these CSBs, the CSBs’ staff help to coordinate the full array of care for the individual by connecting with health plan care managers to discuss their medical needs, including

medication adherence, which is a major issue for this population. The health plan care managers can also inform the CSBs about issues related to an individual’s medical service use, such as

follow-up appointments with PCPs, hospitalizations (including discharge plans and ED visits), and changes to medication regimens that need to be addressed.

L.A. Care Health Plan takes a similar approach by embedding plan staff at Family Resource Centers, a network of organizations in California that offer coordination, social support, and informational services for its members and the health professionals involved in their care. L.A. Care holds monthly behavioral health orientation and in-service workshops for members to explain what benefits are available to them and how they can access them. In addition, members can make on-site appointments with behavioral health care coordinators for these services.

## **F. Exploring Value-Based Payment Arrangements**

Health care purchasers – including the federal government, states, and health plans – are increasingly interested in implementing new reimbursement models that shift away from fee-for-service volume-driven payments toward value-based payment (VBP) arrangements that reward providers for outcomes. Health plans are key partners through which purchasers can accelerate VBP. The demonstrations' three-way contracts provide a vehicle for states and MMPs to establish VBP or alternative payment arrangements with providers to improve care delivery.<sup>51</sup> The inclusion of Medicare and Medicaid funding streams in the capitated payments to cover the full range of services that can impact beneficiary outcomes to the MMPs also creates greater incentives to develop VBP arrangements with a broad range of provider types. These arrangements may include: (1) agreements that require a portion of an MMP's payments to providers to be tied to quality outcomes; (2) payment incentives for PCPs to engage in care coordination or provide enhanced oversight for complex patients; (3) quality incentive payments to providers tied to specific state/federal quality metrics (e.g. reductions in avoidable ED or inpatient use); and (4) gain-sharing arrangements with providers that allow them to share in the savings they help produce. As a result, many of the ACAP MMPs are exploring VBP efforts that could lead to greater accountability for quality improvements. ACAP MMPs are tailoring VBP approaches for different providers, including nursing facilities, community health centers, specialists, and PCPs.

### ***1. MMPs Are Exploring Broad VBP Efforts***

As part of New York's comprehensive Delivery System Reform Incentive Payment (DSRIP) program, the state has developed a multi-year VBP roadmap focused on Medicaid payment reform. New York has a goal to transition 80 to 90 percent of all provider payments made by Medicaid managed care health plan to VBP arrangements by April 1, 2020.<sup>52</sup> MMPs in the state's VBP program are given the opportunity to participate, and several ACAP MMPs have submitted VBP recommendations to improve care delivery to align with the state's broader reform goals. Additionally, VNSNY CHOICE Health Plan is exploring how VBP arrangements developed in partnership with independent practice associations can help the plan advance care delivery for members. The plan is considering enhanced care management payments for contracted physicians, as well as developing VBP arrangements tied to LTSS quality performance metrics for home health aides.

Other ACAP MMPs, including CalOptima, are exploring opportunities to implement VBP arrangements with providers. CalOptima developed a VBP workgroup and is discussing related opportunities with CMS. The plan is considering financial incentives for physicians who meet a minimum threshold of members in the program.

## ***2. Tailoring VBP Approaches to Different Providers***

Financial alignment demonstrations provide opportunities for MMPs to work with contracted nursing facilities to improve integration of overlapping Medicare and Medicaid covered nursing facility benefits. Such financial incentives could address some of the misalignment between the Medicare and Medicaid programs and incentivize higher quality care in nursing facilities.

CareSource has piloted a VBP arrangement with nursing facilities tied to specific demonstration quality measures. CareSource reviews nursing facility performance on a number of LTSS quality withhold measures used in Ohio's three-way demonstration contract, using the Minimum Data Set to validate the data received from nursing facilities and assess overall facility performance. The plan worked with three of its contracted nursing facilities to establish performance targets and a payment incentive that allows each facility to share quality withhold savings if targets are met. CareSource is building a dashboard to track progress across facilities, including member-level indicators that could be used by case managers.

Virginia Premier Health Plan implemented a care management pilot program in nursing facilities as a first step toward developing a shared-risk VBP program. The plan contracted with a vendor that provides specialized care management for individual nursing facility residents. The enhanced support provided to attending physicians enabled them to intervene if there was an acute condition that could be addressed at the facility, rather than sending the resident to a hospital. The plan analyzed data from the enhanced care management pilot and is now designing financial incentives that may allow providers to share in the savings that result from the intervention and any avoided hospitalizations.

ACAP MMPs have developed a variety of payment incentives to improve care provided in the community and allow a range of other providers to share in savings from more efficient care. Commonwealth Care Alliance offers gain-sharing incentives for community health centers that manage the care of its members. The providers receive a separate per-member, per-month capitated payment based on the member's level of care, as well as bonus incentives for meeting specific HEDIS metrics. Commonwealth Care Alliance meets weekly with participating health centers to review clinical and financial outcomes and offer targeted support. The plan also hosts a quarterly learning collaborative that brings all participating community health center providers together to discuss performance issues.

The Health Plan of San Mateo recently began developing a VBP initiative to improve care management for individuals with chronic kidney disease and delay their progression to having end-stage renal disease (ESRD). HPSM noted that individuals with kidney disease typically experience very fragmented care. As a result, 37 percent of the plan's members with ESRD were hospitalized during the past year, with several avoidable episodes.<sup>53</sup> Generally individuals with ESRD are excluded from enrolling in Cal MediConnect, but to provide more coordinated care,

the plan requested and received an exemption to enroll more than 200 individuals with kidney disease into its MMP.<sup>54,55</sup> The Health Plan of San Mateo plans to phase-in a VBP approach focused on improving outcomes and reducing avoidable costs for this population. Health Plan of San Mateo is currently collecting baseline data, including members' needs, provider network, and market conditions to determine which providers might be eligible for incentive payments. The plan will then build a strategy to incorporate performance driven incentives and shared objectives into contracts with relevant providers.

## VII. Early Lessons from ACAP MMPs

ACAP MMPs recognize that the financial alignment demonstrations hold significant promise for improving the quality and effectiveness of care for dually eligible beneficiaries. The innovations discussed in Section VI of this report demonstrate how ACAP MMPs are capitalizing upon this opportunity. However, as one plan noted, "We are just exploring the tip of the iceberg." Major delivery system changes take time. Implementing and overseeing the integration of two separate, complex programs requires unparalleled effort to develop structures, policies, and procedures that can facilitate improvements in care. ACAP MMPs discussed several lessons related to their early experiences with their states' financial alignment demonstrations.

### ***1. Investing in relationships with states and providers is essential to program success prior to, during, and following program implementation.***

All ACAP MMPs noted that working closely with states to identify areas for improvement and sharing program data, on-the-ground information, and other resources with them has been important for building and maintaining strong state-MMP relationships. These relationships have been key to developing ongoing program improvements. MMPs have been able to work with states to modify certain policies, such as those governing requirements for ICT participation and reporting in certain states that, in practice, caused additional burden on plans, providers, and beneficiaries.

ACAP MMPs noted that conducting outreach, education, and engagement activities with providers – particularly nursing facilities and HCBS providers who might not have experience with managed care – required significant investment of time and resources. Investing in these relationships was extremely valuable. One ACAP MMP noted that while it was a long road to develop strong relationships with LTSS providers, doing so was critical for achieving broader LTSS integration goals. Several ACAP MMPs reiterated that investments in provider engagement need to be ongoing and constant, and not just limited to implementation.

Several interviewees were initially surprised by the extent of resistance to the demonstration from certain providers. Even MMPs that operate other Medicaid or Medicare managed care products experienced pushback from providers accustomed to non-integrated Medicare or Medicaid managed care arrangements. ACAP MMPs had to increase provider education that focused on, for instance: the value of integrated care; contracting and continuity of care requirements; and ways the MMP could support provider efforts to coordinate care for demonstration enrollees. One MMP explained that it focused education efforts on how this



program served as a “one-stop shop” that could ultimately make providers’ jobs easier. According to this plan, this emphasis helped providers to focus on what streamlining services would do for beneficiaries and their practices, as opposed to the burden of learning about new program requirements. Some MMPs noted that, in retrospect, they would have increased their provider engagement efforts at the outset. For example, one MMP wished it had started earlier to build relationships with hospitals given the high hospitalization rates in the dually eligible population. However, since the start of the demonstration, this plan has increased efforts to partner with discharge planners and link individuals at risk of hospitalization to community-based programs.

Other lessons related to provider engagement include:

- Focus education on the value of integration for beneficiaries who receive all services from one entity;
- Provide training on billing, contracting, authorization policies, and other related program elements for providers new to managed care;
- Invest time in working with Medicare providers in addition to Medicaid LTSS providers who might be reluctant to participate in a program with new requirements;
- Ensure that part of the engagement process includes collaborative activities to allow providers to share their experiences and perspectives; and
- Expand data sharing and use of incentives that can support providers focused on population health management.

***2. Implementing extensive care coordination and management activities requires a significant investment of time and resources for both plans and providers.***

ACAP MMPs described lessons related to care management in a number of areas including: (1) engaging providers in ICTs; (2) locating members and meeting care plan completion requirements; (3) educating staff, members, and providers on their roles in the care team; and (4) addressing social determinants of health.

ACAP MMPs worked closely with both plan staff and providers to implement the extensive care management activities required under the demonstration. One plan noted that its care planning processes have evolved over time. By listening to feedback from care managers and other ICT members, the plan identified areas of redundancy and streamlined documentation to reduce potential provider burden. All MMPs said they valued having one care manager lead who maintains regular contact with members and coordinates communication across the care team.

Many ACAP MMPs noted that it was difficult to meet requirements for completing assessments and care plans in the time allotted. All the plans described challenges locating members due to outdated or incomplete contact information, and in some cases, homelessness. MMPs used several approaches to locate individuals, including using information from pharmacies, state or local social service agencies, and community ties. The plans also found that it was difficult to perform assessments in a timely fashion. ACAP MMPs discovered that many members were either not willing or not able to have assessments done in their homes. The plans had to develop new strategies to engage individuals who are difficult to reach by conducting assessments in the setting of their choice, including coffee shops, community centers, or other locations where

members felt comfortable. Several MMPs worked with vendors to conduct assessments and develop care plans for MMP staff review and approval because they did not have sufficient internal resources to meet the demand.

ACAP MMPs also noted that although ICTs provide great value to members and providers, this care management approach requires considerable investment in training to make it work. For example, one MMP found it needed to not only train its care managers to adapt to the team-based approach, but it also had to train: (1) administrative support staff to conduct member outreach to solicit their participation; and (2) members and families on their roles as the center of the team.

Finally, ACAP MMPs described the importance of capturing information about social determinants of health within care plans, and building relationships with community-based organizations that can address members' issues. The demonstrations provided opportunities for MMPs to tap community resources. For example, one MMP noted that individuals with untreated serious mental illness often need housing supports, so it identified community organizations to which it could make referrals.

***3. Coordinating physical and behavioral health services requires investment in promoting collaboration and information sharing across primary care and specialty behavioral health settings.***

Overall, MMPs reported that integrating physical and behavioral health benefits enhanced their ability to provide whole-person care. Several MMPs operate in states with behavioral health carve-outs, in which some or all behavioral health benefits are still managed by other entities. While the MMPs in these states thought they had made progress with coordinating physical and behavioral health services, they said that they needed to make a concerted effort to ensure that all providers involved in the care of members with physical *and* behavioral health needs communicate with each other clearly, early and often.

Several ACAP MMPs reported their staff had a lot to learn about the services and supports available for individuals with behavioral health needs, particularly community-based resources that had not been managed by health plans previously. One MMP's behavioral health director spends a considerable part of her job training social workers and care managers on this topic.

Investing in provider education has also been important. ACAP MMPs needed to help behavioral health providers understand managed care operations, and had to educate PCPs and other medical providers about how to address behavioral health issues. One MMP's medical director estimated that 75 percent of individuals with behavioral health needs present in PCPs' offices. At the very beginning of the demonstration, this plan realized that investing in training, information exchange, and other supports for PCPs was critical to enable them to work with these members effectively. As one interviewee commented, "It was a worthy endeavor to make sure physical and behavioral health providers understand each other's language and terminology—this was a crucial element in encouraging working relationships."

Lastly, ACAP MMPs had to take extra precautions with sharing information among providers while maintaining beneficiary privacy protections. The plans had to work very closely with

advocacy organizations to refine safeguards for making behavioral health data accessible to a broader array of providers and entities. Moving forward, all of the MMPs developed ongoing efforts to educate stakeholders about secure information-sharing policies and the value that shared data offers to care management. Some MMPs identified the need for new tools to facilitate information exchange. For example, several MMPs in California worked with county mental health systems to develop consent forms that can be used by both entities.

#### ***4. Simplifying and refining administrative and related processes are key to demonstration success, but doing so takes time.***

Although the demonstrations are expected to streamline administrative processes, there is inevitably considerable complexity in aligning Medicare and Medicaid rules in a way that is invisible to members. Most ACAP MMPs concurred that administrative and operational issues will likely resolve over time as key players become more comfortable and the federal and state governments work through remaining program challenges. Several MMPs have undertaken efforts to address some of these issues, as allowed under existing program rules, and offered these ideas:

- Recommend alternative passive enrollment processes for certain population groups. Most states passively enrolled eligible individuals in phases, typically by region and birth month. ACAP MMPs credited the passive enrollment process with introducing eligible individuals to the program who might not have enrolled independently. One plan noted, “We could not have built up membership in our MMP without the passive enrollment design.” However, ACAP MMPs also experienced some challenges. For example, MMP members are allowed to disenroll and/or change plans at any time, which can be burdensome for the plans to track in their systems. Some MMPs recommended alternative passive enrollment approaches to states to help streamline enrollment and strategically target initial member and provider outreach. One MMP worked with its state to obtain approval to enroll nursing facility residents by facility (as opposed to birth month). This improved the MMP’s ability to engage provider staff and educate all eligible residents at once, resulting in higher enrollment retention.
- Increase flexibility in provider contracting arrangements. In certain states (e.g., California) Medicare and Medicaid health plans often contract with physician networks that include both PCPs and specialists. A few MMPs realized that some physicians preferred to work directly with the MMP, so they allowed providers to contract directly, which resulted in: (1) more providers who were willing to participate; and (2) a subsequent expansion of their networks. One of the primary reasons for beneficiary opt-outs from the demonstrations is fear of losing current providers, so this was an effective response to including more Medicare providers and improving enrollment retention.
- Continue discussions about refining reporting requirements. ACAP MMPs noted that considerable efforts are devoted to reporting a vast array of Medicare and Medicaid data, including existing Medicare and Medicaid requirements and new MMP-specific requirements. Given the inclusion of both Medicare and Medicaid benefits in these programs, the extensive care management and quality requirements, and the need for separate Medicare and Medicaid financial and encounter data reporting, more than a few

plans noted that reporting requirements can be duplicative and unduly rigorous. These plans would be eager to work with state and federal partners to ensure reports can be generated in a timely fashion and remain meaningful to state and federal oversight efforts.

- Identify approaches to minimize provider burden. Many MMPs reported that providers had to meet new administrative requirements to participate in the demonstration. The plans recognized the importance of working on ways to minimize provider burden. For example, plans could work with states to revise policies that create undue burden on practices, such as rigorous in-person requirements for ICT meetings and service authorization requests. Other MMPs suggested developing strategies to streamline the “paperwork” required to manage transitions across care settings, such as creating electronic notifications for PCPs and care managers when individuals are admitted to and discharged from the hospital. Other MMPs developed new divisions of labor for their care management staff by allocating the most clinical and complex tasks to licensed care managers and hiring non-licensed staff to manage more administrative tasks.

## VIII. Conclusion

The 14 ACAP MMPs interviewed for this report described successes and challenges with serving dually eligible beneficiaries in financial alignment demonstrations. While uniform Medicare requirements are the foundation of each state’s demonstration, ACAP MMPs used the unique characteristics of their states’ Medicaid requirements, program designs, and target populations, as well as their own prior integrated care experiences, to craft innovative approaches to serving their dually eligible members. These innovations advance ACAP MMPs’ efforts to: (1) support their members in the community; (2) improve care coordination; (3) identify unmet needs; (4) engage providers; (5) coordinate physical and behavioral health care; and (6) implement value-based purchasing strategies.

ACAP MMPs are clearly committed to achieving a new vision of integrated care. One ACAP MMP noted, “We welcomed the idea of the integrated Medicare-Medicaid health plan. The concept of an integrated program is extremely important, and we are prepared for it to be successful and continue to support this work.” Many plans recognized that adjustments to financing have or will be helpful to supporting their ability to deliver the best care possible. Another plan noted that participating in the demonstrations aligns with the missions of safety net health plans. States are equally invested in the demonstrations, with most of the capitated model states extending their programs for two more years. However, both states and plans recognize that effectively integrating care takes time and are working to address ongoing issues and improve program operations. ACAP MMPs are applying the lessons they have learned to refine their care models. As one plan stated, “The intent of the demonstrations is right on, and we really believe this is the best thing for our dually eligible members. Early on we didn’t have the chance to step back, and now we’ve gleaned major lessons to re-work our case management program and make it even better.”

In addition to the innovations and lessons highlighted in this report, it is important to note that the financial alignment demonstrations created a testing ground for unprecedented partnerships

with social and community organizations, and providers across the spectrum of LTSS, and physical and behavioral health. ACAP MMPs expressed confidence that continued partnerships with state and federal policy makers will improve care for the dually eligible population for years to come.

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