The Duals Demonstration: A First Glimpse at Lessons Learned

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INTRODUCTION

In January 2016, the Centers for Medicare and Medicaid Services (CMS) released the first ever evaluation of the Financial Alignment Initiative (FAI) known as the dual eligible demonstration. Although the dual eligible demonstration was launched over two and a half years ago, this is the first look at data from the CMS-contracted multi-state evaluation, which is designed to closely explore implementation in early demonstration states. The report offers substantial detail on the early challenges, successes, and impact of the dual eligible demonstrations.

CMS contracted with Research Triangle Institute International (RTI) to conduct the evaluation and draft the *Report on Early Implementation of Demonstrations under the Financial Alignment Initiative*.[1] The report focuses on the first six months of operation in each demonstration state. With extensive qualitative and quantitative analysis generated from focus groups, interviews, site visits, and claims data, RTI's report offers an unprecedented insight into the early months of a major Medicare-Medicaid delivery system transformation.

Table of Contents

1 RTI International, *Report on Early Implementation of Demonstrations under the Financial Alignment Initiative*, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf.

The report is significant both in its investigation of the dual eligible demonstrations, and in its observation of the initial implementation of a health care system change. The findings provide guidance for the demonstrations, and can instruct stakeholders contemplating future health care delivery system changes.

This issue brief combines Justice in Aging's analysis of the duals demonstrations with key findings from the RTI report particularly relevant to consumer advocates in dual demonstration states testing a capitated model.[2] In the issue brief, we share six key lessons about early demonstration implementation, based on our dual eligible demonstration work.[3] The lessons and commentary are Justice in Aging's, not RTI's conclusions. After each lesson, we share RTI's findings from the report that support this lesson, and our recommendations to inform future implementation of a dual eligible alignment initiative or other significant health care systems change.

Background: The Dual Eligible Demonstrations and the RTI Evaluation

The Affordable Care Act[4] directed the Department of Health and Human Services to create a new office focused exclusively on improving health care delivery and services for dual eligible individuals. The new entity, the Medicare Medicaid Coordination Office (MMCO), is currently working with thirteen states to develop integrated systems that better align Medicare and Medicaid benefits.[5] This Financial Alignment Initiative (FAI) is also referred to as the dual eligible demonstration. The majority of FAI states are testing a capitated model[6] that integrates Medicare and Medicaid payment and service delivery in one managed care plan. Two states[7] are testing a managed fee-for-service model. The first FAI capitated model launched in Massachusetts in October 2013,[8] and participating states are currently in varying stages of implementation.

MMCO contracted with RTI to monitor demonstration implementation and provide an evaluation of the demonstrations' impact on the dual eligible population. This is the first RTI report and is a preliminary update on demonstration implementation. The report explores the seven states that implemented a demonstration by May 1, 2014,[9] specifically examining the first six months of implementation. The current evaluation is an interim report. MMCO and RTI expect to release more state-specific demonstration evaluations[10] that detail the demonstration's quantitative impact later this year. This issue brief is drawn from Justice in Aging's work and RTI's findings related to the capitated model, not the fee-for-service model.[11]

2 This issue brief is not an exhaustive summary of the extensive and detailed Evaluation Report, but a selection of key findings particularly relevant to consumer advocates.

3 See Justice in Aging, Dual Eligibles, http://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal.

4 Pub. Law 111-148, Section 2602.

5 For more background, see MMCO Financial Alignment Initiative Overview, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

6 Massachusetts, California, Illinois, Ohio, Virginia, Michigan, Texas, South Carolina, New York, and Rhode Island.

7 Colorado and Washington. Minnesota is participating in the demonstration under an alternative model that explores changes to the administration of its Medicare Advantage Special Needs Plans.

8 Massachusetts Department of Health and Human Services: One Care, http://www.mass.gov/eohhs/consumer/insurance/one-care.

9 The following states were included in the RTI analysis: California, Illinois, Massachusetts, Minnesota, Ohio, Virginia and Washington.

10 RTI International, *Measurement, Monitoring and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals*, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf.

11 RTI separately released a report on Washington's managed fee-for-service demonstration. See RTI International, *Preliminary Findings from the Washington MFFS Demonstration*, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalResults.pdf.

Justice in Aging's Six Key Lessons Learned from Early Demonstration Implementation and the RTI Initial Evaluation

The RTI preliminary evaluation findings reinforce the information Justice in Aging has compiled from state-level advocates throughout demonstration design and implementation. Based on our own information and analysis, as well as information gleaned from the RTI findings, we determined six key lessons about early demonstration implementation:

- Integration requires more time and dedicated resources before launch.
- New collaboration and oversight entities help foster program alignment.
- Rigorous information technology system testing should be completed before enrollment.
- The passive enrollment process presents communication challenges.
- Effective care coordination requires workforce preparation.
- Ensuring beneficiary protections requires provider outreach and buy-in.

Each lesson is discussed below, with RTI report findings and Justice in Aging recommendations:

1. Integration Requires More Time and Dedicated Resources Before Launch

The evaluation report underscores the challenge of trying to integrate two health care delivery systems. There are a large number of entities involved in implementing a delivery system reform including, for example, multiple federal and state agencies, county agencies, health plans, local municipal entities, and many different provider groups. A common theme across the states is the need for time and training to prepare all entities for this complex undertaking. Medicare Medicaid Plans (MMPs), states, and providers all required time to get to know each other and to receive training on integration. Integration of new benefits, particularly long-term services and supports (LTSS), also proved challenging for both Medicare Medicaid Plans (MMPs) that lacked experience in the delivery of LTSS and for LTSS providers that had little to no experience with managed care.

RTI Report Findings

- States reported that increased knowledge of Medicare rules and operational policies would have helped with integration.[12]
- States did not anticipate the large amount of time and resources it needed to align Medicare and Medicaid policies, systems, and procedures.[13]
- Many MMPs reported that the delivery of LTSS was an entirely new function with which they had no experience. MMPs reported reaching out to MMPs in other states to work through operational and contracting issues.[14]
- Similarly, a number of LTSS providers, most notably nursing facilities, reported that they had no experience working with managed care.[15]

12 RTI Report, p. 8.

13 RTI Report, p. 9.

14 RTI Report, pp. 5-6.

15 RTI Report, p. 5.

Justice in Aging Recommendations

- States should take the lead by mapping out all relevant entities participating in the delivery systems change and establish roles each will play in the transition. For example, in California there are four state agencies, seven county offices, ten Medicare-Medicaid Plans, and an independent enrollment broker responsible for different components in the implementation of the demonstration. It often was not clear which role each was playing and there were not established means of communicating their respective responsibilities internally to staff and externally to the other entities. The state should document these roles through inter-agency agreements and memorandums of understanding.
- States should develop training targeted specifically at state-specific agency staff about how the different agency roles differ and overlap.
- Future transition planning should also provide ample time to develop and distribute training and educational materials. Such materials should cover both operational and substantive integration topics tailored to the myriad of entities involved in implementation well in advance of the program's launch. For example, Ohio developed specific FAQs for different provider types (nursing facility,[16] assisted living,[17] and home care[18]) impacted by the demonstration, to explain the demonstration's substantive changes.

2. New Collaboration and Oversight Entities Help Foster Program Alignment

The demonstrations offer a unique opportunity for collaboration across agencies, MMPs, providers, and stakeholders. In addition to MMP stakeholder workgroups, some MMPs formed workgroups to tackle specific problems, like LTSS billing issues. One promising collaboration was the creation of Contract Management Teams (CMTs), a joint CMS-state oversight entity. Each state CMT includes representatives from the state Medicaid agency, Medicaid and Medicare groups from the CMS regional offices, and an MMCO state lead. The CMTs helped to monitor day-to-day implementation issues and MMP's compliance with regulatory requirements. Another promising model, the state duals demo ombuds programs, contributed to oversight by providing systemic advocacy and complaint resolution, as well as training and outreach on beneficiary rights.[19]

RTI Report Findings

- MMPs demonstrated new levels of cooperation, and MMP and LTSS provider workgroups were formed to streamline integration.[20]
- Contract Management Teams (CMTs) played an important role in joint oversight of MMP performance.[21]

16 Ohio Department of Medicaid, MyCare Ohio: Nursing Facility: http://medicaid.ohio.gov/Portals/0/For%20Ohioans/Programs/MyCareOhio/nursing-facility.pdf.

17 Ohio Department of Medicaid, MyCare Ohio: Assisted Living Waiver: http://medicaid.ohio.gov/Portals/0/For%20Ohioans/Programs/MyCareOhio/nursing-facility.pdf.

18 Ohio Department of Medicaid, MyCare Ohio: Home Care: http://medicaid.ohio.gov/Portals/0/For%20Ohioans/Programs/MyCareOhio/HomeCare-Transitions.pdf.

19 RTI Report, p. 22.

20 RTI Report, p. 22.

21 RTI Report, p. 6.

- Stakeholders highlighted the importance of the ombuds programs, and there is widespread expectation that ombuds programs will play a critical role in the demonstrations.[22]

Justice in Aging Recommendations

- In addition to CMTs, states should develop taskforces dedicated specifically to operational and implementation training and communication. For example, a task force dedicated specifically to LTSS billing issues would have helped to identify issues prior to implementation and helped to quickly resolve problems during implementation. Instead, in most duals states, billing problems, at least at first, were often addressed on a case-by-case basis after the fact and not systemically.
- MMPs should also formalize agreements with community stakeholders that work directly with consumers impacted by the transition to learn about and expedite the resolution of issues that arise during and after implementation. These include, for example, the long-term care ombudsman, legal services, and the entity responsible for enrollment counseling.

3. Rigorous Information Technology System Testing Should be Completed Before Enrollment

As states prepared to enroll dual eligible beneficiaries, one major challenge was aligning Medicare and Medicaid enrollment systems. Further complicating enrollment, many states decided to mandatorily enroll dual eligibles in Medicaid managed care simultaneously with the duals demonstration.[23]

Inadequate systems testing at the outset had severe consequences throughout implementation. For example, in Ohio, the state and MMPs did not adequately train independent personal care providers on new payment and billing systems. As a result, providers faced payment interruptions, which led to a gap in services for some beneficiaries.[24] In these situations, states, federal agencies and MMPs had to divert resources from serving beneficiaries to putting out avoidable fires. Beneficiaries experienced confusion and disruption. This confusion could lead to adverse health events and distrust of the program and the MMPs long after implementation.

RTI Report Findings

- States and MMPs reported technical challenges during enrollment[25] and struggled to coordinate disenrollment notices from Part D plans.[26]
- Transferring and syncing data across federal, state, and MMP systems caused discrepancies in enrollment information.[27]
- States and MMPs reported that additional time and a platform for end-to-end testing before the launch of the demonstration would have helped states to identify and resolve computer system issues.[28]

22 RTI Report, p. 22.

23 RTI Report, p. 12.

24 Universal Health Care Action Network Ohio, August Newsletter, available at: http://hosted-p0.vresp.com/1027935/98dc1bf217/ARCHIVE. See also Encarnacion Pyle, *Trouble persists for health workers*, The Columbus Dispatch (October 12, 2014), http://www.dispatch.com/content/stories/local/2014/10/12/trouble-persists-for-health-workers.html.

25 RTI Report, p. 15.

26 RTI Report, p. 15.

27 RTI Report, p. 16.

28 RTI Report, p. 16.

Justice in Aging Recommendations

- As noted in the RTI report, future transitions must include end-to-end systems testing to identify and resolve issues prior to implementation.[29]
- States should develop a reporting system that allows both beneficiaries and on-the-ground stakeholders to report issues with enrollment. For example, during enrollment in Virginia, the state held weekly conference calls with beneficiaries and their advocates to listen to reports about implementation.[30]

4. The Passive Enrollment Process Presents Communication Challenges

The report found multiple challenges with beneficiary communication during early implementation. Two areas that presented significant communication challenges were the passive enrollment process and care coordination. On enrollment, all states utilized a passive enrollment process, meaning the state automatically enrolled the beneficiary into a new MMP unless the beneficiary took action to stop enrollment. To preserve beneficiary freedom and Medicare statutory rights, CMS did not permit states to "lock" beneficiaries into a MMP for Medicare services and ensured beneficiaries could change MMPs on a monthly basis.[31] Most beneficiaries received their primary information about this change through notices. Clearly communicating this complex enrollment policy in writing tailored to this population was difficult.

Locating beneficiaries to conduct heath risk assessments proved equally challenging. Assessing a dual eligible individual's needs is an important first step in coordinating the care and services to meet those needs. The dual eligible population is incredibly diverse, and many experience chronic or temporary homelessness, making it difficult to contact them for enrollment or health risk assessments. The evaluation highlighted the importance of sending MMP plan staff into the community, to meet dual eligibles where they are, which might be homeless shelters, community centers, and culturally specific senior centers.[32]

Finally, communicating with beneficiaries regarding the program and what it meant for them individually was a greater undertaking than anticipated. While MMPs reported that passive enrollment was instrumental in building enrollment, beneficiaries did not have an understanding of how the demonstration or managed care could help them. This led to higher opt-out rates before MMPs began investing in educating members about program benefits.

RTI Report Findings

- States enrolled fewer beneficiaries than originally anticipated, due to a combination of higher opt-out rates, lower MMP participation, and lack of good beneficiary contact information.[33]
- Utilizing passive enrollment meant that beneficiaries received many different sets of notices from different entities.[34] Beneficiaries frequently received overlapping and conflicting notices leading to

29 For an example of some of the early implementation challenges to look for during end-to-end testing, see: http://justiceinaging.org/wp-content/uploads/2015/02/CCI-Fix-List-20150309.pdf.

30 Commonwealth Coordinated Care Update, pg. 4, http://www.dmas.virginia.gov/Content_atchs/altc/JulyUpdateToCCCStakeholders.pdf.

31 RTI Report, p. 9.

32 Justice in Aging and Advocates for African American Elders, *Thinking Outside the Box: Creative and Culturally Competent Outreach Strategies in Health Care Transitions*, available at: http://justiceinaging.org/wp-content/uploads/2015/03/AAAE_CulturalCompetencyFINAL.pdf. See also, Center for Health Care Strategies, *Contacting Hard-to-Locate Medicare and Medicaid Members: Tips for Health Plan*, available at: http://www.chcs.org/media/PRIDE-Tips-for-Contacting-Hard-to-Locate-Members_121014_2.pdf.

33 RTI Report, p. 9.

34 RTI Report, p. 14.

increased confusion.[35] The written information in the state notices confused beneficiaries.[36]

- Beneficiary testing of materials and sharing notices with stakeholder workgroups helped improve notices.[37]
- States had incorrect or outdated contact information for beneficiaries, making it difficult to locate them for notices and for setting up health risk assessments.[38]
- MMPs used creative efforts to contact dual eligibles in the community (health and community-based centers) to complete health assessments.[39]

Justice in Aging Recommendations

- Moving forward, states should continue to share notices with stakeholder workgroups for feedback, and notices should be subject to beneficiary testing. Testing and review should be conducted well in advance of enrollment. Beneficiary testing should occur in multiple languages and with populations with visual and hearing impairments.[40]
- States should map out the timeline with the number and type of notices a beneficiary will receive. For example, in Illinois, one advocacy group mapped out the notices to help beneficiaries and counselors prepare for the onset of information.[41]
- States should have policies in place to address when notices are returned as undeliverable.
- States and MMPs should form communications workgroups that are tasked with developing a comprehensive communications strategy. For example, in California most counties set up a communications workgroup composed of health plan(s) representatives, consumer advocates, ethnic groups, disability organizations, and both LTSS and health care providers. The workgroup identified beneficiary groups to target, who was best to communicate to the beneficiary groups, and what means of communication would be most effective.
- States should adopt expansive continuity of care policies that permit a beneficiary to continue seeing out-of-network providers when transitioning into a new plan. Robust continuity of care acts to minimize disruption and allows a beneficiary time to transition to in-network providers. The policies should be expansive both in the length of the period beneficiaries should have to transition and in the providers covered by such policies. States should invest heavily in educating providers, beneficiaries, and community stakeholders to ensure successful utilization of continuity of care.[42]
- Instead of relying on a confusing and complex passive enrollment system, enrollment strategies

35 RTI Report, p. 15.

36 RTI Report, p. 14.

37 RTI Report, p. 14.

38 RTI Report, p. 14.

39 RTI Report, p. 14.

40 Justice in Aging, *Designing Enrollment Notices for a Dual Eligible Demonstration Rollout*, available at: http://dualsdemoadvocacy.org/wp-content/uploads/2015/03/RE_Designing-Enrollment-Notices-for-a-Dual-Eligible-Demonstration-Rollout.pdf.

41 AgeOptions, Medicare Medicaid Financial Alignment Initiative MMAI Timeline of Consumer Mailings and Enrollment Periods, http://www.ageoptions.org/documents/MMAITimeline10-7.pdf.

42 Justice in Aging, *Continuity of Care in the Dual Eligible Demonstrations: A Tool for Advocates*, available at: http://dualsdemoadvocacy.org/wp-content/uploads/2015/03/RE_Care-Continuity-Final-052913.pdf.

should use affirmative choice and focus on effectively communicating the program's benefits and explaining which providers are part of the network. To protect Medicare freedom of choice, lock-ins should be prohibited.

5. Effective Care Coordination Requires Workforce Preparation

Implementing a person-centered care coordination model is the dual eligible demonstration's central goal. The passive enrollment system created a challenge for effective care coordination because MMPs faced pressure to assess a large group of enrollees in a short period of time. The rapid change also limited the MMPs' ability to effectively communicate the benefits of care coordination, causing beneficiaries to forego assessments or opt-out of the demonstration entirely.

RTI Report Findings

- Implementing the full array of care management services was slower than anticipated due to start up issues[43] and a lack of trained care coordinators.[44]
- Care coordinator responsibilities and roles were sometimes confused and overlapped with other case managers in the system.[45]

Justice in Aging Recommendations

- MMPs need adequate time to hire and train new care coordinators on the care model before enrollment begins. Staggering or phasing enrollment would provide MMPs with a clearer expectation of case-load mixes and allow for more time to hire and train care coordinators.
- MMPs should invest in specialized training for care coordinators servicing specific populations. For example, in California, the Alzheimer's Association and the Department of Aging received funds to provide dementia care coordination training to the MMP care coordinators. To date, 255 care coordinators were trained with these project funds.[46]
- Care coordination is a valuable feature of the demonstration but a difficult concept to communicate to beneficiaries. States and MMPs should invest in developing resources that explain care coordination and its value to MMP members.[47]

43 RTI Report, p. 18.

44 RTI Report, p. 19.

45 RTI Report, p. 18.

46 Brooke Hollister, PhD, and Susan Chapman, RN, Phd, FAAN, *Dementia Care Coordination Workforce and Practices in Duals Demonstration States*, (November 20, 2015), available at: http://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/Research_Brief-Dementia_Care_Coordination_Workforce_and_Practices_Seven_Duals_Demonstration_States.pdf.

47 For example, in California, the state created consumer videos to help explain care coordination to beneficiaries and caregivers: http://www.calduals.org/cal-mediconnectoons.

6. Ensuring Beneficiary Protections Requires Provider Outreach and Buy-in

Dual eligible beneficiaries contemplating enrolling in a new health care program were primarily concerned with keeping their relationship with their doctors.[48] All of the demonstrations included continuity of care protections if the provider did not contract with the MMP. However, not all providers understood the demonstration's changes, and this confusion caused some providers to share misinformation with beneficiaries.[49] Early provider education about the system change and information about contracting with MMPs helps beneficiaries maintain care continuity.

RTI Report Findings

- Lack of provider buy-in made enforcing continuity of care protections difficult in at least one state.[50]
- Administrative challenges, like prior authorization and billing procedures, caused a home care interruption in one state.[51]
- Weekly calls with provider groups and provider toolkits helped states obtain provider engagement.[52]

Justice in Aging Recommendations

- States should consider provider outreach as important as beneficiary outreach, and devote separate time and resources to educating the provider community through in-person presentations, meetings and toolkit materials. For example, in New York, the Medicare Rights Center created a toolkit to help explain the demonstration program to providers.[53]
- Part of a state's end-to-end testing should include testing MMPs on prior authorization and billing procedures for both medical and LTSS providers.

CONCLUSION

Aligning Medicare and Medicaid requires an "unprecedented effort" to integrate complex systems. As the Center for Medicare & Medicaid Innovation (CMMI) prepares to test new health and payment models,[54] state and federal legislatures[55] contemplate options to improve service delivery, and MMCO continues to improve the demonstration,[56] early insight into the demonstration program offers instructive examples of start-up hurdles and innovative problem solving.

48 Medicaid and CHIP Payment and Access Commission (MACPAC Report), *Experiences with Financial Alignment Initiative Demonstration Projects in Three States*, p. 17, available at: https://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf.

49 MACPAC Report, p. 7.

50 RTI Report, p. 25, p. 29.

51 RTI Report, p. 5.

52 RTI Report, p. 28.

53 Medicare Rights Center, FIDA Provider Toolkit, available at: http://www.medicarerights.org/FIDA-Provider-Toolkit/Provider-Toolkit-Introduction.pdf?nrd=1.

54 Center for Medicare & Medicaid Innovation, https://innovation.cms.gov/initiatives/map/index.html.

55 United States Senate Committee on Finance Bipartisan Chronic Care Working Group Policy Options Document, http://www.finance.senate.gov/imo/media/doc/CCWG%20Policy%20Options%20Paper1.pdf.

56 RTI Report, p. 31.