Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative

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Table of Contents

Tables

Glossary of Acronyms

AAA	Area Agency on Aging
BH	Behavioral health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CER	Centralized Enrollee Record
CMS	Centers for Medicare & Medicaid Services
FIDA	Fully Integrated Duals Advantage
FIDA IDD	Fully Integrated Duals Advantage Intellectual and Developmental Disabilities
FTE	Full-time equivalent
HRA	Health risk assessment
ICP	Individualized care plan
ICT	Interdisciplinary care team
LTS	Long-term services
LTSS	Long-term services and supports
MLTC	Managed long-term care
MMP	Medicare-Medicaid Plan
PCP	Primary care provider
PIHP	Prepaid inpatient health plan

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Executive Summary

This Issue Brief provides an update on the status of care coordination activities and early findings on successes and challenges of providing care coordination services for the nine capitated model demonstrations implemented between October 2013 and February 2015 under the Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative to test integrated care and financing models for Medicare-Medicaid enrollees. The information included in this Issue Brief covers the period from the start of each capitated model demonstration through February 2016. The managed fee-for-service model demonstrations under the Financial Alignment Initiative are not addressed in this Issue Brief.

Care coordination is a centerpiece of all demonstrations under the Financial Alignment Initiative and is considered a key vehicle for achieving improved outcomes through comprehensive risk assessments and health action plans, person-centered planning, and navigation assistance to access services. Specifically, CMS and participating States believe that robust care coordination will improve quality and cost outcomes by increasing preventive and timely care, reducing avoidable hospitalizations, improving the Medicare-Medicaid enrollee experience, and delaying institutionalization.

Care coordination functions generally include assessing an individual's medical, physical, and social support needs; developing a personalized plan of care; monitoring and clinically helping Medicare-Medicaid enrollees address their complex care needs; assisting enrollees with locating and obtaining needed services; and supporting in enrollees achieving their goals. Medicare-Medicaid Plans (MMPs) perform these functions as part of an integrated care team that includes the enrollee, primary care providers (PCPs), the care coordinator, and, as applicable, specialists, behavioral health providers, long-term services and supports (LTSS) providers, and any other members the enrollee chooses to include.

Information for this Issue Brief was collected from site visit interviews with State officials, consumer advocates, CMS staff, and various other demonstration stakeholders, including MMPs; focus groups with Medicare-Medicaid enrollees; quarterly data submitted by the States; data submitted by MMPs and shared with RTI by the CMS implementation contractor (NORC at the University of Chicago); quarterly meetings with demonstration representatives from the States; available reports from States' internal evaluation activities; and State-specific documentation (e.g., websites, three-way contracts among CMS, the States, and the MMP; final demonstration agreements; and Memoranda of Understanding).

Early evaluation findings on care coordination suggest that although demonstrations vary somewhat, MMPs are implementing new care coordination approaches designed to integrate care across medical, LTSS, and behavioral health systems and that they have overcome major challenges in designing and implementing the operational details of these new care coordination systems. A major accomplishment of the demonstrations is that large numbers of new care coordinators have been hired and trained, and the new system has been implemented. The care

coordinators are providing a new service that Medicare-Medicaid enrollees generally feel is beneficial. Once enrollees become familiar with their assigned care coordinators and forge personal relationships with them, they appreciate the support and learn to ask for assistance with various challenges, including access to needed providers and durable medical equipment. CMS, States, and MMPs are heavily invested in the new system and are working hard to make it succeed.

In terms of implementation, MMPs faced challenges including hiring and retaining large numbers of care coordinators; completing the health risk assessments (HRAs) and individualized care plans (ICPs) within required time frames; involving all members of the ICTs, particularly physicians; sharing information and coordinating with behavioral health providers; resolving overlap and duplication with existing care management systems; and establishing new care coordination data systems.

As the demonstrations proceed, the RTI evaluation team will continue to monitor the implementation of the care coordination model. The effect of the demonstrations, including care coordination, on quality, utilization, and cost outcomes will be assessed in future reports. A major goal of the evaluation is to monitor how care coordination is affecting the beneficiary experience and access to needed services. To address this goal, CMS is tracking beneficiary experience with care coordination in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) supplemental questions; the results of these analyses will be included in future reports.

1. Introduction

The financing and service delivery of medical care, LTSS, and behavioral health for older people and younger people with disabilities are splintered and uncoordinated (Polniaszek, Walsh, & Wiener, 2011; Grabowski, 2007; Wiener & Skaggs, 1995). Fragmentation exists within and across these multiple systems. For example, financing for medical and post-acute care for Medicare-Medicaid enrollees is primarily a Federal responsibility through Medicare, whereas financing for LTSS is primarily a State responsibility through Medicaid. Because of this bifurcation of responsibility, medical care providers have little incentive to be concerned about the LTSS needs of their patients and LTSS providers have little incentive to be concerned about the medical care needs of their consumers. As result, care is not coordinated, utilization of expensive services and costs are higher than necessary, and quality of care is sometimes poor.

To help address this problem, the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation created the Financial Alignment Initiative to test integrated care and financing models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models that integrate medical, behavioral health, and LTSS for Medicare-Medicaid enrollees, with the expectation that integrated delivery models will improve quality of care, enhance the beneficiary experience with care and services, and help control expenditure growth.

Under the Financial Alignment Initiative, CMS made two financial alignment models available to States: (1) a capitated model in which managed health plans receive Medicare and Medicaid payments for the full range of health services and LTSS, and (2) a managed fee-for-service model in which States are eligible to benefit financially from savings resulting from initiatives that improve quality and reduce costs. Only the capitated model demonstrations are discussed in this Issue Brief. Although the demonstrations in these States differ in many ways, they share similar approaches to care coordination.

CMS contracted with RTI International and its subcontractors—the Urban Institute, the National Academy for State Health Policy, the University of Southern Maine, the Center for Health Care Strategies, American Institutes for Research, Actuarial Research Corporation, and the Henne Group—to monitor demonstration implementation, evaluate the demonstrations' impact on enrollee experiences, monitor unintended consequences, and evaluate the demonstrations' impact on outcomes for the eligible population as a whole and for special populations (e.g., people with mental illness or substance use disorders, LTSS users).

This Issue Brief describes early findings on care coordination activities among the demonstration States where managed care organizations are receiving capitated Medicare and Medicaid payments for the care of Medicare-Medicaid enrollees: California, Illinois, Massachusetts, Michigan, New York,[1] Ohio, South Carolina, Texas, and Virginia. Because the start dates of the initiative varied across the States, each demonstration is at a different stage of implementation. Carrying out these demonstrations is complex and challenging, requiring integration of multiple systems and reconciliation of sometimes conflicting Medicare and Medicaid policies, and major investments of time and resources by the States and CMS. ***Table 1*** provides background information, as of February 2016, for the demonstrations in each State included in this Issue Brief.

This Issue Brief draws information from site visits that included interviews with State officials, providers, managed care plan administrators, consumer advocates, and others; focus groups with enrollees; State documents and reports, including those submitted to CMS; data submitted by the States to the State Data Reporting System; and data reported to NORC at the University of Chicago, a contractor to CMS, about enrollment, disenrollment, and other operations of the MMPs. At the time of the writing of this Issue Brief, enrollee focus groups had been conducted in California, Illinois, Massachusetts, Ohio, and Virginia. Focus groups in the remaining States will be conducted at a later date. Although the exact dates covered vary by State because of different start dates, in general, the information was collected during the first 2 years of implementation.

[1] In New York, there are two capitated model demonstrations under the Financial Alignment Initiative. The first demonstration, implemented on January 1, 2015, is the Fully Integrated Duals Advantage (FIDA) demonstration for people needing a nursing facility level of care or community-based long-term care for more than 120 days. New York also recently implemented a second demonstration for individuals with intellectual and developmental disabilities (FIDA-IDD). This Issue Brief includes only the FIDA demonstration, implemented within the covered time period.

Table 1.
Overview of capitated demonstrations: Early implementation

State	Demonstration name	Implementation date	Eligible population and geographic areas	Number of eligible individuals as of February 2016	Number of enrollees as of February 2016
Massachusetts	One Care	October 1, 2013	Aged 21–64,[1] in 9 of 14 counties in Massachusetts[2]	102,428	12,765
Illinois	Illinois Medicare-Medicaid Alignment Initiative	March 1, 2014	Aged 21 or older, in 21 counties in Greater Chicago and Central Illinois	148,131	47,916
California	Cal MediConnect	April 1, 2014	Aged 21 or older, in 7 counties in southern California and around the Bay Area	428,637	124,292
Virginia	Virginia Commonwealth Coordinated Care	April 1, 2014	Aged 21 or older, in 104 localities: Central Virginia, Tidewater Northern Virginia, Roanoke, and Western/Charlottesville	68,221	26,933
Ohio	MyCare Ohio	May 1, 2014	Aged 18 or older, in 29 counties (7 regions of 3 to 5 counties each, including major urban centers)	91,855	61,227
New York	FIDA Demonstration	January 1, 2015	Aged 21 or older needing 120 days or more per year of LTSS, in 6 counties	94,251	5,691
South Carolina	Healthy Connections Prime	February 1, 2015	Aged 65 or older, statewide	23,978	1,788
Texas	Texas Dual Eligible Integrated Care Demonstration Project	March 1, 2015	Aged 21 or older, in 6 counties	151,896	48,223
Michigan	MI Health Link	March 1, 2015	Aged 21 or older, in 2 counties in the Detroit metropolitan area, an 8-county region in southwest Michigan, and the entire Upper Peninsula	106,291	33,463

FIDA=Fully Integrated Duals Advantage; LTSS=long-term services and supports.

[1] The Massachusetts demonstration targets people aged 21–64 at the time of enrollment and allows people to remain in their MMP when they turn age 65 as long as they maintain demonstration eligibility.

[2] Includes eight full counties and one partial county.

SOURCE: RTI International: State Data Reporting System (SDRS). The information submitted by States into the SDRS may differ slightly from other reporting because of the timing of the data submissions (some reports being generated at the beginning of the month vs. at the end of the month).

2. Care Coordination Process

Care coordination is a centerpiece of the demonstrations under the Financial Alignment Initiative and is an important vehicle for improving outcomes, increasing access to needed care and services, and decreasing costs. Specifically, participating States believe that robust care coordination will improve quality and cost outcomes by increasing preventive and timely care, reducing avoidable hospitalizations, improving the Medicare-Medicaid enrollee experience, and delaying institutionalization

Care coordination includes the designation of an individual or team that is responsible for coordinating care for an enrollee; an HRA of an individual's medical, physical, and social support needs; development and implementation of a personalized plan of care/action plan; monitoring and clinical management; and helping Medicare-Medicaid enrollees locate and obtain needed services and supports, including housing. These functions are performed by an integrated care team that includes the enrollee, the PCP, the care coordinator, any other relevant specialist providers, and any other members the enrollee chooses to include. ***Table 2*** details the basic components of care coordination under the Financial Alignment Initiative per CMS guidance and as envisioned by the States when planning and designing individual demonstrations.

Table 2.
Components of care coordination

Components of care coordination	Component description
Care coordinator	• Typically, upon enrollment, enrollees are contacted by their assigned care coordinator[1] who is a clinician or other trained professional responsible for coordinating the enrollee's care. The care coordinator may be employed by the Medicare-Medicaid Plan (MMP) or another organization. • Among other responsibilities, the care coordinator facilitates care coordination services (e.g., conducting [or participating in] the HRA, developing the enrollee's ICP, leading or facilitating the ICT meetings).
Health risk assessment (HRA)	• Once enrolled, each enrollee is assigned to a risk category (e.g., low, moderate, or high risk) based on his or her health history and needs. • Each enrollee receives an HRA, administered by the Integrated Care Organization, to identify needs. • The assessment tool is a screening questionnaire that can vary by State and by MMP, but it must assess the enrollee's needs (e.g., medical, psychosocial, functional, and cognitive requirements).
Individualized care plan (ICP)	• The ICP is required for each enrollee, and the format can vary by State. The care coordinator or the ICT typically develops it in collaboration with the enrollee. • The ICP, which is usually developed after the HRA, includes the enrollee's goals and strategies for meeting those goals. • The enrollee's ICT typically works with him or her to implement the ICP, which is updated annually or when the enrollee has a change in health status or goals.

(continued)

Table 2. (continued)
Components of care coordination

Components of care coordination	Component description
Interdisciplinary care team (ICT)	• Each enrollee is to have access to an ICT that is built on his or her preferences and needs. • The ICT, often led by a care coordinator, is a team of providers that works with the enrollee to implement and maintain his or her ICP. • The ICT typically consists of the enrollee, the PCP, the care coordinator, any other relevant specialist providers, and any other members the enrollee chooses to include. Enrollee participation in ICT meetings (to the extent that such meetings occur) is optional.
Care coordination data systems	• Under the demonstration, there are multiple requirements related to data systems to support care coordination. MMPs are required to electronically track enrollee information to facilitate care coordination. The plans are required to integrate data from multiple sources to track enrollees, including demographics, eligibility data, assessment results, care coordinator assignments, care plans, service authorizations, claims and pharmacy data. Effectively, this requires plans to connect various operational systems (enrollment, claims, utilization management, etc.) with the care management system.

[1] In Illinois, a call center could be involved in this activity. One MMP uses a central call center to conduct health risk screening and other telephonic care coordination in addition to its locally based staff care coordinators.

SOURCE: RTI analysis and Government Accountability Office. (2015). http://www.gao.gov/assets/680/674340.pdf.

Care coordination is not an entirely new function for managed care plans, but its scope is broader for many MMPs participating in the Financial Alignment Initiative. Before these demonstrations, most States provided case management for a subset of dually eligible individuals (e.g., people receiving Medicaid home and community-based waiver services or people needing behavioral health services). However, Medicaid-funded case managers typically have had limited information about the range of client needs and limited ability to coordinate the Medicare-funded services they use. The demonstrations provide a single point of contact for all care coordination services, expand the number of people receiving the service, broaden the scope of the services being managed (e.g., medical, behavioral health, and LTSS), and provide for interdisciplinary care teams (ICTs). The demonstrations also endeavor to have Medicare-Medicaid enrollees consider their care goals, make active decisions about the services they use, and participate in coordinating their own care.

The specific details about care coordination provisions required by CMS and the States for each demonstration under the Financial Alignment Initiative are specified in the three-way contract between the State, CMS, and the participating MMP. These requirements include a definition of who can serve as a care coordinator, composition and function of the ICTs, the scope and timing of the HRAs, and what specific care coordination services are to be provided. The contracts also specify the components of an ICP. Although the overall requirements are the same across all States, the details vary depending on the State-specific model, and States use different terminology for the care coordinator role, HRA, ICP, and ICT. ***Table A-1*** in ***Appendix A***

presents specific State-by-State details of care coordination components for the nine capitated demonstrations described in this Issue Brief.

For the purposes of this Issue Brief, a distinction is made between *care coordination* and *care or case management*. The distinction is based on the breadth and scope of the coordinators' or managers' responsibilities. Care coordination, especially as implemented by the MMPs, involves taking responsibility for the whole person across acute care services, LTSS, and sometimes behavioral health services. Case management involves narrower responsibilities. Care management involves implementing program responsibilities, such as Medicaid home and community-based services (HCBS) waivers, and does not involve very much involvement across service systems. For example, the Multipurpose Senior Services Program (MSSP) waiver in California provides care management for frail elderly individuals aged 65 or older who are certifiable for placement in a nursing facility but wish to remain in the community. Demonstration enrollees receive care coordination from their MMP and care management via the MSSP waiver. Case management supplied by individual service providers is involved with coordinating the services provided by the organization and does not usually involve itself with other providers or systems. This Issue Brief focuses on the coordination provided primarily through the MMPs and not on case management.

2.1 Care Coordination Entities and Individual Care Coordinators

The entities conducting care coordination and care management vary by State and by MMP. Although most MMPs provide care coordination directly, some States require MMPs to contract out the service as a way of building on the expertise of existing service coordinators. For example, Ohio requires the use of some of the care management infrastructures available through Area Agencies on Aging (AAAs) for members who are aged 60 and older. In California, although the State does not require contracting out care coordination, it is quite prevalent and individual MMPs differ in the level of delegation: some MMPs only contract out the completion of the HRAs, whereas others contract out all care coordination functions. In Massachusetts, MMPs are required to provide care coordination and to contract with community-based organizations to offer an additional Long-Term Supports Coordinator (LTS coordinator) to all enrollees to supplement the care coordinator on each member's care team.

States and MMPs also have different approaches to what types of staff they hire to serve as care coordinators. In Massachusetts, MMP care coordinators for enrollees with complex clinical care needs must be registered nurses or other licensed professionals trained to provide clinical care management. However, MMPs establish their own qualifications for other care coordinators. LTS coordinators in Massachusetts must have the knowledge and skills to serve people with physical disabilities, people with behavioral health needs, and older people.

In Michigan, care coordinators must be Michigan licensed registered nurses, nurse practitioners, physician's assistants, bachelors-prepared social workers, or masters-prepared social workers. They also must have specific training, such as that provided by the Michigan Department of

Health and Human Services on person-centered planning. It is not yet clear whether these requirements will affect the supply of available care coordinators or the caseloads for those already employed by Michigan plans.

For New York, the care coordinator may be an employee or under contract to the Fully Integrated Duals Advantage (FIDA) plan, and he or she must have the appropriate experience and qualifications to address the enrollee's assigned risk level and individual needs. Care coordinators are not required to possess a specific educational degree, but they must have knowledge in certain areas, including physical health, community support services, commonly prescribed medications and their side effects, behavioral health, and use of durable medical equipment.

Some States tailor the requirements to suit the types of enrollees served by the care coordinators. In South Carolina, care coordinators must have at least a bachelor's degree, preferably in a health- or social services–related area, and those who serve enrollees assigned to moderate to high risk levels must have a clinical background and may also have community-based experience working with older people, people with disabilities (including developmental disabilities), and person-centered planning approaches. Care coordinators who serve enrollees assigned to lower risk levels are not required to have a clinical background. Illinois and Texas put forth similar requirements. In Illinois, MMPs are required to employ clinicians in addition to care coordinators for enrollees living in nursing facilities. These clinicians, known as SNFists, specialize in care management for nursing facility residents and work alongside the care coordinator to ensure that enrollees' needs are met.

2.2 Health Risk Assessment (HRA)

All demonstration States require some form of an HRA of enrollees to be conducted within a specified time frame, which usually varies by the level of risk or care need. New York FIDA requires plans to use a statewide uniform assessment tool, the Uniform Assessment System for New York. California is working on a statewide uniform assessment tool to be implemented in the later stages of the demonstration. Although most three-way contracts do not require a standardized instrument, assessment requirements are quite detailed and MMPs are obligated to include specific domains such as LTSS and social unmet needs. However, each MMP generally develops its own assessment tool based on detailed State specifications. Moreover, MMPs may vary in how they translate the findings from the assessment into a care plan (e.g., plans may have different algorithms for determining hours of personal care).

In addition, States and MMPs use various methods to stratify Medicare-Medicaid enrollees by risk categories, including using claims-based algorithms and other care-need criteria (e.g., residing in a nursing facility or receiving home and community-based waiver services). These risk stratifications help MMPs to allocate care coordination resources, determine the time frames for conducting assessments and reassessments, and develop care plans.

Demonstrations vary in how soon after enrollment HRAs should be done, and some of them have requirements that are shorter than 90 days (at least for some groups of Medicare-Medicaid enrollees). For example, Ohio requires assessments to be completed within 15 days of enrollment for enrollees in the highest risk group, and within 75 days for those assigned to "low" and "monitoring" tiers. California requires assessments to be completed within 45 days for those in its highest risk category and 90 days for all others. In addition to a comprehensive assessment, Massachusetts requires MMPs to complete the standardized Minimum Data Set–Home Care for confirmation of high LTSS or high behavioral health rating category assignment within 90 or 180 days, depending on the rating category.

Some States adjusted their timelines after their demonstration was implemented based on their early and past experiences. Initially, the New York FIDA three-way contracts required plans to complete an assessment within 30 days of opt-in enrollment and 60 days of passive enrollment. As part of a larger package of reforms, the State and CMS modified that requirement, stipulating only that MMPs assess new-to-service enrollees within enough time to complete the care plan within 90 days of enrollment. MMP enrollees transferring from a related managed LTSS product administered by the MMP do not need to be reassessed until 6 months after the date of their previous assessment completed by the original plan. These MMPs, however, are responsible for contacting enrollees and reviewing any available medical record and claims history for changes in health status or needs that may trigger a reassessment. Although adjusting the processes more than the actual timelines, Massachusetts plans made updates on using claims data for beneficiaries they were unable to reach and changed some protocols for telephonic reassessments.

2.3 Individualized Care Plan (ICP)

The ICP is a comprehensive blueprint of services needed for each enrollee. In general, the plan is intended to cover the full range of the enrollee's needs, goals, and care preferences. Typically, the MMP care coordinator leads the development of the ICP in close collaboration with the enrollee, but other members of the ICT may also be involved, such as the PCP, LTSS providers, behavioral health service providers, other case or care managers, and family members. ICPs are informed by findings from the HRA and usually include assessment results; the enrollee's preferences for care, supports, and services; the enrollee's prioritized list of concerns, goals, and objectives; and the plan for addressing these concerns, goals, and objectives. Many three-way contracts specify that ICPs should be person-centered and outcomes-based, meaning that goals and objectives should be driven by the enrollee and should be measureable. ICPs typically incorporate existing service plans, such as Medicaid home and community-based services waiver care plans. The ICT implements the ICP.

Requirements for the timing and content of ICPs vary by State. For example, in Illinois and Michigan, with some exceptions for enrollees who receive home and community-based waiver services or who reside in nursing facilities, the MMP care coordinators and the ICT develop ICPs

within 90 days of enrollment. In contrast, the Ohio demonstration requires that the ICP be completed within 15 days of completion of the HRA.

ICP requirements may also differ by risk category. In some States, HRAs are used to determine whether enrollees are low, medium, or high risk. ICPs for higher-risk enrollees may be more extensive or may be created on a more accelerated timeline. ICPs are typically updated annually or when the enrollee experiences a change in health status or needs. Some States, like South Carolina, require that the MMP monitor ICPs for higher-risk enrollees more frequently than those for lower-risk enrollees (every 30 days vs. every 120 days).

2.4 Interdisciplinary Care Team (ICT)

ICTs generally include the PCP, the care coordinator, the enrollee, the LTSS and/or behavioral health care manager for recipients of these services, and other specialists or providers deemed appropriate based on enrollees' needs and preferences. The three-way contract requires that each enrollee in the demonstrations should have access to an ICT that reflects the enrollee's preferences and needs. The ICT, often led by a care coordinator, is a team of multidisciplinary providers that works with the enrollee to implement and maintain his or her ICP.

The goals of ICTs are to manage care and services, avoid fragmentation, ensure access to appropriate person-centered care, and provide a team approach to address clinical, social, and behavioral health needs (Philip & Soper, 2016). In some States (e.g., New York), ICTs also authorize services, so long as the service is within the ICT members' scope of practice.

In Texas, the three-way contract requires service coordinators to lead teams of providers, which include PCPs and professionals with specified expertise (e.g., behavioral health and knowledge of community resources). In Ohio, the exact structure varies based on enrollees' needs and preferences. The three-way contract requires the team to include the enrollee, the enrollee's family or caregiver(s), a care coordinator, a waiver services coordinator (if the enrollee receives waiver services), the enrollee's PCP, and any specialists or other providers as necessary and appropriate.

Care coordinators have in-person or telephonic meetings with enrollees; initiate and maintain assessment of the enrollee's health status and needs; develop, implement, and review plans of care; ensure the enrollee's participation in these plans of care; and coordinate service delivery. ICTs also can play a role in improving health care setting transitions for enrollees.

Care team composition and how the teams are actually implemented varies by MMP and across States. According to the three-way contract in California, for example, ICTs are offered for each enrollee as necessary and always at enrollee request. Decisions about whether enrollees require an ICT are driven by care plan goals and needs. Cases for enrollees with low levels of need are reviewed once a year, and those categorized as high level are assigned a full team that meets more frequently.

In New York, physician participation in ICTs is now optional, based on the enrollee's preference and physician availability. A physician may participate in team meetings or may just review and approve the care plan. If the physician does not participate in the ICT and does not sign off on the plan, the MMP's utilization management staff physician reviews and authorizes any services in the plan outside the scope of practice of team members who attended the meeting.

2.5 Care Coordination Data Systems

Under the demonstrations, designing a centralized enrollee record to support care coordination is a goal in many States. MMPs are required to electronically track enrollee information to facilitate care management, and the plans are required to integrate data from multiple sources to track enrollees, including demographics, eligibility data, assessment results, care coordinator assignments, care plans, service authorizations, and claims and pharmacy data. This effectively requires plans to connect various operational systems (enrollment, claims, utilization management, etc.) with the care management system.

In New York, plans are required to have a comprehensive health record that includes extensive detail on the enrollee's care, services use, contacts, laboratory results, and other information. Moreover, MMPs are "encouraged" to make the health record electronically available to members of the ICT and to participate in a regional Health Information Network. Plans may also use paper records as long as all team members have swift and easy access. Other States have provided similar flexibility to their plans.

Overall, State data systems needed to be developed to track care coordination encounters and accept such data from MMPs. Additionally, some States are using Medicare Parts A, B, and D claims data from CMS to support case management activities by analyzing prior Medicare utilization to stratify enrollees into risk tiers. On the other hand, MMPs also need to set up data systems for care coordinators, which they can use to develop ICPs, share data with ICTs, and document care coordination workflows and their interaction with beneficiaries and other providers.

3. Early Findings on Care Coordination

The demonstrations under the Financial Alignment Initiative had successes and challenges implementing care coordination in the early stages of operations. Much of the initial work was devoted to hiring and training care coordination staff, defining MMP workflows and workloads, and designing information systems to support care coordination activities. Moreover, in many States, the implementation of a full array of care coordination services was slower than anticipated.

MMPs reported investing heavily in hiring language- and culture-concordant staff and in providing training to care coordinators on the needs of special populations, such as enrollees

with Alzheimer's disease and other dementias. Although the demonstrations encountered major start-up challenges and the system does not always work perfectly, the care coordination capacity and infrastructure are now in place in all of the demonstration States. Evidence from focus groups and State-provided beneficiary surveys[2] from early implementation States suggests that most Medicare-Medicaid enrollees generally are satisfied with the new set of care coordination services and that they benefit from care coordination once they are assigned a care coordinator and establish a personal relationship with them. For later implementers, such as South Carolina and Texas, it is too early to assess enrollee satisfaction. In early 2015, CAHPS surveys were sent to a sample of MMP enrollees[3] with at least 6 months of continuous enrollment, who were asked to evaluate their health care experience over the previous 6 months (CMS, 2016). A total of 30 percent of respondents recalled receiving help from their health plan or providers in coordinating their care in the past 6 months. A total of 45 percent of respondents were very satisfied with the help they received to coordinate care; 41 percent were somewhat satisfied and 15 percent were neither satisfied nor dissatisfied, or somewhat or very dissatisfied with the help they received.[4] Results of additional surveys will be reported in future reports.

Some of the issues that States and MMPs faced in the early period of implementation included

- implementing the care coordination system, including hiring and training care coordinators in time for serving a large number of passively enrolled Medicare-Medicaid enrollees;
- care coordination workforce challenges (e.g., high turnover, need for additional training);
- locating and contacting Medicare-Medicaid enrollees and conducting HRAs within required time frames, especially for Medicare-Medicaid enrollees who were passively enrolled;
- lack of understanding of the care coordination benefit by enrollees, and lack of enrollee awareness of care coordinators and how to reach them;
- convening the ICT and ensuring participation of PCPs in these teams;
- overlap of MMP care coordination with other care managers (e.g., behavioral health, substance use, home and community-based services waivers) and confusion among Medicare-Medicaid enrollees with different care managers; and
- implementing data management systems to support centralized enrollee tracking.

[2] Reports on beneficiary focus group findings for the evaluation will be available in the future.
[3] The CAHPS surveys were sent to enrollees in MMPs participating in the five capitated model demonstrations that began in 2013 and 2014: California, Illinois, Massachusetts, Ohio, and Virginia.
[4] An overall 22.4 percent response rate was obtained. Averages were computed by averaging across MMPs without weighting for the number of enrollees. The results were case-mix adjusted.

3.1 Implementing the Care Coordination System, Including Hiring and Training Care Coordinators

During the early stages of the demonstrations, hiring and training care coordinators and establishing procedures for their activities were major tasks for MMPs; these tasks are still in progress. For most MMPs, establishing this comprehensive system of care coordination was a new endeavor.

In 2015, a total of 4,595 full-time equivalent (FTE) MMP care coordinators were involved in the demonstrations (see ***Table 3***).

Table 3.
Capitated demonstrations: Care coordination staffing, 2015

State	Total number of care coordinators (full-time equivalents)	Percentage of care coordinators assigned to care management and conducting assessments	Average member load per care coordinator assigned to care management and conducting assessments	Average turnover rate[1]
California	1,337	76.8	114	14.8
Illinois	546	95.6	102	17.6
Massachusetts	125	80.0	123	14.4
Michigan	192	95.8	194	13.1
New York	473	69.3	20	12.9
Ohio	1,015	91.3	65	14.0
South Carolina	24	83.3	90	29.2
Texas	650	71.7	101	15.0
Virginia	233	85.2	136	24.7

[1] Average turnover rate was averaged across MMPs and weighted by the number of care coordinators in each MMP.

NOTE: Percentages and averages in this table were calculated using annual data from 2015.

SOURCE: RTI analysis of MMP-reported data for Core Measure 5.1. The technical specifications for Core Measure 5.1 are provided in the Medicare-Medicaid Capitated Alignment Model Core Reporting Requirements document, which is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

MMPs in demonstration States with a linguistically diverse population of enrollees, such as California and New York, reported major efforts to hire language-concordant care coordinators. MMPs noted that spoken language was a primary criteria in assigning care coordinators.

South Carolina had the fewest FTE care coordinators (24), whereas Ohio and California had more than 1,000 FTE care coordinators each (1,015 and 1,337, respectively). The low number of care coordinators in South Carolina reflects the demonstration's low enrollment and the use of community resource navigators, who are used in addition to care coordinators to connect

enrollees to services in the community, arranging for home modifications (particularly in rural areas), and serving on multidisciplinary teams.

Care coordinators conduct a variety of other tasks in addition to direct care coordination services. The proportion of care coordinators assigned to care management and conducting assessments instead of supervision and other management/administrative tasks varied by State. This proportion was lowest in New York (69.3 percent) and highest in Michigan (95.8 percent). The average number of members per care coordinator also varied widely, ranging from 20 in New York to 194 in Michigan. In New York, MMPs ramped up for higher enrollment than was achieved in the first year of operations, but fewer people than expected actually joined, which might explain the low use of care coordinators for care management and conducting assessments. In addition, assessments in New York are not conducted by the care coordinator associated with the demonstration. Registered nurses who may not work full time for the FIDA demonstration complete the assessments. Because of low enrollment, some split their time between New York's Managed Long-Term Care (MLTC)[5] and FIDA. In addition, to ensure continuity of care coordinators from enrollees who change from MLTC to FIDA, several FIDA MMPs allow participants to keep their MLTC care coordinators when they transition to FIDA. In California, some MMPs reported hiring a lot of care coordination staff in preparation for large anticipated enrollment and then having to lay some off due to the lack of enrollment.

Because care coordination across primary and acute care, LTSS, and behavioral health for the dually eligible population is a new role for most health plans, a large number of care coordinators had to be hired. According to site visit interviews, hiring so many new care coordination staff was a challenge for many health plans, especially identifying care coordinators with experience across acute care, LTSS, and behavioral health. In Virginia, the MMPs reported steep learning curves in providing LTSS partly because most care coordinators previously worked with medical providers or institutions and did not have broad LTSS experience. In New York, some plans operated another MLTC product (either a partially capitated plan or a partially capitated plan with a sister Medicare Advantage plan) before the demonstration. As a result, MMP start-up related to LTSS was less of a challenge in New York than it might have been in other States, although implementing the Medicare benefits was more difficult for MMPs that did not offer another Medicare product prior to their FIDA plan.

Turnover was a significant issue, with about one in eight care coordinators leaving their positions within a year of employment. Several focus group participants in Illinois and Ohio reported losing care coordinators to turnover. The average proportion of all care coordinators who left their positions during the year was greatest in South Carolina (29.2 percent) and lowest in New York (12.9 percent).

It appears that MMPs also compete for qualified staff. In Illinois, State and MMP respondents reported that some care coordinators had changed jobs several times to take advantage of better

[5] MLTC is a system that provides home and community-based services through managed long-term care plans approved by the New York State Department of Health. This system streamlines the delivery of long-term services to people who are chronically ill or disabled by providing all services to enrollees through their chosen MLTC plan.

wages and fringe benefits at other plans. One MMP respondent expressed the opinion that the State's requirements for care coordination staffing are very high and that it was especially challenging in Cook County (the Chicago area), which has many health plans and not enough care coordinators. Similarly, MMPs in California reported that they often compete with each other to hire care coordination staff.

The pressure to hire a large number of new staff resulted in employing less-experienced staff for these new roles. In Illinois, enrollee advocates agreed that care coordination is a positive feature of the demonstration that was not available under fee-for-service, but they said that the quality of care coordination was uneven because some care coordinators are less knowledgeable and less effective in engaging enrollees. When care coordinators are less skillful at engaging enrollees, care coordination may depend on whether enrollees can clearly articulate their needs.

In California and Illinois, the large number of limited English-proficient enrollees has been challenging for MMPs. One Chicago-area plan reported that more than half of its enrollees do not speak English or Spanish. Although plans have hired some bilingual care coordinators representing ethnic groups they serve, MMPs said translators are often needed. Some focus group participants reported that their care coordinators were bilingual, whereas others said their care coordinators brought translators to home visits. Although some MMPs arrange for interpreters to attend assessments, one plan uses a telephonic translation service that an enrollee advocate said makes it difficult to assess enrollees' needs and preferences. MMPs in California also reported using the telephonic translation when language-concordant care coordinators are not available. Also, despite MMPs' efforts to provide culturally appropriate care coordination, one enrollee advocate in Illinois said gaps in cultural understanding sometimes interfere with consumer engagement. For example, care coordinators may have more success engaging some Asian-American enrollees if they take time to sit down and drink tea with the family as part of the process of getting acquainted, but some care coordinators do not have the time to do so or do not feel comfortable in this type of activity.

Interviews with stakeholders revealed that despite these difficulties, MMPs were making progress in establishing care coordination services. In six States where RTI focus groups were conducted, most focus group participants said that they had care coordinators assigned. Although some participants generally understood that their care coordinators worked for their MMPs and that their role is to help enrollees access services to meet their needs, others expressed confusion about their role and function. Stakeholders also reported that because care coordination is not explained in the enrollment notices, few beneficiaries understand the notion or the potential value of this new benefit offered to them with demonstration enrollment.

Focus group participants often referred to their care coordinators as "case managers" and did not necessarily understand how the care coordinator role differs from the roles of other personnel who managed their LTSS or behavioral health services or staff from provider agencies who coordinate and monitor services. A small number of participants indicated awareness of care coordinators' broad responsibility to coordinate across delivery systems. However, in each State, some focus group participants were wholly unaware of care coordination.

Those enrollees who were able to identify their care coordinators often reported high satisfaction with that relationship and the types of assistance they receive.

> I have one person in charge of all of [the people helping me]. Even if I have 15 people calling me, [my care coordinator] is the only one [in charge]. (*Hispanic female, LTSS, Massachusetts*)

> Besides my health plan, I have a caseworker. She's very good. We have a good rapport. And she calls me pretty often. And whenever I have a need that I see she can help with, I call her and she always helps me a lot. (*White male, LTSS, California*)

Within each State, focus group participants reported variable frequency of contacts and level of engagement with their care coordinators. Some participants stated that their care coordinators visited or called monthly, whereas others described quarterly visits or visits based on need between regular contacts.

> [My] case manager visits me every 3 months. Whatever I need, she helps me get it. And it wasn't like that before, so that's something new. (*Black female, LTSS/BH, Illinois*)

> [S]he's calling me, I would say, once a month and meeting with me every 3 months…Very helpful, and she's not going to rest till I get what I need. (*White male, LTSS, Illinois*)

Others said that their care coordinators were not in regular contact and that they have difficulty reaching them by telephone or identifying them at all.

> I just don't know who [my mother's] care manager is because nobody has ever informed me about that… (*Proxy for Hispanic female, LTSS, California*)

MMPs are learning about providers and services that they have not traditionally delivered and are educating their newly hired care coordinators. Several MMPs reported working hard to build relationships with LTSS and behavioral health service providers. For example, MMPs in California reported hiring coordinators specifically dedicated to LTSS and behavioral health who are either co-located with county LTSS offices or who visit them several times a week.

However, some enrollees opt to be their own care coordinators. In Virginia, a small number of enrollees have decided to coordinate their own care. These enrollees are reminded annually about their right to a care coordinator and are contacted by care coordinators after any health event.

3.2 Effects of Care Coordination

MMP leadership interviewed during the site visits strongly support care coordination. During the site visits, care coordinators seemed passionate about their role in assisting enrollees with their health and social needs. Care coordinators provide services such as inpatient and skilled nursing facility discharge planning, medication reconciliation, and arranging transportation to physician offices and personal care services. They also provide services that go beyond what is medically

necessary, or what is considered strictly health care, linking enrollees to all types of social services, including housing, food delivery, and pest control. MMPs described providing nonmedical transportation services for enrollees (e.g., to church, to a baseball game with family members), if that would help integrate enrollees back into the community. The MMPs consider integrating enrollees into the community to be a stepping stone to building trust with enrollees and helping them with their health care needs.

Care coordinators also perform the important tasks of alerting the ICT to the unmet needs among Medicare-Medicaid enrollees, determining the scope of these needs, and then linking enrollees with additional flexible benefits available through MMPs. In several demonstration States, including California, Illinois, Massachusetts, Michigan, Ohio, South Carolina, and Texas, plans may offer enrollees flexible benefits, as specified in the enrollee's ICP. These flexible benefits differ by State and include a wide variety of services. MMPs, stakeholders, and enrollees reported that MMPs have used flexible benefits to provide home-delivered meals (such as Meals on Wheels), home modifications, household appliances, safe dwellings, additional vision and hearing services, podiatry services, transportation services, exercise programs, health and wellness services such as smoking cessation, adult education, over-the-counter drugs, and gift programs such as a personal blanket and grooming kit. South Carolina MMPs first use their community navigators to connect members to community- and faith-based organizations that may provide such services without cost; if community resources are unavailable, MMPs will then use the flexible benefits to pay for necessary services. One MMP reported using the funds to cover some costs associated with a transition from nursing facility to community. Stakeholders in California and Illinois expressed that these flexible benefits, particularly additional amounts of personal care assistance in enrollees' homes, should be used more widely. Although enrollees who are aware of their flexible benefits appear to appreciate them, many enrollees are not taking advantage of the MMPs' benefits due to a lack of awareness.

Anecdotes about the positive effects of care coordination were reported by MMPs, State officials, and focus group participants. Medicare-Medicaid enrollees in focus groups in California, Illinois, Massachusetts, Ohio, and Virginia seemed generally satisfied and grateful for these new services. Many enrollees said that their care coordinators had helped them obtain the services they needed. Participants also mentioned receiving information and help to resolve various problems. Although more enrollees reported only participating in the HRA, some reported receiving care coordination assistance. These Medicaid-Medicare enrollees said that their care coordinators helped them set and achieve goals, with some participants achieving weight loss, reducing blood sugar levels, and overcoming social isolation. For example:

> My doctor would help me too, but [the MMP] is more proactive… When I told my case manager about my eyes, she came up with a name like that… It's just that [my care coordinator] is more accessible. (*Black female, BH, Massachusetts*)

> Those are […] case managers. They monitor your health, your weight, your eating, make sure that … you have everything at home that you need. Chairs, shower chairs, cane,

whatever. But the doctor is the one that decides with the patient what health or medication you need. (*Hispanic female, LTSS, California*)

Before, I… didn't know when this [benefit] exhausted, then I would have to call these people. But my case manager [says], "Don't worry, I'll handle it." (*Hispanic female, LTSS, California*)

Moreover, enrollees reported that it was a relief to have a care coordinator assigned to help them resolve problems and navigate the complexities of the health care system.

[My mother's care coordinator] has been a godsend because she has fought for everything. When I don't get an answer from the doctor's office, she's on the phone with them. (*Proxy for Hispanic female, LTSS, California*)

[My care coordinator is] excellent… because she explains things to me; she gives me peace of mind. (*Hispanic male, LTSS/BH, Massachusetts*)

Anytime I have a question, I can call anybody… I have people that genuinely care and they are trying to help me, and you can sense that. (*White female, LTSS, Massachusetts*)

Although communication and coordination among doctors, hospitals, and other providers is an important component of care coordination, focus groups yielded mixed results in this area. In California and Virginia, most participants said their providers and care coordinators seemed to be informed about all of the services they receive; in Illinois, many enrollees receive their medical care from hospital-based integrated health systems whose electronic health records allow for an easy exchange of information between PCPs and specialists. A few participants mentioned receiving assistance from care coordinators with care transitions. In New York, more than one MMP emphasized the importance of having real-time access to information about an enrollee's hospital admission and having contracts with providers that required their cooperation during discharge planning. In Ohio, participants provided mixed reports on whether their providers were working as a team and knew whether they had been hospitalized or in the emergency room. However, in Ohio and Texas, discussions with stakeholders suggest that in some cases (e.g., because of limitations in IT systems or care coordinator turnover), care team members may not be aware of hospital admissions and discharges.

3.3 Completing the Health Risk Assessments in a Timely Fashion

Requirements on the scope and time frame for completing the HRAs varied by state. Although completing HRAs is a major focus of the MMPs, and a key quality measure used to monitor plans, MMPs in most States had difficulty conducting an HRA within the first 90 days of an individual's enrollment (see ***Table 4***). To aid States and MMPs in locating Medicare-Medicaid beneficiaries, CMS has established a Batch Eligibility Query process allowing MMPs to request CMS address data on a batch basis; previously, MMPs could only request data on an individual basis. In six of the nine States, MMPs were unable even to reach at least one-fifth of beneficiaries enrolled in their plans within the first 90 days of enrollment. The proportion of Medicare-Medicaid enrollees who were not locatable within their first 90 days of enrollment was

highest in California (35.2 percent); this contrasts with Ohio (7.1 percent), South Carolina (7.1 percent), and New York (1.4 percent). In South Carolina, the overall small demonstration enrollment made the job of locating individuals easier, and in New York, almost all enrollees were passively enrolled from a related MLTC product into the demonstration plan; as a result, finding enrollees was not as challenging.

Table 4.
HRA completion within 90 days of enrollment, 2015

State	Enrollment as of quarter 4, 2015	Percentage of members whom the MMP was unable to locate	Percentage of members who are documented as unwilling to participate	Percentage of members with an HRA completed	Percentage of members willing to participate and locatable with an HRA completed
California	116,757	35.6	8.4	46.8	83.4
Illinois	53,277	20.9	1.2	63.8	81.8
Massachusetts	12,290	26.6	4.8	61.8	90.1
Michigan	35,684	24.0	5.3	40.2	56.9
New York	6,574	1.4	1.8	92.2	95.3
Ohio	60,331	7.1	1.3	68.6	74.9
South Carolina	1,806	7.1	2.1	73.9	81.4
Texas	46,988	28.3	2.6	58.3	84.4
Virginia	26,903	22.7	2.3	59.9	80.0

NOTES: Percentages in this table were calculated using quarterly data from 2015. Data availability was dependent on demonstration start date. For Michigan, South Carolina, and Texas, data were only available for quarters 2–4. Percentages reported do not account for disenrollments, re-enrollments, or uncompleted HRAs. Members who disenrolled in one quarter and re-enrolled in another may be counted twice. Members who reached their 90th day of enrollment for whom the MMP did not complete an assessment and who were not documented as unwilling or unable to be reached are not included in this table.

SOURCE: RTI analysis of MMP-reported data for Core Measure 2.1. The technical specifications for Core Measure 2.1 are provided in the Medicare-Medicaid Capitated Alignment Model Core Reporting Requirements document, which is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Locating passively enrolled beneficiaries is particularly difficult because they may be unaware that they are enrolled in the demonstration. MMPs and stakeholders shared several reasons for these difficulties. Because Medicare-Medicaid enrollees receive their Social Security/ Supplemental Security Income payments via direct deposit to their bank, they often do not bother to update their contact information with the State. Similarly, enrollees no longer receive paper Medicaid cards in the mail, so they do not have to provide their current addresses to the State to obtain services. Gaps and inaccuracies in enrollees' addresses and phone numbers mean that MMPs have to spend a considerable amount of time and effort locating individuals who have been passively enrolled. Some Medicare-Medicaid enrollees are homeless or live in temporary

accommodations, such as a shelter or hotel or with relatives, and many do not have a telephone. Behavioral health issues, such as substance use or mental illness, also may affect an individual's ability to remain in touch with MMPs. Reportedly, locating community-dwelling enrollees who use fewer services was particularly challenging compared with waiver and institutionalized populations, because the well population had fewer ongoing relationships with providers.

Some MMPs used innovative strategies to address this problem. In California, MMPs have hired lower-level, noncredentialed staff with local experience or language capabilities to search for Medicare-Medicaid enrollees in the community. MMPs also are learning from one another and are finding creative ways to reach enrollees. For example, one MMP reported locating enrollees by regularly checking two jails, a homeless shelter, and a soup kitchen. This plan reported using social media sites, such as Facebook, to find passively enrolled beneficiaries. They also changed their systems to flag enrollees with incomplete HRAs, so these enrollees are identified if they contact the MMP for any other reason. One MMP is working with one of the State's home care programs to provide incentives to caregivers if they provide care recipients with Cal MediConnect information. CMS has also supported efforts to locate the beneficiaries by allowing MMPs to request CMS address data through the Batch Eligibility Query process.[6]

Similarly, one MMP in Illinois supplemented its care coordinators with a team of 25–30 staff focused exclusively on locating enrollees; another MMP receives notifications from pharmacies when enrollees fill prescriptions; these notifications are used to update enrollee contact information. Some MMPs are contracting with community-based organizations to reach enrollees and to provide care coordination for special populations, such as individuals with behavioral health needs and residents of supportive living facilities. In Ohio, State officials report that each plan developed protocols to reach enrollees, including a minimum of three to five follow-up attempts.

Plans identified specific strategies, such as visiting an enrollee's last known address and contacting physicians and pharmacies that have recently provided services to the enrollee, as a way of locating enrollees. At least one MMP in Ohio is conducting assessments and developing care plans for enrollees based on available utilization data even if they are ultimately unable to reach an enrollee. Another Ohio MMP established educational "resource days" held at supportive housing developments where care management staff could conduct assessments on the spot. Some MMPs conduct assessments on site in senior centers and other locations. A representative of one Ohio MMP said that his plan continues to conduct outreach and engagement activities even if enrollees decline to participate in care management activities because enrollees may not see the need for care management until they are in the middle of an acute episode of care. In Texas, one MMP reported using "community connectors," who are community outreach workers who coordinate with community-based organizations such as AAAs, Aging and Disability Resource Centers, and homeless shelters to find enrollees for the

[6] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/BEQEnhancement082615.pdf

purpose of conducting HRAs. The health plan makes 10 attempts[7] at locating enrollees to engage in HRAs.

Once the MMPs reached Medicare-Medicaid enrollees, the HRA completion rate in most States was high. Once successfully contacted, only a small proportion (less than 10 percent in all States) of enrollees were unwilling to participate in an HRA. Nonetheless, the high proportion of enrollees who could not be reached meant that many enrollees did not have an HRA completed within their first 90 days of enrollment; the proportion of enrollees who met the time target for completion of HRAs ranged from 40.2 percent (Michigan) to 92.2 percent (in New York). Of Medicare-Medicaid enrollees who were locatable and willing to participate in an HRA, the completion rate was higher—more than 50 percent in all demonstration States. The rate was lowest in Michigan (56.9 percent) and highest in New York (95.3 percent).

3.4 Development of ICPs

ICPs are intended to establish a detailed set of services to meet the needs and goals of Medicare-Medicaid enrollees. MMPs in most States had considerable difficulties completing the ICPs, with only one State exceeding 80 percent of its enrollees and four States with completion rates of less than 50 percent (see ***Table 5***). Although ICP completion rates vary widely, they need to be considered in the context of where each State is in its implementation process: States in which passive enrollment was not yet over generally had lower ICP completion rates. Among States where MMPs report ICP completion rates within 90 days of enrollment (Illinois, Massachusetts, Michigan, Ohio, South Carolina, and Texas), the completion rate ranged between 42.6 percent (in Michigan) to 81.8 percent (in South Carolina) in 2015.[8] In California, the ICP completion rate is computed based on risk categories. For high-risk enrollees, the rate includes those who have been enrolled for at least 90 days who have an ICP completed. For low-risk enrollees, the rate includes those who have been enrolled for at least 135 days. In total, 45.7 percent of enrollees in California who fall into these categories had an ICP completed in 2015. In New York, about one-quarter (24.2 percent) of enrollees had an ICP completed within 30 days of initial assessment or re-assessment. In New York, until standards were modified, MMPs initially were required to schedule their ICT meetings with in-person participation of the PCPs and to have the "wet" signature of all team members. More flexible ICT standards became effective on December 9, 2015; the results of this new approach are not reflected in most of the 2015 data in Table 5. MMPs were unable to consistently meet these requirements, especially within the short 30-day turnaround.

[7] The three-way contract (CMS & the State of Texas, 2015, p. 66) requires MMPs to make at least five attempts to reach enrollees within the first 90 days of enrollment to conduct HRAs.

[8] In South Carolina, higher ICP completion rates may be due to lower enrollment. Passive enrollment in South Carolina began in April 2016.

Table 5.
Percentage of members with a completed ICP in 2015

State	Percentage	State-specific measure definition
California	50.1	Members with ICPs completed within 30 working days of initial HRA
Illinois	42.6	Members with ICPs completed within 90 days of enrollment
Massachusetts	55.9	Members with ICPs completed within 90 days of enrollment
Michigan	32.1	Members with ICPs completed within 90 days of enrollment
New York	24.2	Members with ICPs completed within 30 days of initial assessment or re-assessment [1]
Ohio	57.5	Members with ICPs completed within 90 days of enrollment
South Carolina	81.8	Members with ICPs completed within 90 days of enrollment
Texas	53.6	Members with ICPs completed within 90 days of enrollment
Virginia	15.6	Members with ICPs completed within 90 days of enrollment[1]

[1] Unlike other demonstrations, in Virginia, the ICP is not considered complete without the member's signature. This was also true in New York until new standards became effective on December 9, 2015.

NOTES: Percentages in this table represent the overall rate of ICP completion, including among members who are unreachable or who refuse to participate. Percentages were calculated using quarterly data from 2015. Data availability was dependent on demonstration start date. For Michigan, South Carolina, and Texas, data were only available for quarters 2–4. For New York, consistent data were only available for quarters 1–3; specifications for this measure were changed beginning in quarter 4 of 2015 to measure ICPs completed after 90 days of enrollment. Percentages reported do not account for disenrollments and re-enrollments. Members who disenrolled in one quarter and re-enrolled in another may be counted twice.

SOURCE: RTI analysis of MMP-reported data for State-specific measures. The technical specifications for these measures are available in State-specific reporting requirements, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Focus group participants reported mixed experiences with being involved in developing ICPs. Some participants were aware of and reported positive experiences with goal-setting. For example, although goal-setting was not specifically described as a key part of their interactions with care coordinators, some participants in Ohio reported that their care teams were helping them achieve goals such as increasing mobility, independence, and overall functioning.

In Illinois, some participants set goals with care coordinators, but others said they set goals for themselves or did so based on physician recommendations. Some participants in Illinois and Massachusetts identified goal-setting as a key part of their interaction with their care coordinators. Several Virginia participants remembered being asked by a care coordinator or provider about life goals, and they reported that professional involvement in goal-setting and arranging for needed services helped them work toward those goals. In California, very few participants reported setting personal or care goals with their care coordinator.

At the time of the site visits, health plan representatives and other stakeholders in most States reported that the processes around ICP development have been slowed because of challenges with conducting initial assessments. ICPs are developed following the comprehensive HRA, but

because care coordinators are encountering significant challenges locating enrollees and completing the assessments, many enrollees did not yet have an ICP. In States where the plans have had success in locating enrollees and completing the initial assessments, there has been greater progress in developing care plans. In Illinois, for example, State officials and MMP representatives reported that care plan completion improved substantially since the first year.

In a survey of Massachusetts One Care enrollees conducted from June 2014 through January 2015, about two-thirds (63 percent) of survey respondents reported that someone from One Care met with them to assess their medical and other needs, but only slightly more than one-third (38 percent) reported having an ICP. Further, more than one-third of respondents reported that they did not know or were not sure if they had an ICP (35 percent), and nearly one-quarter of respondents (24 percent) reported that they did not have a care plan (Henry, Fishman, Gettens, Goody, & Alsentzer, May 2015). Although One Care was designed to place enrollees at the center of the care planning process, enrollees may not have been engaged in or may not have understood the care plan development process.

In California, MMPs reported that enrollees are discussing their health care goals with care coordinators or providers but not necessarily as part of a formal process with their ICT. Health plans reported that Medicare claims can be used as a starting point for a care plan and updated after the HRA and input from the enrollee. One MMP reported that it uses Medicare claims to devise a draft care plan before contact with an enrollee is established. California consumer advocates reported some concern that the process of establishing a care plan is not truly patient centered.

3.5 Convening the ICTs

Progress toward establishing and convening ICTs has varied by State. For example, Texas officials believe that, in practice, most teams are limited to the service coordinator and a PCP. Texas MMPs described flexible service coordination models that can incorporate professionals with expertise in a variety of disciplines as needed. One California MMP reported that the primary case manager and medical director may decide, based on care plan goals and HRA information, whether a full ICT is necessary.

In some States, such as California, Ohio, New York, South Carolina, and Virginia, MMPs reported difficulties in engaging PCPs. In Ohio, for example, health plan representatives suggested that physicians have been slow to engage because of the administrative burden associated with reviewing enrollee assessments and care plans. Some MMPs in California reported that low levels of understanding of the concept and requirements of care coordination acted as a barrier to PCP participation.

MMPs shared that arranging in-person care team meetings has proved to be challenging, particularly for physicians, so most meetings occur telephonically. In Virginia, stakeholders noted the difficulty in gaining provider participation in ICTs, which has affected the completion

of the care plans. In South Carolina, if a PCP is unable to participate, sometimes the plan medical director will participate instead and approve the care plan.

The difficulty of ensuring provider participation is also related to lack of reimbursement for their time. Providers are not currently compensated for participating in ICTs in California, and some MMPs there reported that they are considering doing so to incentivize participation. One plan in New York has made the decision to pay providers for their participation in the ICTs. Another New York plan reported that at least one large hospital system has requested a capitated payment for providers participating in the care team. Although this MMP had not agreed to that payment at the time of the site visit, it anticipates that other providers will make similar requests.

Another challenge to provider participation is ensuring access to enrollee records. Texas health plans reported that their health IT systems are not designed to allow PCPs to routinely access enrollees' plans of care. Rather, PCPs must contact the health plan to request access each time they want it. Similarly, one Texas plan reported difficulty obtaining timely data from providers once the HRAs were completed. This challenge is often associated with providers who did not previously participate in STAR+PLUS, the State's mandatory Medicaid managed care program.

Finally, the MMPs report that scheduling a team meeting within the specified time window is also challenging, and scheduling the date, time, and place, and notifying the participants are perceived as a "huge administrative burden." Stakeholders reported that enrollees and family members also find the scheduling challenges to be frustrating.

3.6 Coordination for Medicare-Medicaid Enrollees with Behavioral Health Problems

Coordinating care for Medicare-Medicaid enrollees with behavioral health needs is especially challenging. First, coordination is difficult because of the silos among the medical, LTSS, and behavioral health delivery and financing systems. For example, in California, the county behavioral health system providing Medi-Cal services historically has operated separately, without much interaction with other health programs (even with psychiatrists and other providers delivering Medicare behavioral health care). Although county behavioral health staff reported that MMPs have made an effort to improve communication between MMPs and behavioral health providers serving the Medi-Cal population, they also suggested that much more time is necessary to educate plans on how the county behavioral health system operates and to adapt their systems to align with new billing mechanisms for Cal MediConnect. However, some counties have begun working closely with MMPs to create provider networks capable of delivering Medicare and Medi-Cal behavioral health services.

In Ohio, MyCare Ohio plans operating in demonstration counties with approved Community Behavioral Health Center Health Homes were required to contract with these entities to provide care management for Medicare-Medicaid enrollees with serious and persistent mental illness. These individuals could choose to have all services coordinated by either a MyCare Ohio plan or a health home, if a health home was available in their area. The program was limited to five

counties, only two of which overlapped with the demonstration counties. In Michigan, the MMPs have primary responsibility for care coordination and work with support coordinators for prepaid inpatient health plans (PIHPs), which continue to provide case management and other Medicaid behavioral health services for individuals with behavioral health needs. The MMPs and PIHPs also have a subcontracting arrangement for the Medicare behavioral health services.

Other policy contexts in the States may affect coordination with behavioral health providers. For example, Massachusetts, Michigan, and Texas had Medicaid managed care for behavioral health before the Financial Alignment Initiative. Virginia had some managed behavioral health before the demonstration, but not for the population eligible for the demonstration. Before the demonstration, Illinois did not have a separate managed behavioral health program; instead, it had inpatient and outpatient behavioral health services that beneficiaries could receive in their two managed care programs.

Second, the Health Insurance Portability and Accountability Act was often cited as a barrier to information exchange, even when all data exchange participants are trying to take care of the same enrollees. For example, in California, despite the Memorandum of Understanding in place between the State and the county behavioral health agencies, county agencies reported the inability to share some behavioral health/substance use information with other providers because of Federal privacy regulations, which prevent behavioral health providers from sharing sensitive information about selected diagnoses and hospitalizations, including receipt of any substance use services. California State demonstration administrators, stakeholders, and county mental health agencies all reported this as a major barrier to care coordination data exchange and to effective care coordination in general.

Plans noted the challenge of integrating behavioral with medical health and the difficulty of doing that while safeguarding an enrollee's right to privacy. Plans reported that Medicare-Medicaid enrollees were not always willing to accept assistance or to allow behavioral health information to be shared across providers. One MMP mentioned that it was essential to gain the trust of enrollees to better achieve integration of care for members with behavioral health needs. Gaining the trust of enrollees took time and effort, especially because many enrollees have not had this type of assistance before.

3.7 Overlap with Other Care or Case Managers

Care coordinators from the MMPs do not operate in an environment devoid of care coordination; in some cases, the new system overlapped and duplicated existing coordination systems, creating tensions and concerns about job security. In Virginia, for example, case managers employed by LTSS providers were worried that the MMP care coordinators would eliminate their jobs. Some adult day services providers in California voiced similar concerns.

Moreover, because of the complexity of providing services to people with behavioral health needs, some States (e.g., California, Michigan, Texas) are retaining case management available through other existing programs, including targeted case management and health homes. In

Virginia, the MMPs assign each enrollee a care coordinator; however, enrollees with behavioral health needs may have up to three care or case managers across organizations. The intention of the MMPs and the States is that the enrollee have one primary care or case manager and that this person be the one most familiar with the enrollee. The other care or case managers will then coordinate the enrollees' care "in the background" to ensure seamless care and prevent confusion over care or case manager roles.

In some States, the design of the demonstration consciously built on existing care management arrangements rather than seeking to replace them. For example, in Ohio, many enrollees served by the demonstration—particularly those participating in the Medicaid home and community-based services waiver for people aged 60 or older—had existing relationships with the AAAs. The three-way contract requirement that MyCare Ohio plans contract with the AAAs or other knowledgeable organizations to provide waiver service coordination for people aged 60 or older has allowed for continuity in these relationships, where possible. In New York, the care coordination function was also built on similar experiences in the Program of All-Inclusive Care for the Elderly and on MMPs' other MLTC products.

In Massachusetts, the demonstration requires MMPs to contract with community-based organizations to provide LTSS coordination services. The coordinator role was designed to provide an independent voice with community expertise and to bring independent living skills and recovery model services to Medicare-Medicaid enrollees. However, the lack of clearly defined roles and responsibilities led to inconsistencies and confusion related to LTSS coordination.

In California, many agencies serving Medicare-Medicaid enrollees, including the county-based mental health and substance use agencies, In-Home Services and Supports agencies, and the Multipurpose Senior Services Program and Community-Based Adult Services programs, have their own care coordinators and comprehensive assessment processes. At the time of the site visits, representatives from plans, agencies, and provider groups reported that the boundaries or possible redundancies of the different types of care coordinators had not been entirely worked out. Accounts were inconsistent regarding who acts as the primary care coordinator for Medicare-Medicaid enrollees who receive multiple services. For example, although one plan stated that the MMPs' care coordinators are primary, a State official claimed that the primary care coordinator varies on a case-by-case basis but that MMP care coordinators house all of the Medicare-Medicaid enrollees' care plans.

3.8 Establishing Care Management Information Systems

Many MMPs have made substantial progress in building care management information systems and providing access to these systems to providers participating in the care management process. However, some MMPs experienced difficulties in creating a centralized enrollee record that the entire ICT can access. For example, during the first Ohio site visit, State officials acknowledged that the time and resources required to create a true single record were not available and, in the

meantime, plans were working to create interfaces in which care coordinators and other staff could access the various unintegrated systems as a workaround. Plans were still expected to meet this requirement, although a specific timetable was not identified during the site visit. Each plan has adopted its own care management system, but the degree of integration with other systems (e.g., claims or eligibility) varies from plan to plan.

In California, depending on the participating county, MMPs varied in their progress and reported data exchange difficulties in sending information across settings. Specifically, MMPs experienced problems exchanging data with county agencies that administer LTSS and behavioral health services. For example, because of systems incompatibility, the Multipurpose Senior Services Program, an intensive LTSS care management support program, still provides data for MediConnect enrollees in a PDF file that must be entered manually every quarter.

Lack of effective electronic medical record systems across settings is also an impediment. Some counties are undergoing a lengthy process of implementing an electronic medical record system. Some county mental health departments have electronic medical record systems in place but have not been able to find a technical interface solution that works with the MMPs' system.

Although the general requirements are the same for participating States, implementation of care coordination data systems varied among States and MMPs. At the time of RTI's first annual site visit, States reported various degrees of progress in developing these systems. For example, in Massachusetts, to facilitate care coordination, MMPs were required to maintain a single, centralized, comprehensive record, known as the Centralized Enrollee Record (CER), that documents the enrollee's medical, prescription, functional, and social status. The CER must be available and accessible at all times to manage communication and information flow regarding referrals, transitions, and care delivery. All three MMPs had to make up-front investments in electronic documentation systems to meet these requirements. The extent to which the CER could be accessed by providers, such as community-based organizations providing LTSS coordination, varied across plans.

In California's second demonstration year, it started working with all seven counties participating in the demonstration to develop a consistent definition of a care coordination encounter; once the definition was finalized, the State implemented a comprehensive tracking system that collects care coordination data directly from MMPs and includes data on the total number of care coordination teams in place and the number of teams that involve consumers and providers. Because coordination with LTSS providers is one of the key goals of the California demonstration, the system also tracks the number of MMP referrals to the In-Home Supportive Services, increases and decreases in service hours, and nursing facility–to–community transitions. MMPs in California report developing comprehensive web portals accessible to providers participating in care coordination.

In South Carolina, Phoenix, the electronic Medicaid home and community-based services waiver case management and service authorization system, was modified to meet the demonstration's needs, including to maintain records of all intake, assessment, and care planning activities.

Phoenix includes information on home assessments, caregiver supports, and quality indicators and has capacity for provider notes, correspondence among users, and other features (e.g., alerts for follow-up appointments) that can be modified to ensure compliance with Federal regulations and State policies and programs. MMPs are required to use Phoenix as a uniform centralized electronic record system to document all assessments, ICPs, provider information, caregiver support systems, waiver case management, and quality assurance activities for demonstration enrollees. Any ICT (called multidisciplinary teams in South Carolina) member can access Phoenix to read or input notes on his or her particular enrollees.

4. Conclusions

Care coordination is one of the main components of the capitated demonstrations of the CMS Financial Alignment Initiative and is hypothesized to be a key mechanism by which unnecessary utilization and expenditures are reduced, quality is improved, and the needs of Medicare-Medicaid enrollees are better met. This Issue Brief reports on the early qualitative findings of the evaluation of this initiative from site visits, focus groups, and review of available documents.

Although demonstrations vary somewhat, States and MMPs are implementing new care coordination approaches designed to integrate care across medical, LTSS, and behavioral health systems. Key elements of the care coordination models are care coordinators or entities, HRAs, ICPs, ICTs, and integrated care coordination data systems.

States and MMPs have overcome major challenges in designing and implementing the operational details of these new care coordination systems. A major accomplishment of the demonstration is that large numbers of new care coordinators have been hired and trained, and the new system has been implemented. The care coordinators are providing a new service that Medicare-Medicaid enrollees generally feel is beneficial. Once enrollees become familiar with their assigned care coordinators and forge personal relationships with them, they appreciate the support and learn to ask for assistance with various challenges, including access to needed providers and durable medical equipment. States and MMPs are heavily invested in the new system and are working hard to make it succeed.

In terms of implementation, States and MMPs faced several challenges including hiring and retaining large numbers of care coordinators, locating and reaching enrollees, completing the HRAs and ICPs within required time frames, and involving all members of the ICTs, including physicians and Medicare-Medicaid enrollees. Engaging busy PCPs in the care planning process is particularly difficult, especially if they do not receive additional compensation. States and MMPs also experienced difficulties with sharing information and coordinating with behavioral health providers, resolving overlap and duplication with existing care management and care coordination systems, and establishing care coordination systems that allow providers to share information about the client.

As the demonstration proceeds, the RTI evaluation team will continue to monitor the implementation of the care coordination model. A major goal of the evaluation is to assess how the demonstrations, including care coordination, are affecting quality, utilization, and cost outcomes. Also critical is whether the demonstrations are improving the beneficiary experience and access to needed services and whether they lead to a corresponding improvement in the quality of life for Medicare-Medicaid enrollees.

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Appendix A:
Details of Care Coordination Components for the Nine Capitated State Demonstrations

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Table A-1
Details of care coordination components for the nine capitated State demonstrations

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
Massachusetts One Care	• The care coordinator/clinical care manager is the primary care coordinator, unless plan has elected to delegate components out. Long-Term Services Coordinator provides expertise on LTSS and/or BH aspects of assessment and care planning.	• Within 90 days of each enrollee's effective enrollment date and at least annually thereafter, One Care plans must complete a comprehensive assessment using an assessment tool selected or developed by the plan and informed by at least one in-person meeting. • Reassessments should also be completed whenever an enrollee experiences a major change in health status. Reassessments may take place over the phone in certain situations. • One Care plans must also complete the MDS-HC for certain beneficiaries to determine assignment to a rating category. • There is no standard assessment tool, but it must include specific domains of information (e.g., immediate needs and services, health conditions, functional status, mental health and substance use).	• The ICT develops the ICP under the direction of the enrollee or his or her representative and on an ongoing basis consults with and advises acute, specialty, LTSS, or behavioral health providers about care plans and clinically appropriate interventions. • The ICP includes treatment goals (medical, functional, and social) and measures progress and success in meeting goals. • The ICP is also informed by data gathered from the comprehensive assessment.	• The ICT must respect the needs and preferences of the enrollee and consist of at least the PCP; the care coordinator or clinical case manager; and if indicated, the behavioral health clinician and LTS coordinator. It may include other professions (e.g., nurses, specialist clinicians, social workers), family members, advocates, or other case managers. • The ICT must be accessible to the enrollee and able to provide alternatives to office visits, including as-appropriate home visits, emails, and telephone contacts. • ICT members must participate in required training on person-centered planning processes, cultural competency, accessibility and accommodation, independent living and recovery, and wellness principles.

(continued)

Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
Illinois Medicare-Medicaid Alignment Initiative	• MMP care coordinators are responsible for coordinating medical services, behavioral health services, LTSS, and HCBS waivers. • Plans may contract with existing case management agencies. • HCBS waiver administrative agency case managers will continue to administer assessments for eligibility determination. • MMPs are required to offer care management services to link and coordinate between medical homes and other providers and services, and to support integration of physical health and behavioral health care by embedding care coordinators on site at willing federally qualified health centers (FQHCs), community mental health centers (CMHCs), and high-volume providers, as appropriate.	• When beneficiaries enroll in the demonstration, plans are required to make their best effort to administer health risk screenings (HRSs) within 60 days. • MMPs typically conduct HRSs by telephone, using nonclinical staff. • Plans use the results of the HRSs, claims-based predictive modeling, and surveillance data (e.g., referrals, service authorizations, LTSS assessments) to stratify enrollees into low-, moderate-, and high-risk categories. • MMPs are also required to complete more comprehensive health risk assessments (HRAs) for moderate- and high-risk enrollees within 90 days of enrollment, or within 180 days for enrollees receiving HCBS waivers or residing in a nursing facility; HRAs are conducted face to face by clinical staff.	• MMP care coordinators and the ICT are responsible for developing care plans within 90 days after enrollment, or within 180 days for enrollees receiving HCBS waiver services and for nursing facility residents. • Care plans incorporate enrollees' medical, behavioral health, social, functional, and LTSS needs, and their goals based on their needs and preferences. They also identify and evaluate risks, and incorporate enrollee participation and input from the PCP, other providers, and family. • Care plans include covered and noncovered services, although MMPs are not required to pay for noncovered services. Enrollees' HCBS waiver service plans, known as the Person-Centered Service Plan (PCSP), are also part of their care plans.	• Every enrollee has access to an ICT, headed by a care coordinator. The ICT's composition may vary based on the enrollee's needs and preferences. • The ICT's role includes supporting the medical home; assisting in care coordination; assessing the enrollee's risks and needs; providing medication management and health education; ensuring integration of medical, behavioral health, and LTSS; making referrals to community-based resources, as appropriate; and assisting in development of a PCSP.

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Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
California Cal MediConnect	• Cal MediConnect plan care coordinators coordinate services for enrollees, including CBAS, IHSS, and MSSP waiver populations. Other waivers are excluded from the demonstration. • Plans may employ care coordinators or contract for these services. • Care coordinators include registered nurses (RNs), licensed practical nurses (LPNs), and social workers; plans match the care coordinator's education, experience level, and language to the enrollee's needs. • Targeted care management is excluded from the capitated rate and will continue to be provided by county-administered agencies. MMPs will coordinate these services with county-administered agencies per each plan's BH-MOU.	• Cal MediConnect plans use a risk-stratification method to identify newly enrolled members who are at high or low risk. • For enrollees who are at increased risk of having adverse or worsening health outcomes or whose health conditions require monitoring, an HRA must be completed within 45 days of the coverage date. • All other enrollees, including those residing in nursing facilities, are required to have their assessments completed within 90 days. • The HRA is completed by the care coordinator and used to identify primary, acute, behavioral health, LTSS, and functional needs of each enrollee and is the basis of an ICP. • Reassessments are conducted at least annually, or as often as the enrollee's health requires.	• The ICP must be completed within 30 days of HRA completion. LTSS includes care in nursing facilities; HCBS, such as IHSS, CBAS, and MSSP. • The ICP must be person centered and outcomes based, and it should focus on the least restrictive setting and on transitions between settings. • Together with the enrollee, the ICT develops an ICP that includes all clinical care, behavioral health, and LTSS, as appropriate.	• The care coordinator works with the enrollee to develop an ICT tailored to the enrollee's needs. • Each enrollee is offered an ICT, as necessary, but any enrollee may request one. The care coordinator and the PCP are the core of the ICT, which, according to plan interviewees, usually meets ad hoc and by phone. An ICT also might include a pharmacist or social worker, family supports, and others selected by the enrollee.

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Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
Virginia Commonwealth Coordinated Care	• MMP care coordinators coordinate medical, LTSS, and many social services for the enrollee. • Enrollees with behavioral health needs may have up to three care and/or case managers (e.g., one each at the MMP, Community Services Board clinic, and Behavioral Health Home). The intention of MMPs and DMAS is that the enrollee has one primary care or case manager, and this person is the one most familiar with the enrollee. The three care and/or case managers then coordinate the enrollees' care "in the background" to ensure seamless care and prevent confusion over care/case manager roles.	• In the first demonstration year, HRAs are conducted within 60 days of enrollment for vulnerable populations residing in the community, Elderly or Disabled with Consumer Direction (EDCD) waiver enrollees, and nursing facility residents, and within 90 days for all other enrollees. • During subsequent years of the demonstration, HRAs must be completed within 30 days of enrollment for EDCD waiver enrollees and within 60 days of enrollment for all other enrollees. • MMPs may also incorporate a behavioral health screener into the HRA or use a longer assessment for the LTSS population.	• The HRA informs the plan of care, which is tailored to the enrollee's needs and preferences.	• The ICT is a group of providers and informal caregivers recommended by the enrollee and includes the PCP and care manager and may include behavioral health providers, LTSS providers, pharmacists, targeted case managers, and family members. The ICT focuses on enrollees' treatment goals and progress indicators.

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Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
MyCare Ohio	• MyCare Ohio plans provide integrated care management through a single plan care coordinator. • Individuals with severe and persistent mental illness can choose to have care coordination of all services provided by either the plan or a health home, if available in their area. Plans must contract with health homes in their service areas.[1] • Plans must contract with Area Agencies on Aging (AAAs) for waiver service coordination for enrollees aged 60 or older, and they may contract with other entities. Plans may also provide waiver service coordination directly for enrollees younger than 60, or contract with another entity for this service. • There is no set time frame for when plans assign an enrollee to his or her care coordinator.	• MyCare Ohio plans are required to conduct enrollee assessments and develop care plans on a timeline that varies according to an enrollee's risk-stratification level (within 15 to 75 days after enrollment). • Assessments must be completed in person for individuals assigned to the high and intensive tiers; plans may conduct telephone assessments for individuals in the monitoring, low, and medium tiers. • Annual reassessments must be completed for all enrollees. • Plans can use AAAs and other community-based organizations to conduct comprehensive assessments on behalf of the plan.	• The central feature of MyCare Ohio's care management model is each enrollee's ICP. • The care plan must address the entirety of an enrollee's clinical and nonclinical needs. • The enrollee has a role in developing the care plan, which must take the individual's preferences into account and include his or her prioritized measureable goals. • Care plans are monitored and updated as appropriate based on changes in an enrollee's needs or health status; revisions to the care plan must be made within 14 days of identifying such changes. • The ICT is required to develop an enrollee's care plan within 15 days of the required comprehensive assessment.	• Each beneficiary is supported by an ICT, led by a care coordinator, which includes the enrollee, the primary care provider, the waiver services coordinator, and others as appropriate or as requested by the enrollee.

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Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
South Carolina Healthy Connections Prime	• Under the demonstration, such services and supports are identified by care coordinators and secured by a network of community resource navigators for new enrollees. • All enrollees will receive care coordination of all medical and behavioral health services, preventive services, medications, LTSS, social supports, and enhanced benefits as needed through plan care coordinators. • For enrollees in the Community Choices, HIV/AIDS, or Mechanical Ventilation Dependent waivers, plans match intensity of care coordination, frequency, and mode of interaction to the enrollee's complexity, needs, and preferences. • Because the demonstration covers extensive rural areas in the State, some plans initially contracted with home care and in-home medical care service agencies located throughout the State to conduct the screenings and assessments.	• Within the first 30 days of enrollment, all enrollees should participate, via phone or in person, in an initial health screen that collects medical, psychosocial, LTSS, function, and cognitive needs, and determines low, moderate, or high risk. • Plans may forgo an enrollee's initial health screen if the comprehensive assessment is completed within 60 calendar days of enrollment. • Plans may elect to complete the comprehensive assessment and the screener at the same time if they are completed within 60 days. • Some plans have augmented the State's assessment tool to include NCQA elements (e.g., advance directives, preventive health information). • Reassessments are conducted every 12 months or upon certain trigger events as specified in the three-way contract (e.g., transitions, changes in diagnoses).	• The ICP includes the enrollee's language, culture, and service history and identifies the enrollee's medical, behavioral, functional, and psychosocial needs. • Within 90 days of enrollment, the ICP is developed by the care coordinator with the enrollee and his or her family supports, providers, and members of the ICT. • Measurable short- and long-term services and goals, preferences, and expected outcomes are the key elements of ICPs that are updated in Phoenix, the State's automated case management system, and monitored according to risk level. • ICPs of high-, medium-, and low-risk enrollees are monitored by the CICO at 30, 60, and 120 days, respectively, and the ICT addresses any concerns.	• The ICT may include the enrollee's family supports, primary, and specialty providers. • The plan care coordinator—along with the enrollee, the enrollee's family supports, and the multidisciplinary team—develops an ICP that includes all clinical, nonclinical, HCBS, and facility care, as appropriate. • Any multidisciplinary team member may access Phoenix, the State's automated case management system, to read or input notes on their particular enrollees.

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Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
New York Fully Integrated Duals Advantage (FIDA) Demonstration Program	• FIDA plans are responsible for person-centered care coordination and care management through using ICTs. • Each enrollee has a designated care manager. The care manager may be an employee or under contract to the FIDA plan and must have the appropriate experience and qualifications to address the enrollee's assigned risk level and individual needs. Care managers are not required to possess a specific educational degree. • The care manager ensures that the ICT fulfills its responsibilities and assists it in doing so. • The role may include scheduling an enrollee's appointments, arranging transportation, and following up to obtain test or other appointment results. • The care manager is responsible for notifying the ICT of any "trigger" events that may necessitate reconsideration of the PCSP, such as hospitalizations, transitions between care settings, or changes in functional status.	• FIDA plans must perform a comprehensive assessment of an enrollee's medical, behavioral health, LTSS, and social needs using the Uniform Assessment System for New York (UAS-NY) tool or a State-approved equivalent. The assessment be completed with enough time to complete the care plan within 90 days of enrollment. For enrollees rolling over from a sister MLTSS plan operated by the FIDA plan, the FIDA plan has 6 months from the date of the last assessment to complete a new assessment. • The assessment must address a range of domains, including social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as enrollee preferences, strengths, and goals. • The assessment must be performed by a registered nurse, employed by or under contract to the FIDA plan. • The assessment is completed in the individual's home, hospital, nursing facility, or any other setting where the person resides.	• Assessment results are used as the basis for developing the integrated PCSP. • The PCSP is required to include an enrollee's goals and preferences, needs, specified interventions, a communications plan, and other elements. • Developing the PCSP is meant to engage the enrollee in considering the full range of his or her needs, goals, and preferences, and create the foundation for integrated service delivery and care management through the ICT. • The ICT also implements the PCSP, including delivery of services or arranging for their delivery, and all care coordination that may be necessary.	• An enrollee's ICT is led by the FIDA plan care manager who, in consultation with the enrollee, identifies the individuals who will be on the enrollee's ICT. • Initially, the ICT was required to include the enrollee (or designee); the enrollee's care manager, home care aide(s), PCP, and, if appropriate, behavioral health professional and nursing facility provider; other providers requested by the enrollee or designee, or recommended by the ICT members as necessary for adequate care planning and approved by the enrollee or designee; and the RN who completed the enrollee's HRA, if approved by the enrollee or designee. Effective December 9, 2015, the only required participants for the ICT are the care manager, the enrollee, and/or an authorized representative. The enrollee may choose to include other members.

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Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
New York Fully Integrated Duals Advantage (FIDA) Demonstration Program (continued)		• A comprehensive reassessment must occur at least once every 6 months, or no more than 30 days after certain "trigger" events. • The nurse conducting the assessment may not be the enrollee's care manager but may participate on the ICT with the enrollee's approval.		• The enrollee's home care aide may participate if the enrollee approves. The ICT may include additional individuals at the enrollee's request. • The ICT must convene to develop the enrollee's PCSP, and at least every 6 months thereafter. • The ICT's clinical decisions, reflected in the PCSP, act as service authorizations as long as members of the ICT are able to make such authorizations within their scope of practice. These authorizations cannot be modified by the FIDA plan, except in cases where the enrollee (or providers, designees, and/or authorized representatives) appeals the ICT service authorizations. Any services included in the PCSP that are outside of the scope of practice of the members of the ICT that participated in the PCSP development will be authorized by the plan through the utilization management process.

(continued)

Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
Texas Dual Eligible Integrated Care Demonstration	• Under the three-way contract, MMPs provide service coordination to all beneficiaries enrolled in the demonstration, including nursing facility residents. Service coordinators coordinate covered and noncovered services with enrollees' PCPs and service providers. • Service coordination models vary among MMPs, which may have different dollar thresholds for the services that service coordinators can authorize. • Case managers employed by mental health provider agencies assist individuals who have a severe and persistent mental illness and receive mental health rehabilitative services in accessing and coordinating services.	• Before service coordination can occur, MMPs must arrange for each enrollee to have a comprehensive HRA to evaluate his or her physical and behavioral health, social needs, functional status, use of wellness and prevention services, caregiver status and capabilities, and health and safety. HRAs also must consider the enrollee's preferences, strengths, and goals. • MMPs are required to have enrollees' HRAs completed within 90 days of enrollment. • Based on findings from HRAs, MMPs must categorize enrollees into two risk levels—with Level 1 comprising the highest risk and Level 2 comprising moderate and lower risk—and must develop ICPs based on their needs.	• Based on the results of HRAs, service coordinators are required to work with enrollees, their families, health care providers, and other team members to develop a comprehensive plan of care.	• Service coordination teams must include PCPs. Service coordination teams are generally composed of service coordinators and PCPs, and may expand in some cases to include professionals with expertise in a variety of disciplines as needed.

(continued)

Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
Texas Dual Eligible Integrated Care Demonstration (continued)	• MMP service coordinators coordinate with targeted case management providers to address integration of behavioral and physical health services. • Service coordinators for Level 1 enrollees must be RNs or nurse practitioners (NPs).	• Level 1 includes enrollees eligible for HCBS under STAR+PLUS, as well as enrollees in nursing facilities and others with complex medical needs. • Level 2 includes enrollees receiving LTSS for personal assistance services or day activity and health services, those with a history of behavioral health issues, and those with a history of substance use.		

(continued)

Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration came	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
Michigan MI Health Link	• Integrated Care Organizations (ICOs) have primary responsibility for care coordination. Care coordinators will coordinate with LTS coordinators, prepaid inpatient health plan (PIHP) Supports Coordinators and case managers, and PCPs. • ICO care coordinators must be a Michigan licensed RN, NP, physician's assistant, bachelors-prepared social worker, or masters-prepared social worker (limited or full license). They need to have specific training on person-centered planning. • ICOs can use plan staff as care coordinators and/or delegate the function via subcontract. However, to avoid conflicts of interest, the ICO cannot delegate the function to an LTSS provider who also delivers services to the enrollee. • ICOs will provide LTS coordination for enrollees who qualify for waiver services based on the nursing facility level of care, including those who disenroll from MI Choice to opt into the demonstration.	• The demonstration uses a three-part assessment process to identify enrollees' needs and develop an Individual Integrated Care and Support Plan (IICSP) for each enrollee: Initial screens are brief questionnaires that can be conducted by the enrollment broker or the ICO via telephone or a mailed questionnaire. All enrollees also receive comprehensive Level I assessments, and those with possible LTSS and behavioral health needs also receive Level II assessments. • Initial screening occurs within 15 days of enrollment in the plan, although plans may choose to substitute a Level I assessment for the initial screening. • Level I assessments must be completed by the ICO care coordinator, who uses comprehensive assessment tools that are pre-approved by the State to assess an enrollee's health and functional needs. All enrollees must receive a Level I assessment no later than 45 days after enrolling in the plan.	• The IICSP is developed by the ICT through a person-centered planning process. • The IICSP must be developed within 90 days of enrollment (unless the enrollee refuses) and must contain assessment results; a summary of the enrollee's health; the enrollee's preferences for care, supports, and services; the enrollee's prioritized list of concerns, goals and objectives, and strengths; the plan for addressing concerns or goals; specific services including amount, scope and duration, providers, and benefits; the person(s) responsible for specific interventions, monitoring, and reassessment; and the due date for the intervention and reassessment. • The IICSP must be updated annually or more often if needed.	• ICOs establish an ICT for each enrollee. The ICT always includes the enrollee, his or her chosen allies or legal representative, the ICO care coordinator, and the PCP. • The ICT will also include other types of providers, an LTS coordinator, and/or a PIHP supports coordinator. • The enrollee may choose which member of the ICT will be the enrollee's primary contact. • The ICT works together to develop, implement, and maintain an IICSP and to coordinate the delivery of benefits and services to the individual.

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Table A-1. Details of care coordination components for the nine capitated State demonstrations (continued)

State demonstration name	Care coordination entities	Assessments	Individualized care plan (ICP)	Interdisciplinary care team (ICT)
Michigan MI Health Link (continued)	• PIHPs will continue to provide supports coordination for individuals with IDD receiving waiver services. • Case management is provided through the PIHPs for individuals with behavioral health needs and individuals receiving Assertive Community Treatment provided through PIHPs. • PCPs coordinate primary care, initiate referrals for specialty care, and maintain enrollees' medical records.	• If the initial screen, an enrollee's utilization history, or the Level I assessment indicates the need for a Level II assessment, that assessment must be conducted within 15 days of the identification of the need. Level II assessments must be completed by professionally knowledgeable and trained LTS coordinators, PIHP supports coordinators, or behavioral health case managers.		

BH-MOU = behavioral health Memorandum of Understanding; CBAS = community-based adult services; CICO = coordinated and integrated care organization; DMAS = Department of Medical Assistance Services (Virginia); HCBS = home and community-based services; IDD = intellectual and developmental disorders; IHSS = In-Home Supportive Services; LTS = long-term services; LTSS = long-term services and supports; MDS-HC = Minimum Data Set – Home Care; MLTSS = managed long-term services and supports; MMP = Medicare-Medicaid Plan; MSSP = Medicare Shared Savings Program; NCQA = National Committee for Quality Assurance; PCP = primary care provider.

[1] State officials noted that health homes have not had a large impact on the MyCare Ohio demonstration because of the limited nature of Ohio's health home State Plan Amendment. At the time of the first site visit, the health home program was limited to individuals with serious mental illness in five counties, only two of which overlap with MyCare Ohio demonstration regions: Butler County in the Southwest region and Lucas County in the Northwest region. During the annual site visit, Ohio Medicaid staff indicated that the health home program would terminate on June 30, 2016, as part of a broader initiative to implement a managed behavioral health care system.

SOURCE: CMS & State of Massachusetts, 2015; CMS & State of Michigan, 2015; CMS & State of Ohio, 2014; CMS & State of South Carolina; 2014.