

Issue Brief:
**Special Populations Enrolled in Demonstrations
under the Financial Alignment Initiative**

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by

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Executive Summary

This Issue Brief provides an update on the beneficiary experience in the first two demonstrations that were implemented as part of the Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative to test integrated care and financing models for Medicare-Medicaid enrollees. The Washington Health Homes MFFS demonstration, a managed fee-for-service model demonstration, and the Massachusetts One Care demonstration, a capitated model demonstration, began operations on July 1st and October 1st of 2013, respectively.

For the purposes of this report, special populations encompass the following: (1) enrollees who use long-term services and supports (LTSS) which include nursing facilities, personal care services, residential care facilities, and adult day care; (2) enrollees with behavioral health needs, including those with serious and persistent mental illness (SPMI) such as schizophrenia and bipolar disorder; and (3) linguistic, ethnic, and racial minorities enrolled in the demonstrations. The purpose of this brief is to report how enrollees who use these services are faring under the Washington and Massachusetts demonstrations and to understand if disparities in services and demonstration experiences exist for these groups.

Data sources include feedback from beneficiaries enrolled in these demonstrations who participated in focus group discussions, responses from enrollees who completed the Managed fee-for-Service and Medicare-Medicaid Plan (MMP) Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and data from the RTI evaluation team's analysis of service utilization also described in the first Annual Reports for Washington and Massachusetts. The beneficiary focus groups and surveys were conducted in mid to late 2015 and early 2016; however, analyses of administrative, claims, and encounter data are from the first demonstration year ending December 31, 2014, and therefore provide an early glimpse into the beneficiaries' experience under the demonstrations.

CAHPS survey results show the level of satisfaction with services under the demonstrations, while excerpts from focus group sessions with demonstration enrollees provide insights into the reasons why enrollees may be satisfied or dissatisfied. Satisfaction in both demonstrations did not appear to vary along racial or ethnic lines. Spanish speaking focus group participants noted the importance of having language concordant materials and providers. Focus group participants are generally pleased with the services provided by care coordinators and described improvements to their quality of life. However, it appears that more outreach is needed to improve enrollee awareness of their rights and protections; many focus group participants were unaware of existing resources. Access to care, particularly of behavioral health providers, appeared to be a more prevalent concern in Washington (a fee-for-service model demonstration) rather than in Massachusetts (a capitated model demonstration in which enrollees have access to service providers within their Medicare-Medicaid Plan's network). Concern about durable medical equipment was expressed by focus group participants in both demonstrations. Both

demonstrations targeted beneficiaries with high and complex needs; both CAHPS results and focus group findings show progress toward meeting those needs.

1. Introduction

The Medicare-Medicaid Coordination Office (MMCO) and Center for Medicare and Medicaid Innovation (CMMI) have created the demonstrations under the Financial Alignment Initiative (FAI) to test integrated care and financing models for full-benefit Medicare-Medicaid enrollees.¹ The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical and behavioral health services and LTSS for Medicare-Medicaid enrollees, with the expectation that integrated delivery models would improve beneficiary outcomes and address challenges associated with the lack of coordination of Medicare and Medicaid benefits.

Under the FAI, CMS made two financial alignment models available to States: (1) a capitated model in which health plans coordinate the full range of health care services, and (2) a managed fee-for-service (MFFS) model in which States are eligible to benefit financially from savings resulting from initiatives that improve quality and reduce costs. Previously, investments needed to improve care delivery through enhanced systems of coordinated care would have been borne by States through Medicaid expenditures. However, cost savings that would have been achieved through better coordination of health care would have primarily accrued to Medicare through reduced hospitalizations and emergency department (ED) admissions, making States reluctant to allocate needed funds to systems coordinating both health services and LTSS without being able to recoup some of their investments. The Financial Alignment Initiative removes this financial misalignment by permitting savings generated through improved integrated care delivery to be shared between Medicare and Medicaid.

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

¹ “Full-benefit Medicare-Medicaid enrollees” refers to individuals who are eligible for Medicare and for full Medicaid benefits. “Partial Medicare-Medicaid enrollees” refers to individuals who receive only Medicare premium assistance and cost-sharing assistance from Medicaid.

As of September 2016, 11 capitated model demonstrations are operating in 10 States, and two MFFS model demonstrations are underway in Washington and Colorado.² In addition, CMS has partnered with the State of Minnesota to implement a demonstration focused on administrative changes to better align the Medicare and Medicaid operational components of the existing Minnesota Senior Health Options program.

Purpose and Approach

This Issue Brief examines the impact of the demonstrations on special populations enrolled in two States, Washington and Massachusetts. The purpose of this brief is not to compare or contrast the two demonstrations or the two model types. Every State has a unique set of systems and approaches resulting from its history and needs. Rather, the purpose is to examine how special populations are faring in each of these demonstrations. Successes and challenges identified in Washington and Massachusetts may prove useful to guide integration policies in other States.

This brief draws from data in RTI's first Annual Reports for Washington and Massachusetts, which include qualitative descriptions and analyses from quarterly monitoring, focus groups, annual site visits, and quantitative analyses of Medicare and claims/encounter data. Analyses of service utilization in *Section 5* are taken from the Annual Reports and are based on Medicare claims and encounter data for both Washington and Massachusetts for 2 baseline years prior to the demonstration, and for Demonstration Year 1 (July 1, 2013–December 31, 2014 for Washington and October 1, 2013–December 31, 2014 for Massachusetts). RTI is using an intent-to-treat (ITT) approach for the quantitative analyses conducted for the evaluation, comparing the eligible population under each State demonstration with a similar population that is not affected by the demonstration (i.e., a comparison group). ITT refers to an evaluation design in which all Medicare-Medicaid enrollees eligible for the demonstration constitute the evaluation sample, regardless of whether they actively participated in demonstration models. Thus, under the ITT framework, analyses include all beneficiaries eligible for the demonstration, including those who are eligible but are not contacted by the State or participating providers to enroll in the demonstration or care model, those who enroll but do not engage with the care model, and a group of similar eligible individuals in the comparison group.

To understand the experience of beneficiaries in special populations who are enrolled in these demonstrations, RTI summarized Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, interviewed stakeholders who represent enrollees, and conducted focus groups with beneficiaries or their proxies. Forty-two enrollees or proxies participated in six focus groups in Washington, and 41 enrollees, in three One Care plans, participated in seven focus groups in Massachusetts. Two focus groups in each State were conducted in Spanish; one focus group in Massachusetts was comprised entirely of Black or African American enrollees, the remaining focus groups in both states were racially diverse. The focus groups were conducted between June

² States participating in demonstrations under the FAI include: California, Colorado, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, Rhode Island, South Carolina, Texas, Virginia, and Washington.

2015 and February 2016. Participants represent a mix of populations, including racial and ethnic minorities, LTSS users, and beneficiaries with behavioral health needs. Focus group participants reported their experiences with service integration, care coordination, and the impact of the demonstration on their well-being and quality of life. As with any focus group data, the results presented here represent the experiences of the participants and should not be generalized to the enrolled population.

2. The Washington and Massachusetts Demonstrations

The Washington and Massachusetts demonstrations were the first MFFS and capitated model demonstrations implemented under the FAI, beginning in July and October of 2013, respectively. Officials in each State identified similar goals for their demonstrations: to improve beneficiary outcomes by enhancing the quality and coordination of care, alleviate fragmentation by integrating care, and reduce costs for the State and the Federal government. The demonstrations' objectives are also similar: to improve the beneficiary experience in accessing care, deliver person-centered care, promote independence, improve quality, and eliminate cost shifting between Medicare and Medicaid. High need, high cost beneficiaries are the focus of both demonstrations.

The Washington Health Homes MFFS Demonstration

The Washington Health Homes MFFS Demonstration began in July 2013 and operates in all but two counties of the State; as of March 31, 2016, there were 19,660 beneficiaries enrolled. Jointly administered by the State's Medicaid agency and the State office responsible for LTSS and behavioral health, the demonstration uses Medicaid health homes to integrate care for high-cost, high-risk full-benefit Medicare-Medicaid enrollees of any age, using an MFFS approach.

Enrollment in a health home enrolls a Medicare-Medicaid beneficiary in the Washington Health Homes MFFS demonstration. This differs from the process of aligning beneficiaries with the demonstration. A beneficiary who is not enrolled in a health home but is eligible for the Washington Health Homes MFFS demonstration is aligned with the demonstration for purposes of determining whether the State is eligible to share in demonstration savings.

These health homes, established under Section 2703 of the Affordable Care Act, are the lead entities that organize enhanced integration of primary, acute, LTSS, and behavioral health services for demonstration enrollees. Medicare-Medicaid beneficiaries who meet the State's health home eligibility criteria (e.g., having one chronic condition and being at risk of developing another) are enrolled into health homes to receive Medicaid health home services. They continue to receive their health care and LTSS through fee-for-service Medicare and Medicaid, except for Medicaid community mental health services, which are capitated. Medicare and Medicaid services available to enrollees in the demonstration are unchanged, except for the addition of Medicaid health home services.

Health home services consist of six statutorily defined services: comprehensive care management; care coordination; health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; and referral to community and social support services, if needed. Washington's eight health home lead entities (six of which serve individuals in Medicaid fee-for-service, including those dually eligible for Medicare and Medicaid) include Area Agencies on Aging (AAAs), a provider consortium, and managed care organizations. Health homes typically provide care coordination services directly, or they contract with care coordination organizations (CCOs) which include federally qualified health centers, community mental health agencies, social service agencies, faith-based organizations, and an AIDS service provider.

Experience with the State's Chronic Care Management Program led Washington to adopt a comparable model for the demonstration, organized around the principles of patient engagement and providing support for enrollees to take steps to improve their own health. In the course of integrating care for enrollees across primary care, LTSS, and behavioral health delivery systems, health home care coordinators engage enrollees to set health action goals and increase self-management skills to achieve optimal physical and cognitive health. Together with each enrollee, health home care coordinators develop a person-centered Health Action Plan (HAP) as the first step toward service integration. Data stored in the State's web-based clinical support tool (known as the Predictive Risk Intelligence System, or PRISM) includes enrollee utilization of Medicare- and Medicaid-financed services, hospitalizations, ED visits, and specific medication usage; this data informs the development of the HAP. PRISM integrates individual-level information from payment and assessment data systems covering primary, acute, LTSS, behavioral health, and social services. The health home care coordinator and the enrollee review this information, prioritize health action goals, specify personal actions to achieve the goals, and identify needed interventions and supports.

The State established the Health Home Advisory Team to foster a meaningful role for ongoing stakeholder input regarding the demonstration. Members include consumer advocacy organizations, provider associations, State and county agencies, and the union representing most home care workers.

Washington expects health outcomes to improve and hospital and ED use to decline when enrollees are provided with intensive care coordination across delivery systems, individualized coaching, and mentoring to increase self-management skills. In the first demonstration year, the State targeted beneficiaries to enroll and engage in health homes who, on average, were using services more intensively than the average demonstration eligible beneficiary. These beneficiaries are those with the greatest health care, LTSS, and/or behavioral health needs, as identified by their PRISM scores.

The Massachusetts One Care Demonstration

The One Care demonstration is a capitated model demonstration that began in October 2013 and operates in 9 of the Commonwealth's 14 counties.³ CMS, the Commonwealth of Massachusetts, and Medicare-Medicaid Plans, known as One Care plans, entered into three-way contracts to provide comprehensive, coordinated care for beneficiaries dually eligible for Medicaid and Medicare services, aged 21 to 64 at the time of enrollment. The demonstration integrates the full array of functions performed by Medicare and Medicaid, including the processes required to determine Medicare and Medicaid eligibility and to complete enrollment; the coordinated delivery of all medical, acute, and pharmacy services, and LTSS; coordinated quality management processes and systems; and a coordinated grievance and appeals process. Enrollees receive a single insurance card that covers all Medicaid services (including LTSS and behavioral health services), Medicare medical and acute services (including physician and hospital services), and all pharmacy benefits. As of March 31, 2016, there were 12,602 beneficiaries enrolled in One Care.⁴ There are currently two One Care plans, Commonwealth Care Alliance and Tufts Health Unity (a part of Tufts Health Plan); each receives monthly capitated payments from Medicaid and Medicare to manage the care and services of enrollees.⁵

Because Massachusetts did not have an integrated Medicare-Medicaid program that served adults under age 65 with physical or behavioral disabilities, the State and CMS designed One Care to serve individuals with LTSS and/or behavioral health needs. The State and CMS hoped to improve enrollee outcomes and cost-effectiveness by improving the coordination of care; integrating physical and behavioral health services and LTSS; increasing consumer engagement in care; and expanding access to enhanced community-based services. Under One Care, enrollees receive all Medicare and Medicaid services, as well as new and expanded services including diversionary behavioral health services that had generally been available to Medicaid-only beneficiaries enrolled in managed care, but have not been available to Medicare-Medicaid beneficiaries in Massachusetts. Diversionary services include community crisis stabilization and support programs, psychiatric day treatment, intensive outpatient programs, and addiction treatment programs. Other new or expanded services include dental care, homemaker services, non-medical transportation, and other LTSS.

To provide LTSS coordination, One Care plans must contract with community-based organizations which include Aging Service Access Points, Independent Living Centers, and Recovery Learning Communities. The plans must also offer care coordination to all enrollees through a care coordinator or clinical care manager employed by or under contract with the One Care plan.

The care coordinator or clinical care manager works with the enrollee and his or her providers to develop an Individualized Care Plan (ICP); the long-term services (LTS) coordinator is included

³ In Plymouth County, One Care is not available in the towns of East Wareham, Lakeville, Marion, Mattapoisett, Wareham, and West Wareham.

⁴ State Data Reporting System

⁵ Fallon Health Care withdrew from the demonstration as of September 30, 2015.

in this process if desired by the enrollee. The ICP reflects the enrollee’s preferences and needs, and designates how services and care will be integrated and coordinated among providers. All enrollees are assigned to one of eight One Care rating categories, depending upon level of nursing or activities of daily living (ADL) needs, and certain diagnostic criteria.

To ensure beneficiary needs and concerns were met, Massachusetts established an Implementation Council, with majority representation by beneficiaries with disabilities or family members or guardians of beneficiaries with disabilities. The council began meeting 9 months prior to implementation, has ongoing input into demonstration activities, and has influenced many operational aspects of the demonstration that are particularly important to enrollees who access behavioral health services and LTSS. For example, the Implementation Council focused on behavioral health privacy issues; developed guiding principles to decrease stigma; and enhanced plan policies, procedures and education regarding privacy and data sharing.

Massachusetts expects the increased consumer engagement in care, and expanded and coordinated access to enhanced community-based services, to improve member experience and contribute to a more cost-effective and efficient delivery of services.

Table 1 presents a summary of key features of each demonstration.

Table 1.
Summary of demonstration characteristics

Demonstration State	Type of Financial Alignment model	Eligible population	Beneficiaries enrolled as of March 2016	Lead organizations	Care coordination
Washington	MFFS except capitated for Medicaid community mental health services	All ages, statewide except for Snohomish and King counties	19,660	6 health homes	Care coordinators employed by health homes and care coordination organizations, which are primary CBOs
Massachusetts	Capitated	Aged 21–64 ^a in 9 of 14 counties	12,602	2 One Care plans	Care coordinators employed or contracted by One Care plans.

CBO = community-based organizations; MFFS = managed fee for service.

^a The Massachusetts demonstration targets individuals aged 21–64 at the time of enrollment, and allows people to remain in their MMP when they turn 65 as long as they maintain demonstration eligibility. Includes eight full counties and one partial county.

Source: Enrollment data is from the State Data Reporting System as of March 31, 2016.

Enrollee Characteristics

Table 2 provides the demographic profile for beneficiaries enrolled in the Washington demonstration as of December 31, 2014. Included in this table are demographic characteristics for all enrollees, for enrollees who use LTSS, and for those who use LTSS and health home services. LTSS in these data include enrollees with use of nursing facility, personal care services,

residential care services, and adult day care. Also shown are enrollees with a diagnosis of SPMI in the past 2 years and those enrollees with SPMI who use health home services.

Table 2.
Washington demonstration demographic and health characteristics for all enrollees, including LTSS users, and enrollees with SPMI: Demonstration period July 1, 2013–December 31, 2014

Characteristics	Demonstration enrollees	Eligible LTSS users who are enrollees	LTSS enrollees with health home service use	Eligibles with SPMI who are enrollees	SPMI enrollees with Health home service use
Number of beneficiaries	10,285	6,423	970	3,171	518
Age					
18–64	47.1	41.5	46.0	64.4	71.0
65–74	27.5	28.1	28.9	23.5	20.7
75 and older	25.4	30.4	25.2	12.1	8.3
Gender					
Male	35.3	34.9	32.7	33.4	34.0
Female	64.7	65.1	67.3	66.6	66.0
Asian/Pacific Islander	4.2	2.7	1.7	1.9	1.0
Black or African American	3.7	3.6	4.4	3.8	2.2
Hispanic	7.6	5.4	6.5	3.9	3.6
White	84.5	88.4	87.4	90.5	93.2
Serious and persistent mental illness	30.8	31.3	33.7	100	—
Disability as basis for original Medicare entitlement	60.1	60.3	62.9	78.7	84.0
Hierarchical Condition Category score					
<1	24.0	18.3	16.5	20.1	15.4
1<2	40.7	39.8	41.9	41.3	43.4
2<4	27.2	31.4	30.9	28.7	30.5
4+	8.0	10.5	10.7	9.9	10.6

Health home service user = an enrollee is defined as having used Health Home services if they were enrolled in the demonstration and had any health home service use during the demonstration period. LTSS = long-term services and supports; — = not available; SPMI = serious and persistent mental illness.

Note: With the exception of the first row, all figures in tables are percentages.

Sources: Financial Alignment Initiative First Annual Report: Washington Health Homes Demonstration tables 3, 12, and 19.

The age distribution of Washington enrollees reflects the fact that this demonstration does not have age restrictions; nearly 50 percent are under age 64 and approximately one-quarter are in the 65–74 age range; 35.3 percent are aged 75 or older. Sixty percent of beneficiaries in Washington were originally eligible for Medicare prior to age 65 because of their disability status. Almost one-third of eligible beneficiaries had been treated in the past 2 years for SPMI

such as schizophrenia or bi-polar disorder (identified from RTI's analysis of Medicare claims data over the 2 years prior to the beginning of the demonstrations). Of the 30.8 percent of enrollees diagnosed with SPMI, nearly two-thirds (64.4 percent) are under age 65. Of those with an SPMI diagnosis who used health home services, 71 percent are under age 65. Approximately one-quarter of enrollees who use LTSS and enrolled in a health home were aged 75 and older.

In Washington, the largest enrolled minority group is Hispanics, who comprise 7.6 percent of all enrollees; 4.2 percent of the population is Asian or Pacific Islander. Almost 4 percent of the population is Black or African American. Hispanic enrollees who use LTSS comprise 5.4 percent of all LTSS users; Hispanic enrollees who use LTSS and also used health home services represent 6.5 percent of all LTSS users enrolled in health homes. Almost 4 percent of Hispanic enrollees have been diagnosed with SPMI (3.9 percent); those Hispanic enrollees with an SPMI diagnosis comprise 3.6 percent of all enrollees with SPMI who use health home services. Among enrollees with SPMI who use health home services, 93.2 percent were White and 6.8 percent were minorities. Similarly, most LTSS users who use health home services were White, at 87.4 percent.

The Hierarchical Condition Category (HCC) score is a measure of the predicted relative annual cost of a Medicare beneficiary based on the diagnosis codes present in recent Medicare claims and on demographic information. Beneficiaries with a score of 1 are predicted to have average cost in terms of annual Medicare expenditures. Beneficiaries with HCC scores less than 1 are predicted to have below average costs, whereas beneficiaries with scores of 2 are predicted to have twice the average annual cost. In Washington, approximately one-quarter of enrollees analyzed had HCC scores less than 1, whereas between approximately 40–43 percent of eligible beneficiaries had scores between 1 and 2, meaning their Medicare costs were predicted to be between those of the average Medicare beneficiary and double the average beneficiary costs. Similarly, about one-quarter of beneficiaries had predicted costs between twice and four times that of the average Medicare beneficiary, whereas about 6–8 percent of eligible beneficiaries had predicted costs over four times the average Medicare beneficiary.

Table 3 provides a demographic profile for beneficiaries enrolled in the Massachusetts demonstration as of December 31, 2014. It also shows profiles for enrollees who use LTSS and those who had a diagnosis of SPMI within the previous 2 years. Approximately 37 percent of the 23,872 One Care demonstration enrollees were in other Medicare shared savings programs at some point during the first demonstration period, prior to enrolling in One Care, leaving 15,131 demonstration enrollees for analysis. Beneficiaries aligned with a Medicare shared savings program at some point in the demonstration period are excluded from analysis because their outcomes were potentially shaped by their non-FAI experience. There were only 1,131 Massachusetts demonstration eligible beneficiaries (enrollees and nonenrollees) with any LTSS nursing facility use. Among these beneficiaries, only 56 were One Care enrollees. Therefore, results on One Care enrollees with LTSS use should be viewed with caution.

Table 3.
Massachusetts demonstration demographic and health characteristics for the enrolled, LTSS, and SPMI populations: Demonstration period October 1, 2013–December 31, 2014

Characteristics	All enrollees	LTSS ¹	SPMI
Number of beneficiaries	15,131	56	7,938
Age			
21–44	35.4	12.5	39.1
45 and older	64.6	87.5	60.9
Gender			
Male	49.8	60.7	47.5
Female	50.2	39.3	52.5
Asian/Pacific Islander	1.7	1.8	1.4
Black or African American	16.8	25.0	15.4
Hispanic	15.3	1.8	14.2
White	61.6	67.9	64.4
Serious and persistent mental illness	52.5	25.0	100
Disability as basis for original Medicare entitlement	95.4	91.1	96.8
Hierarchical Condition Category score			
<1	60.7	26.8	53.2
1<2	32.8	41.1	38.7
2<4	5.2	21.4	6.6
4+	1.2	10.7	1.6

LTSS = long-term services and supports; SPMI = serious and persistent mental illness.

¹ Medicaid data on LTSS users were not available for the first Annual Report for Massachusetts. RTI identified those with any LTSS use from CMS administrative data derived from monthly State Medicare Modernization Act (MMA) data submissions that identify Medicaid beneficiaries with any institutional LTSS, any HCBS, and no LTSS use. The Commonwealth excludes HCBS waiver recipients from demonstration eligibility. Although the Medicare-Medicaid plans had submitted Medicaid encounter data, the only identifier available to RTI and ready for analysis was that of institutional LTSS use.

Note: With the exception of the first row, all figures in tables are percentages.

Sources: Financial Alignment Initiative First Annual Report: Massachusetts One Care Demonstration tables 28, 32, and 37.

The age distribution of One Care enrollees reflects the fact that this demonstration is designed for those aged 21–64 at the time of enrollment. Younger enrollees (aged 21–44) make up 35.4 percent of all enrollees; this group comprises 12.5 percent of the enrollees who use LTSS, and nearly 40 percent of the enrollees who had a diagnosis of an SPMI, such as schizophrenia or bipolar disorder. All enrollees are evenly split by gender, however 60.7 percent of LTSS users are male; slightly more females had a diagnosis of SPMI.

In Massachusetts, the largest minority group is Black or African American, with 16.8 percent of the demonstration enrollees. Hispanic enrollees make up 15.3 percent, and Asians comprise 1.7 percent of the demonstration enrollees in the State. Overall, more than half (52.5 percent) of enrollees have been diagnosed with SPMI and 95.4 percent are eligible for Medicare based on disability status. One-quarter of LTSS users are Black or African American, less than 2 percent are Hispanic; nearly 68 percent are White. Whites also have a high proportion (64.4 percent) of those with an SPMI diagnosis. Hispanic enrollees and Black or African American enrollees comprise 14.2 and 15.4 percent of the population with SPMI, respectively.

3. Long-Term Services and Supports

Background

Integrating or coordinating care for people with LTSS needs is a major objective of the demonstrations under the Financial Alignment Initiative. A substantial portion of the dually eligible population has disabilities, including limitations in the activities of daily living (ADLs), such as eating, bathing, and dressing; instrumental activities of daily living (IADLs), such as meal preparation and money management; or cognitive functioning, such as dementia from Alzheimer's disease. Medicare-Medicaid beneficiaries with disabilities have a very high use of expensive LTSS, such as nursing facilities, personal care services, residential care facilities, and adult day care. Nationally, in 2010, 21 percent of full-benefit Medicaid fee-for-service Medicare-Medicaid beneficiaries used institutional services, which accounted for half of total national Medicaid spending for dually eligible beneficiaries; 13 percent of full-benefit fee-for-service dually eligible beneficiaries used Medicaid home and community-based services (HCBS) waivers, which accounted for 23 percent of Medicaid spending on dually eligible beneficiaries (MedPAC and MACPAC, 2015). Thus, nationally, institutional services and Medicaid HCBS waivers accounted for nearly three-quarters of Medicaid spending on dually eligible beneficiaries.

Medicare does not cover LTSS, although its benefits include post-acute care services in skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. Medicare-Medicaid beneficiaries have much higher use of Medicare skilled nursing facilities and home health than do Medicare-only beneficiaries, but use of these services only constitutes about 15 percent of Medicare spending for this population. Because users of LTSS are also high users of acute care services, average costs for Medicare-Medicaid beneficiaries who use LTSS are high. In 2010, average Medicare and Medicaid expenditures for Medicare-Medicaid beneficiaries who used any LTSS totaled \$60,801, split about 60 percent/40 percent between Medicare and Medicaid (MedPAC and MACPAC, 2015).

Although in the last 2 decades some States have undertaken demonstrations experimenting with Medicare-Medicaid integrated care, people with disabilities currently receive care in a fragmented and uncoordinated financing and service delivery system, both within and between

the health and long-term care systems (Wiener, 1996). Financing for acute care is largely the responsibility of Medicare and the Federal government, while long-term care is principally the responsibility of Medicaid and State governments. As with the general dually eligible population, the principal problem for older and younger people with disabilities is that there is no organization that has financial responsibility and accountability for both acute care and LTSS; that is, no organization is responsible for managing all aspects of care for a person. Indeed, under the current system, the financial incentives are to shift costs between Medicare and Medicaid, especially for users of LTSS, where Medicaid's financial role is so large and Medicare's financial role is so small (Grabowski, 2007).

Washington

Washington has been a leader in LTSS rebalancing since the 1980s, and has been particularly successful in transitioning individuals from nursing facilities to the community. Between 2005 and 2010, Washington decreased the number of Medicaid-supported nursing facility residents by 6 percent, a rate double the national average (Houser, Fox-Grage, and Ujvari, 2012). The Washington Health Homes MFFS demonstration attempts to achieve better and less expensive outcomes for LTSS beneficiaries by enrolling them in health homes where LTSS delivery can be coordinated with acute care delivery. Given that Washington already had one of the most balanced LTSS delivery systems, State officials thought that the demonstration would have little effect on reducing nursing facility use. Potentially, if a greater percentage of chronic and LTSS service needs can be met in the community, then those beneficiaries who do need institutional placement will have higher frailty than before the demonstration.

Massachusetts

CMS and Massachusetts expect positive effects on service utilization, expenditures, and quality of care for Medicare-Medicaid beneficiaries with LTSS needs, within a capitated environment in which One Care plans are accountable for Medicare and Medicaid, acute care, and LTSS. These plans are encouraged to provide services to people with LTSS needs that address their medical, social, and functional needs, so that inpatient admissions, readmissions, and potentially avoidable admissions will be reduced.

Before the One Care demonstration, Medicare-Medicaid beneficiaries under age 65 had been ineligible to enroll in Medicaid managed care. In the absence of One Care, Massachusetts did not have a mechanism to provide comprehensive care coordination and care management services to this population, nor a way to integrate Medicare and Medicaid payments and services. Before the demonstration, most Medicare-Medicaid enrollees received their LTSS services through the existing fee-for-service (FFS) system under the Medicaid State Plan. This included a personal care services benefit delivered through a consumer-directed delivery model only. Some may have received services in Program of All Inclusive Care for the Elderly (PACE), a program that serves people aged 55 or older. Massachusetts has several home and community-based service waivers, including for children, adults with intellectual disabilities and adults with acquired brain

injury. Massachusetts does not have a waiver specific to individuals with behavioral health needs or adults with physical disabilities.

Experience of LTSS Users under the Demonstration: Focus Group Findings

To gain a deeper understanding of how demonstration enrollees are faring under the demonstration, the RTI evaluation team solicited feedback directly from enrollees via focus group discussions. Focus group participants were asked about access to and quality of services; new benefits, including care coordination; relationships with providers; beneficiary rights; and overall satisfaction with their care and with LTSS.

In Washington, focus group participants were health home enrollees who had engaged with their care coordinators to complete a HAP. Focus group participants recognized setting and achieving goals as being closely associated with health home care coordination. They were less clear on the relationship of other care coordination functions to health homes, possibly because health homes are still new and focus group participants receive services from multiple agencies. When they needed help accessing services, some focus group participants said they contacted their health home care coordinators, while others described advocating for themselves or contacting familiar agencies for assistance, such as HCBS and behavioral health case managers. Overall, many were actively engaged in setting goals for improving their health status and quality of life with support from their care coordinators.

In Massachusetts, focus group participants were enrollees who self-reported LTSS or behavioral health needs and who had visited a health care provider more than once in the past 12 months. Accounts provided by focus group participants illustrate that most were generally satisfied with their experience under One Care, with some enrollees reporting that the impact of the demonstration on their services and quality of life has been profound. For those individuals, the demonstration has opened up services and opportunities that were not available prior to the demonstration.

In both States, some focus group participants still struggled—as they did prior to the demonstration—to access specialty services and some focus group participants experienced additional struggles with communicating across providers.

Complex Needs and High Service Utilization

Often, focus group participants with complex needs who use LTSS and who have not had coordinated care in the past utilize health care services at high rates. One focus group participant described how his high utilization of ED services led to enrollment in a health home. Another explained how her use of ED services was drastically reduced due to the impact of the demonstration's care coordinator.

The reason they started [my health home services] is because I was going to the ER multiple times in 1 week for the same thing. They're like, "Well, something's

obviously going on here.” So then they start—he [the care coordinator] started coming over...Before I got my transplant, I was going into the ER three or four times a week for the same thing. *(White male, Washington)*

I was going to the emergency room three or four times a week for little things. Since I started working with [the care coordinator] over the last 2 years, I’ve been to the ER once in 2 years. *(White female, Washington)*

Assessment/Coordination

Enrollees in both demonstrations received an initial health care assessment as part of the care planning process. During the assessment and care plan development, enrollees set goals and the coordinator helps to identify unmet needs. Subsequently, care coordinators are required to check in with enrollees on a regular basis. Some focus group participants were pleased with the outcome; however, some remarked on the lack of follow-up with providing services or confusion with multiple coordinators visiting them in their homes.

The first year, they did the full assessment, everybody came. They made their salary that day, but they just didn’t do anything for me, [and the services and equipment they talked about never happened]. It was so discouraging that I didn’t even fill out the survey... They came the second year, and that time everything I needed was done within the year, and we even have another plan, so for this year they were very good... They followed through with everything. *(Black female, Massachusetts)*

[They don’t know me] because it’s different people. You don’t have the same one and you have three different people coming out. They’ve got the paper in front of them about what [the last person] did, but they don’t know me. *(Black female, Massachusetts)*

Positive Changes through Goal Setting

Some focus group participants reported improvements in their health and quality of life since enrolling in the demonstration. Focus group participants reported a wide range of positive changes including improved access to regular care (which they said reduced their use of the ED), and reduced use of unnecessary medications, and increased physical activity and weight loss. Focus group participants indicated successes such as improved management of chronic conditions, increased activity, and increased community engagement.

Washington focus group participants were more likely to achieve their goals by working with their care coordinator to change their own behavior rather than by accessing additional services. Goals included managing diabetes, quitting smoking, losing weight, maintaining ambulation, and increasing community engagement. Massachusetts focus group participants generally related their improved quality of life to new or additional services provided by the demonstration.

Actually, I had a goal where I use the walker when I walk...My goal is to walk around the house at least twice a day and I met that goal. My next goal is to be

able to go from the living room to the bathroom and back. I met that goal also.
(*White female, Washington*)

My goal is to get better and to continue [to follow] the doctor's advice. [I feel I have the support] with the services they are now offering... [Before,] there was no help. (*Hispanic, female, Massachusetts*)

I set up the goal of wanting to stay out of a wheelchair. So far I'm not in a wheelchair yet. [This participant went on to say that she walks to maintain her ability to ambulate.] (*White female, Washington*)

Some focus group participants reported positive experiences with care coordinators to identify their needs and discuss service options, while others said they were accustomed to managing their own care.

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

She [the care coordinator] comes once a month. She asks me, "Who's doing what for you, and what do you need and can I get some information for you?" Basically, if I didn't have her, I'd really be lost. I'm lost right now. But if I didn't have her, I wouldn't have what I have right now. (*Hispanic female, Washington*)

I would call [the care coordinator] if I needed help with something, but I don't think she would be very necessary because I have so many different layers of help for different things that I think she would be one of the later people I would try.
(*White male, Washington*)

Additional Services and Access to Care

New services that enrollees received took many forms, depending upon the needs of beneficiaries and the differences in the two demonstrations. Focus group participants noted various types of assistance that was meaningful to them, including additional health information, pain management instruction, nutrition information, and health hotlines. Care coordinators helped enrollees to decipher health related information and to find specialist care and care in the home. Other enrollees reported that their care coordinators arranged for home modifications to keep them safe in their homes.

[M]y doctor only tells me, "You have this problem; you should look for a specialist." But all I can do is make a Google search or something like that... Because one just doesn't know what to do, right? ... So I just tell [the care coordinator], "I have this problem but don't know where to go." She says, "OK, I'll bring you information regarding which doctors within the insurance are available, which ones will see you and which ones you can choose to go to." And that's it. That's how she helps me. (*Hispanic female, Washington*)

The [positive] change [made by One Care] was in regard to the personal care attendant that was offered to me. *(Hispanic female, Massachusetts)*

Every year he [the care coordinator] comes to evaluate my mother, every year. However, he always keeps in touch with me and me with him. If something new comes up I just have to talk to him and tell him what's going on... he knows all of her doctors, all of her medications... *(Proxy for Hispanic female, Washington)*

Other focus group participants reported that their care coordinators arranged various services in the home or arranged for modifications to the home.

I don't take pain meds because I was on so many when I was in the nursing home. And they [the health home staff] have gone over and above. I have access to an EMPI machine [pain management system]... They've got me everything for my neck to hold it in place. I have everything that anybody could possibly want. *(White female, Washington)*

[One Care] provided me everything for the bathroom, the railings, the shower, the chair for bathing... Another thing was therapy. They sent me home therapy... I can now walk. *(Hispanic male, Massachusetts)*

If you have a problem with falling, they pay for the unit now for you to have a pendant at home so you can get help. Before if you were having that problem, I had to try to get that for myself. *(White female, Washington)*

Challenges with Obtaining Durable Medical Equipment

Several focus group participants in both States said they experienced difficulties getting wheelchairs or wheelchair repairs; some said that they had not sought help from their care coordinators. One focus group participant in Massachusetts stated that he was provided an expensive wheelchair, but it only worked for a few months; since it broke down, his attempts to get the Plan and the vendor to fix or replace his chair have been unsuccessful. A focus group participant in Washington noted the following:

Right now I'm having this problem... I need a wheelchair for my father. I've already been chasing the doctor for 2 or 3 months and all that, just to get the chair... I had to really struggle to get that doctor to sign for a [parking permit for a person with disabilities]... I had to call and call. *(Proxy for Hispanic male, Washington)*

Medical Providers

All focus group participants reported having a primary care provider (PCP), and many reported positive relationships with their long term (prior to enrollment in the demonstration) or recently-assigned PCP. They appreciated the fact that their provider listened to them and that decisions were made jointly. Others indicated that they prefer making their own decisions and change

providers if they do not agree with them. One focus group participant said that when her care coordinator accompanied her on one visit to her PCP, her doctor was more responsive.

I interview mine. I've been very lucky [with regard to] the medical people that I've been involved with, but mostly I feel that is because of the fact that I won't let them get away with anything. I make a lot of my own decisions. *(White, North American Indian, or Alaskan Native female, Washington)*

I have been seeing [my doctor] for many years and I love [her]. I can call her if I have questions, and she will call me. We are always communicating with each other. *(Hispanic female, Massachusetts)*

I have wanted to get off medicines because I take so many of them. My doctor listens to what I say and she gives me options and she really hears them. She throws out, "We can do this, this and this, and which one would you prefer?" She has to be listening to me to be able to come up with the options. *(White female, Washington)*

Some focus group participants who were dissatisfied with their PCPs nonetheless expressed reluctance to switch providers. This appeared to be irrespective of whether they were the PCP prior to enrollment, or if they had been newly assigned. Others reported "firing" doctors who did not listen to them, and trying several providers before finding one with whom they could communicate well. Examples of supporting quotes are:

It's as if I don't have the courage to [switch], or I don't know if I will feel bad about it... because I have been with her so long. As they say, you may go from bad to worse. She has been with me for many years... she doesn't help me with many things, but I don't know how to find another doctor. *(Hispanic female, Massachusetts)*

I've been seeing my primary doctor for the last few months. Prior to that, I went through three doctors. Not one of them did I like or understood me until I went to [my current PCP], and she listened and she understood. *(White female, Washington)*

Satisfaction

Those focus group participants who were satisfied with their care coordination services described their satisfaction with coordination services in the past year in various ways. The knowledge that the care coordinator was available and helpful to them seemed to give them peace of mind.

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, Massachusetts)*

Anything I need, like when I have my treatment or something, I tell my case manager. She tells me, "You need a small step for your bathroom so you can bend

over,” she gets it for me. Or that the battery of my wheelchair is not working, she calls and says, “OK, I’ll call them and tell them to come over and help you with that”... We are well coordinated for everything. *(Hispanic female, Washington)*

It is an exceptionally good plan... because with One Care, I have not had any problems getting an orthopedist, cardiologist, and therapist... If there is one I cannot go to, they will help me find someone else who is more convenient, who is closer, so that you don’t go through any difficulties. *(Hispanic female, Massachusetts)*

And it’s also set up if I get admitted to the hospital, he [the care coordinator] gets an email. He calls me and asks what’s going on or whatever. He had it set up for just the local hospitals. Well, then I got admitted to the one in Seattle and I called and told him. So he set it up for the entire state. If I’m admitted to any hospital in the state, he gets an email and he messages me. *(White male, Washington)*

4. Behavioral Health and Serious and Persistent Mental Illness

Background

Behavioral health disorders (e.g., serious mental illnesses and/or substance use disorders) are highly prevalent among Medicare-Medicaid enrollees. Over 10 million of these beneficiaries live in United States today, comprised of low-income seniors and under-65 adults with disabilities, and many of these beneficiaries have complex physical and mental health disorders (CMS, 2015). It has been widely documented that Medicare-Medicaid beneficiaries generate greater health care costs than those with Medicare only, and research has documented that Medicare-Medicaid beneficiaries with behavioral health disorders have greater health care expenditures than those without such disorders (SAMHSA, 2014; Kasper et al., 2010). Despite the obvious need to provide behavioral health care to dually eligible beneficiaries, the demand for these services remains unmet in various parts of the country, especially in States with large portions of populations in rural areas (SAMHSA, 2012).

Medicare-Medicaid beneficiaries often have co-occurring physical and behavioral health illnesses, and their needs are often greater than beneficiaries with only physical conditions. In 2003, almost 40 percent of Medicare-Medicaid beneficiaries had both a physical and mental illness, compared to only 17 percent of all other Medicare beneficiaries (Kasper et al., 2010). Medicare-Medicaid beneficiaries with co-occurring conditions were found to utilize a greater amount of inpatient hospital, nursing facility, and community-based long-term care services than those with only a physical condition (Kasper et al., 2010). A greater prevalence of co-occurring physical and behavioral conditions has also been documented in older Medicare-Medicaid enrollees (aged 65 and older) than in those aged 18–64 (CBO, 2013; Kasper et al., 2010). Given their greater use of services, Medicare-Medicaid beneficiaries with co-occurring conditions have

been found to generate greater health care costs than those without co-occurring conditions (CBO, 2013; Kasper et al., 2010; SAMHSA, 2014).

Washington

Of the estimated 126,444 Medicare-Medicaid beneficiaries in Washington State as of 2009, approximately 40 percent of those aged 65 and older, and 60 percent aged 18 to 64, had behavioral health needs (DSHS, 2011). Among Medicare-Medicaid beneficiaries aged 65 and older, 20 percent are estimated to have dementia (DSHS, 2011), which has been documented as a significant driver for health care costs (Schaller et al., 2015). Additionally, 20 percent of Medicare-Medicaid beneficiaries aged 18 to 64 were identified as having substance use disorders (DSHS, 2011). Overall, total expenditures for treating mental health and substance use disorder needs were higher for Washington Medicare-Medicaid beneficiaries age 18 to 64 (approximately \$137 million) than for those age 65 and older (approximately \$29 million, DSHS, 2011). Although the prevalence of behavioral health disorders in Washington is higher than national averages, many individuals do not receive treatment (Kaiser, 2014).

Analyses of claims data show that by the end of 2014, nearly one-third (30.8 percent) of all Washington Health Homes MFFS demonstration enrollees were diagnosed with a serious and persistent mental illness (SPMI) in the 2 years prior to the demonstration (Table 2) and about two-thirds of those enrollees (64.4 percent) are in the 18 to 64 age group. At that time, less than one-quarter of enrollees with SPMI had been enrolled in a health home. Whereas 90.5 percent of the enrollees with SPMI were White, that group comprised 93.2 percent of the population with health home service use at that point. Although the population of Black or African American enrollees with SPMI was nearly 4 percent of the SPMI enrollee population, Black or African American enrollees constituted only 2.2 percent of all enrollees with SPMI who had any health home service use. Because demonstration implementation is relatively new and fluid, service utilization by race will be monitored throughout the demonstration to understand if disparities exist.

Massachusetts

In 2008, there were approximately 110,000 Medicare-Medicaid beneficiaries aged 21 to 64 in Massachusetts. Of those beneficiaries, approximately 35 percent had a diagnosis of SPMI and approximately 28 percent were diagnosed with a substance use disorder (Commonwealth of Massachusetts, 2012). Beneficiaries with three or more inpatient admissions represented less than 6 percent of this population but accounted for over 30 percent of Medicare spending. Almost 80 percent of those with inpatient admissions had a diagnosis of either SPMI or a substance use disorder. For this same population (Medicare-Medicaid beneficiaries aged 21 to 64), approximately 70 percent did not use any institutional or home and community based LTSS; 17 percent received LTSS in a home and community based setting only; and 13 percent received LTSS in an institutional setting. Of those individuals receiving LTSS in an institutional setting, 70 percent had a diagnosis of SPMI; of those receiving LTSS in a home and community based setting, 18 percent had a diagnosis of SPMI (Commonwealth of Massachusetts, 2012).

Prior to the demonstration, the One Care target population with behavioral health needs did not generally have access to diversionary behavioral health services available to Massachusetts Medicaid-only members with similar needs and, for the most part, did not have access to care coordination services. More than half of all One Care enrollees had been diagnosed with a serious and persistent mental illness (SPMI) in the 2 years prior to the demonstration (see *Table 3*).

During the RTI evaluation team's site visit interviews, One Care plans reported finding high levels of unmet need, including for behavioral health needs, for new enrollees during the first demonstration year; full implementation of the care model, including integration of behavioral, medical and LTSS, required significant time and investment. Plans also reported difficulties contacting and locating new enrollees, especially those with behavioral health needs who were passively enrolled. The One Care Ombudsman (OCO) reported an increase, over time, in the number of complaints received from enrollees with behavioral health needs, noting the complexity of the complaint and the lack of clarity on the outcome sought by the beneficiary, making resolution challenging for both the plans and the OCO. In these cases, the OCO offered the enrollee a process and pathway for communication, even if no specific resolution was being sought.

Experience of Behavioral Health Service Users under the Demonstration: Focus Group Findings

Focus group participants who use behavioral health services referenced their complex needs, multiple providers, and fragmented care prior to the demonstration. They reported how their lives had changed as a result of their enrollment in the demonstration, noting positive changes as well as continued challenges. Some had difficulty finding behavioral health providers and other specialists, as they had prior to the demonstration.

Complex Needs and Social Isolation

Enrollees with behavioral health issues or SPMI (such as schizophrenia or bi-polar disorder) can have multiple mental and physical health conditions that exacerbate each other and lead to social isolation. Some focus group participants spoke of their social isolation; they also talked about how they overcame it with the services available in the demonstration.

I couldn't move. I couldn't walk... I felt I wasn't going to survive if I didn't get help from [One Care]... I really felt my life was not going to go anywhere; I was physically very done, and I didn't think I had a future... I don't think I would have lived too much longer [without the help One Care gave me]... It helped me immensely. (*Black female, Massachusetts*)

And so [my care coordinator] said, "But you're always here. Don't you ever visit anyone?" And well no, I don't. I felt very negative because of my own health condition. I had many health issues, but she said, "You're always locked in here, go out and socialize with some friends or with your family, go."... it was true, I

used to lock myself in my sickness and she was right to say, “Go out and socialize.” And so now I go to the shops, to where they have all those toys and dolls that sing and stuff like that. *(Hispanic female, Washington)*

Mental Health Providers

Some focus group participants said that they have limited choices for behavioral health professionals. Some of those who did have a mental health provider said they had found someone who listened to them, offered choices, and included them in decision-making.

It’s difficult unless you go with an agency. There’s no psychiatrist in the Vancouver area, I think, that takes Medicare. *(White female, Washington)*

There aren’t a lot of psychologists, psychiatrists in town that take Medicare and Medicaid. Mainly if a person is on Medicare and Medicaid, they have to go through the public mental health providers. *(White male, Washington)*

I am waiting to see a psychiatrist and since they have a lot of patients [they don’t give me an appointment]. They first have to see those who are in crisis. *(Hispanic female, Massachusetts)*

I was having depression because of the seasonal things [that] were happening, and we were talking about an antidepressant...my psychiatrist threw out a couple options for depression and anxiety medications. And he told me all of the side effects that were associated with them and the pros and cons. We just kind of picked one together and we eventually went with Prozac. *(White male, Washington)*

Regular Provider

Many focus group participants with behavioral health needs expressed satisfaction with their PCP, reporting that their provider knew them, communicated well, and cared about their health. Some had long-standing relationships with their PCP, with one participant reporting a relationship going back over 20 years and several participants reporting relationships over 10 years. Examples of supporting quotes are:

I like [my doctor] because I feel he educates me on a lot of different things. *(Black female, Massachusetts)*

She gives me great information, the health care, on how to take care of myself. She just breaks it down plainly to say, “There’s not that much we can do for you, you have to do this for yourself.” I love to hear that. You’re not going to throw me some medication for every little thing, you’re going to tell me how to take care of my health. *(Black female, Massachusetts)*

Many focus group participants in Washington, but fewer in Massachusetts, said their providers worked as a team and shared pertinent information; however, a few did not feel that they were part of a team or had a role in the decision-making process. Examples of supporting quotes are:

In my case, yes, [my primary care provider and specialist work together]... As soon as I go to my primary, she tells me exactly what the specialist told her. *(Black female, Massachusetts)*

I don't feel like [there is a team]. I just go to my doctor and let her know who came in, who just did my blood pressure and vital signs. I don't feel like my doctor knows that much about it. She writes down who came in and what did they say, stuff like that. *(Black female, Massachusetts)*

New Services

Behavioral health systems are often only able to focus on treatment and do not have the resources to address enrollees' other needs, such as health care, transportation, nutrition and providing information and support. Care coordination is a new service for enrollees in both demonstrations; care coordinators identify gaps in needed supports across physical and behavioral health delivery systems. Focus group participants with behavioral health needs in both states expressed satisfaction with this new service.

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

I don't have any complaints about my care coordinator. She resolves 100 percent of everything. There are no problems. *(Hispanic male, Massachusetts)*

I do not complain about [my care coordinators]. They are concerned about me. They do whatever they have to do so that I feel well. *(Hispanic male, Massachusetts)*

Impact on Quality of Life

Many focus group participants with behavioral health needs remarked on changes to their quality of life after having received care coordination and other services in the demonstrations. Some stated that they achieved goals by changing their own behavior, others pointed to accessing new or additional services provided by the plans.

Well, I'm completely off my psych medications, and I was on a lot of them for many years. I go outside. I interact with my neighbors. I go to church. My cholesterol is down to normal. It was dangerously high for many years. *(Hispanic female, Washington)*

They changed my plan [to One Care], and it is tremendous... [The people] are concerned about me. They do whatever they have to do so I feel well. *(Hispanic male, Massachusetts)*

I also see myself functioning better... This new coverage was able to give me things... that I couldn't get before... I can relax now knowing that [One Care] offered something to us that we definitely need. Not only that we want but we need. *(Black female, Massachusetts)*

5. Beneficiary Experience: Utilization by Race, Language Accessibility, and Beneficiary Rights

The demographic composition of the two demonstration groups, including racial and ethnic groups, is presented in *Section 2* of this Issue Brief. The sections on LTSS and behavioral health contain themes that emerged from focus group participants, many of whom were from minority groups. This section discusses differences in health care utilization by ethnic and racial groups, and additional focus group findings regarding linguistic minorities and beneficiary rights and protections.

Generally, appeals and grievances do not reflect enrollees' demographics and provide limited data on special populations unless the complaint or appeal relates to language or physical access to services where that information is self-evident. Few formal complaints related to language access barriers, including failure to provide an interpreter, were reported in Massachusetts; similar data were not available in Washington.

As an incentive for improved quality of care, Medicare-Medicaid plans (MMP) participating in the capitated model demonstrations are eligible for increased payments if they perform well on certain quality withhold measures. The Massachusetts quality withhold measure MA 5.1 monitors the extent to which enrollee race, ethnicity, language, homelessness, and disability type data are collected and maintained in the MMP centralized enrollee record. Results from these measures will be available for future reports.

Service Utilization by Race

The first Annual Reports include Medicare utilization data for the 2 year baseline period and the first demonstration periods for Washington (July 1, 2013–December 31, 2014) and for Massachusetts (October 1, 2013–December 31, 2014).⁶ The Washington and Massachusetts Annual Reports compare utilization patterns in the demonstration group (composed of demonstration enrollees and those eligible for the demonstration but not yet enrolled) with comparison groups, to determine changes in the demonstration group relative to similar populations. The purpose of the analyses is to understand the trends over time in each demonstration so that CMS, the State, and stakeholders can understand utilization patterns. We have drawn on relevant demonstration group data from those analyses for inclusion in this section. Not surprisingly, there is limited evidence of the demonstrations' effect during the first demonstration period. Enrollment into the demonstrations began slowly and increased gradually, and engagement with care coordination services took time. Thus, while these results cover the full demonstration period for each State, care coordination and service integration takes time to

⁶ Sections 8.7 in the Massachusetts Annual Report and Section 7.10 of the Washington Annual report. Utilization for inpatient admissions is defined as number of admissions during the eligible/user month. Utilization for emergency department (non-admit) and primary care visits are defined as the number of visits during the eligible/user month.

affect changes in health care seeking behaviors. The RTI evaluation team will monitor utilization by race and ethnicity throughout the demonstration to discern if any racial disparities occur or, if possible, if there are any positive impacts indicating a reduction in disparities.

Inpatient Admissions and Emergency Department Visits

In Washington, the percentage of inpatient admissions among Black and African American beneficiaries in the demonstration group decreased from the baseline period to the demonstration period from 86.6 to 71.4 admissions per 1000 eligible months. Despite this reduction, Blacks or African Americans in the demonstration period continued to have higher inpatient admissions than their White and Hispanic counterparts (60.8 and 57.9, respectively). The number of ED visits per 1,000 eligible months declined from 186.6 to 156.1 among Black or African American beneficiaries in the demonstration group, and increased from 127.2 to 139.3 among Whites, 123.9 to 142.0 among Hispanic beneficiaries, and 53.0 to 69.0 among Asian beneficiaries from the baseline to demonstration period.

In Massachusetts, Blacks or African Americans in the demonstration group maintained a slightly higher rate of inpatient admissions over time relative to White, Hispanic, and Asian beneficiaries during the baseline and demonstration periods. During the demonstration period, for example, Blacks or African Americans had 36.2 admissions per 1,000 eligible months, Whites had 34.9, Hispanics 20.0, and Asians 16.7.

In Massachusetts, the percentage of demonstration group beneficiaries with ED use declined for all racial groups by at least 0.3 percentage points from the baseline to the demonstration period. Blacks or African Americans had higher rates of utilization, in general, from the baseline to the demonstration period, relative to other racial groups. For example, during the demonstration period, Blacks or African Americans had 108.5 visits per 1,000 eligible months, Whites had 96.8, Hispanics 99.0, and Asians 38.5.

Primary Care Visits

In Washington, the percentage of Blacks or African Americans and Whites in the demonstration group who had a primary care visit was similar across the baseline and demonstration periods. The percentages for Blacks or African Americans and Whites were 62.8 and 62.4 in the baseline period and increased slightly to 65.6 and 66.7, respectively. Hispanic beneficiaries in the demonstration group increased their primary care visits from 58.9 percent in the baseline period to 63.4 percent in the demonstration period. Likewise, Asian and Pacific Islander beneficiaries increased use from 62.1 to 64.5 during these periods. There was little variation in use per 1,000 user months.

The percentage of demonstration group beneficiaries in Massachusetts with a primary care visit increased from the baseline to the demonstration period for all racial groups. However, the increase was greatest for those who were White (43.1 to 50.2 percent) and Asian (36.0 to 44.2 percent). White beneficiaries who had any primary care visit consistently had a higher rate of use

per 1,000 user months (1,011.9 for Whites, compared to a range of 794.7 to 848.2 visits among other racial groups, during the demonstration period).

Language Accessibility

Focus group participants in the Spanish-language focus groups reported that linguistic access is a major concern when seeking health care; several participants preferred to have Spanish speaking providers rather than interpreters. A few participants, especially those who spoke only Spanish, reported that language was an essential consideration for them.

I go [to the Federally Qualified Health Center (FQHC)] because they give us interpreters every time... that's why I changed from the clinic where I was before, because I had to pay for an interpreter all the time, they wouldn't give me one. And so I didn't want to be at that clinic, so I came here [to the FQHC], and here they did give me an interpreter. It's also important because the man... the doctor who sees me doesn't speak Spanish, but he's been very good to me... (*Hispanic male, Washington*)

[The clinic] asked me [about choosing a doctor] and I said that if he spoke Spanish it was all okay... set me up with him. [And this doctor was assigned to the participant]. (*Hispanic male, Massachusetts*)

[My PCP visits] are always in Spanish and when I need someone they get me an interpreter. And because I've been going to the doctor for many years, I now understand a lot of English. I find it hard to speak the language, but I speak... I use both enough and I almost always ask for an interpreter, even if I understand... But the language is sometimes a huge impediment; it's hard on us. (*Hispanic female, Washington*)

Beneficiary Rights and Protections

Ombuds offices in many demonstrations work to increase accessibility and understanding of beneficiary rights. For example, the Massachusetts OCO produced a series of educational videos that provide an overview of the basic healthcare access rights under State and Federal law for persons with disabilities. These videos are accessible on the OCO website in six languages (English, American Sign Language, Chinese, Haitian-Creole, Portuguese, and Spanish).

Some focus group questions were designed to elicit beneficiaries' understanding of their rights and protections. In Massachusetts, very few participants were aware of the demonstration's ombuds services; however, other focus group participants in both States reported that they advocated for themselves to obtain the services they needed and appeared to know their rights, as illustrated in the examples below.

I told [the One Care provider] that if they didn't [process the application], that I was calling somewhere in Boston to get an ombudsman to figure out—for them to

answer to them as to why an application wasn't completed. And then the application was completed that day. *(Black female, Massachusetts)*

And in my case I asked many times to be appointed to one single care coordinator, and one who preferably spoke Spanish so that he could understand my parents. It was a struggle but we managed in the end... And now... both my parents have the same care coordinator. *(Proxy for Hispanic male, Washington)*

Some focus group participants said their care coordinators informed them about their rights and protections, assisted them with complaints about services, and advocated for them. Others did not seem to know their rights, nor had they taken further action when providers did not explain services to them.

They just tell you that if you'll be having an operation, you must sign as to show that you acknowledge what will be done to you. If it comes out right or wrong, you've already signed... You can't do anything about it because you've already signed, that's what they tell you. *(Hispanic male, Washington)*

When the [care coordinator] came I told her everything and she made a formal complaint to the city and to the ambulance, and so they sent me a letter apologizing and saying they had acted wrong. But that was because she made the complaint. She's like having another voice. *(Proxy for Hispanic female, Washington)*

When [the care coordinators] came and talked to me, they told me about my rights... If someone has a physical problem, there are [services]. If one cannot do it on their own, they will call the place... I did not know this before [being enrolled with One Care], and now I feel I have support for this. This is good because sometimes one does not know where to go [for services]. *(Hispanic female, Massachusetts)*

6. CAHPS Surveys

Medicare requires all Medicare Advantage plans, including Medicare-Medicaid Plans in the demonstrations under the Financial Alignment Initiative, to conduct an annual assessment of the experiences of beneficiaries using the standardized Consumer Assessment of Health Plans and Systems (CAHPS) survey instrument, available in English or Spanish. The 2015 survey for One Care plans was conducted in the first half of 2015 and included the core Medicare Advantage CAHPS questions, 10 supplemental questions added by the RTI evaluation team, and 9 supplemental questions added by MassHealth. Findings are available at the One Care plan level only; 739 enrollees completed the survey. Only results with more than 10 respondents in each of the three One Care plans are reported.

In 2015, CMS contracted NORC at the University of Chicago and Health Services Advisory Group, Inc. to administer a modified CAHPS survey to adult dually eligible beneficiaries enrolled in the Washington Health Homes Demonstration. This was the first such administration of the FAI CAHPS and, therefore, the results are considered a baseline assessment of enrollees' satisfaction with the demonstration (NORC, 2016). Enrollees who had completed a health assessment and who had been enrolled for at least 5 months were sampled; 827 completed the survey. In 2015 the survey was available in English; in future years it will be available in Spanish as well.

Neither CAHPS results provide race or ethnicity detail; however, they do provide results regarding enrollees who receive LTSS and behavioral health services.

Coordination of care. In Massachusetts, the CAHPS survey indicated that less than half (between 37 and 47 percent) of respondents in each One Care plan reported that anyone from their health plan, doctor's office, or clinic helped them coordinate their care among doctors or other health providers; a range from 33 to 54 percent in each plan reported being usually or always satisfied with the help they received to coordinate their care. Over half of all respondents for each One Care plan (range of 51 to 61 percent) indicated that they usually or always received information that they needed from their plan.

The Washington CAHPS survey questions relating to coordination measured enrollee satisfaction with care coordination by their personal physician and, separately, with coordination of care by other health providers; 86 percent and 83 percent of respondents reported satisfaction in these regards, respectively. Respondents also reported high satisfaction rates with health education and promotion of health care goals (81 and 79 percent, respectively).

Treatment or counseling. Results of the Massachusetts CAHPS survey indicated that the percentage of people who needed any treatment or counseling for a personal or family problem ranged from 30 to 42 percent. Of those who needed treatment or counseling, over 80 percent of respondents in each One Care plan reported that it is usually or always easy to get the treatment or counseling they need through their health plan. The Washington CAHPS survey question addressed overall satisfaction with counseling or treatment; those results indicated that 53 percent of enrollees were satisfied with their counseling or treatment program.

Care in the home. About one-quarter of respondents to the Massachusetts CAHPS survey reported that they needed someone to come into their home to give them home health care or assistance. Enrollees' experiences obtaining these services varied by plan. Of respondents indicating a need for in-home assistance, 68 to 82 percent reported that it was usually or always easy to get the personal care or aide assistance at home through their care plan. The Washington CAHPS question asked about enrollee satisfaction with home health care or assistance: approximately 62 percent of respondents needed these services, of which 66 percent expressed satisfaction, 20 percent were neutral, and about 14 percent were dissatisfied.

Medical equipment. In Massachusetts, approximately one-third of respondents in each One Care plan had a health problem for which they needed special medical equipment, such as a cane, wheelchair, or oxygen equipment. Experiences in this area also varied by plan. Of the respondents needing special equipment, 60 to 78 percent of enrollees reported that it was usually or always easy to get or replace the medical equipment they needed through their health plan. The Washington CAHPS survey did not ask about medical equipment.

Interpreters, accessibility, and cultural competence. Several MassHealth supplemental CAHPS questions asked about the availability of interpreter services. Seven to 10 percent of respondents reported needing an interpreter to help them speak with doctors or other health providers. Responses regarding the availability and ease of access to interpreter services were too few (<10) to report. MassHealth also included several questions related to accessibility issues in the doctor's office that are of particular concern to persons with physical disabilities. Between 65 and 70 percent of respondents enrolled in each plan reported they were usually or always examined on the examination table when they visited their personal doctor's office. Washington enrollees were asked about cultural competence of their providers: 87 percent responded that they were satisfied.

7. Summary

The Washington and Massachusetts demonstrations serve very different populations, both of which have complex needs. The Washington Health Homes MFFS Demonstration targeted enrollees who were utilizing health care services at a higher rate than other beneficiaries eligible for the demonstration. Organized around the principles of patient engagement and support to enable enrollees to take steps to improve their own health, the demonstration serves enrollees of any age. About half are age 65 or older. The Massachusetts demonstration serves individuals aged 21 to 64 at the time of enrollment; 35 percent are under age 45. More than half have an SPMI and 95 percent became eligible for Medicare as a result of their disability. The goal of the One Care demonstration is to increase consumer engagement in care and expand access to enhanced community-based services.

The goal of both demonstrations is to improve enrollee outcomes and cost-effectiveness by improving the coordination of care and the integration of physical and behavioral health services and LTSS. Results from focus groups and CAHPS surveys discussed in this brief provide an early glimpse into the effectiveness of the demonstrations on reaching this goal. In future years, results of utilization and cost data analyses will provide further understanding of the effects of the demonstrations.

Although focus group findings are gleaned from a limited number of enrollees, and thus are less generalizable, their value is in capturing the voice of the enrollee. Those results suggest that demonstration services have helped at least some enrollees achieve a wide range of improvements in their lives, from managing chronic conditions to increasing community

engagement. CAHPS results provide additional insights from a larger enrollee population. Taken together, this information can be used to understand which aspects of the demonstrations appear to be working well from the beneficiary perspective, and to identify areas that may require attention by the States and the Medicare Medicaid plans.

Overall satisfaction. Many focus group participants reported that they had experienced improvement in their health or quality of life as a result of the demonstration services. The achievement of personal health-related goals often had benefits such as decreased use of EDs, reduced medication use, increased physical activity, and weight loss, as reported by focus group participants. In Washington, which promotes goal-setting, changes resulted from participants working with their care coordinators to set goals and take responsibility for their own health. In Massachusetts, participants, many of whom may have had unmet needs prior to enrollment, were more likely to report satisfaction with new or additional services provided by the plans.

Care coordination. Although focus group participants provided numerous examples of ways they received support from their care coordinators, in some instances they appeared unaware of the range of supports available through their care coordinators. Some focus group participants view their care coordinators as helpful with setting goals, developing plans to achieve them, and accessing needed services. A number of participants also noted that care coordinators helped them access health information or resources. Several focus group participants reported that having a contact person to talk to, and help resolve problems, reduced stress and anxiety.

In Washington, some focus group participants had trouble differentiating their care coordinators from service-specific case managers who have more limited responsibilities. Massachusetts participants also noted that it was confusing to sometimes have multiple care coordinators, particularly during the initial assessment; they noted lack of follow-up with services that had been identified during the initial assessment, but not provided. It was not clear whether these coordinators were from different organization or the result of staff turnover. The Washington CAHPS survey respondents reported very high satisfaction with care coordination provided by their providers; they also rated very highly the health promotion and education they received.

Several Massachusetts focus group participants reported that they did not know who to contact when they had issues with delivery or implementation of LTSS; this may be due to confusion about the role of the LTS coordinator. Of further concern is that less than half of CAHPS survey respondents in One Care plans reported receiving care coordination from their plans. Of those who did, enrollees in only one plan said that they were “very satisfied” at a rate higher than 50 percent.

Impact of demonstration services on health, well-being, and quality of life. Many focus group participants with LTSS and behavioral health needs described improvements in their health or quality of life in the past year, including increased physical functioning and reduced social isolation. Focus group participants credited these improvements to the new or enhanced services offered through the demonstrations, such as the service provided by a care coordinator in order to set goals.

Access to and quality of services. All focus group participants reported having a PCP, and they typically also reported seeing specialists in addition to their PCPs. Some in Washington reported difficulties with access to or limited choice of specialists who accept Medicare or Medicaid, a long-standing problem that pre-dates the demonstration. Focus group participants with behavioral health needs, in particular, reported difficulty finding therapists. Those who do receive specialty care reported that their PCP and specialists share information.

Access and satisfaction with behavioral health services. Washington CAHPS survey results did not indicate that enrollees had high satisfaction with their counseling or treatment program; only 53 percent of enrollees were satisfied with this service. Considering that more than half of enrollees in Massachusetts have SPMI, it was surprising that CAHPS results indicated that only 30 to 42 percent of those surveyed said they needed any type of treatment. This may indicate an unmet need. Those who were receiving treatment through One Care Plans were very satisfied with access to this service: 80 percent said it was usually or always easy to get treatment or counseling.

Access to durable medical equipment. Some focus group participants reported improved access to assistive devices, although obtaining wheelchairs was a challenge for others. The Washington CAHPS survey did not ask about medical equipment; however, in Massachusetts, approximately one-third of respondents in each One Care plan had a health problem for which they needed special medical equipment (a cane, wheelchair, or oxygen equipment). The majority (60 to 78 percent) of enrollees reported that it was usually or always easy to get or replace the medical equipment they needed through their health plan.

Importance of patient-centered care and patient engagement. Participants in both demonstrations' focus groups indicated they wanted to be involved in their health care, and emphasized the need to advocate for themselves. Having providers who listened to them, offered choices, and included them in decision-making was valued. However, some indicated that they had difficulty finding providers with whom they felt comfortable; others reported "firing" their physicians.

Impact of the demonstration on ethnic, linguistic, and racial minorities. Satisfaction of health care services, including provider relationships, did not appear to vary along racial or ethnic lines in the focus group discussions. CAHPS results were not reported by the respondents' race or ethnicity, therefore it is not known if satisfaction in those surveys varied by race or ethnic origin. A number of participants who spoke only Spanish noted the importance of having care coordinators and providers who spoke their language. In Massachusetts, the ombudsman reported receiving very few complaints that involved language access issues, such as lack of interpreter services.

Beneficiary rights and protections. Feedback from focus group participants suggests that some beneficiaries are not aware of available resources, such as ombudsmen, to assist them when they disagree with the providers or plans or when they need help with understanding their rights. Additional training and education appears warranted to ensure beneficiary access to complaint

and appeal processes. Linguistic minority enrollees appear to have the most need for greater outreach in this area.

8. Next Steps

The RTI evaluation team will continue to collect information on a quarterly basis from State officials through the online State Data Reporting System (SDRS), covering enrollment statistics and updates on key aspects of implementation. The evaluation team will continue conducting quarterly calls with the demonstration State staff, request the results of any evaluation activities conducted by the State or other entities, and review quality measures the States are required to report to CMS. During the course of the demonstration, additional site visits and beneficiary focus groups will provide further data for analyses and evaluation. As additional administrative, claims, and encounter data are analyzed in successive years, additional utilization results that provide information about service trends over time, comparing the demonstration and comparison groups, will become available.

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