Integrated Care Resource Center

TECHNICAL ASSISTANCE BRIEF

APRIL 2013

Options for Attracting and Retaining Enrollment in Financial Alignment Initiatives for Medicare-Medicaid Enrollees

Developing integrated care initiatives that are attractive to Medicare-Medicaid enrollees is a priority for the Centers for Medicare & Medicaid Services (CMS), states, and other stakeholders. The capitated financial alignment model requires states to use a voluntary enrollment process in which Medicare-Medicaid enrollees may be automatically or "passively" enrolled into an integrated health plan for both their Medicare and Medicaid services if they do not actively select an integrated health plan or delivery system in which to participate. Enrollees, however, have the option to opt out or disenroll from these integrated initiatives. Because participation will be voluntary, integrated care plans must attract and maintain sufficient enrollment to remain viable. Further, the larger goals of integration–streamlining service delivery, eliminating inefficiencies, and improving the quality of life for Medicare-Medicaid enrollees–will not be achieved unless enrollees find the programs beneficial. This brief from the *Integrated Care Resource Center (ICRC)* describes options for attracting and retaining enrollment in capitated models of care integration. At the end of this brief, there is a short discussion of how a number of these options can be also be used in managed fee-for-service financial alignment models.

IN BRIEF: Enrollee participation in new integrated Medicare-Medicaid s financial alignment initiatives will be voluntary. To achieve the quality improvement and financial goals of integration, as well as maintain program viability, these integrated care initiatives must attract and retain sufficient beneficiary enrollment.

This brief provides suggestions for designing and implementing integrated care initiatives that: are of high quality; offer attractive benefits and services; and provide easy-to-understand education, outreach, and marketing information. Retaining enrollees in these initiatives requires concerted efforts to ensure consumer access to benefits and maintain channels of communication with enrollees. While the strategies discussed in this brief are aimed primarily at states using capitated integration models, states using managed fee-for-service models can use many of the same education, outreach, marketing, and beneficiary communication strategies.

Attracting Enrollees to Integrated Care Initiatives

States have a number of tools available to achieve enrollment goals. Some of these tools can be classified as design features that make the integrated care model attractive to beneficiaries. Other tools are better categorized as process features that affect the way that the integrated care initiative makes initial contact with potential enrollees.

The Role of Program Design

Program design features include covered benefits, network design, and service delivery. Descriptions of these features help potential enrollees to compare characteristics among several integrated health plans and between integrated care and their current provider. For an integrated care model to attract enrollees, it must offer benefits or providers not usually available to potential enrollees, and/or it must include service delivery mechanisms to make these benefits or providers more easily accessible than they would otherwise be.

Building and Maintaining a Robust Provider Network

Building and maintaining a robust provider network is vital to the success of an integrated care model. When asked about what is important in a provider network, Medicare-Medicaid enrollees most often say that they want to keep their current providers, so building a provider network that enables them to maintain these relationships is a very important element in program design. Beneficiaries also want providers who are geographically and physically accessible and who are trained to deliver care to individuals with their specific needs.

Developing this kind of provider network can be challenging. Providers – especially physicians and other acute care providers – may be difficult to identify through Medicaid data and they may be reluctant to participate in a new delivery system. Network development requires early stakeholder meetings, particularly with providers serving the Medicare-Medicaid eligible population.

Beneficiaries want to maintain existing relationships with providers and access providers trained to meet their specific needs.

One executive at a Special Needs Plan (SNP) suggested using Medicare data to identify these providers for targeted marketing that presents the case that participation is financially viable. If states and health plans can take steps to reduce the administrative burden on providers by simplifying claims submission and reimbursement requirements, it could increase the appeal of integrated models to providers.

In addition, states can help allay provider fears that managed care will produce savings by cutting provider rates. For example, Tennessee decided to set nursing facility provider rates for the first few years of the state's managed long-term services and supports program (TennCare CHOICES) to assuage fears that rates would change dramatically under managed care.[1] Ensuring an adequate number of providers is imperative; however, states may also want to use the transition to integrated care as an opportunity to ensure that the providers in the new network are of the highest quality. States may not want to obligate plans to include existing Medicaid-contracted providers that have received high numbers of complaints or who have other indications that they are providing a questionable level of quality.

The early enrollment experiences of two California dual eligible SNPs underscore the importance of a robust provider network in retaining beneficiaries. CalOptima's SNP chose to create a smaller network when the SNP was established in 2005-2006, focusing on providers with Medicare managed care experience, but it encountered significant backlash from physicians who actively encouraged patients to disenroll. In contrast, San Mateo County's SNP chose a more inclusive strategy and soon realized that offering a broad, open network was important to beneficiary retention.

Strategies to help maintain the provider network include incentive payments and ongoing stakeholder meetings at both the state and plan level. The CalOptima SNP maintains a pay-for-performance program that provides bonuses to physicians for high quality care. Wisconsin encourages health plan contractors participating in its managed long-term services and supports program, Family Care, to organize committees that include consumer and provider representatives to ensure that health plans address local needs.[2] This strategy may be particularly beneficial for national plans that are less connected with local environments.

Creating an Attractive Benefit Package

An attractive benefit package not only includes benefits that are currently provided through Medicare and Medicaid, but also additional or "supplemental" benefits that are not required through Medicare and not offered through most states' State Plans or home- and community-based services (HCBS) waiver programs. These services are typically financed through savings in costly hospital and nursing facility services that can be achieved by integrated health plans through improved service coordination and more effective use of HCBS. Supplemental benefits can include:

- Dental coverage for preventive care, basic dental services like fillings, and major dental services like root canal treatment;
- Vision care such as routine eye exams and corrective lenses (eyeglasses or contact lenses);
- Hearing evaluations and hearing aids;
- Podiatry and foot care services;
- Durable medical equipment (DME) that may not be covered by either program or that is historically difficult to obtain;
- Chiropractic benefits that cover manipulations and adjustments;
- Health, exercise, and wellness resources to improve overall well-being;
- Specialized geriatric support services;
- Adult day services; and
- 24-hour access to medical and service support.

Tailoring Service Delivery to Enrollee Needs

Integrated care initiatives should also deliver services in a way that meets the broad range of needs of Medicare-Medicaid enrollees. This includes employing well-trained care managers and care coordinators with the skills to support enrollees' needs and keeping the enrollee-to-care team ratio low. Models also should include easy-to-schedule transportation to appointments that meets the needs of enrollees. For example, models could provide in-home to in-office transportation instead of just "curb to curb" transportation for individuals who need this level of assistance. Integrated care initiatives also should use information-sharing systems that enable enrollees to move from one provider to another without being re-tested or having care delayed due to lack of information from a previous provider. Services and supports should be tailored to the heterogeneous Medicare-Medicaid enrollee population. Exhibit 1 lists additional ways in which integrated health plan services could be tailored to meet the needs of Medicare-Medicaid enrollees. This table is intended to highlight some of the specific needs of Medicare-Medicaid enrollee populations. Care should be person-centered, so many of the strategies and benefits included in Exhibit 1 also apply to other populations.

Medicare-Medicaid enrollees are different from Medicare-only or Medicaid-only populations, and health plans should tailor the services they offer to meet the complex needs of these beneficiaries.

Exhibit 1: **Tailoring Services to Meet the Needs of Medicare-Medicaid Enrollees**

Population	Strategies and Benefits
Individuals with physical disabilities[3]	▪ Opportunity to self-direct services; ▪ Individualized budgeting authority; ▪ Facility-to-community transition services such as those provided through Money Follows the Person Demonstrations (e.g., first month's rent, security deposits, basic household necessities, and transition counseling.); ▪ Assistance locating accessible, safe, and affordable housing; ▪ Ability to continue relationships with existing providers; ▪ Access to specialists and primary care providers with offices that are disability-accessible (including exam tables, equipment, and offices); and ▪ Access to providers who have expertise and experience serving people with physical disabilities.
Individuals with communication limitations	▪ Availability of member materials in accessible formats, (e.g., Braille, audio, large font, compact disc, digital, reading-level appropriate, etc.); ▪ Availability of bi-lingual materials and interpreters; ▪ Availability of sign language interpreters to participate in appointments; ▪ Access to assistive listening devices during appointments; and ▪ Providing TTY and Relay telecommunication services for the deaf.
Seniors	▪ Access to their current providers; ▪ Access to providers knowledgeable about geriatrics; ▪ Involvement of and training for family or community caregivers as requested; ▪ Social and community engagement opportunities; and ▪ Strategies and benefits for individuals with disabilities listed above.
Individuals with behavioral health needs	▪ Access to specialist and primary care providers knowledgeable about working with individuals with behavioral health needs; ▪ Access to peer supports and non-traditional providers; and ▪ Access to community integration activities such as clubhouses, social and recreational activities, and supports for independent living.
Individuals with intellectual or developmental disabilities	▪ Access to specialist and primary care providers knowledgeable about working with individuals with intellectual or developmental disabilities; ▪ Access to a choice of community residential settings; ▪ Access to a choice of day-support activities; ▪ Availability of longer appointments if needed; and ▪ Involvement of and training for family caregiver as requested.

States should consider ways to use existing managed LTSS or Medicaid managed care programs as a bridge to enrollment in integrated care initiatives.

Using Mandatory Medicaid Enrollment in Managed Long-Term Services and Supports as a Building Block

States can mandate enrollment of Medicare-Medicaid enrollees in capitated managed care plans for their Medicaid services using managed care waiver authority. Medicaid, however, does not cover a meaningful portion of acute care services for Medicare-Medicaid enrollees, so unless managed care programs cover long-term services and supports (LTSS), there is little reason to mandate managed care enrollment for these beneficiaries. Arizona, Minnesota, New Mexico, Tennessee, and Texas currently include LTSS services under capitation and require that Medicare-Medicaid enrollees participate in capitated managed care for their Medicaid-covered services. This approach can lay the groundwork for greater coordination of Medicare and Medicaid services and can also provide health plans with the enrollment volume they need to support the more extensive care coordination and support services that many of these beneficiaries require.[4] States considering mandatory enrollment for Medicaid services as a default for beneficiaries who opt out of integrated care should note that this option will necessitate a number of additional program components such as member and enrollment materials, Medicaid Management Information System (MMIS) changes, and capitation rates tailored to Medicaid-only services.

Minnesota has successfully navigated these differences and uses mandatory enrollment of Medicare-Medicaid enrollees in its Medicaid services-only Minnesota Senior Care Plus (MSC+) program to encourage enrollment in its voluntary Minnesota Senior Health Options (MSHO) program, which provides integrated Medicare and Medicaid benefits. The state contracts with the same health plans for both programs, so beneficiaries have the option of enrolling either in the mandatory MSC+ program and receiving only their Medicaid benefits through the health plan, or enrolling in MSHO and getting both their Medicare and Medicaid benefits from the same plan. Not surprisingly, Medicare-Medicaid enrollee participation is much larger in MSHO (36,500 enrollees) than in MSC+ (12,500 enrollees as of December 2012).[5]

The Role of Education and Outreach

States and CMS must take steps to ensure that Medicare-Medicaid enrollees eligible for integrated care initiatives are fully informed about program options and services–including the option to participate in other programs, such as PACE, or to not participate in integrated care. Enrollees should also be informed about the beneficiary protections in integrated care initiatives, including continuity-of-care provisions, grievance and appeal rights, and other protections. Providing this type of education for Medicare-Medicaid enrollees can be challenging because they have significantly more complex needs than beneficiaries traditionally enrolled in managed care and are frequently difficult to reach because they often experience housing instability and the state may not have their current phone numbers or addresses. Also, beneficiaries may prefer to have a friend or family member present during outreach activities and this individual may not be available during business hours. Further, Medicare-Medicaid enrollees often need additional counseling time to ensure understanding and comprehension of member materials and the enrollment process.

It is critical that states, CMS, and integrated care initiatives take these population-specific issues into consideration when planning and designing beneficiary education programs. Following are experiences from states with existing managed LTSS or contracted-SNP programs. These states provide education and enrollment counseling to eligible beneficiaries through several different channels.

A number of states contract with Area Agencies on Aging (AAAs) or Aging and Disability Resource Centers (ADRCs) to provide education and enrollment counseling for eligible beneficiaries. When Tennessee implemented the CHOICES managed LTSS program in 2012, for example, state staff worked with Area Agencies on Aging and Disability (AAADs) to identify their new role in the managed LTSS system, and, based on these discussions, the AAADs continue to serve as the point of entry into the Medicaid managed LTSS program.[6] Minnesota also contracts with AAAs to provide beneficiary education and enrollment counseling for the MSHO and MSC+ programs. Other states, such as Arizona, use state outreach staff to provide beneficiary education and enrollment counseling. Arizona Long Term Care System (ALTCS) offices are located throughout the state and serve as the point of entry for eligibility determination, and also provide enrollment counseling to help beneficiaries select the plan that is best for them.

Other states contract with enrollment brokers to help develop educational materials and provide enrollment counseling. Few states have the staff to internally manage the volume of calls and questions that beneficiaries have about the plans. Enrollment brokers are able to "staff-up" to meet the needs of their contract and have the time and resources to continually educate staff on the different plans and programs. Additionally, enrollment brokers may have experience in both the Medicare and Medicaid program, and understand the rules and regulations of both programs.

If a state decides to use an enrollment broker, they can require the broker to subcontract with community-based organizations (e.g., local departments of social services, AAAs, ADRCs, etc.) that have considerable experience in working with local Medicare-Medicaid enrollees and can tailor outreach to specific populations.[7] For example, New York City's Medicaid enrollment broker partnered with over 40 community-based organizations to conduct outreach and education.[8]

Existing managed care programs have found that individuals are more likely to remain with a health plan if they feel they were engaged and involved in the choosing of the plan. For example, when Michigan moved to capitated managed care in the late 1990s, the state's enrollment broker found that by providing expanded information and an opportunity for face-to-face counseling, individuals can participate in plan selection and understand the benefits of enrolling in integrated health plan. This led to a decrease in beneficiaries opting out of Michigan's Medicaid managed care program.[9]

Enrollment brokers have the capacity and experience to educate potential enrollees about integrated care options.

The Role of Marketing

State Medicaid programs and Medicare both have extensive requirements with respect to marketing by health plans. States should plan to use the integrated marketing standards materials for plans participating in financial alignment demonstrations for Medicare-Medicaid enrollees. Enrollee materials must be "accessible and understandable to beneficiaries, including those with disabilities and limited English proficiency," and will be approved in advance by CMS and the state in accordance with a single set of rules.[10] Integrated marketing materials offer states and plans the opportunity to present integrated care as a single set of coordinated benefits for which Medicare-Medicaid enrollees are eligible.

Approaches and materials should take into account the audience's size, geographic location (rural vs. urban), language and cultural diversity, education and socio-economic level. For example, in both Texas and New York, states with significant immigrant populations, outreach materials are designed with particular attention to specific health literacy details such as: (1) translation into languages used by target audiences; (2) use of culturally-appropriate content; and (3) use of text written at a 5th grade reading level.

Health plans need to have processes in place that link beneficiaries to the full range of available benefits.

Retaining Enrollees in Integrated Care Initiatives

Once beneficiaries are enrolled in integrated care initiatives, the programs should employ additional tools to increase the likelihood that beneficiaries will remain enrolled. Both states and health plans can play a role in retention efforts. Consultants that advise Medicare health plans stress that it is much less costly to retain existing enrollees than it is to market to and enroll new members. While this advice is especially pertinent in Medicare managed care, where enrollment is voluntary and most beneficiaries enroll individually rather than through groups, the advice is relevant for any health plans that want members to remain enrolled.

With that in mind, states developing integrated care models can make use of program design strategies and contracting requirements to ensure that programs: (1) include processes to ensure beneficiaries receive needed services during and after program transition (for example, transition requirements, needs assessment, monitoring, and performance measurement); and (2) maintain excellent communication channels with beneficiaries.

Ensuring Consumer Access to Benefits

A model's comprehensive benefits are only evident to consumers and, thus, effective in encouraging retention, if there are processes in place to help beneficiaries receive them. States can employ strategies either on their own or in partnership with health plans or independent contractors to ensure such access.

- **Continuity during transition period.** Strategies to limit service disruptions experienced by beneficiaries as they transition into a new model will lessen disenrollment. Continuity of care requirements are being addressed in the memorandum of understanding (MOU) that each state participating in a capitated financial alignment initiative agrees to with CMS. Many state programs already include such requirements. Tennessee's managed LTSS program, for example, required plans to contract with all currently operating nursing facilities to maintain stability in the system during the program's transition period. In addition, as noted earlier, the state retained responsibility for setting nursing facility reimbursement rates for the first few years, further assuring provider stability.[11]

At the beginning of California's new mandatory Medicaid enrollment program for seniors and persons with disabilities who are not eligible for Medicare, the state required health plans to provide access to beneficiaries' existing providers for at least 12 months after enrollment.[12] As another example, the New Mexico CoLTS program required health plans to honor prior authorizations for the first 90 days of enrollment and extended this time to ensure smooth transitions and care plan development. This requirement extended to providers who were not part of the health plans' networks. The plans reimbursed providers at the contracted rate in place with the state prior to implementation.[13]

Texas STAR+PLUS Program

The Texas Health and Human Services Commission (HHSC) contracts with MAXIMUS for enrollment broker services for its STAR+PLUS Program in 29 counties throughout the state. STAR+PLUS is a Texas Medicaid program designed to integrate service delivery of acute and long-term care services through a managed care model. Individuals are referred to MAXIMUS through a toll-free help line, the HHSC website, various mailings, advocates, and service providers. MAXIMUS brokers go to clients' homes and counsel them on what managed care plan options would best fit their needs. Enrollment brokers do not get an incentive based on the plan the individual chooses. Enrollment brokers are simply available to help individuals navigate through the information, answer questions, and correctly fill out their applications.

- **Timely needs assessment.** Assessment tools help identify beneficiaries' service and care management needs upon enrollment. States can require health plans or contract with independent organizations (for example, enrollment brokers) to conduct timely assessment of beneficiary needs, develop care plans with enrollees and caregivers, and provide ongoing reassessment. Wisconsin's Family Care program requires health plans to contact new enrollees within three days of enrollment, draft an initial care plan within ten days, develop a full plan within 90 days, and provide ongoing in-home visits every 90 days. Tennessee's CHOICES program requires quarterly in-home visits with monthly contacts.[14]

  States may also include program design features that ensure plans have enough time and manpower to conduct initial and ongoing assessments. Given the intensity of initial assessments for new enrollees, many of whom will have extensive care needs, states could phase in enrollment to provide health plans enough time to complete assessments. New Mexico's CoLTS program allowed 120 days for enrollment and required health plans to provide services under existing care plans until new evaluations were completed. To ensure that plans have enough manpower to assess and manage beneficiaries, Arizona's ALTCS program and Hawaii's QExA program require health plans to use specific case manager-to-beneficiary ratios (for example, 1:48 in-home for ALTCS).[15] In addition, states can also contract with an organization that is independent of provider services to help complete initial assessments. Some states have chosen to use such organizations to ensure that the process is more objective. For example, Pennsylvania employed this strategy for their HCBS program.

- **Track disenrollment patterns.** States could require health plans to track and report on disenrollment to determine if it reflects issues with service network adequacy, quality of care, enrollment processes or other problems that the state and the health plans should address. In addition, during open enrollment an independent organization could track changes in enrollment (for example, switching between plans) as well as reasons behind changes to identify problems that can be resolved. The Kaiser Commission on Medicaid and the Uninsured convened a roundtable of stakeholders and experts to discuss the use of measures to monitor eligibility and enrollment performance by states. Potential measures included those for all disenrollments, continuous coverage rate, churn rate, timely administrative approval rates for renewals, and disenrollment for reasons not related to program eligibility, which could be due to dissatisfaction with the plan.[16] Similar measures could be useful for monitoring new integrated care programs.

- **Beneficiary hotline**. States could offer a beneficiary hotline, operated by the Medicaid agency, an enrollment broker, or some other entity independent of the health plan that would allow enrollees a place to seek help or report problems. In California, San Mateo County set up a specialized member services unit for people enrolled in SNPs.

- **Track beneficiary satisfaction.** States could require health plans to report on performance measures that track user experiences. In Pennsylvania's HealthChoices program, an enrollment broker conducted quality checks every three months to ask consumers if they were satisfied with components of the new program. An enrollment broker could be well-positioned to conduct beneficiary satisfaction surveys after enrollment in an integrated program as they can leverage existing infrastructure (such as call centers). The Kaiser Commission roundtable provided potential measures for user experience that could be useful for tracking satisfaction in new integrated programs–availability of customer support, timeliness of customer support, customer satisfaction, and customer appeals.[17]

Outreach and communication from members of the integrated care plan and care management team help to reduce isolation and encourage positive relationships with enrollees.

Integrated care models based on primary care case management, accountable care organizations, or other structures should also apply these design guidelines for attracting and retaining enrollees.

Maintaining Channels of Communication

Maintaining frequent and positive communications with beneficiaries is extremely important. Medicare-Medicaid enrollees are often at risk for social isolation, and outreach and communication from members of the integrated health plan and care management team may be especially appreciated and provide an opportunity for the health plan to cull important information. Following are examples of what health plans can do to encourage retention through communication and outreach:

- Use welcome calls, mailings, and initial needs assessments to create a relationship with new enrollees;
- Make sure each enrollee has an individual whom they can call for help with care coordination or other problems;
- Require care coordinators to contact enrollees assigned to them on a regular basis to check on how they are doing and see what help they may need;
- Provide a hotline that enrollees can call with requests and problems, and make sure that follow-up is prompt and responsive;
- Make home visits as needed to enrollees with mobility or other problems accessing care outside the home;
- Use technology (cell phones, iPads, laptops, portable printers) to help staff who have direct contact with enrollees through home visits or otherwise to operate with maximum efficiency and responsiveness to beneficiary needs; and
- Devote extra resources to assist with transitions from hospital or nursing facility care to home care (telephone calls, medication reconciliation, in-home visits).

In addition, many Medicaid health plans have included beneficiaries on plan grievance and appeals committees and plan governance committees. This can underscore and facilitate plan responsiveness to beneficiary needs and concerns, further encouraging enrollment and retention.

Potential Applicability to Managed Fee-for-Service Models

The majority of enrollment and retention strategies included in this technical assistance brief are tailored to states developing integrated care initiatives using health plans or other capitated entities; however, many of the strategies and tools discussed above are also relevant for states no matter what type of entity will be accountable for a beneficiary's care. States building integrated care models upon existing primary care case management systems, accountable care organizations, or other structure still want to ensure that beneficiaries understand program features and options, are provided continuity of services during enrollment and transition, and have clear communication channels for asking questions, making requests, and presenting concerns.

States using managed fee-for-service and alternative models will also want to ensure that their programs offer a benefit package that includes benefits beyond what are typically offered in Medicare and Medicaid (e.g., vision and oral health care) and includes an adequate number of providers with the experience and clinic facilities to meet the heterogeneous needs of Medicare-Medicaid enrollees. These models will also want to track disenrollment patterns and conduct beneficiary satisfaction surveys to be certain that these programs are providing the care and supports envisioned.

Conclusions

Encouraging beneficiaries to enroll and stay enrolled in an integrated model requires that the programs be of high quality; offer attractive benefits and services; and provide easy to understand education, outreach, and marketing information. Resources and systems for person-centered service planning, a key component of integrated care, should be developed as early as possible and discussed with potential enrollees so they are aware of this added benefit of integrated health plans. The

outreach and education processes should be designed with the primary purpose of making certain that beneficiaries have the information that they need in a format that is most accessible to them in order to make an informed choice about services programs that are designed with the beneficiaries' needs at the forefront and clearly communicate program benefits should achieve success in attracting and retaining enrollees.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicaid's high-need, high-cost beneficiaries. The state technical assistance activities provided within the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit **www.integratedcareresourcecenter.com.**

ENDNOTES

[1] A. Lind, S. Gore, L. Barnette, and S. Somers. *Profiles of State Innovation: Roadmap for Managing Long-term Supports and* Services. Center for Health Care Strategies, November 2010. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261187.
[2] Lind et al. op.cit.
[3] Based on information provided by Anne Cohen, MPH with Disability Health Access. http://www.disabilityhealthaccess.com/.
[4] For details on these Medicaid managed long-term care programs, see D. Lipson, J. Libersky, R. Machta, L. Flowers, and W. Fox-Grage. *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports.* Washington, DC: AARP Public Policy Institute, July 2012. See also P. Saucier, J. Kastern, B. Burwell, and L. Gold. *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update.* Prepared for the Centers for Medicare and Medicaid Services, July 2012. Available at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.
[5] Pamela Parker. "Minnesota's Alternative Dual Eligible Demonstration." Presented at Center for Health Care Strategies webinar on "Innovations in Medicare-Medicaid Integration: Updates from Three State Pioneers," January 25, 2013.
[6] Lind et al. op.cit.
[7] Baragar, Lisa, D. MAXIMUS: Michigan's Medicaid Enrollment Broker. September 1997. Available at http://www.pscinc.com/Portals/0/Publications/PSR/HPB/1997/0997.html.
[8] MAXIMUS. "Forming Local Public-Private Partnerships to Serve Our Clients Better." http://www.maximus.com/our-company/partnerships.
[9] Baragar, op.cit.
[10] M. Bella and J. Blum. *Guidance to Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans.* Centers for Medicare & Medicaid Services, January 25, 2012, Available at https://www.cms.gov/medicare-medicaid-coordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.
[11] Lind et al. op.cit.
[12] G. Burke and K. Prindiville. *Medicare and Medicaid Alignment: Challenges and Opportunities for Serving Dual Eligibles.* National Senior Citizens Law Center. August 2011. Available at: http://www.nsclc.org/wp-content/uploads/2011/08/Duals-Alignment-Issue-Brief.pdf.
[13] Based on communications with the state on March 15, 2012.
[14] Lind et al. op.cit.
[15] Lind et al. op.cit.
[16] J. Hudman, C. Trenholm, and S. Artiga. *Performance Measurement Under Health Reform: Proposed Measures for Eligibility and Enrollment Systems and Key Issues and Trade-Offs to Consider.* Kaiser Commission on Medicaid and the Uninsured, Publication # 8264. December 2011.
[17] Hudman et. al. op. cit.