CHCS Center for
Health Care Strategies, Inc.

State Insights on Refining Integrated Care for Dually Eligible Beneficiaries

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IN BRIEF

States are using different integrated care models — including Financial Alignment Initiative demonstrations and Medicare Advantage Dual Eligible Special Needs Plans — to improve care for those dually eligible for Medicare and Medicaid. As leading states gain experience operating integrated Medicare-Medicaid programs, they are refining and expanding their efforts. This brief, made possible by The Commonwealth Fund and The SCAN Foundation, highlights insights from states that are fine-tuning their integrated care programs. Formal evaluations of some integrated care programs are underway; however, until these results become available, the refinements made by states participating in the *Implementing New Systems of Integration for Dually Eligible Enrollees (INSIDE)* project can help others design their own integrated care programs to meet the needs of their dually eligible populations.

S tate Medicaid agencies have made considerable progress in implementing integrated Medicare-Medicaid programs to address the diverse needs of dually eligible individuals and better coordinate their care. States committed to getting these complicated programs right have had to thoughtfully assess what is and is not working, and make ongoing program adjustments based on their findings. Formal evaluations of some states' integrated care programs are underway.[1] In the meantime, states are using early findings to actively work with the federal government, health plans, and other stakeholders to continuously refine their programs.

Through The Commonwealth Fund and The SCAN Foundation-supported *Implementing New Systems of Integrated Care for Dually Eligible Enrollees* (*INSIDE)* project,[2] the Center for Health Care Strategies facilitates learning across 14 leading-edge states working to advance their Medicare-Medicaid integration models. To guide other states in building effective integrated approaches, this brief highlights key priorities for program improvement identified and implemented by *INSIDE* states:

(1) Modifying care management models and requirements;
(2) Improving beneficiary understanding of coordinated care;
(3) Developing strategies to increase enrollment;
(4) Enhancing administrative alignment between Medicare and Medicaid program rules; and
(5) Supporting health plan sustainability.

State Integrated Program Model Options

States are using two primary models to improve care for dually eligible beneficiaries.[3] Under the Centers for Medicare & Medicaid Services' (CMS) Financial Alignment Initiative, states are testing capitated or managed fee-for-service models of payment and service delivery.[4,5] States are also using Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) as the platform for integration by pairing them with Medicaid managed long-term services and supports (MLTSS) programs.

INSIDE states use both of these integrated care models—and sometimes employ both within one state (see Exhibit 1). Eight *INSIDE* states (California, Massachusetts, New York,[6] Ohio, Rhode Island, South Carolina, Texas, and Virginia) have capitated model financial alignment demonstrations, and one,

Washington, has a managed-fee-for-service model demonstration. Minnesota has an alternative model administrative alignment demonstration based on its Minnesota Senior Care Options program, which has a D-SNP/MLTSS platform. Three *INSIDE* states (Arizona, Florida, and New Jersey) use integrated care models based on D-SNPs and their MLTSS programs. Notably, Massachusetts has both a demonstration for dually eligible beneficiaries under age 65 and a D-SNP/MLTSS program–Senior Care Options–for dually eligible individuals ages 65 and over. New York also has D-SNPs aligned with an MLTSS program— Medicaid Advantage Plus. California has D-SNPs, but they are not required to align with the state's MLTSS program; however, some California D-SNPs are Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), which means that they must provide comprehensive LTSS benefits. Idaho's sole D-SNP contractor is a FIDE SNP, and FIDE SNPs also operate in Arizona, Massachusetts, New Jersey, and New York.[7]

Exhibit 1. INSIDE States' Integrated Care Models

| State | Financial Alignment Demonstration | | Alternative Alignment Demonstration | FIDE SNP or Aligned D-SNP/ MLTSS Program |
	Capitated Model	Managed Fee-for-Service Model		
Arizona				✔
California	✔			✔
Florida				✔
Idaho				✔
Massachusetts	✔			✔
Minnesota			✔	✔
New Jersey				✔
New York	✔			✔
Ohio	✔			
Rhode Island	✔			
South Carolina	✔			
Texas	✔			
Virginia	✔			
Washington		✔		

Priorities for Improving Integrated Programs

As identified by the *INSIDE* states, following are key opportunities for refining integrated approaches to care with a focus on sustaining programs, improving care for beneficiaries, and working more effectively with other program stakeholders.

1. Modifying Care Management Models and Requirements

As integrated programs mature, states are learning more about the diverse needs of their dually eligible populations, which include adults over age 65 as well as individuals under age 65 who often have combinations of behavioral health needs or physical or developmental disabilities. Nearly half of dually eligible beneficiaries have long-term services and supports (LTSS) needs, many have low health literacy, and all have low incomes.[8]

All of the *INSIDE* states require integrated D-SNPs and Medicare-Medicaid Plans (MMPs) operating under the capitated model financial alignment demonstrations to use person-centered care management models to provide covered benefits. Some *INSIDE* states initially had prescriptive requirements related to

the composition of the interdisciplinary care teams (ICTs) that manage enrollees' care, the frequency and location of ICT meetings, and the approval of enrollees' care plans.[9] However, states learned to balance those requirements with greater flexibility for health plans to develop innovative, person-centered strategies and reduce provider burden. For example, in New York's financial alignment demonstration, *Fully Integrated Duals Advantage (FIDA)*, primary care physicians were required to attend in-person ICT meetings. However, this was burdensome to some providers and challenging to implement, as evidenced by very low provider participation rates. New York subsequently revised its ICT policies to allow primary care physicians to send designees to meetings and join by phone. The New York State Department of Health also worked with stakeholders to identify areas where ICT flexibility was needed for participants, plans, and other providers.[10] Similarly, Idaho initially required registered nurses to approve all interdisciplinary care plans developed by the state's FIDE SNP. The health plan had difficulty meeting these requirements, so the state revised the requirement to allow providers to submit the care plan through an online portal for approval if a nurse's signature could not be obtained. The refinements made by New York and Idaho may help to encourage active participation by beneficiaries and providers in care planning and management.

2. Improving Beneficiary Understanding of Coordinated Care

As *INSIDE* states gain experience with their integrated programs, they increasingly recognize the importance of beneficiary engagement both before and after program implementation and seek to improve their approaches to beneficiary communication. For example, over the years Arizona refined the way it communicates with beneficiaries. It now sends letters to them that explain the benefits of enrollment in aligned D-SNP/MLTSS plans, and it lifted some restrictions on plans to allow them to market their products to beneficiaries through billboards, radio and television ads, and signage on buses.

States have also found that targeted outreach to cultural and linguistic subgroups improves beneficiary understanding of integrated programs and promotes program enrollment. New York, California, and Virginia learned more about reaching the different cultural/linguistic groups eligible for or enrolled in financial alignment demonstrations in their states and developed targeted outreach campaigns in several languages. They are also working with key provider liaisons within these communities. New York refined its marketing approaches to target advertisements in regions where more language-specific communication was needed to improve beneficiary understanding of the *FIDA* demonstration. California found that providers serving large numbers of individuals in particular cultural/linguistic subgroups can significantly influence beneficiaries' decisions about joining its demonstration, *Cal MediConnect*. The state fostered connections with provider champions who can convey the value of integrated programs to beneficiaries. Virginia also recognized that identifying a community champion facilitated efforts to connect beneficiaries with counselors to answer questions about its demonstration, *Commonwealth Coordinated Care*.

INSIDE states also have improved processes for gathering information about key beneficiary questions and concerns. South Carolina found value not just in identifying beneficiaries' concerns about its

> **Making Program Changes Based on Beneficiary Feedback**
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> Massachusetts developed the Early Indicator Project (EIP) soon after the launch of *One Care*, its financial alignment demonstration, to assess beneficiary experience via focus groups and telephone and mail surveys.[11] The survey findings highlighted the need to improve communication with enrollees to increase understanding and empower them in the person-centered care planning process. Massachusetts worked with its EIP workgroup, a subset of the state's stakeholder advisory body called the Implementation Council, to publish survey findings, develop a communication strategy around the findings, and agree on a set of actionable recommendations to improve the program. The state published survey findings and recommendations in two publicly available reports that included recommendations to: (1) focus on certain populations of *One Care* enrollees; (2) emphasize educating enrollees beneficiaries about the role and benefits of working with a LTSS coordinator; (3) ensure sufficient numbers of and training for LTSS coordinators; (4) improve assessment and care planning related to enrollees' needs for substance abuse services; and (5) address the dental needs of enrollees.[12] The state has since worked with the Implementation Council and MMPs to address gaps identified in the EIP findings.

demonstration *Healthy Connections Prime*, but also in refining communications over time based on questions received. The state contracts with SC Thrive, a non-profit organization that fields questions about *Healthy Connections Prime* via its call center or in-person encounters. Through this partnership, the state has obtained candid, valuable feedback regarding the beneficiary and caregiver experience. The state has since used the feedback received to better tailor outreach and communications about the program. Similarly, Texas worked with plans and its enrollment broker to collect common beneficiary questions about its *Texas Dual Eligible Integrated Care Demonstration Project* and refine enrollment broker scripts to alleviate frequent sources of confusion. The state found that many questions relate to beneficiaries' ability to: (1) keep their primary care physicians; and (2) connect with the health plan. The state is continuing to refine scripts for the demonstration call center to help beneficiaries better understand the program.

California reviewed independent data gathered by university and foundation partners that examined early beneficiary experience in the *Cal MediConnect* program.[13] The results showed that beneficiaries had a variety of reasons for opting out of the demonstration including: concerns about losing provider choices; fear of having to change doctors; and lack of understanding of the program. The results drove improvements in beneficiary education and outreach, including clearer beneficiary education materials that specifically addressed beneficiary questions and clarified continuity of care periods.

3. Developing Strategies to Increase Enrollment

INSIDE states have sought new strategies to increase enrollment in financial alignment demonstrations and aligned D-SNPs and MLTSS plans. Although states can mandate that individuals enroll in a health plan for Medicaid MLTSS, enrollment in any type of Medicare managed care product, including D-SNPs and MMPs, is voluntary. States can work within this requirement, however, to encourage enrollment. To create a pathway for beneficiary enrollment into aligned plans, Arizona restricts D-SNPs that also operate a Medicaid product to directly market only to individuals enrolled in the health plans' own Medicaid product. The state reports that plans honor this agreement and that aligned enrollment is increasing. Arizona has also encouraged aligned enrollment by helping its D-SNPs obtain approval from CMS to seamlessly enroll newly Medicare-eligible individuals who are currently enrolled in a health plan's Medicaid product into its companion D-SNP.[14] This includes individuals aging into Medicare, as well as those qualifying for Medicare upon the completion of the 24-month waiting period due to a disability. Individuals enrolled in D-SNPs in this way can also opt to choose a different D-SNP, Medicare Advantage plan, or move to Original Medicare. Arizona also periodically reassigns beneficiaries' Medicaid acute care plan to align with their D-SNP, thus encouraging coordination of care. These reassignments have significantly increased aligned enrollment.

States with financial alignment demonstrations have worked with CMS to passively enroll beneficiaries— who can then choose to opt out before their effective date of enrollment or to disenroll after that. As initial waves of passive enrollment ended, states faced higher-than-expected opt-out and disenrollment rates. Several *INSIDE* states have analyzed beneficiary opt-out data to understand trends in or correlations with disenrollment, then worked with health plans, enrollment brokers, and external evaluators to better target outreach strategies going forward. Virginia developed a logistic regression model that analyzes the factors associated with nursing facility residents opting out of its *Commonwealth Coordinated Care* demonstration. It found that some nursing facilities had significantly higher opt-out rates among their residents than did others. Virginia officials used this analysis to target outreach activities to administrators in facilities with the highest opt-out rates, and sent a memo to providers to educate them on the demonstration's benefits to dissuade them from encouraging beneficiary disenrollment. After implementing this multi-faceted outreach strategy, the number of opt-outs from nursing facilities decreased significantly.

California also used data to analyze opt-out patterns in *Cal MediConnect* and found that in certain regions of the state a large number of beneficiaries who opted out were patients of a few specific provider groups. The state then developed a targeted, tiered provider outreach approach with increasingly intensive

engagement activities, ranging from mailed letters to in-person visits, depending on the number of beneficiary opt-outs associated with a provider or provider group. In addition, dedicated outreach staff worked with health plans to identify providers who contracted with those plans for other Medicare and Medicaid lines of business to encourage their support of the *Cal MediConnect* plan.

4. Enhancing Administrative Alignment in D-SNP Based Programs

There are several misalignments in the program administration requirements for Medicare and Medicaid. For example, each program has different policies related to health plan marketing, standards for assessing provider network adequacy, and rules governing beneficiary appeals processes. These misalignments are challenging for states trying to design integrated care programs; however, several *INSIDE* states have made significant strides in addressing these issues in their D-SNP/MLTSS programs.

Minnesota's long-standing D-SNP/MLTSS program, *Minnesota Senior Health Options (MSHO),* provides integrated care to nearly 40,000 dually eligible beneficiaries age 65 and older. While the state chose not to pursue a financial alignment demonstration, it is implementing an alternative model demonstration to address administrative misalignments and refine MSHO processes. Notably, the demonstration is testing new network adequacy standards tailored to the specific needs and locations of the state's dually eligible population. The state is now able to concurrently review a D-SNP's network with CMS and provide CMS with input if deficiencies in the network are found.

Another administrative alignment issue addressed by Minnesota's demonstration is the overlap in Medicare and Medicaid quality reporting and performance improvement requirements. The state hopes that refinements in this area will further reduce administrative burdens and control costs for the state, CMS, and health plans. For example, both Medicare and Minnesota's Medicaid agency required health plans to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which asks health plan enrollees about their experiences with health care. Since the surveys were sent at different times and by different vendors, there were concerns that an enrollee would get two surveys, causing confusion and possibly lowering response rates. Minnesota added care coordination questions to the Medicaid CAHPS survey and wanted to ensure that it still received responses for those questions. Under the demonstration, CMS approved the addition of the Medicaid care coordination questions for the Medicare survey for all MSHO plans. A single survey was then sent, and CMS shared the data with the state. In addition, Minnesota's demonstration now allows D-SNPs to use the quality improvement projects that are required by Medicare to meet the state's Medicaid requirements for plans to complete performance improvement projects—thus reducing administrative burden on plans.

5. Supporting Health Plan Sustainability

In most states' financial alignment demonstrations, Medicare and Medicaid payment rates for MMPs were initially based on separate historic claims data. However, some states discovered that their initial rate-setting methodologies did not accurately reflect costs of serving the dually eligible population. One key reason for this was the identification of significant unmet needs among enrollees through rigorous assessment and care management requirements in the integrated care programs. In addition, the baseline Medicaid fee-for-service data used to set those rates may not have included information about services delivered by other state agencies outside of Medicaid, such as Mental Health, Aging, Disabilities, and Public Health. Also, MMPs often had to make considerable investments in staff, care management tools, and information technology and organizational infrastructure before they could begin enrollment.[15] Demonstrations that were projected to have upfront or early savings often did not account for those investments or factored a savings target into their rates for the first year based on the assumption that better coordination would lower costs more quickly than was reasonable. Several states new to operating integrated care programs found that their savings assumptions were too high and that rates for the Medicaid component of their financial alignment demonstrations did not adequately reflect enrollees' needs.

Some *INSIDE* states renegotiated demonstration payment rates with CMS and their MMPs, including lowering savings percentage targets early in a demonstration program. For example, MMPs participating in *One Care*, Massachusetts' financial alignment demonstration, reported significant losses during the first 18 months. Several factors contributed, including high startup costs, high levels of unmet needs of new enrollees, difficulties in locating enrollees, and inaccuracies in the initial rating categories assigned.[19] Massachusetts worked with CMS to make adjustments to its rate methodologies to address some of these issues. It agreed to make transitional adjustments in 2014 and again in early 2015, such as decreasing savings percentage targets, extending and increasing risk corridors, and retroactively adjusting rating categories.[20] In September 2015, the state made additional adjustments to better reflect the costs of covering adults with disabilities, who comprise the majority of *One Care* enrollment. At the end of 2016, the state plans to reevaluate its base payment rate across several categories including: administrative spending; expanded community support services; dental services; additional behavioral health services; and complex care management.[21] State officials from Massachusetts reported a number of lessons from this experience, including the need to: (1) ensure that certain administrative and care management supports are included in rates; and (2) maintain close stakeholder involvement, particularly with representatives from organizations that advocate for people with disabilities, to sustain program support while working through financial negotiations. Although one of the state's three MMPs ultimately decided to withdraw, the other plans have experienced financial improvement and enrollment growth during the last year, with both plans continuing waves of passive enrollment in 2017.[22]

> **Changes to Medicare Rates Impact Integrated Programs**
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> CMS recently made adjustments to the Medicare payment rates for dually eligible beneficiaries enrolled in managed care plans. In an October 28, 2015 memo, CMS stated that the Hierarchical Condition Category (HCC) model, which is the basis for risk adjustment in Medicare Advantage, under-predicts costs for full benefit dual eligible enrollees.[16] As a result, CMS announced that Medicare Part A and B payments to MMPs would be adjusted in 2016 to better align payments with fee-for-service costs.[17] In addition, in the 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, CMS announced changes to the HCC risk adjustment model that improve payment accuracy for dually eligible individuals enrolled in Medicare Advantage.[18] To more accurately predict costs for dually eligible enrollees, particularly for individuals residing in the community, the new methodology creates six risk groups for individuals who reside in the community (non-dual aged, non-dual disabled, full benefit dual aged, full benefit dual disabled, partial-benefit dual aged, and partial-benefit dual disabled).

New York recalibrated its rates for *FIDA* to achieve parity with rates for the state's *Managed Long Term Care (MLTC)* program. *FIDA* rates had originally been calculated using slightly different assumptions compared to *MLTC*. For example, *FIDA* rates: (1) were built on a more aggressive managed care efficiency adjustment assumption; (2) were scheduled to have more frequent adjustments (i.e., quarterly as opposed to *MLTC* rates updated annually on state fiscal year basis); (3) did not include quality pool dollars that are part of *MLTC* rates; (4) were developed independently of *MLTC*; and (5) were not risk-adjusted for the first three months of the demonstration. These differences resulted in lower payment rates for *FIDA* MMPs compared to *MLTC* plans and raised concerns among participating MMPs that they might not be able to adequately cover required services and that the *FIDA* rates were lower than rates absent the demonstration, giving plans a financial incentive to enroll individuals in their *MLTC* plan rather than their *FIDA* plan. CMS and the state worked together to retroactively adjust the Medicaid component of the rate to achieve parity with the *MLTC* plan payment rate.

States not participating in the Financial Alignment Initiative can use their D-SNP contracting processes to gain access to Medicare financial and encounter data to refine Medicaid rate setting and identify areas of unmet need that can impact plan sustainability. It is possible for states to include provisions in their D-SNP contracts that require plans to share Medicare Advantage bid information with state, which can help determine if and where Medicare savings might be achieved, as well as identify gaps in coverage that Medicaid can fill. This can particularly support state Medicaid rate-setting efforts when the D-SNP is responsible for provision of Medicaid covered benefits and payment of cost sharing.[23] Some states have

begun to require submission of Medicare Advantage encounter data to identify potential savings and gaps in care. Arizona's D-SNPs, which also serve as MLTSS plans, are required to submit encounter and financial data on a quarterly basis. In return, the state sends the plans "blind spot" data for individuals who are enrolled with the plan for Medicaid services but not Medicare (thus creating a "blind spot" in the plan's data on them). For example, if an individual is enrolled in a plan for Medicaid MLTSS but not Medicare, the state will send the plan information about original or D-SNP Medicare service use (when the claim has no Medicaid liability). While Arizona encourages dually eligible beneficiaries to enroll in the same health plan for Medicare and Medicaid LTSS, not all of them do so. Thus, providing blind spot data allows plans access to beneficiaries' full clinical profile, which is important for managing risk and ensuring that needs are addressed and services are coordinated.

Conclusion

Integrated care programs that serve dually eligible beneficiaries are important vehicles for coordinating and delivering services across the otherwise separate Medicare and Medicaid delivery systems. States participating in the *INSIDE* project provide integrated care through a variety of models, and as they gain experience, they continue to refine their programs. Formal evaluations will help catalyze additional program improvements;[24] however, until these results become available, the adjustments made by *INSIDE* states can help others design their own integrated care programs to meet the needs of their dually eligible populations.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

[1] The Centers for Medicare & Medicaid Services (CMS) released initial evaluation findings for Washington State's managed fee-for-service model financial alignment demonstration and Massachusetts' capitated model financial alignment demonstration. Initial evaluations for other states' financial alignment demonstrations will follow later this year and will be available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) recently released a study of the Minnesota Senior Health Options program, an integrated care program based on Dual Eligible Special Needs Plans, which is available at: https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis.

[2] The *INSIDE* project is supported by The Commonwealth Fund and The SCAN Foundation. For more information see: http://www.chcs.org/project/implementing-new-systems-of-integration-for-dual-eligibles-inside/.

[3] Other integrated care models for dually eligible beneficiaries include the Program of All-Inclusive Care for the Elderly (PACE) and Medicaid Accountable Care Organizations (ACOs). PACE programs are provider led, so states have relatively little ability to refine or improve their operations. Medicaid ACOs to serve dually eligible populations are in their very early stages, and no lessons from their operation are available at this time. N. Archibald and A. Kruse. "Snapshot of Integrated Care Models to Serve Dually Eligible Beneficiaries." Center for Health Care Strategies, December 2015. Available at: http://www.chcs.org/resource/snapshot-integrated-care-models-serve-dually-eligible-beneficiaries/.

[4] Medicare-Medicaid Coordination Office. "Financial Alignment Initiative." Accessed October 16, 2016. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-CoordinationOffice/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

[5] Minnesota is also testing new strategies for Medicare-Medicaid administrative alignment in a demonstration outside of the Financial Alignment Initiative.

[6] New York has two capitated model financial alignment demonstrations--one focused on individuals with intellectual and developmental disabilities and another for other dually eligible beneficiaries.

[7] FIDE SNPs also operate Illinois and Wisconsin, but these states do not participate in *INSIDE*.

[8] Massachusetts' CommonHealth program allows *One Care* plans to enroll individuals with disabilities ages 21 to 64 with higher incomes who work 40 or more hours/month if they meet program requirements; however, these individuals may pay a monthly premium to maintain their MassHealth eligibility.

[9] A. Philip and M. Soper. "Interdisciplinary Care Teams for Medicare-Medicaid Enrollees: Considerations for States." Center for Health Care Strategies, January 2016. Available at: http://www.chcs.org/resource/interdisciplinary-care-teams-for-medicare-medicaid-enrollees-considerations-for-states/.

[10] New York State Department of Health. FIDA: New Flexibility Offered. December 9, 2015. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/fida/docs/2015-12-09_fida_reform_summary.pdf.

[11] Four EIP focus groups, conducted between December 2013 and April 2014, elicited information about beneficiaries' awareness and understanding of *One Care*, reaction to program materials, and the reasons for their enrollment decisions. The focus groups included individuals who enrolled voluntarily, were passively enrolled, or who opted out of the program. Two surveys were conducted. The first, fielded between December 2013 and January 2014, examined perceptions and experiences of beneficiaries who voluntarily enrolled in the program, who opted out, or who had not taken an enrollment action. The second, conducted between June 2014 and January 2015, focused on *One Care* enrollees (both voluntarily and passively enrolled) 120 days after enrollment, and examined enrollees' perceptions and experiences of the enrollment process, the assessment and care planning process, access to and satisfaction with services, and overall satisfaction with the program.

[12] Highlights from survey findings presented by MassHealth representatives during an INSIDE project call on June 25, 2015. For detailed survey findings see: http://www.mass.gov/eohhs/consumer/insurance/one-care/one-care-early-indicators-project-eip-reports.html.

[13] More information on the independent assessment of beneficiary experience in the *Cal MediConnect* program can be found on The SCAN Foundation's website. See: http://www.thescanfoundation.org/evaluating-medicare-medicaidintegration.

[14] As of October 21, 2016, CMS has placed a moratorium on approval of new plan request for seamless conversion. See: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/HPMS_Memo_Seamless_Moratorium.pdf.

[15] J. Verdier. "Financial Challenges in New Integrated Care Programs: Deconstructing Rate Setting Issues in Search of Solutions." Presentation, October 22, 2015. Available at: https://www.mathematica-mpr.com/our-publications-and-findings/publications/financial-challenges-in-new-integrated-care-programs-deconstructing-ratesetting-issues-in-search.

[16] Centers for Medicare & Medicaid Services. "Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017." October 25, 2015. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/HCCRiskAdjustmentModel102815.pdf.

[17] Centers for Medicare & Medicaid Services. "Medicare A/B Payment to Medicare-Medicaid Plans Participating in the Financial Alignment Initiative for Contract Year 2016." November 12, 2015. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/PartABPaymenttoMMPs111215.pdf.

[18] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf

[19] E. Walsh. Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare First Annual Report. RTI International, September 2016. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASSFirstAnnualEvalReport.pdf.

[20] For more information on Massachusetts' One Care contract amendments and summaries of changes see: http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/one-care-three-way-contract-and-mou.html

[21] C. Altman Moore. "Massachusetts' Experience with the Financial Alignment Demonstration Methodology and Key Lessons." Presentation, October 22, 2015.

[22] Massachusetts Executive Office of Health and Human Services. "One Care: MassHealth plus Medicare Demonstration to Integrate Care for Dual Eligibles." Open Meeting May 24, 2016. Available at: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/2016/160524-masshealth-presentation.pdf.

[23] J. Verdier, A. Kruse, R. Lester, A. Philip, D. Chelminsky. State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options. Integrated Care Resource Center, February 2015. Available at: http://www.chcs.org/media/ICRC-Issues-and-Options-in-Contracting-with-D-SNPs-FINAL.pdf.

[24] Formal evaluation reports on financial alignment demonstrations are expected to be released in the next year.