

# Innovations in Integration: State Approaches to Improving Care for Medicare-Medicaid Enrollees

By Michelle Herman and Brianna Ensslin, Center for Health Care Strategies, Inc.

FEBRUARY 2013

The passage of the Affordable Care Act (ACA) in 2010 created the Medicare-Medicaid Coordination Office (MMCO)<sup>1</sup> in the Centers for Medicare & Medicaid Services (CMS), establishing unparalleled potential to improve care for individuals who are dually eligible for Medicare and Medicaid. MMCO has since released two opportunities, the *State Demonstrations to Integrate Care for Dual Eligible Individuals* and the *Financial Alignment Demonstration*, for states and the federal government to work together to improve coordination and alignment of care for Medicare-Medicaid enrollees. These demonstrations provide states with new vehicles to test innovative financing and delivery models that better integrate Medicare and Medicaid services, improve care delivery and beneficiary experience, and reduce unnecessary spending for this population.

Through support from The SCAN Foundation and The Commonwealth Fund, the Center for Health Care Strategies (CHCS) is providing targeted technical assistance to many of the states that received an award through the *State Demonstrations to Integrate Care for Dual Eligible Individuals*.<sup>2</sup> During the design phase of their demonstrations, states have changed operational and programmatic elements of their original proposals to respond to federal guidance, meet Medicare standards, or address operational issues that arose in designing these complex programs. Many states have decided to pursue a financial alignment model; some of those states have expanded or revised the scope of their original demonstration proposals, while others have reduced their scope or delayed implementation. A few states determined that the financial alignment model was not a viable option for their state and decided to explore alternative approaches to improve integration of Medicare and Medicaid.

This brief provides a snapshot of participating states' plans for financial alignment and examines some of the states' innovative design approaches. Sharing this information can help other states in developing similar programs for this high-need, high-cost population. Providing insight into the states' experiences may also help stakeholders understand the intricacies and effort involved in building these

## IN BRIEF

Through opportunities created by the Affordable Care Act, states are testing new models of care for Medicare-Medicaid enrollees that may better integrate Medicare and Medicaid services, improve care delivery and beneficiary experience, and reduce inappropriate spending for this population.

This policy brief summarizes select states' plans for financial alignment initiatives and examines some of the innovative design approaches that have been proposed. This information and a discussion of common issues states face in creating integrated programs may be valuable to other states considering similar programs for this high-need, high-cost population.

programs, and how they can support states' efforts to advance what works in improving Medicare-Medicaid integration and alignment.

## Overview of Medicare-Medicaid Alignment Opportunities

There are more than nine million individuals in the United States who are dually eligible for both Medicare and Medicaid. They are a high-need, high-cost population and account for a disproportionate share of spending in both programs. These dually eligible enrollees and their providers face several challenges in navigating the two programs including: uncoordinated and fragmented services; separate policies regarding provider reimbursement, beneficiary protections, benefits, and enrollment; and conflicting financial incentives.

In April 2011, CMS awarded design grants of up to \$1 million each to 15 states for *State Demonstrations to Integrate Care for Dual Eligible Individuals* to develop approaches to coordinate care for Medicare-Medicaid enrollees across primary, acute, behavioral health services, and long-term services and supports (LTSS).<sup>3</sup> Three months later, CMS announced related guidance for the *Financial Alignment Demonstration* program for states that outlined two new

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Colorado will use the Primary Care Medical Homes and Regional Care Collaborative Organizations developed through its Accountable Care Collaborative to identify beneficiaries' needs and connect them to provider networks.

integrated care models: a capitated model and a managed fee-for-service (MFFS) model. The capitated model is based on a three-way contract signed by states, CMS, and health plans that will provide comprehensive, integrated Medicare and Medicaid services and align administrative functions between the two programs.<sup>4</sup> Under the MFFS model, states sign an agreement with CMS to manage an enhanced FFS program that integrates primary, acute, behavioral health and LTSS for Medicare-Medicaid enrollees and may incorporate other care coordination models introduced in the ACA, such as health homes or accountable care organizations (ACOs).

### **Current State Plans for Financial Alignment Demonstrations**

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Within certain federally-mandated parameters, states have the flexibility to design demonstrations that work effectively with their current Medicaid programs.<sup>5</sup> Several factors have affected the directions states have taken to pursue a financial alignment model or another strategy, including:

- Current program infrastructure and experience, including with enrolling disabled and/or elderly populations into managed care arrangements;
- Medicare Advantage market capacity;
- Wide-ranging stakeholder input; and
- Related Medicaid payment and delivery reforms already underway, such as the state plan option for health homes (established by §2703 of the ACA).

As of February 2013, 23 states are working on proposals to implement a *Financial Alignment Demonstration* or improve integration through another vehicle. In addition, a few states that determined that neither of the financial alignment models would work in their states are pursuing alternative options to improve integration, with some similarities to the financial alignment model framework.

In the 18 months since the *Financial Alignment Demonstration* was announced, states have made tremendous progress in the design of their demonstration programs. CHCS, as a provider of targeted technical assistance to many of the participating states, has observed the evolution of their plans for enrollment processes, rate setting, oversight, targeted geographic regions, and other administrative provisions of the proposed demonstration programs.<sup>6</sup> The following section shares highlights from CHCS' observations of states' innovative approaches to integration for Medicare-Medicaid enrollees.

### **Innovative Approaches to Integrated Program Design**

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State efforts over the last several years to design innovative approaches to better align Medicare and Medicaid provide a foundation to continue to address the long-standing issues related to misaligned systems and prepare for the implementation and operation of integrated care programs. This section details how select states approached several program design elements, including: (1) building upon existing reforms; (2) developing payment and financing methodologies and data analytic systems; (3) designing targeted interventions to identify high-risk individuals; (4) coordinating care across various service sectors; and (5) engaging key stakeholders throughout the proposal process. These examples describe only a subset of states' creative and resourceful program design activities to advance these initiatives.

### **Colorado Leverages its Recent Medicaid Reform Initiative**

Colorado is using its MFFS *Financial Alignment Demonstration* to advance a major Medicaid delivery reform initiative it implemented in 2011: the Accountable Care Collaborative (ACC) Program. The demonstration will be implemented statewide for approximately 45,000 full benefit Medicare-Medicaid enrollees.<sup>7</sup>

Organized in seven geographic regions, the ACC Program is comprised of three elements that work together to improve care for Medicaid beneficiaries and better support Medicaid providers. First, Regional Care Collaborative Organizations (RCCOs) connect Medicaid beneficiaries to providers, provide medical management and care coordination services, and identify appropriate community and social services and supports. RCCOs support providers with clinical tools, client materials, data, and analytics. Second, beneficiaries are assigned to a medical home with a Primary Care Medical Provider (PCMP), who also helps to identify appropriate specialty service providers and other supports. Third, the Statewide Data and Analytics Contractor collects and analyzes client utilization and program performance data for the RCCOs, PCMPs, and the state.

Colorado intends to maintain existing provider relationships for Medicare-Medicaid enrollees who participate in the demonstration. RCCOs are recruiting primary care Medicare-Medicaid providers who currently serve those eligible for the demonstration to be PCMPs in the ACC Program. In addition, the state will improve coordination of physical and behavioral health and acute care and LTSS in the demonstration. Improvements will include:

- **Strengthening collaboration** between RCCOs and behavioral health organizations (BHOs) through new RCCO contract requirements and written protocols outlining BHO obligations for meeting the care needs of Medicare-Medicaid enrollees;
- **Enhancing care coordination** between providers and/or care coordinators by expanding exchange of data to include BHO encounter data along with the already available physical health information and substance abuse claims, and by developing platforms for RCCOs and BHOs to exchange this data;
- **Reducing potentially-preventable readmissions** and improving discharge planning for Medicare-Medicaid

enrollees by including them in the current ACC Program that encourages hospitals to work closely with RCCOs and PCMPs;

- **Improving communication and capacity** to develop interventions between hospitals, nursing facilities and post-acute care settings with LTSS providers, Single Entry Point agencies, Community Centered Boards, Area Agencies on Aging, and home health providers; and
- **Increasing timely identification of decline** in Medicare-Medicaid enrollee functional status or quality of life and needs for LTSS by incorporating functional assessment data into those collected by the Statewide Data and Analytics Contractor.

### Washington Designs a Multi-Faceted Effort Using Early Stakeholder Input

All states pursuing a demonstration must maintain a robust, public, and transparent stakeholder engagement process during program design and implementation phases. All states highlighted in this brief have made concerted efforts to involve a broad range of stakeholders including providers, beneficiaries and their families, advocacy groups, health plans and other state or county-based entities and officials.<sup>8</sup> Many states sought extensive feedback from stakeholders before deciding to move forward with submitting a proposal, and have emphasized the importance of rigorous stakeholder involvement.<sup>9</sup>

Washington is one of the few states pursuing both a capitated and MFFS model. Washington was the first state to sign a Memorandum of Understanding (MOU) with CMS to implement a MFFS *Financial Alignment Demonstration*, to be phased in by seven geographic regions in 2013. The MFFS demonstration will build upon Medicaid health homes; the state is working with CMS to finalize a State Plan Amendment to establish these health homes statewide for all Medicaid beneficiaries.

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Experience with prior integration initiatives led stakeholders to advocate for a combined capitated and managed fee-for-service approach to Washington State's Financial Alignment Demonstration.

## Additional State Initiatives that Leverage Program Innovations

In addition to the state activities profiled in the text, following are insights from additional states that can help inform efforts to advance integrated models and leverage existing infrastructure and resources.

- **Working with health plans to provide LTSS.** As a state leader in managed LTSS, *Arizona* has extensive experience developing comprehensive Medicaid managed acute and LTSS systems; working effectively with health plans; and building provider networks and program monitoring. *Arizona* plans to implement a statewide capitated financial alignment model in 2014 for most full benefit Medicare-Medicaid enrollees, building on its current Medicaid managed care organization (MCO)/Medicare Special Needs Plan (SNP) system to expand the number of enrollees that receive integrated Medicare and Medicaid services.
- **Integrating behavioral and physical health.** *Connecticut* completed two major Medicaid reforms in January 2012: transitioning from a capitated managed care arrangement to an Administrative Services Organization model and implementing a Person Centered Medical Home (PCMH) initiative in select regions. Both models improve coordination of medical and behavioral health services and care management, and the state plans to implement a MFFS model for most full-benefit Medicare-Medicaid enrollees by expanding care coordination, predictive modeling, and data analytics to Medicare services and providers.
- **Expanding a local approach to managing care.** *Vermont* is the only state that is proposing a public Managed Care Entity (MCE) to provide Medicare and Medicaid managed care services for the *Financial Alignment Demonstration*. The MCE currently serves Medicaid beneficiaries in the state, including Medicare-Medicaid enrollees. Drawing upon the state's local approach to managing care and recruiting current providers who already serve the Medicaid population, the MCE will identify qualified providers to serve as Integrated Care Providers (ICPs) responsible for providing, coordinating, and integrating a range of Medicare and Medicaid services and supports.
- **Leveraging prior efforts to inform state readiness requirements.** *Virginia* initiated a major reform to integrate Medicaid acute care and LTSS in 2006. Additional reforms were planned in 2008 to increase acute and long-term care service integration. Although the state was unable to move forward then due to financial and operational barriers, *Virginia* designed their demonstration using the significant work and resources that they had invested including planning and infrastructure assessment activities. *Virginia* was able to build on its prior work to solve several operational issues more quickly than other states, and it is on track to implement a capitated model demonstration in January 2014 for all eligible full benefit, adult Medicare-Medicaid enrollees.
- **Developing a preliminary health plan certification process.** *Wisconsin* developed a phased certification process to determine Integrated Care Organizations' (ICOs) capability to operate its integrated demonstration. The certification standards, derived from CMS' Program of All-Inclusive Care for the Elderly (PACE) application, include several Medicare and state-specific Medicaid requirements. *Wisconsin* issued the initial certification standards early in the model design planning process. This protocol is a platform for *Wisconsin* to confirm that selected entities meet preliminary criteria. It informs potential ICOs about program requirements, with incrementally more detailed requirements as the program is phased-in. *Wisconsin's* certification process may serve as useful baseline information for states developing a Request for Proposals.<sup>10</sup>

Washington plans to pursue its capitated model in select counties in 2014. The state's decision to pursue both approaches was driven considerably by stakeholder input that the state collected prior to submitting their proposal.

Along with the influence of stakeholder input, Washington State's experiences with prior initiatives influenced the evolution of the proposed models.<sup>11</sup> The capitated managed care model takes advantage of lessons learned in the implementation of the Washington Medicaid Integration Project, and the more recent addition of persons with

disabilities into its statewide managed care program. The MFFS approach builds on Washington's successful Chronic Care Management Initiative and will be based in part on its \$2703 Health Home State Plan Amendment submitted to CMS in 2012, which will target high-need, high-cost Medicaid enrollees in the state.

It is challenging enough to implement one new model for Medicare-Medicaid enrollees, let alone two. As outlined below, many voices contributed to Washington's decision to implement both models.

- Internal Cross-Agency Team:** Washington’s integration project included leadership from both the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA). While HCA and DSHS’ Aging and Disabilities Services provided day-to-day planning, DSHS also contributed critical resources from its Research and Data Analysis division. The Project Steering Committee also included representatives from the governor’s office, who remained involved as key stakeholders through the end of the governor’s term.

- External Stakeholders:** The cross-agency team gathered input from stakeholders around the state, well before any design elements were finalized. For example, in Fall 2011 the state staff led a series of statewide meetings in which they presented Medicare-Medicaid enrollees’ utilization data, information about which services are covered by Medicare and Medicaid, and the requirements of the integration model. Break-out sessions sought stakeholder input about the core elements and consumer protections necessary. Other focus groups were held to get stakeholder input on contract language for the capitated model. The stakeholders – including beneficiaries, providers, advocacy organizations, managed care organizations, and county government representatives – were emphatic in their desire to test multiple options. Based on their input, Washington’s proposal called for three models: the two outlined in the *Financial Alignment Demonstration* opportunity (a health home model and a capitated managed care model), and a third model of three-way contracting and performance incentive payments, which was eventually dropped.

- Authorizing Entities – CMS and the Washington State Legislature:** Although Washington requested that

beneficiaries have the option of two or three different models, CMS determined that the evaluation would not accommodate multiple models within a single county. The Washington State legislature required that county legislative authorities take action to accept the implementation of the capitated model. To date, two counties have partnered with the state to move forward with implementation planning, procurement, plan selection, and readiness review.

### California’s Process for Ongoing Stakeholder Communication

As part of its statewide Coordinated Care Initiative (CCI), California plans to implement a capitated model in eight counties in 2013. Most full benefit Medicare-Medicaid enrollees in these counties will be eligible to participate.<sup>12</sup> The health plans will cover all services except for specialty mental health and substance use disorder services that are currently provided through a county-administered system.<sup>13</sup> California has executed a multi-faceted plan to maintain continuous communication between the state and several stakeholder groups, including advocates, providers, health plans, lawmakers, county governments, beneficiaries and their family members throughout the design and implementation of its demonstration.

California sought input on its policy goals and framework for the demonstration from several key stakeholder groups across the state during early design phases. The state kicked-off this process with four large public meetings of more than 250 participants each to discuss concerns, barriers, and opportunities. California also produced a communications toolkit to describe information about the initiative for the public on its Section 508-compliant “CalDuals” webpage ([www.calduals.org](http://www.calduals.org)).<sup>14</sup> In addition to public content, the state uses the website for internal, non-public activities, such as managing its 3,300-person

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California is using a comprehensive communication plan to maintain transparent and continuous two-way communication with stakeholders throughout the design and implementation of its Financial Alignment Demonstration.

Massachusetts developed a risk mitigation strategy including risk corridors and high-risk pools for its Financial Alignment Demonstration to protect all entities from significant over- or under-estimates in reimbursement rates.

stakeholder list, planning meetings, conducting surveys, and hosting conference calls.

California held several public meetings to explain and solicit comments on its Request for Solutions (RFS), a document the state released in January 2012 to procure health plans. California revised the RFS several times to incorporate stakeholder input and added new requirements that meet the Special Needs Plan (SNP) Model of Care guidelines. To promote full transparency, California published a version of the final RFS that included comments in redline so that all interested parties could see what comments were offered and what changed in the final version. The state selected 11 health plans for participation, pending successful completion of the readiness review.<sup>15,16</sup>

Throughout 2012, California collected targeted input to refine the proposal and develop implementation strategies. Several stakeholder work groups were established to help the state develop policies on specific topics, each of which held public meetings and published information on [www.calduals.org](http://www.calduals.org). Work groups include Long-Term Services and Supports and In-Home Supportive Services Integration; Behavioral Health Integration; Beneficiary Notices and Protections; Quality and Evaluation; Fiscal and Rate Setting; and Provider Outreach.

California's legislature also required that the state collect public feedback on specific topics before submitting official procurement documents, proposals, contracts, or policies. In turn, the state held public meetings to address issues including:

- A programmatic transition plan;
- Demonstration evaluation scope and structure;
- Quality and fiscal measures;
- Enrollment process and timelines;
- Beneficiary notices and communication plan;
- Quality assurance indicators for LTSS;

- Scope, duration, and intensity of home- and community-based services (HCBS) plan benefits;
- Any changes to population eligibility; and
- Development of a universal assessment process.

Stakeholders continue to provide feedback on important documents through early 2013, including quality measures and key policies and procedures. The state incorporated this feedback into its readiness review, set to be posted on [www.calduals.org](http://www.calduals.org) in mid-2013.

California is focusing its efforts now on education and outreach campaigns to help prepare beneficiaries and providers for implementation, recognizing that clear information is critical to the early success. The state is working with several stakeholder partners to develop and implement this campaign, including consumer advocacy organizations; community-based organizations that serve the target population; low-income housing providers; County Behavioral Health Offices; regional offices of state and national legislators; medical societies and professional organizations, including those representing specific ethnic groups; and health plans, when appropriate.

### Massachusetts' Risk Mitigation Strategy

Setting appropriate rates across two programs that encompass primary, acute, behavioral health and LTSS is extremely challenging. Few existing models offer states and CMS guidance on building a comprehensive, prospective payment rate that blends Medicare and Medicaid funding streams. The most pressing challenges are coordinating medical and LTSS needs and ensuring that capitation payment rates account for the different risk levels of beneficiaries.<sup>17</sup> Medicare-Medicaid enrollees are a very heterogeneous population with a wide range of health needs; however, only a small number of these beneficiaries are heavy users of services in both programs, underscoring the importance of developing

targeted approaches to capture the highest-need, highest-cost subset within a state. In addition to calculating adequate payment rates for covered services, other factors for consideration in developing a payment methodology include apportioning shared risk and savings between the states, CMS, and health plans; incorporating performance targets for health plans and providers; and promoting the use of HCBS for Medicare-Medicaid enrollees through savings achieved from decreased use of Medicare services.

Taking into consideration the uncertainty of developing new, complex payment rates, the MOU that Massachusetts signed with CMS to implement a capitated financial alignment model provides insight into how states might approach risk-sharing. The demonstration will serve most full benefit Medicare-Medicaid enrollees ages 21 to 64, excluding those residing in intermediate care facilities for individuals with intellectual disabilities and those enrolled in an HCBS 1915(c) waiver program. The state issued a competitive procurement and

has identified six organizations currently undergoing readiness reviews and contract negotiations to serve as Integrated Care Organizations (ICOs) to coordinate all current Medicare and Medicaid services, and supplemental services to enhance community behavioral health and LTSS benefits.<sup>18</sup>

Massachusetts developed two risk mitigation strategies for the first year of its demonstration (which is actually 18 months) to protect all entities from significant over- or under- estimates. Sharing risk – and profit – may reduce the effects of enrollment bias and attract higher health plan participation at the outset, as well as manage federal and state government costs more effectively.

In the first part of its strategy, the state established three risk corridor tiers for the first year of the demonstration to help mitigate potential ICO losses or profits. If ICOs gain or lose:

- **Zero to 5 percent**, the ICOs bear all of

## Calculating the Demonstration Payment Rate Baseline

CMS established a prospective methodology to set a baseline payment rate for health plans in the capitated model, which is made up of separate Medicare, Medicaid, and Part D components. The Medicare component will be set at a county-level, blending:

- An amount that represents what Medicare Advantage payments would be expected to be in the absence of the demonstration, reflecting historical bid amounts trended forward to the current year;
- The star ratings of plans serving beneficiaries who are expected to enroll; and
- Current Medicare Advantage benchmarks with Medicare fee-for-service spending data for beneficiaries in each county at the beginning of the calendar year.

CMS also includes a Part D component in this rate to account for prescription drug utilization and spending. The Medicaid component of the blended rate is based on historic spending data trended forward to the payment year for Medicare-Medicaid enrollees in that state enrolled in both Medicaid managed care and FFS arrangements.

The payment rates will be risk-adjusted to capture the diverse needs of the populations expected to enroll. For example, the Medicare rates will be risk-adjusted based on the Medicare hierarchical condition categories model, while Medicaid rates could be risk-adjusted based on variables such as the rate of facility-based care, HCBS needs, behavioral health utilization, among others.

The blended capitation methodology has a mechanism to hold health plans to high performance standings while operating efficiently. The rate will be prospectively lowered from the baseline rate to reflect savings assumptions that the health plans must meet, which will increase annually in the first three years. For example, in Massachusetts and Ohio, the savings assumptions that represent what would have been spent in absence of the demonstration are one, two and four percent in years one, two and three, respectively. Also, a percentage of the capitation rate will be withheld (one, two and three percent in years one, two and three, respectively) that plans may earn back if they meet established performance thresholds for core quality measures consistent across all demonstrations, as well as state-specific quality measures.

Minnesota is designing an alternative administrative alignment proposal that will build upon its current Minnesota Senior Health Options model and other comprehensive, statewide Medicaid purchasing and delivery reform initiatives.

the risk or reward;

- **Five to 10 percent**, the ICOs receive or bear half of the amount, while CMS and Massachusetts receive or bear the other half. Of the latter, CMS will bear up to one percent of the downside risk, and the state will bear the remainder; and
- **Above 10 percent**, the ICOs earn or bear all of this loss or gain.

The risk corridors provide basic protection to all parties involved, and may indicate areas to improve CMS' and the state's rate setting process or the health plan's ability to provide high-quality, efficient care. A profit or loss deviation of more than 10 percent may suggest that CMS could consider adjusting the payment rate, and/or that the ICO could reassess its care management strategy.

In the second part of its strategy, the state will create high-cost risk pools for ICOs that enroll Medicare-Medicaid enrollees meeting an established risk level that is based on reaching an amount of LTSS spending. The risk pools will be financed through a portion of the state's Medicaid capitation rate contribution that will be withheld from all ICOs in the risk pool. The risk pool funds will then be divided among all ICOs based on their percentage of total enrollee costs for beneficiaries who meet that risk level.<sup>19</sup>

### Minnesota's Efforts to Further Alignment Opportunities

Minnesota launched the nation's first integrated Medicare-Medicaid demonstration in 1995. In developing a capitated *Financial Alignment Demonstration* proposal, the state sought to build on Minnesota Senior Health Options (MSHO), an existing integrated managed care program that serves almost 80 percent of the state's Medicare-Medicaid enrollees over age 65. Most MSHO members are enrolled in fully-integrated Dual Eligible

Special Needs Plans (FIDE-SNPs), which have achieved high clinical outcomes and consumer satisfaction ratings for several years, as well as a high Medicare Advantage Star Rating average of four stars.

However, after working with actuarial and other external organizations, Minnesota decided not to pursue a *Financial Alignment Demonstration* proposal in June 2012. (For additional details about Minnesota's decision, see sidebar, "Assessing the Feasibility of the Financial Alignment Demonstration Model in Individual States.") Instead, Minnesota is designing a new administrative alignment proposal, "Demonstration to Align Administrative Systems for Improvements in Beneficiary Experience," that will build on the current MSHO model and other statewide Medicaid purchasing and delivery reform initiatives. Under this demonstration, Minnesota is working with CMS to revise Medicare and Medicaid contract requirements for existing SNPs to assure continued administrative alignment across several areas such as enrollment, provider networks, grievances and appeals, member premium protections, and marketing, among others for senior Medicare-Medicaid enrollees enrolled in MSHO.

A key feature of Minnesota's redesigned demonstration is to promote payment and delivery reform in Minnesota's managed care programs for dually eligible seniors and people with disabilities. Minnesota is developing Integrated Care System Partnerships (ICSPs) designed especially for dually eligible seniors and people with disabilities enrolled in managed care. ICSPs align with other provider-level payment delivery reform efforts such as the state's all-payer Health Care Homes and new Medicaid Health Care Delivery System Demonstrations.



The ICSP models support SNP and Medicaid managed care organizations' contracting arrangements with Minnesota's Health Care Homes (medical homes) and primary, acute, LTSS and behavioral health providers. For example, contracting arrangements may include performance and financial metrics under a range of pay-for-performance or risk- and gain-sharing models, and focus on improvements in administrative alignment, seamless care delivery and accountability between Medicare and Medicaid providers. Minnesota has amended its contracts with SNPs to outline requirements for submitting

proposals to the state for ICSPs in 2013, planning for ICSPs to be in place by 2014.

Minnesota is also working to adopt policies to improve integration between Health Care Homes, LTSS, and behavioral health providers through a "Virtual Care System" approach that coordinates care in areas where more fully-integrated ICSP approaches are not possible.

Lastly, Minnesota is considering options for expanding the administrative alignment improvements underway to Medicare-Medicaid enrollees under age 65 with

### Assessing the Feasibility of the Financial Alignment Demonstration Model in Individual States

Minnesota, Oregon, and Tennessee submitted proposals for a capitated demonstration, but subsequently determined that the demonstration was not a viable option for their state. One major factor in each state's decision was that demonstration payment rates were projected to be lower than what Medicare Advantage plans are currently paid.

In Minnesota, offering current MSHO plans a lower rate in the demonstration could create barriers to plan retention. Given its robust SNP market and enrollment in high-performing plans, and the fact that the state had already achieved many of the quality outcomes in its MSHO program that are goals of the *Financial Alignment Demonstration*, Minnesota determined that the capitated model was not a financially viable option. Tennessee has a robust Medicare Advantage and managed Medicaid LTSS market as well, and faced similar constraints.

Oregon described two key reasons why the demonstration rates would likely be lower than the state's current rates. In Oregon, average Medicare FFS expenditures are lower than both the national average and current payment rates for Medicare Advantage plans in the state, or the regional Medicare Advantage benchmark. As described above in *Calculating the Demonstration Payment Rate Baseline*, Medicare FFS spending is one of the weighted components required under the demonstration, and would thus lower the capitation payment calculation. In addition, Oregon has many high-performing Medicare Advantage plans that have earned financial bonuses under the Medicare Star Rating system. Under the demonstration model, plans exceeding specified performance levels would be eligible for a county-averaged bonus payment that would likely be a lower amount than under the Star Rating system.

Similar to Minnesota, Oregon and Tennessee plan to examine alternatives to improve Medicare-Medicaid integration. In 2012, Oregon passed a health reform law to establish Medicaid "coordinated care organizations" (CCOs), based on a patient-centered medical home model. CCOs provide comprehensive services, including care coordination for those with chronic physical and behavioral health needs. Oregon is examining how to integrate Medicare services for Medicare-Medicaid enrollees in this model. Tennessee, a state leader in delivering managed acute, LTSS, and behavioral health services through one coordinated Medicaid system, continues to examine alternatives to integrate Medicare services within its current system.

Of note, Wisconsin designed a financial data analytic resource that may serve as a valuable template to other states. The state developed a comprehensive financial model to assess key areas of cost and savings estimates for their proposed capitated demonstration. This model, to be updated with new data as program design planning proceeds:

- Develops assumptions on upfront costs on both the Medicare and Medicaid sides, such as administrative and care coordination costs;
- Analyzes trends in spending, enrollment and service utilization to calculate baseline estimates as well as the cost of the population had they continued to remain in FFS; and
- Projects the savings likely to be realized over time based on initial assumptions, such as savings through managed care and integration of various clinical services.

Stakeholder input spurred Michigan's decision to keep its behavioral health system carved out of its Financial Alignment Demonstration, but it will use the demonstration to improve coordination and alignment between physical and behavioral health providers.

disabilities in 2014. This would build on current efforts to manage and integrate mental and physical health services for Medicaid-only and Medicare-Medicaid enrollees ages 18 to 64 diagnosed with cognitive and/or behavioral health impairments, including co-occurring substance abuse, brain injury, and other cognitive impairments.

### **Michigan Focuses on Physical and Behavioral Health Integration**

Although most states are designing demonstrations to include all or most service categories under one contract, many state Medicaid programs provide services through separate managed entities, carve-outs, and waivers for certain services. Recognizing the value of maintaining the current delivery system to prevent destabilization of current, effective practices, some states have proposed to keep these structures in place in their demonstrations. In turn, these states will incorporate shared accountability and new coordination requirements between participating health plans, behavioral health and other providers as necessary.

Michigan has decided to retain its separate managed physical and behavioral systems in its capitated model, but will use this demonstration as an opportunity to improve care coordination and alignment in the current system between behavioral and physical health providers. All full-benefit Medicare-Medicaid enrollees residing in select geographic regions, excluding PACE enrollees and categorically medically needy beneficiaries, will be eligible for the demonstration. The decision in Michigan to keep the current behavioral health system intact was the result of strong stakeholder support for the current program and concern that major changes to the delivery model would disrupt care for vulnerable beneficiaries.<sup>20</sup> Local, county-based Prepaid Inpatient Health Plans (PIHPs) have provided managed behavioral health specialty services in Michigan for 15 years, and have established provider networks, contracts and other infrastructure to serve all Medicaid beneficiaries who have a behavioral health condition.<sup>21</sup> Michigan

will contract with Integrated Care Organizations (ICOs) to provide physical health and LTSS, covering both institutional and HCBS. In turn, the ICOs will subcontract with regional PIHPs, which will continue to provide all behavioral health services, including specialty services for beneficiaries who have a serious mental illness, intellectual/developmental disability (I/DD), and/or a substance abuse disorder. The state plans to create incentives for ICOs to contract with primary care providers who partner with PIHPs for the physical co-location of primary care services at community mental health centers (CMHCs) or in Federal Qualified Health Centers (FQHCs) to improve care for beneficiaries with serious mental illness, substance use disorder and I/DD.

To ensure integration and coordination of services across each delivery system, Michigan is working through operational details for developing and implementing a protected web-based platform, a “care bridge,” between ICOs, PHIPs, care managers and all other providers to share beneficiary data, reports, care plans, medications and other documents critical to managing care. The care bridge will advance shared accountability among providers, care coordination, and seamless access to services. The state will determine roles and responsibilities between the state, ICOs and PIHPs for building and maintaining the platform; creating communication tools; and collecting, analyzing, and reporting data.

### **Washington Adds Medicare Data to Enhance Predictive Modeling**

Integrating Medicare and Medicaid data to compile complete information on service utilization and expenditures is critical to establishing an aligned care model. Without access to Medicare data, state Medicaid agencies and providers have only a limited picture of individuals' care and support needs. CMS and states have undertaken efforts to improve access to and the quality of linked Medicare and Medicaid data, which create significant new opportunities to improve care, target appropriate care interventions, and reduce avoidable

expenditures. In 2011, CMS released guidance to inform state Medicaid agencies about the opportunity to and process for requesting Medicare Parts A, B and D claims/event data for Medicare-Medicaid enrollees to support care coordination, and offered federal support to help states use, link and analyze this data.<sup>22,23</sup> Using merged data is a critical step toward supporting both program planning for care coordination and actual care coordination efforts provided to improve care at the individual beneficiary level.

Washington State has had considerable success in integrating data from several state systems to identify Medicaid beneficiaries with complex health needs, and in building upon its existing technology to expand this system to target Medicare-Medicaid enrollees. Using its predictive modeling capabilities, the Department of Social and Health Services (DSHS) has been able to identify high-cost, high-risk Medicaid beneficiaries in its chronic care management programs since 2009. The predictive model identifies individuals most in need of comprehensive care coordination based on risk scores calculated on demographics, diagnoses, and filled prescriptions drawn from integrated claims data. The risk scores and contributing risk factors are provided to care coordinators through a web-based clinical decision support tool called PRISM (Predictive Risk Intelligence System). PRISM also allows the user to view integrated information from primary, acute, social services, behavioral health, and long-term care payment and assessment data systems. The system includes health and demographic information from administrative data sources to display complete patient profiles for providers.

Leveraging its innovative modeling system, the state recently added Medicare data to its integrated data warehouse that includes Medicaid claims, encounter data and assessment information.<sup>24</sup> The state will use linked Medicare and Medicaid data to identify Medicare-Medicaid enrollees with the highest prospective risk scores for

enrollment into the demonstration health homes. The availability of linked Medicare and Medicaid data provides complete information about a beneficiary's care experience and will improve Washington's ability to better target Medicare-Medicaid enrollees who would most benefit from additional care management services or specific service interventions.

### **Massachusetts Incorporates Behavioral Health and LTSS Standards into its Readiness Review**

Before a state implements a capitated model or allows a health plan to enroll Medicare-Medicaid enrollees, CMS and the state will conduct a readiness review to assess and ensure that every selected plan is ready to accept enrollment, provide the necessary continuity of care, ensure access to the full spectrum of Medicare, Medicaid, and pharmacy services, adhere to all federal and state requirements, and fully protect and meet the diverse needs of the Medicare-Medicaid population.<sup>25</sup> The readiness review will also help CMS and states refine a monitoring strategy after implementation by identifying areas in which they should focus oversight efforts and where ongoing monitoring may be required.

Massachusetts was the first state to make its readiness review document publicly available on November 28, 2012. Before enrolling any beneficiaries, selected ICOs must provide sufficient evidence to pass the readiness review. The readiness reviews of the ICOs will be a combination of desk audits, a network validation review and site visits, and will be conducted by CMS and state staff, or their contractors.

The detailed readiness review includes several domains and requirements, many of which will be reflected in the readiness reviews of other states proposing a capitated model. The criteria that will be used to evaluate whether ICOs have the operational capacity to provide high-quality services to Medicare-Medicaid enrollees fall into categories set by Massachusetts and CMS; for example, Assessment Processes, Care Coordination, Enrollee Protection,

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Using combined Medicare and Medicaid data and PRISM, its web-based clinical decision support tool, Washington State will identify Medicare-Medicaid enrollees with complex care needs.

Organizational Structure and Staffing, Performance and Quality Measurement, and Provider Network. Massachusetts and CMS took into account the unique needs of Medicare-Medicaid enrollees in arriving at the readiness review criteria. In addition, all readiness reviews will include criteria to evaluate the plans' ability to provide appropriate care management and support for the complex and heterogeneous Medicare-Medicaid enrollee population. The criteria will also focus on whether health plans have policies in place that:

- Provide beneficiary protections related to the Americans with Disabilities Act;
- Use person-centered language and reinforce beneficiary roles and empowerment;
- Reflect independent living philosophies; and
- Promote recovery-oriented models of behavioral health services.<sup>26</sup>

Examples of the criteria used to gauge readiness of ICOs are shown in Exhibit 1, along with summaries of specific evidence needed for each criterion.

### Exhibit 1: Massachusetts Readiness Review Criteria<sup>27</sup>

Category	Sample Criteria
<b>Assessment</b>	<ul style="list-style-type: none"> <li>▪ For enrollees identified in their initial assessments as needing intensive behavioral health services or LTSS, during the comprehensive assessment, the ICO will determine (for example):</li> <li>▪ The enrollee's understanding of available services; the enrollee's desire to self-manage all or part of his/her care plan regardless of the severity of disability, and understanding of his or her self-management responsibilities;</li> <li>▪ The enrollee's preferences regarding privacy, services, caregivers, and daily routine;</li> <li>▪ The enrollee's understanding of and engagement in recovery-oriented activities;</li> <li>▪ The enrollee's preferred living situation and a risk assessment for the stability of housing; and</li> <li>▪ The enrollee's understanding of his/her rights.</li> </ul>
<b>Care Coordination</b>	ICO has a process to ensure every enrollee who wants an Individualized Care Team to coordinate the delivery of care and services will have access to one.
<b>Enrollment</b>	Member services staff have cultural and disability competencies based on the target populations and must be knowledgeable in effective communication with individuals with disabilities.
<b>Enrollee Projections</b>	Emergency services (for example): ICO has a back-up plan in case an LTSS provider does not arrive to provide assistance with activities of daily living.
<b>Organizational Structure and Staffing</b>	<p>The training program for Care Coordinators includes (for example):</p> <ul style="list-style-type: none"> <li>▪ Needs assessment and care planning;</li> <li>▪ Service monitoring;</li> <li>▪ Long term services and support;</li> <li>▪ Self-direction of personal care attendant services;</li> <li>▪ Behavioral health and the recovery model;</li> <li>▪ Care transitions; and</li> <li>▪ Independent living philosophy.</li> </ul>
<b>Utilization Management</b>	<p>The ICO shall develop and maintain behavioral health inpatient services and diversionary services authorization policies and procedures (for example):</p> <ul style="list-style-type: none"> <li>▪ A plan and a system in place to direct enrollees to the least intensive but clinically appropriate service;</li> <li>▪ Verification and authorization of all adjustments to behavioral health inpatient services treatment plans and diversionary services treatment plans; and</li> <li>▪ Processes to ensure that treatment and discharge needs are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the primary care physician and other providers, such as community based mental health services providers, as appropriate.</li> </ul>

## Conclusion

Several states intend to hit the ground running in 2013 and 2014 with newly-launched integrated models, seizing unprecedented federal support, state innovation and the vast potential for states to advance alignment of Medicare and Medicaid services. Stakeholders and policymakers alike can learn from the experiences of pioneering states that have taken significant steps toward implementing financial alignment models. Much of the progress achieved to date is the result of partnerships between states, the federal government and a wide range of stakeholders committed to

improve clinical outcomes and performance measurement, expand person-centered, coordinated care, reduce fragmentation across delivery systems, and eliminate incentives for either program to shift costs to the other. There are still many programmatic and policy details to tackle; designing programs that attempt to address long-standing, systemic misalignments for a complex population is a daunting task. However, states are actively working with CMS and stakeholders to resolve outstanding issues and achieve the ultimate goal of improving the beneficiaries' care experience and aligning programs.

## About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS 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](http://www.chcs.org).

This brief is part of CHCS' *Technical Assistance for Dual Eligible Integrated Care Demonstrations* program, made possible through The SCAN Foundation and The Commonwealth Fund. Through this program, CHCS is helping demonstration states develop and implement integrated-care models for individuals eligible for both Medicare and Medicaid services. For more information, visit [www.chcs.org](http://www.chcs.org).

## Endnotes

<sup>1</sup> Referred to in statute as the Federal Coordinated Health Care Office.

<sup>2</sup> Participating states include California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, Oklahoma, Oregon, Tennessee, Vermont, Washington and Wisconsin. CHCS is also providing technical assistance to states participating in the Financial Alignment Demonstration through the CMS-funded Integrated Care Resource Center.

<sup>3</sup> U.S. Department of Health and Human Services. "New Flexibility for States to Improve Medicaid and Implement Innovative Practices." Press Release, April 14, 2011. Available at: [http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicaidAnnouncement4\\_11.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicaidAnnouncement4_11.pdf).

<sup>4</sup> Kaiser Commission on Medicaid and the Uninsured. "Financial Alignment Models for Dual Eligibles: An Update. November, 2011. Available at: <http://www.kff.org/medicaid/upload/8260.pdf>.

<sup>5</sup> For more information see the Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office website available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html>.

<sup>6</sup> For a comprehensive summary of the Financial Alignment Demonstration program in all states that submitted a proposal see: Musumeci M. "State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS." Kaiser Family Foundation, October 2012. Available at: <http://www.kff.org/medicaid/upload/8369.pdf>.

<sup>7</sup> Groups excluded from Colorado's demonstration include: 1) Denver Health Medicaid Choice plan enrollees; 2) Rocky Mountain Health Plan enrollees; 3) PACE enrollees; 4) Medicare Advantage/Special Needs Plan (SNP) enrollees; 5) beneficiaries who reside in an ICF-ID; or 6) other Medicare-Medicaid beneficiaries already participating in another recognized program that provides care coordination.

<sup>8</sup> Summary of participants' discussion at CHCS-facilitated multi-state meetings; July 6-7, 2011; November 16-17, 2011; March 8-9, 2012; and July 19-20, 2012.

<sup>9</sup> Ibid.

<sup>10</sup> All information, including the protocol, standards, instructions and certification process results for the first phase, are posted online at <http://www.dhs.wisconsin.gov/virtualPACE/icos/index.htm>.

<sup>11</sup> See the case study "Washington State Medicaid: An Evolution in Care Delivery" – found at [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=759948](http://www.chcs.org/publications3960/publications_show.htm?doc_id=759948).

<sup>12</sup> Populations excluded from California's demonstration include: Partial-benefit dual eligible beneficiaries; Beneficiaries with other health coverage; Children under age 21; Current ESRD beneficiaries; Developmentally disabled; 1915 (c) waiver enrollees; and Beneficiaries not in areas covered by managed care.

<sup>13</sup> California Department of Health Care Services (2012). Proposal to the Center for Medicare and Medicaid Innovation. Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Beneficiaries. May 31, 2012. Available at <http://www.calduals.org/wp-content/uploads/2012/06/CADemoProposal0531121.pdf>.

<sup>14</sup> Section 508 is a part of the Rehabilitation Act of 1973, which requires that electronic and information technology developed, procured, maintained or used by the Federal government be accessible to people with disabilities.

<sup>15</sup> California CCI health plans include: Alameda Alliance for Health, CareMore (Anthem Blue Cross), CalOptima (OneCare), Care 1<sup>st</sup>, Community Health Group, Health Net of California, Health Plan of San Mateo, Inland Empire Health Plan, L.A. Care Health Plan, Molina Health Care of California, and Santa Clara Family Health Plan.

<sup>16</sup> CalDuals (2012). 2013 Medicare Star Ratings of CCI Health Plans. November 15, 2012. Available at <http://www.calduals.org/2012/11/15/2013-medicare-star-ratings-of-cci-health-plans/>.

<sup>17</sup> P. Neuman, B. Lyons, J. Rentas, D. Rowland. "Dx for a Careful Approach to Moving Dual-Eligible Beneficiaries into Managed Care Plans." *Health Affairs*, June 2012, 31: 1186-1194.

<sup>18</sup> Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. Proposal to the Center for Medicare and Medicaid Innovation: State Demonstration to Integrate Care for Dual Eligible Individuals. February 16, 2012. Available at [http://www.chcs.org/usr\\_doc/Massachusetts\\_Duals\\_Demonstration\\_Proposal.pdf](http://www.chcs.org/usr_doc/Massachusetts_Duals_Demonstration_Proposal.pdf).

<sup>19</sup> Kaiser Commission on Medicaid and the Uninsured. "Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries." October 2012. Available at: <http://www.kff.org/medicaid/upload/8291-02.pdf>.

<sup>20</sup> Michigan Department of Community Health. Integrated Care for People who are Medicare-Medicaid Eligible. April 26, 2012. Available at [http://www.chcs.org/usr\\_doc/MichiganProposal.pdf](http://www.chcs.org/usr_doc/MichiganProposal.pdf).

<sup>21</sup> Michigan Department of Community Health. Integrated Care for People who are Medicare-Medicaid Eligible. April 26, 2012. Available at [http://www.chcs.org/usr\\_doc/MichiganProposal.pdf](http://www.chcs.org/usr_doc/MichiganProposal.pdf).

<sup>22</sup> Medicare Part A includes care provided by hospital inpatient and outpatient units, skilled nursing facilities, clinics, ambulatory surgical centers, home health providers, and hospice. Medicare Part B includes physician services, diagnostic tests, laboratory, ambulance, durable medical equipment, Part B drugs (administered by or under close supervision of a physician). Medicare Part D covers prescription drugs.

<sup>23</sup> Refer to the Medicare-Medicaid Integration Toolkit for resources to help states to request and use Medicare data from the Medicare-Medicaid Coordination Office (MMCO), <http://www.integratedcareresourcecenter.com/icmdatatoolkit.aspx>.

<sup>24</sup> "Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the State of Washington." <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf>.

<sup>25</sup> Centers for Medicare & Medicaid Services. "Readiness Reviews." Memo of November 28, 2012. Available at : [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Mass\\_RR\\_memo.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Mass_RR_memo.pdf).

<sup>26</sup> Ibid.

<sup>27</sup> Massachusetts Readiness review, MMCO, op. cit