

Key Consumer Provisions in the Dual
Demonstrations:
Findings from a Survey of ACAP Plans



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It's been more than two years since the Centers for Medicare & Medicaid Services (CMS) began implementing one of most significant delivery system demonstrations in years. Made possible by the passage of the Affordable Care Act, the Financial Alignment Demonstrations (“the demonstration”) are testing new models of care coordination and integrated financing for consumers dually eligible for Medicare and Medicaid benefits. These are low-income seniors and persons with disabilities, many of whom suffer from multiple chronic conditions addressed by a patchwork of service providers, and who could benefit the most from the promise of coordinated care and an interdisciplinary care team of primary, acute, behavioral health and long-term service providers, as needed.

Today, 13 states¹ participate in these demonstrations, with 10 states enrolling consumers in fully capitated managed care plans known as Medicare-Medicaid Plans (MMPs). Although the enrollment timeline differs between the states, studies have begun to report on early findings² and

Financial Alignment Demonstration at a Glance As of September 2015

- There are 10 million Medicare/Medicaid beneficiaries (“dual-eligible beneficiaries”); only full-benefit dual-eligible beneficiaries are eligible to enroll
- All eligible enrollees are low-income seniors and persons with disabilities
- Approximately 400,000 dual-eligible beneficiaries are enrolled as of Sept. 2015
- Fully capitated demonstrations are in 10 states with 67 participating plans
- There are 2 managed FFS (CO, WA) and one alternative model underway (MN)
- Fifteen ACAP plans are participating in six states with more than 100,000 enrollees*

* RI Memorandum of Understanding (MOU) was approved August 2015; enrollment begins in January 2016. ACAP plan participating in demonstration.

¹ For a full list of states, see <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html> RI was approved in August 2015 and will not begin enrollment until 2016.

² In May and June 2015, Kaiser Family Foundation produced early insights reports on Massachusetts, Ohio and Virginia. For more information, see [http://kff.org/search/?s=dual+demonstrations&fs=search&orderby=&tab=&layout=&facets\[start_date\]=&facets\[end_date\]=&facet\[s\[tag\]\]\]=dual-eligible](http://kff.org/search/?s=dual+demonstrations&fs=search&orderby=&tab=&layout=&facets[start_date]=&facets[end_date]=&facet[s[tag]]]=dual-eligible)

policymakers are looking closely at the progress underway.³ CMS has contracted with RTI International to conduct a formal evaluation expected at a later date. This study is an effort to get a snapshot of progress made to date by a subset of MMPs.

In each state participating, two legal documents contain the requirements for the demonstrations: the Memorandum of Understanding (MOU) between CMS and the state; and a three-way contract between CMS, the state and participating managed care plans. These documents detail provisions ranging from the payment rates, scope of benefits and enrollment rules, to care coordination standards, options for receiving home/personal care services and the need for ongoing member engagement. It is these latter three provisions that were the focus of this survey research project.

The Association for Community Affiliated Plans (ACAP) represents 61 not-for-profit Safety Net Health Plans serving more than 15 million people. Community Catalyst is a non-profit consumer health advocacy organization with partners in over 40 states. Both organizations have common missions, including serving and advocating for the needs of many of the most vulnerable consumers in the country. Community Catalyst and ACAP joined together to examine how the consumer protection provisions in the demonstrations are being implemented. ACAP plan members have long been serving Medicaid and Medicare consumers and are leading participants in these demonstrations. Community Catalyst's *[Voices for Better Health](#)* project has been a strong promoter of integrated care for high-risk populations and is actively working to ensure that the demonstrations protect and improve the quality of care for beneficiaries.

This issue brief discusses key findings from this research and proposes recommendations in two areas: operational or practice changes for health plans and program adjustments for policymakers.

Methodology:

This study applied a mixed methods approach by collecting online survey data and conducting telephone interviews. Participants were recruited by ACAP via email with invitations sent to leaders at 15 ACAP plans participating in the demonstration. The email provided the purpose of the study, a confidentiality statement, and a website link for participants to access the online survey and anonymously provide feedback. The survey contained 21 questions with a mix of multiple choice and open-ended questions specific to the three areas of interest and was available for two weeks. Surveys were completed over a five-week period ending in July 2015.

In total, data was drawn from eight completed online surveys and telephone interviews with nine health plans from six states. The interviews comprised 20 open-ended questions exploring the survey questions in more detail. All interviews were conducted in August 2015, and interviewees included at least two and up to six plan employees from a variety of roles including leadership, member services and quality committee staff.

³ "Experience with Financial Alignment Initiative Demonstration Projects: Feedback from Beneficiaries in California, Massachusetts and Ohio", Perry/Undem Research Communication, for MACPAC; May 14, 2015 <https://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-Demonstration-Projects.pdf>

Survey Elements:⁴ Care coordination and interdisciplinary, team-based care; consumer or self-direction; and consumer advisory committees. These are three key features of the demonstrations and are fundamental to achieving the goal of person-centered care.

- **Care Coordination and team-based care** are the central features of these demonstrations, designed to help manage care and services to avoid fragmentation, ensure access to appropriate care, and provide a team approach to address clinical, social and behavioral needs. The Memoranda of Understanding and three-way contracts include specific – though differing by state – language on how plans must implement care coordination (see Appendix A). Further, the coordinator must pull together an interdisciplinary care team (ICT) comprised of the person’s primary care physician and other providers, as needed, to support the consumer; including but not limited to nursing, social work, behavioral health, long-term services and supports, and pharmacy.
- **Consumer direction**, also referred to as self-direction, refers to the option for a consumer utilizing home or personal care services to hire, manage and fire their own aide. This option is intended to support the goal of consumer choice and person-centered care. Two Medicaid programs offer consumer direction: the Personal Care Services option state plan benefit⁵ and home- and community-based waivers. All demonstrations require consumer direction to be available to all enrollees.
- **Consumer Advisory Committees:** State and plans are required to ensure that the voices of older adults, persons with disabilities and their caregivers are heard in the design, implementation and oversight of the demonstrations.⁶ Consumer Advisory Committees are one requirement of MMPs. They are intended to help MMPs solicit input and feedback from members about a wide range of issues, including their benefits, quality of care, and other health plan services and supports. The committees also offer plans a way to both understand individual as well as system-wide issues.

Key Findings:

Care Coordination and ICT: The survey and interviews explored a number of provisions including types of contracts with care management staff; the disciplines that comprise the care team; how the plans train the members of their care team; and communication among the care management team.

- Seven of the eight MMPs employ their own coordinators.⁷
- All plans offer training to care coordinators upon hiring and annually; half also offer training quarterly. Training included a range of topics including cultural competencies,

⁴ Titles differ by state; for this report we use care coordinator (also referred to as manager), consumer direction (also referred to as self-direction), and Interdisciplinary Care Teams (also referred to as IDTs)

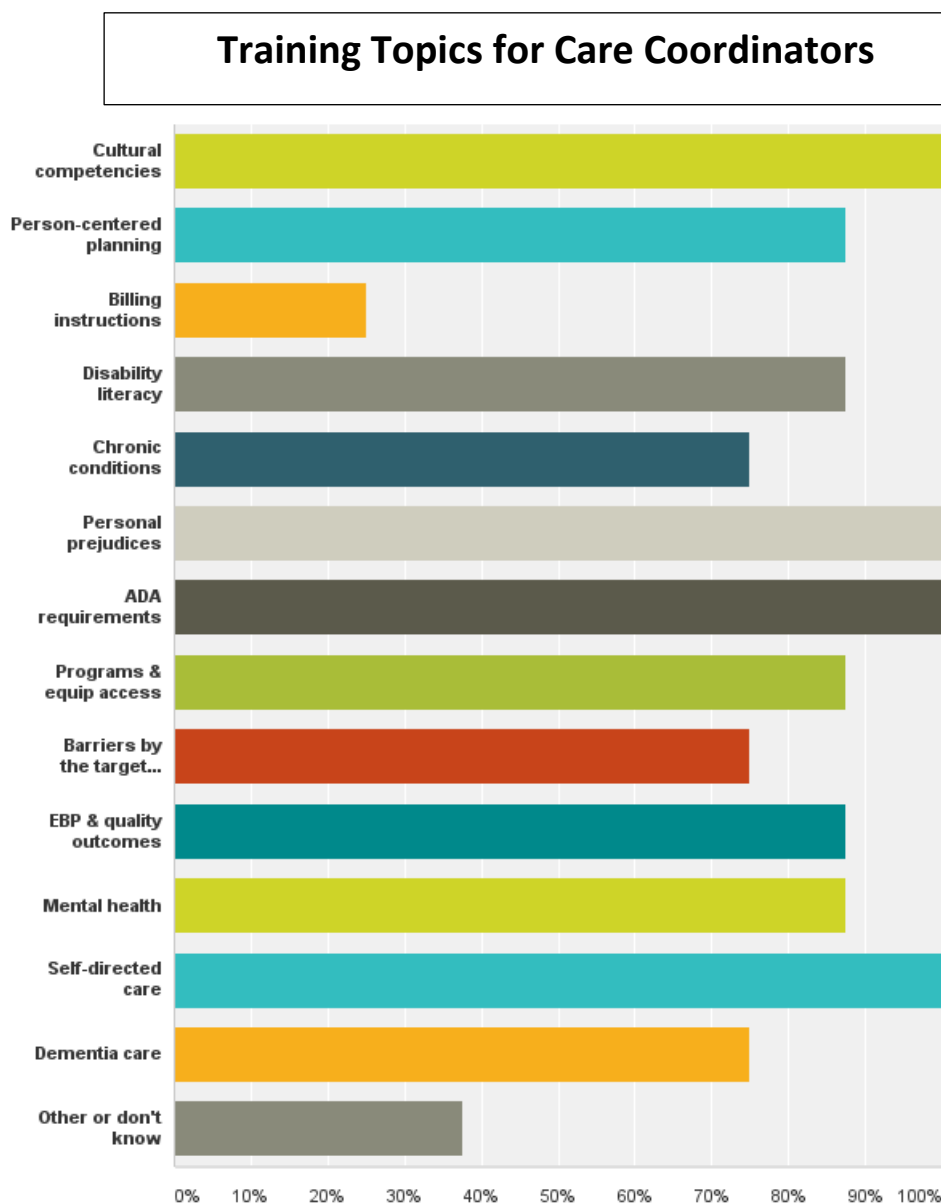
⁵ Thirty-one states have chosen this option: <http://kff.org/medicaid/state-indicator/personal-care-services/>

⁶ See CMS State Medicaid Directors letter; July 12, 2012 at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf>

⁷ One of the seven employing care coordinators also contracts out for coordinators

awareness of personal prejudices,⁸ and self-direction. All plans included ADA compliance in this training.⁹

- Nearly all (7 of 8) utilize registered nurses as their primary care coordinator, some also use social workers, and half reported that they vary the primary care coordinator based on the needs of the client.
- Six plans said their ICT met as needed; two said every six months.

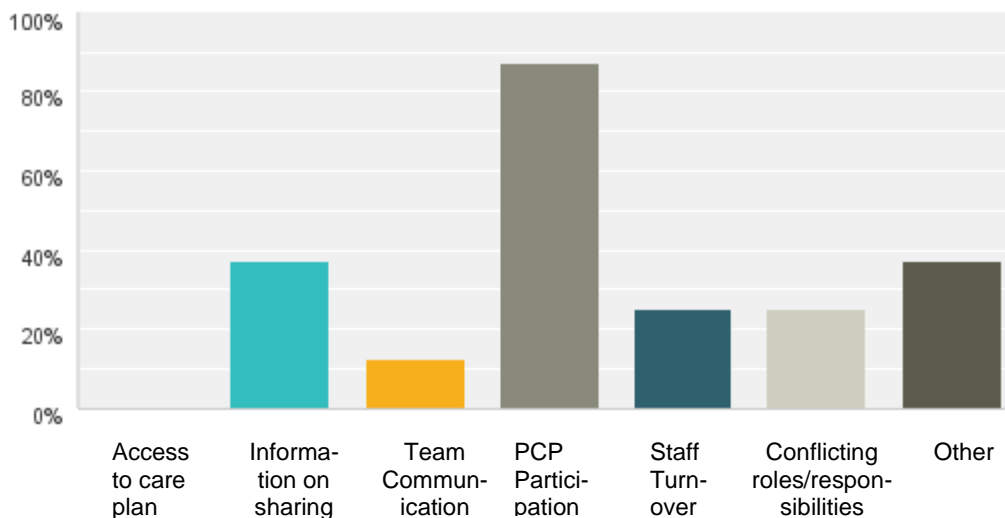


⁸ This refers to training on recognizing biases regarding age, disability and health status.

⁹ The ADA, enforced by the U.S. Equal Employment Opportunity Commission (EEOC), is a federal law designed to prohibit discrimination against any “qualified individual with a disability” in all aspects of employment, including hiring, promotions, discharge, training, and benefits of employment.

- The plans reported that after completing health assessments, the most common services members needed were personal care/homemaker services, medication management and behavioral health services.
- By far the most commonly identified challenge was a problem getting primary care physicians (PCPs) to participate in the ICT.
- Additional challenges included getting the initial health risk assessment (HRA) done in time,¹⁰ getting members to participate on the ICT, and the availability of data (e.g., addresses, phone numbers).

Key Challenges in Operationalizing Interdisciplinary Care Teams



“A person out there without this care coordination, his problems wouldn’t have been identified and he would’ve ended up in the hospital.”

¹⁰ Requirements range from completed the health risk assessment between 60 and 90 days from the date of enrollment; Ohio requires 30 days for high-risk enrollees.

Consumer-Direction: In accordance with the demonstration requirements, all of the health plans responded that members can hire their own aide, and most plans indicated that the personal care aide can be part of the consumer’s interdisciplinary care team.

- Only a few of the respondents had information on the number or percentage of members needing LTSS that chose self-direction, suggesting that this option is highly underutilized.
- Most plan enrollees utilizing the consumer direction option were under age 65.
- Half of those surveyed reported offering training to the consumer on self-direction, including by asking consumers to assist with a care plan, and have plan staff develop and disseminate member materials on self-direction including during home visits.
- Those not offering training indicated they are either exploring training options or that it was being done by an external entity (e.g., employer of record¹¹ or service coordinator)

Consumer Advisory Committees (CAC): All of the health plans have established CACs for their dual eligible members with one plan reporting that they expanded their existing CAC. All of the plans designate staff to support the CAC. Two plans have dedicated staff hired solely for this function whereas the others drew from Quality Assurance, member or customer services, and other staff from the plan leadership. Several of the plans also have Stakeholder Advisory Committees comprised of community organizations, providers and consumer advocates; other participants include the Ombudsman, Board members, vendors and representatives from the state Medicaid office.

“A lot of people don’t know what self-direction means”

- All of the plans allow caregivers to attend CAC meetings with the member/enrollee; three-quarters of the plans provide food and three-quarters offer transportation.
- Half reported having an internal organizational feedback loop to take issues raised by the CAC to plan staff and back to the CAC and cited using this feedback to fix problems, such as improving communication between the plan and members, improving member materials, and improving vendor services (e.g., transportation).
- Difficulty in getting members/enrollees to participate was a common theme. Respondents noted several barriers to participation, including the health status of members and the lack of good contact information for their enrollees.
- Plans stressed the importance of training members for this role and the need to address individual problems as well as assisting with broader, programmatic issues that could impact all members.

The list below indicates some commonly-raised issues with the demonstrations that plans have heard about from their members, through CAC engagement.

¹¹ Some states with the PCS Medicaid option have pooled personal care aides (PCA) together, often through collective bargaining, into a group referred to as the employer of record for all PCAs.

Types of Concerns Raised by CAC

- Access to out-of-network providers
- Obtaining pre-authorization for services
- Access to provider network including dentists
- Problems with benefits including DME, pharmacy policies and transportation
- Understanding of how the care team works
- Reliability of services

Discussion:

Care Coordination: Care coordination is critical to the success of the demonstrations as one goal of the demonstration is to eliminate the fragmentation from separate financing and benefit structures. Most plans indicated that this is an area they are working to refine. The plans in this study indicated they are committed to figuring out approaches to improve the processes and suggested operational changes and adjustments.

The first and foremost care coordination activity is to ensure timely completion of health risk assessments. This requires the development of a care plan with the member's PCP; and the PCP and the members of the ICT must then sign off on the care plan. Plans participating in the study identified difficulty getting PCPs to participate in the care plan development as a barrier that must be addressed in order to begin serving the members. Based on this study, it is clear that personal care and behavioral health services are crucial benefits being utilized by new enrollees; ensuring these providers are part of the care teams and integrating these services into primary care is also essential.

Second, plans identified some operational system issues that needed to change to facilitate care coordination, such as implementing improved IT systems that help plans set up ICT meetings, enable communication between ICT members, streamline health risk assessments,¹² and recruit and train staff. Noting that they may not have accurate or complete contact information for members, plans reported exploring creative strategies for reaching members including utilizing outreach workers to go into the community (e.g., homeless shelters, adult day facilities) to locate members. Finally, plans raised concerns about provider resistance to the demonstration, including that some PCPs have encouraged their patients not to enroll or to dis-enroll from the demonstration. Plans are looking for ideas to improve PCP participation in the ICTs and care plan development for their enrolled patients and are also looking to identify ways to encourage them to see the benefit of the demonstrations in helping their patients access a wide range of non-primary care services offered by the plans.

Consumer Direction: While consumer-direction is a topic that all plans included in the training of their care coordinators, it is an area plans and consumers are still learning about and that remains

¹² Completing health risk assessments in time required was also noted in the Kaiser early insights reports. See footnote #2.

underutilized, particularly for older adults. Self-direction is an increasingly popular choice for consumers who want to choose their own caregiver instead of having their plan utilize the more traditional method of contracting with an agency for these services. Plans expressed an interest in ideas on how to develop the consumer-direction option. More information is needed, not only by health plan staff, but also for consumers to understand this option, how it works, and how it is integrated into their care plan.

Consumer Advisory Committees: Plans consistently reported valuing input from CAC members and the community at large and regard this as part of their mission. The dual eligible population can often be hard to reach and/or are frail, face language barriers and are often isolated. Utilizing innovative strategies to gain input from enrollees (e.g., one plan is using video conferencing) should be pursued. The plans welcomed ideas on how to improve recruitment and participation of member/enrollees.

“We have the attention of the senior [leadership] who have authority to effect change”

Recommendations

The following recommendations fall into two categories - policy and operations – and if adopted would yield significant improvements for enrollees.

Care Coordination:

Policy recommendations

- Offer plans more flexibility in the time to complete the Health Risk Assessments: For most enrollees, it is essential that an HRA and care plan be developed in a timely fashion, particularly given the fact that many suffer from significant and multiple chronic conditions and may have unmet needs. However, for numerous reasons (e.g., incorrect enrollee contact information) it can be difficult to complete a risk assessment and care plan for some enrollees within the 60- or 90-day timeframe specified in most contracts. Moreover, enrollment of large numbers of beneficiaries at the same time, often through passive enrollment, also challenged the plans’ abilities to complete HRAs within the timeframe. Flexibility around HRA and care plan completion dates should be offered to plans that are able to document the attempts made to reach enrollees.
- A more proactive effort must be made to improve primary care physician education and engagement: CMS, the state and plans should collaborate to increase efforts to engage primary care physicians. Recently CMS has increased their efforts to reach out in multiple ways to discuss the demonstrations with provider groups. Additional ideas could include holding joint regional provider forums and targeting large provider practices to meet and share information

and concerns. In addition, CMS and states should issue guidelines for how plans can more effectively engage PCPs.¹³

- Promote additional reimbursement for physician participation in care teams: Many physicians have patients in more than one plan (in some cases in New York this could be up to 20 plans) and the time needed to participate in individual plans can be overly time consuming. Additional reimbursement from CMS to plans or providers to enable physician practices for additional staff to assist with this could be very beneficial. For example, New York State is pursuing concrete steps to address this problem, including reimbursement for PCPs to participate in team meetings, allowing non-PCP practice staff to participate in the ICT, and allowing specialists to serve as the PCP for purposes of the ICT.

Operational recommendations for plans

- Implementing changes to the care team: Depending on the care team model, this could include the use of transition coordinators (to help with transition from hospital to home for example), the use of a smaller ratio of clinicians to enrollees so that clinicians are able to focus more intensely on their patient panel; the use of nurse practitioners as substitutes for physicians, and in Massachusetts, the inclusion of the Independent Living-LTSS Coordinator.
- Improving the participation of PCPs by using technology to facilitate information sharing between ICT members: One plan found beneficial using a courier service to get PCP signatures on care plans.
- Given the importance of personal care and behavioral health services, plans should encourage these providers to be part of the care team, facilitating the integration with primary care.
- Be more rigorous about making sure there is regular contact between care coordinator and member: Ideas include sending each member a refrigerator magnet with the name of their care coordinator so they know who their point of contact is.
- Reinforce to the care coordination team that they ask about members' values, goals and preferences (including self-direction): These should be documented in the care plan and utilize alternative means to ensure the member and family are part of the care planning process and ongoing ICT via conference call, video etc.)

Consumer-Direction

Policy recommendations

- Improve the state's process for personal care benefit approval: The delay in approval of self-direction budgets¹⁴ was viewed as holding up the plan's ability to approve budgets and care

¹³ See tip sheets on outreach to providers at

<http://www.integratedcareresourcecenter.com/integrationResourceLib/engagement/ProviderCommunication.aspx> for more

¹⁴ An individualized budget is the amount of funds that is under the control and direction of the individual. The budget plan is established in the service plan. States must describe the method for calculating the dollar values of individual budgets based on reliable costs and service utilization, define a process for making adjustments to the budget when changes in participants' person-centered service plans occur and define a procedure to evaluate participants'

plans in timely fashion. The need for a process to expedite cases would help prevent a gap in a member receiving personal care services.

- Disseminate resources to MMP plans on consumer direction: Many plan care coordinators could benefit from additional information on the benefits of consumer-direction and how to implement this option. Several national organizations offer these resources; CMS and states should encourage the use of these, including securing support from the Administration for Community Living.¹⁵ Further, many states with dual demonstrations (CA, IL, MA, OH, RI, and TX) host matching services registries that connect consumers with personal care providers based on their needs and preferences.¹⁶

Operational Recommendations for plans:

- Enhance training on consumer direction as part of regular care coordinators' training: Many plan care coordinators could benefit from additional information on the benefits of consumer-direction and how to implement this option. This could include additional outreach and education to members, especially those over age 65.
- Conduct annual surveys of enrollees and family members and caregivers to better understand how they are experiencing consumer direction.

Consumer Advisory Committees:

Policy Recommendations

- CMS should offer concrete guidance to plans regarding stipends: Many plans would like to offer a stipend to members for their participation, yet plans had differing opinions regarding whether MMPs are permitted by CMS to pay consumers for their service. The role of members is an essential part of quality improvement and plan responsiveness, demonstrating the value of their members' time and input, and compensating members would reflect this. Further, it could help overcome barriers to participation

Operational Recommendations for Plans

- Offer training to enable effective member participation: Once members have signaled an interest in participating, it is important to offer training for “onboarding” members as a way to both educate them about their role as well as to reinforce the value of their participation and contribution. Tools for meaningfully engaging members are available for plans¹⁷ and the [Resources for Integrated Care website](#) has links to webinars offered to plans and other stakeholders.

expenditures. For more information, go to <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html>

¹⁵ The Administration for Community Living offers technical assistance on self-direction www.adrc-tae.acl.gov/tiki-download_file.php?fileId=29505, as does the National Resource Center for Participant Directed Services <http://www.bc.edu/schools/gssw/nrcpds/>

¹⁶For more information on registries, see <http://phinational.org/policy/resources/phi-matching-services-project>

¹⁷ For more information, go to <http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement>

- Partner with community-based organizations: Utilizing community linkages, including the Ombudsman, community providers, faith-based groups, and advocacy organizations can help not only recruit members to participate on the committees but also help address broader, community-wide programmatic issues.

Conclusion:

This study identified challenges as well as plan innovations and offers solutions to improve and strengthen care, services and ultimately the health of the dual-eligible beneficiaries enrolled in the Financial Alignment Demonstration. ACAP and Community Catalyst acknowledge the limits of data from a small sample of participating plans. However the results of this survey help inform the progress of the demonstrations and help identify promising practices in reaching the goal of coordinated and person-centered care. It also indicates the need for multi-stakeholder involvement in operationalizing these provisions to their full extent, for improved communication between the various stakeholders – policymakers, plans, providers, consumers, and community-based organizations – and ongoing improvements as new challenges arise and plans develop more experience implementing the demonstrations.

CMS recently offered the states participating in the dual demonstrations the option of extending the demonstration for two years; all participating states indicated that they are interested in at least preserving the extension option. This is recognition of the time it takes to adopt and implement new models of care and to develop care plans for all enrollees. These extensions, should they be taken up, will allow CMS and states to review and change policies needed to address problems, and allow MMPs to adjust and/or change practices as needed.



Acknowledgments: The research for this report was conducted by Angelina Flores Montoya, MSN, RN, who worked at Community Catalyst in the summer of 2015. Angelina is a Robert Wood Johnson Foundation Nursing and Health Policy Fellow and a PhD student at the University of New Mexico College of Nursing.

ACAP's vision is to improve health and well-being of lower-income and vulnerable populations and the communities in which they live. ACAP represents 61 local, not-for-profit, community-affiliated Safety Net Health Plans serving more than 15 million people. ACAP-member plans primarily serve members who are enrolled in public or state-sponsored coverage programs, such as Medicaid, Medicare, CHIP or other state-only subsidized programs.

Community Catalyst's mission is to organize and sustain a powerful consumer voice to ensure that all individuals and communities can influence the local, state and national decisions that affect their health. Community Catalyst partners with organizations in forty states by offering policy, legal, communications and advocacy expertise so advocates are equipped with the right strategies, information and tools to succeed.

Appendix A: Care Manager Requirements by State

As of June 2015

State	Care Manager/Care Coordinator Requirements
<i>States linked to CMS documents</i>	<i>Every managed care plan must assign a care manager or care coordinator to work with a beneficiary. Within the Memorandum of Understanding (MOU), requirements of the care manager or care coordinator are defined as such:</i>
California	Care manager is licensed RN or other individual licensed to provide clinical care management
Colorado	State testing managed fee-for-service model using its existing Accountable Care Collaborative program for Medicaid beneficiaries, a hybrid of a primary care medical home and an ACO. Pilot is statewide.
Illinois	Care Coordinator could be RN, LCSW, Rehabilitation Specialist or other with relevant clinical background
Massachusetts	Clinical Care Manager – licensed RN or other individual licensed to provide clinical care management
Michigan	ICO Care Coordinator: RN, Nurse Practitioner, Physician Assistant or Bachelor or Masters prepared SW
Minnesota	N/A (Minnesota's demonstration will test the integration of administrative functions without financial alignment)
New York	An appropriately qualified professional
Ohio	Care Manager must be an appropriately qualified manager
South Carolina	Clinical Care Manager must be licensed RN or other individual employed by Primary Care Providers or CCIO and licensed to provide clinical care management
Texas	No language in MOU. 3-way contract: Service Coordinator level 1 Enrollee must be: RN or NP & LVNs (employed before 3/1/13). Level 2 Enrollee: must have an undergraduate or graduate degree in social work or a related field or be an LVN, RN, NP, or PA; or have a minimum of a high school diploma or GED, and direct experience with the aged, blind, or disabled (ABD)/SSI population in 3 of the last 5 years prior to beginning in the role of Service Coordinator.
Virginia	No language in MOU. 3-way contract: Care manager must have a minimum of a bachelor's degree or be a RN in Virginia with at least one year of experience working as a RN.
Washington - Capitated	Washington will utilize both a managed fee-for-service demonstration and a capitated model. Its managed fee-for-service relies on a Health Home Lead Entity (HHLE) who subcontract with a Health Home Coordinated Care Organization (HCCO) to coordinate the health home services. The capitated demonstration, will take place in two counties (King and Snohomish) and has the following care manager provisions: Intensive Care Coordinator: RN, Masters in behavioral health sciences and one year paid on-the-job social services experience; bachelors in behaviors or health sciences and two years of paid on-the-job social services experience; or bachelors and four years paid on-the-job experience.