



## Financial Alignment Demonstrations Update: Summary of Three Briefs on Evaluation Findings, March 2017

### Overview

The [Medicare-Medicaid Coordination Office](#) (MMCO) recently published [three evaluation briefs](#) on the [Financial Alignment Demonstrations](#). These demonstration projects are currently underway in 13 states to test models of care that align Medicare and Medicaid financing and services – medical, social, behavioral and long-term services and supports (LTSS) – for the dual eligible population. Participating states had the option of choosing from [two financial models](#) for their demonstrations – capitated or managed fee-for-service.

The three evaluation briefs are:

1. [Beneficiary Experience](#): Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative
2. [Early Findings on Care Coordination](#) in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative
3. [Special Populations](#) Enrolled in Demonstrations under the Financial Alignment Initiative

Each brief is summarized in the sections below, drawing on excerpts from the findings.

The release of these evaluations is an important step toward understanding and building the evidence base for the numerous innovations that are underway in our health system, particularly around coordination and integration of care. Monitoring and evaluating these innovations is critical to creating and building a system that is responsive to the needs of our most vulnerable populations. The evidence shows that innovative models of care hold promise and need to continue. The findings from these evaluations point toward the importance of investing in new models of care. Advocates and other stakeholders can draw upon evidence from the FAI evaluation findings both to publicize the successes of, and work toward addressing the challenges of, designing and implementing new systems of care.

### **1. Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative**

#### **Methodology**

For this evaluation, MMCO focused on six demonstration states: California (CA), Illinois (IL), Massachusetts (MA), Ohio (OH), Virginia (VA), and Washington (WA). In this group of states, only WA undertook a managed fee-for-service financing model. The primary method of data collection was through beneficiary focus groups. Once beneficiaries agreed to participate, the

evaluation team made assignments to a focus group based on criteria such as behavioral health needs, LTSS use, race/ethnicity, enrolled health plan, and gender. In some states, certain focus groups were conducted with only Black or only Hispanic participants. English-proficient native speakers of other languages such as Mandarin also participated. A Spanish-speaking moderator conducted the Spanish language focus group using a translated moderator's guide document.

## **Highlights**

- Black and Spanish-speaking focus group participants did not identify cultural or language barriers to their care. Although some Spanish speakers were not aware of the availability of Spanish-translation materials, linguistic access is helpful.
- Participants identified positive changes including greater access to a broader and more flexible range of services (i.e., home care and home modification services), better quality of life and more coordinated and patient-centered approach to their care.
- Identified challenges include limited beneficiary understanding of—and Medicare-Medicaid Plan (MMP) communication about—benefits, rights, and protections because written materials were not easy to understand; issues regarding access to provider networks in the capitated model due to limited networks, particularly behavioral health providers; limited access to pharmacy, medical equipment and supplies; and concerns about the quality, reliability and accessibility of non-emergency medical transportation.

## **Deep Dive**

### ***Understanding of the demonstrations***

- In the capitated models, some focus group beneficiaries expressed a strong understanding of how their health plans had changed and that Medicare and Medicaid coverage had been integrated under their new health plans, while other focus groups reported confusion and dissatisfaction about changes in enrollment or coverage occurring without their knowledge or consent. These issues occurred at the point of receiving care services when they realized they were enrolled in new plans with changes to covered services or limitations to provider networks.
- Beneficiaries reported that materials with overwhelming amount of information were difficult to understand. For limited English Proficient (LEP) participants, access to information in their own language was an issue. In some cases, participants were not aware that states are obligated to provide materials in most commonly spoken languages and they were not aware that they could request these materials.
- Focus groups revealed that awareness of the ability to opt out of the demonstrations or change plans throughout the year varied. Some were aware of this option, but others believed they needed to wait for the next enrollment period to make a change.

### ***Satisfaction with the demonstration***

- For focus group participants in CA, IL, MA and WA, satisfaction was influenced by their experience with the benefits and services received. For participants from OH and VA, as well as MA, satisfaction meant easy access to medical care and services which cost less, thus improving their access to care and quality of life.
- While some participants felt health care services received were easier to navigate in the demonstration, others reported difficulties with finding a provider or specialist.

- Many participants, particularly those receiving LTSS, reported how easy it became under the demonstration to get their needed services or medical equipment.

### ***Health risk assessment process***

- Focus group findings reveal mixed experiences with assessment process and goal-setting. In some cases, it was an obligatory process without meaningful conversations about their unmet needs. In other cases, there was no follow-through once assessments were complete.
- Some participants in IL, MA and WA identified goal-setting as an important part of the process with their care coordinators. Those in the WA demonstration region reported positive experiences with health home care coordinators helping to identify their needs, discuss service options, and set personal goals.
- In the OH demonstration some participants reported confusion or frustration with the goal-setting process. Their care teams had not asked them about their health-related goals nor worked with them to achieve such goals.

### ***Care coordination***

- The majority of beneficiaries were aware of the role of care coordinators and had regular contact with them. However, a few in each state said they were unaware of care coordination until learning about it at the focus group.
- Focus group findings show that those with LEP, interpreter services are available when needed, but reported that even with translators, language could still be a barrier in care coordination. Participants state that it is more helpful when care coordinators are bilingual. Many participants spoke of cultural preferences and the need for care coordinators to receive training to be sensitive to these preferences.
- Participants said that the level of care coordination among their providers (including doctors, hospitals and other providers) varied. For example, participants in VA, some in IL and a few in WA reported that their primary care providers (PCPs) and specialists were affiliated with the same hospital-based health system, so they all used the same electronic health record system. However, in those states where providers and specialists are not in the same system, then their regular providers did not receive information on test results or discharge plans.

### ***Patient engagement***

- Focus group participants reported mixed experiences when it came to involvement in their care decisions or (if proxies) in planning for their family members' care.
- In the WA demonstration, where patient engagement is a key feature, many participants reported not thinking to contact their care coordinators when they need help, either because they thought of themselves as self-advocates or relied on other resources.
- In WA, most participants said they had found doctors who listen, offer choices and include them in decision-making.

### ***Role of regular providers***

- Most of the focus group participants reported positive experiences with regular providers, especially with PCPs.
- The LEP participants reported that they valued having providers who spoke their language, which influenced their selection of, and satisfaction with, their demonstration health care provider network.

- The availability of language access was important for all of the participants in the Spanish-language focus groups, even for those who could communicate in English.

### ***Access to and Quality of Services***

- The focus groups reported mixed experience regarding network size and scope – ranging from limited, same or increased access.
- IL, MA, OH, VA and WA participants reported more limited provider choices than before – difficulties in accessing certain types of specialists and long waits for appointments. Limited choices of, or access to, behavioral health providers, psychiatrists, pain specialists and dentists seem to be a common theme.
- Participants reacted positively to their increased access to new flexible benefits (which were facilitated by care coordinators) such as contact lenses, specialized wheelchairs, homemaker services, home modifications, in-home behavioral health supports, nutrition classes, and weight-loss counseling.
- Participants reported ongoing significant issues with the reliability and accessibility of non-emergency medical transportation.

### ***Beneficiary protections and rights***

- In most states, awareness of the ombudsman program was low, except for OH where more participants were aware of the program.
- In the majority of the states, participants reported not fully being aware of the protections under the demonstration. For example, in IL and OH, participants believed they could not disenroll or change plans throughout the year.
- In the MA demonstration, some participants said they did not receive written notices when benefits were denied so they did not have information on how to request reconsideration or file an appeal.

### ***Impact of services on health, well-being and quality of life***

- Majority of the participants thought their quality of life has improved and credited to specific features of the demonstration like care coordination or improved benefits.
- When participants worked with a care coordinator to set goals and monitor progress toward these goals, they reported changes in their behavior and health management that improved their quality of life. These changes included weight loss, tobacco cessation, increased social activity and improved functionality.
- There were a few participants from states that reported no change in quality of life. For example, in MA, some expressed that their quality of life decreased because they did not have access to the medical supplies they needed.

## 2. Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative

### Methodology

For this evaluation, MMCO focused on the care coordination activities<sup>1</sup> and early findings on successes and challenges of providing care coordination services for the nine capitated model demonstrations<sup>2</sup> that were implemented between October 2013 and February 2015. Data for the evaluation was collected from a number of sources, listed below.

- site visit interviews with state officials, consumer advocates, CMS staff, and various other demonstration stakeholders, including MMPs
- focus groups with Medicare-Medicaid enrollees
- quarterly data submitted by the states; data submitted by MMPs
- quarterly meetings with demonstration representatives from the states
- available reports from states' internal evaluation activities
- state-specific documentation (e.g., websites, three-way contracts final demonstration agreements; and Memoranda of Understanding).

### Highlights

- While the demonstrations vary from state to state, health plans are implementing new care coordination approaches designed to integrate care across medical, LTSS and behavioral health systems and that they have overcome major challenges in designing and implementing the operational details of these new care coordination systems – e.g., hiring and training of new care coordinators and implementing new systems.
- Health plans faced a number of challenges including hiring and retaining large numbers of care coordinators; completing required health risk assessments (HRAs) and individualized care plans (ICPs) for new enrollees within required time frames.
- Once beneficiaries become familiar with the care coordination function, they appreciate the support and learn to ask for assistance with various challenges, including access to needed providers and durable medical equipment.

### Deep Dive

#### *Implementing a Care Coordination System*

- Those demonstration States with a linguistically diverse population of enrollees, such as CA and NY, reported major efforts to hire care coordinators who were linguistically appropriate. According to site visit interviews, hiring so many new care coordination staff<sup>3</sup> was a challenge for many health plans, especially identifying care coordinators with experience across acute care, LTSS and behavioral health. For example, in VA, health plans reported steep learning curves in providing LTSS, partly because most care

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<sup>1</sup> See [Table 2](#) for key components of care coordination.

<sup>2</sup> California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas and Virginia.

<sup>3</sup> See [Table 3](#) for details on care coordination staffing.

coordinators previously worked with medical providers or institutions and did not have broad LTSS experience.

- Most plans had difficulty conducting an HRA within the first 90 days of an individual's enrollment. It was particularly difficult to complete HRAs for passively enrolled beneficiaries because many health plans lacked updated contact information.<sup>4</sup>
- Many beneficiaries found it helpful and a relief to have a care coordinator to help navigate the health care system.
- While health plans have made progress in establishing information systems, many reported difficulties in creating a centralized enrollee record that the entire Integrated Care Team (ICT) can access.

### ***Integrated Care Plans and Integrated Care Teams***

- Health plans in most states had considerable difficulties completing the Integrated Care Plans (ICPs). This was in part due to some states still being in the passive enrollment stage, which generally correlates to lower ICP completion rates.
- Focus groups revealed mixed experiences with developing ICPs. Some participants were aware of and reported positive experiences with goal-setting while some did not do goal-setting with their care coordinator.
- Some health plans reported difficulties in engaging PCPs. For example, in OH health plan representatives suggested that physicians have been slow to engage because of the administrative burden associated with reviewing enrollee assessments and care plans.
- A barrier to provider participation in the ICTs is the lack of reimbursement for their time participating on the team. For example, in CA providers are not currently compensated for participating in ICTs, and some plans said that they are now considering reimbursement to incentivize participation.

### ***Coordination with Behavioral Health***

- Evaluation findings report a number of challenges with coordinating care for beneficiaries with behavioral health problems. A major contribution to this problem is the existence of silos among the medical, LTSS and behavioral health delivery and financing systems. For example, in California, the county behavioral health system providing Medicaid services historically has operated separately, without much interaction with other health programs.
- Another barrier to behavioral health coordination was that in some states, managed care already existed for behavioral health making integration problematic, or it existed but did not cover the demonstration population. This added an extra layer of complexity when it came to actual policy implementation when the Financial Alignment Initiative opportunity came along.
- Many health plans noted the challenge of integrating behavioral and medical health and the difficulty of doing that while safeguarding an enrollee's right to privacy.
- Plans reported that Medicare-Medicaid enrollees were not always willing to accept assistance or to allow behavioral health information to be shared across providers – this took time and effort to build trust between provider and patient.

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<sup>4</sup> Some states are utilizing innovative strategies to locate beneficiaries. In California, health plans hired lower-level, non-credentialed staff with local experience or language capabilities to search for Medicare-Medicaid enrollees in the community.

### 3. Early Demonstrations: Enrolled in Demonstrations under the Financial Alignment Initiative (MA and WA)

#### Methodology

For this evaluation, MMCO focused solely on the first two demonstrations that were implemented: MA and WA. The MA demonstration focused exclusively on the population of persons with disabilities under the age of 65. The WA demonstration focused on high-need, high-cost adult population of any age, using the health home model.<sup>5</sup> The purpose of this evaluation was not to compare the two demonstrations but to examine how special populations are faring in each of these demonstrations.

The evaluation of these two state demonstrations focuses on the following special populations:

- enrollees who use LTSS
- enrollees with behavioral health needs, including those with serious and persistent mental illness (SPMI)
- enrollees from linguistic, ethnic and racial minority groups

Data was collected from the following sources:<sup>6</sup>

- focus group discussions conducted in mid to late 2015 and early 2016
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses
- analysis of WA and MA annual reports for two baseline years prior to the demonstration, and for Demonstration Year 1 – used for the quantitative analyses

#### Highlights

- Demonstration services have helped at least some beneficiaries achieve a wide range of improvements in their lives, from managing chronic conditions to increasing community engagement.
- Care coordination was generally helpful, but many beneficiaries had difficulties in differentiating between their care coordinator and other service providers or were unaware of a wide range of supports available.
- Patient-centered care and patient engagement were important to participants, but some indicated they had difficulty finding providers with whom they felt comfortable.
- Some beneficiaries are not aware of available resources, such as ombudsmen, to assist them when they disagree with the providers or plans or when they need help with

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<sup>5</sup> See [Table 2 and 3](#) for more detail on each demographic and health characteristics for the enrolled, LTSS, and SPMI populations.

<sup>6</sup> The evaluators used an intent-to-treat (ITT) approach for the quantitative analyses conducted for the evaluation. Under this framework, analyses include *all beneficiaries eligible for the demonstration*, including those who are eligible but are not contacted by the State or participating providers to enroll in the demonstration or care model, those who enroll but do not engage with the care model, and a group of similar eligible individuals in the comparison group.

understanding their rights. Additional training and education appears warranted to ensure beneficiary access to complaint and appeal processes. Linguistic minority enrollees appear to have the greatest need for additional outreach in this area.

## **Deep Dive**

### ***Enrollees who use Long-Term Services and Supports (LTSS)***

- Many of the focus group participants with complex needs who use LTSS and did not have their care coordinated in the past utilized health care services at high rates. For example, one focus group participant described how his high utilization of Emergency Department (ED) services led to enrollment in a health home. Another explained how her use of ED services was drastically reduced due to the assistance provided by the demonstration's care coordinator when she had a medical issue arise.
- When it came to assessments and coordination, some focus group participants were pleased with the outcome; however, some remarked on the lack of follow-up with providing services or confusion with multiple coordinators visiting them in their homes.
- Some focus group participants reported improvements in their health and quality of life since enrolling in the demonstration (e.g. improved access to regular care and reduced use of unnecessary medications).
- Several focus group participants experienced difficulties getting durable medical equipment such as wheelchairs supplied or repaired.

### ***Enrollees with Behavioral Health Needs including those with Serious and Persistent Mental Illness (SPMI)***

- Participants (or proxies) with behavioral health issues or SPMI reported improvement in quality of life and decrease in social isolation (e.g., going out more)
- Some participants found limited choices for behavioral health professionals, but those who did have a mental health provider found s/he listened to them, offered choices and included them in decision-making.
- Some participants with behavioral health issues reported that providers worked as a team and shared pertinent information; but others expressed that they were not part of their own care team, and had no role in the decision-making process
- Focus group participants with behavioral health needs in both states expressed satisfaction with the integration of physical and behavioral health services via their care coordinators.

### ***Enrollees from Linguistic, Ethnic and Racial Minority Groups***

- Largely, the data on appeals and grievances do not reflect enrollees' demographics and provide limited data on special populations unless the complaint or appeal relates to language or physical access to services. There were only few formal complaints reported related to language access barriers from MA, including failure to provide an interpreter. Similar data were not available for WA.
- Linguistic access is a major concern when seeking health care. Several participants preferred to have Spanish-speaking providers rather than interpreters. A few participants, especially those who spoke only Spanish, reported that language was an essential consideration for them.



- A majority reported that, instead of using ombudsman services, they advocated for themselves to obtain the services they needed and appeared to know their rights.
- Some reported they did not know their rights. Others said their care coordinators informed them about their rights and protections, assisted them with complaints about services, and advocated for them.

*Highlights from CAHPS survey*

<b>Topic</b>	<b>Massachusetts</b>	<b>Washington</b>
<b>Description of surveys available</b>	The CAHPS survey was available in English or Spanish; 739 enrollees completed the survey. Only results with more than 10 respondents in each of the three One Care plans (at the time of evaluation there were three plans) are reported.	Enrollees who had completed a health assessment and who had been enrolled for at least 5 months were sampled; 827 completed the survey. The survey was available in English.
<b>Care coordination</b>	33 to 54 percent reported being usually or always satisfied with the help they received to coordinate their care; Over half indicated they always receive needed information from their plan.	High satisfaction (70-86 percent) rates with care coordination, health education and promotion of health care goals.
<b>Treatment or counseling</b>	Over 80 percent of the 30-40 percent of respondents who needed treatment or counseling for personal or family problems usually received needed services.	53 percent were satisfied with treatment or counseling program.
<b>Care in home</b>	¼ of respondents needed someone to come into their home to give them home health care or assistance. 68 to 82 percent of those reported that it was usually or always easy to get the service	62 percent of respondents needed these services, of which 66 percent expressed satisfaction, 20 percent were neutral, and about 14 percent were dissatisfied.
<b>Medical equipment</b>	1/3 of respondents had a health problem for which they needed special medical equipment, and 60 to 78 percent of those people reported that it was usually or always easy to get or replace the medical equipment through health plan.	No question asked
<b>Interpreters, accessibility, and cultural competence</b>	7-10 percent of respondents reported needing an interpreter to help them speak with doctors or other health care providers. Responses regarding this were too few (<10) to report. 65 and 70 percent of respondents with disabilities reported they were usually or always examined on the examination table when they visited their personal doctor's office.	87 percent responded that they were satisfied with the cultural competence of their providers.