



July 2013

# Development of the Financial Alignment Demonstrations for Dual Eligible Beneficiaries:

PERSPECTIVES FROM NATIONAL AND STATE DISABILITY STAKEHOLDERS

## EXECUTIVE SUMMARY

As part of the implementation of the Affordable Care Act, 26 states submitted proposals to the Centers for Medicare and Medicaid Services (CMS) to implement demonstrations to integrate care and align financing for beneficiaries who are dually eligible for Medicare and Medicaid; as of July 2013, six states have received approval from CMS to implement a demonstration, and 16 proposals remain pending review. Given the degree of interest in these demonstrations, we sought to identify common issues and potential solutions to inform other states as they develop and implement demonstrations.

With an emphasis on illuminating the specific concerns of beneficiaries under age 65 who use long-term services and supports (LTSS), we conducted a series of 26 structured interviews with national and state disability stakeholders from October 2012 through January 2013. Respondents included representatives of cross disability coalitions and organizations representing people with physical, mental health, and developmental disabilities (DD), as well as legal services providers. In addition to representatives of national organizations, we focused on examining the experience to date in Colorado, Massachusetts, Michigan, Ohio, and Washington. This issue brief provides an early snapshot of disability community perspectives on state design and implementation efforts related to the new demonstrations. Key interview findings include the following:

**Respondents see opportunities for improving the delivery of services presented by the demonstrations as mostly overshadowing risks from changing the status quo, although they have some outstanding concerns about the demonstrations' implementation.** Respondents observed that improved care coordination from the demonstrations might improve beneficiary health outcomes and reduce health disparities that stem from a lack of physically accessible care for people with disabilities. They also recognized the demonstration's potential to increase access to home and community-based services (HCBS) and mental health services. Respondents were most focused on the thoroughness of the process to assess health plan competency and capacity before enrollment begins and

the possible disruption of beneficiaries' established provider arrangements. Respondents also voiced concern about potential gaps in LTSS, such as if a home care worker misses a shift, which could be hazardous or even life-threatening for beneficiaries with disabilities.

**Many details about how beneficiaries will be passively enrolled in the demonstrations and how beneficiaries will be matched with health plans remain to be determined, which concerns respondents.** Given the vulnerability of the population, most respondents expressed a strong preference for purely voluntary enrollment, where beneficiaries would choose to participate in the demonstration. Failing a purely voluntary system, respondents preferred a period of voluntary enrollment lasting at least several months before any automatic enrollment of beneficiaries into demonstration health plans. Respondents view access to impartial in-person counseling for beneficiaries to assess enrollment options as important to help beneficiaries, such as some with developmental or mental health disabilities, navigate complex health plan choices.

**Respondents observed that there are clear benefits to better integrating and coordinating LTSS with medical services, but also some risks if integration adopts a “medical” model that favors providing treatment for illness over non-medical services to support independent community living.** Respondents generally believe that most health plans currently have limited experience with providing person-centered care, managing home and community-based LTSS, and administering self-directed service delivery models and expressed concern that health plans may not necessarily be accustomed to viewing people with disabilities as expert in their own care. Respondents noted that a minority of health plans have reached out to disability groups to develop their LTSS expertise. Respondents supported Massachusetts' requirement for independent Long-Term Supports Coordinators from community-based organizations and otherwise had questions about the undefined role for existing community-based organizations in some states' demonstrations, especially those organizations that are focused on meeting the needs of people with disabilities under age 65.

**Respondents suggested that the demonstrations should be viewed as a means to spending program money more effectively as opposed to realizing savings.** Respondents viewed federal guidance that requires first year savings in the capitated model as unrealistic in the early phases of the demonstrations, given the need for upfront investments to build capacity and monitor new systems. At the time of the interviews, little was known about plan and provider payment rates, which respondents view as a critical determinant of the demonstrations' feasibility and success, especially regarding LTSS access.

**Respondents supported state efforts to provide for ongoing stakeholder engagement that includes beneficiaries with disabilities and incorporate beneficiary protections such as independent ombudsman programs.** Respondents reported that not enough attention, in both the disability community and in the state and federal development of the demonstrations, has focused on effective LTSS quality metrics or clinical measures for subpopulations of people with disabilities. Respondents also believed that physical and programmatic accessibility could be improved if standards to evaluate Americans with Disabilities Act compliance are built into health plan readiness reviews.

**While disability stakeholders have been engaged in the development of the financial alignment demonstrations, respondents point out that many important details of the demonstrations still remain to be specified and are hoping that changes will strengthen protections for people with disabilities.** The financial alignment demonstrations offer the potential to develop new approaches to care delivery. As the demonstrations

proceed, the interview findings suggest that additional attention should be paid to issues that are important for beneficiaries with disabilities, such as the need for increased access to HCBS, improved care coordination, standards for physical and programmatic access, adequate payment rates and risk adjustment for high need populations, LTSS quality metrics, and beneficiary protections. Throughout this process, people with disabilities are critical partners in working with states, CMS, and others to maximize the lessons learned through the demonstrations.

## INTRODUCTION

Many provisions of the Affordable Care Act (ACA) seek to rationalize the health care delivery system, better integrate services, and adopt more efficient and effective service delivery models, especially for populations that have extensive needs and are high users of health services. Numerous policy initiatives are underway to improve how care is delivered for these individuals, including the establishment of Medicaid health homes and the creation of accountable care organizations (ACOs). Dual eligible beneficiaries, who are seniors and people with disabilities under age 65 who are eligible for both Medicare and Medicaid, are affected by many of these efforts.

The ACA also includes provisions specifically focused on improving care for dually eligible beneficiaries, including new demonstration authority through which states can seek to better integrate the overlapping and complementary services provided by Medicare and Medicaid. Often for dual eligible beneficiaries, the challenge is how to integrate and coordinate primary care medical services, for which Medicare is largely responsible, and long-term services and supports (LTSS), for which Medicaid is largely responsible. This issue brief provides an early snapshot into disability community perspectives on the states' design and preliminary implementation efforts related to new demonstrations that seek to integrate care and align financing for dual eligible beneficiaries (informally known as the “duals demos”).

## BACKGROUND

### *Dual Eligible Beneficiaries*

Nationally, there are over 9 million dual eligible beneficiaries, who are low-income seniors and non-elderly people with significant disabilities who have diverse types of health conditions, various levels of need, and differing preferences for community-based versus institutional care.<sup>1</sup> Medicare is the primary payer for dual eligible beneficiaries and covers hospital, physician, and post-acute services, diagnostic tests, and prescription drugs. Just over 7 million “full duals” receive Medicaid assistance with paying their Medicare premiums and cost-sharing, as well as services covered by Medicaid that Medicare does not cover, the most significant of which are LTSS. The remaining 2 million “partial duals” receive Medicaid assistance only with paying their Medicare premiums and cost-sharing and are not the focus of the financial alignment demonstrations.

This brief focuses on the impact of the financial alignment demonstrations on dual eligible beneficiaries under age 65. These beneficiaries have a wide range of disabilities, including physical disabilities, mental health disabilities, intellectual and developmental disabilities (I/DD), spinal cord and traumatic brain injuries, and chronic disabling diseases. Nearly four in 10 dual eligible beneficiaries are non-elderly people with disabilities.<sup>2</sup> Non-elderly dual eligible beneficiaries differ from elderly dual eligible beneficiaries in several ways. Non-elderly dual eligible beneficiaries are less likely than elderly dual eligible beneficiaries to have three or more chronic conditions (43% vs. 63%), and a slightly smaller share of non-elderly dual eligible beneficiaries requires assistance with one or more

activities of daily living as compared to elderly dual eligible beneficiaries (40% vs. 46%).<sup>3</sup> Non-elderly dual eligible beneficiaries are less likely than elderly dual eligible beneficiaries to live in a mental health facility or nursing facility (9% vs. 21%).<sup>4</sup> However, a larger share of non-elderly dual eligible beneficiaries than elderly dual eligible beneficiaries has cognitive or mental impairments (73% vs. 48%).<sup>5</sup>

Non-elderly dual eligible beneficiaries generally used fewer Medicare-covered services than elderly dual eligible beneficiaries in 2008. These include inpatient hospitalization (22% vs. 29%), hospice services (1% vs. 7%), home health services (7% vs. 15%), and skilled nursing facility services (4% vs. 13%).<sup>6</sup> The exceptions are physician visits and emergency room visits. Notably, nearly twice as many non-elderly dual eligible beneficiaries had one or more emergency room visits compared to elderly dual eligible beneficiaries (22% vs. 13%) in 2008.<sup>7</sup>

There are some differences in spending patterns for non-elderly dual eligible beneficiaries as compared to elderly dual eligible beneficiaries. Medicare spending for non-elderly dual eligible beneficiaries is substantially lower than spending for elderly dual eligible beneficiaries (\$11,423 per capita vs. \$15,924 per capita, on average).<sup>8</sup> This difference may partly be due to lower rates of hospitalization among non-elderly dual eligible beneficiaries.

Medicaid spending for non-elderly dual eligible beneficiaries is far greater for long-term care than for acute care services (\$31.0 billion vs. \$12.9 billion).<sup>9</sup> Almost 40 percent of Medicaid spending for this group is for home health and personal care services, and another 31 percent is for institutional long-term care (ICF/DD, nursing facility or mental health facility).<sup>10</sup> The remaining 29 percent of Medicaid spending is distributed among various acute care services.<sup>11</sup> While the composition of Medicaid spending for older dual eligible beneficiaries is similar to that for non-elderly dual eligible beneficiaries, spending for non-elderly dual eligible beneficiaries is more concentrated in community-based rather than institutional long-term care settings.<sup>12</sup>

### ***The Financial Alignment Demonstrations***

As part of the implementation of the ACA, 26 states submitted proposals to the Centers for Medicare and Medicaid Services (CMS) to implement financial alignment demonstrations for dual eligible beneficiaries (Figure 1).<sup>13</sup> CMS has proposed two models that it would like to test. One is a capitated model that involves a three-way contract between CMS, the state, and participating health plans. Plans will receive a prospective blended rate for all primary, acute, behavioral health, and LTSS. A set percentage is deducted upfront from the Medicare and Medicaid contributions to the blended rate, which is intended to allow CMS and the state to share savings. The other is a managed fee-for-service (FFS) model, which involves an agreement between CMS and the state in which the state will be responsible for care coordination and the delivery of fully integrated Medicare and Medicaid benefits. In return, the state will be eligible for a retrospective performance payment if a target level of Medicare savings, net of increased federal Medicaid costs, is achieved and if specified quality thresholds are met. In this model, providers will continue to be reimbursed on a FFS basis by CMS for Medicare services and by the state for Medicaid services. CMS is presently reviewing the states' proposals and working with selected states to develop memoranda of understanding (MOUs) to implement the demonstrations. As of July 2013, MOUs have been finalized with California, Illinois, Massachusetts, Ohio, and Virginia to implement a capitated model and with Washington to implement a managed FFS model.<sup>14</sup>

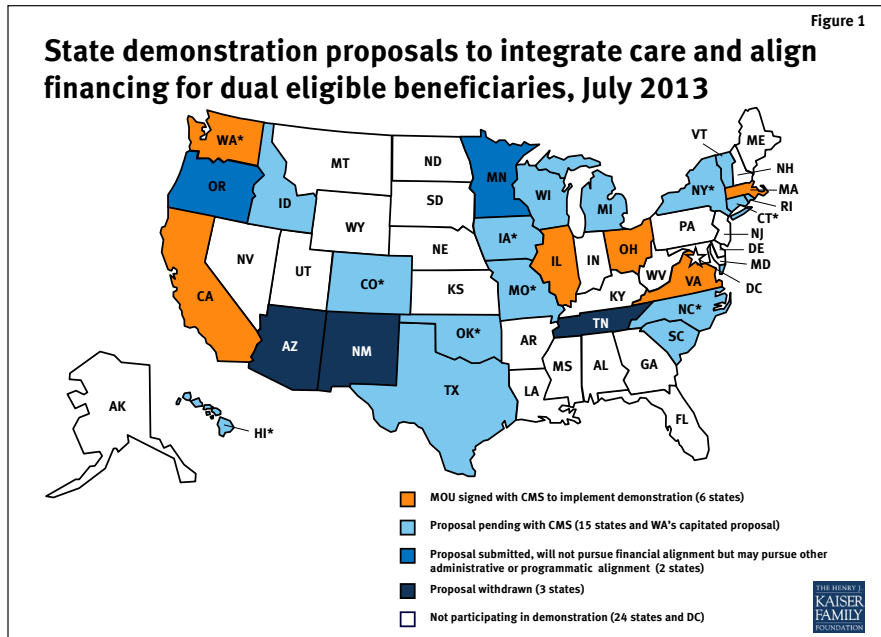


FIGURE 1 NOTES: \*CO, CT, IA, MO, and NC proposed managed FFS models. NY, OK, and WA proposed both capitated and managed FFS models; however, NY has withdrawn its managed FFS proposal. All other states proposed capitated models. WA's MOU is for its managed FFS model only; its capitated proposal remains pending with CMS. HI's proposal remains pending, but it does not anticipate implementation in 2014. SOURCE: CMS Financial Alignment Initiative, State Financial Alignment Proposals, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html>, and state websites.

The financial alignment demonstrations offer an opportunity to improve coordination of services and beneficiary outcomes while also minimizing unnecessary health spending. For this reason, they have attracted support, although sometimes cautious support, from a wide range of stakeholders ranging from state program administrators to some individual beneficiaries and their advocates. While the demonstrations offer the potential for innovation that could lead to improvements in how services are delivered, they also could pose risks for beneficiaries, especially if implementation leads to an upending of carefully crafted, individual provider networks or if these new programs are not equipped to adequately meet beneficiaries' needs. Stakeholders' caution generally arises from the potential disruption of established beneficiary-provider relationships as a result of changing the care delivery model and a lack of details to date about key aspects of demonstration implementation.

## PROJECT OVERVIEW

Given the degree of state interest in these demonstrations, we sought to identify common issues and potential solutions to inform other states in the development and implementation of their demonstrations. With an emphasis on illuminating the specific concerns of beneficiaries under age 65, particularly those who use LTSS, we conducted a series of structured interviews with national and state disability representatives from October 2012 through January 2013. A total of 26 interviews were completed with representatives of cross disability coalitions and individuals representing non-elderly people with physical, mental health, and developmental disabilities, as well as legal services providers. In addition to representatives of national organizations, we focused on examining the experience in Colorado, Massachusetts, Michigan, Ohio, and Washington (Table 1). To inform policy decisions and implementation efforts in states whose financial alignment demonstration proposals have not yet been approved by CMS, we selected states from among those that initially proposed implementation in 2013 to provide as much diversity as possible in terms of financing models, geography, and political landscape. Respondents were asked about their views and experiences on topics ranging from the responsiveness of the state to community input in developing the demonstrations, to enrollment targets and procedures, to the capacity of private plans to deliver LTSS. Key areas of inquiry are summarized in the following sections.

**TABLE 1: SNAPSHOT OF SELECTED STATES' FINANCIAL ALIGNMENT DEMONSTRATIONS FOR DUALY ELIGIBLE BENEFICIARIES, JULY 2013**

State	Total Number of Beneficiaries Eligible for Participation (Estimated)	Target Population <sup>1</sup>	Statewide	Passive Enrollment	Financial Model	MOU Approved by CMS	Anticipated Implementation Date
Colorado	62,982	Full benefit dual eligible beneficiaries (excludes beneficiaries receiving DD services and beneficiaries in certain home and community-based services (HCBS) waivers)	X	X	Managed FFS		2013 (pending CMS approval)
Massachusetts	115,000	Full benefit dual eligible beneficiaries ages 21 to 64 (excludes intermediate care facilities for individuals with DD (ICF-DD) residents and all § 1915(c) HCBS waiver participants)	X	X	Capitated	X	October 2013
Michigan	198,644	Full benefit dual eligible beneficiaries	4 regions <sup>2</sup>	X	Capitated		July 2014 (pending CMS approval)
Ohio	114,972	Full benefit dual eligible beneficiaries ages 18 and older (excludes beneficiaries with DD receiving services in an ICF/DD or § 1915(c) HCBS waiver)	Seven regions comprising 29 counties	X	Capitated	X	March 2014
Washington	115,000 (21,000 in managed FFS model)	Full benefit dual eligible beneficiaries (managed FFS model limited to high cost/high risk beneficiaries eligible for Medicaid health home services)	Managed FFS model statewide except in 2 urban counties pursuing capitated model	X	Both	X (managed FFS model only)	July 2013 (managed FFS); 2013 (capitated, pending CMS approval)

NOTE: <sup>1</sup> For a complete listing of groups excluded from the state's proposals, see Kaiser Commission on Medicaid and the Uninsured, *Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS* (July 2013), available at <http://www.kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/>; Kaiser Commission on Medicaid and the Uninsured, *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS* (Oct. 2012), available at <http://www.kff.org/medicaid/report/state-demonstrations-to-integrate-care-and-align/>.

<sup>2</sup> Michigan's original proposal was for statewide implementation, but the state is now proposing four regions. See Michigan Dep't of Community Health, "Michigan's Integrated Care Proposal Launch Date Moved to July 2014" (May 8, 2013), available at [http://www.michigan.gov/mdch/0,4612,7-132-63157\\_64754-302253--,00.html](http://www.michigan.gov/mdch/0,4612,7-132-63157_64754-302253--,00.html).

SOURCE: CMS Financial Alignment Initiative, State Financial Alignment Proposals and MOUs, available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html> and state websites.



## INTERVIEW FINDINGS

### Demonstration Proposal Development

In assessing the development of their demonstration proposals, it is important to consider the different starting point for each state, which may determine the financing model used in the demonstration and often how the demonstration fits into a state's broader strategy for strengthening and integrating its existing care delivery system. States have had differing levels of experience with Medicaid managed care, especially with regard to serving seniors and people with disabilities through capitated programs. Further, some states have not made as much progress as others in rebalancing their overall long-term care systems by expanding access to home and community-based services (HCBS). In addition, some beneficiaries with certain disabilities may have greater access to community-based services through longstanding Medicaid waiver programs than people with other types of disabilities.<sup>15</sup> This means that there may be additional room for some states to demonstrate more rapid gains in – and potential cost savings over time from – rebalancing, whereas others that have achieved this progress already may face slower going if they are left with more resource-intensive cases to transition to community settings. The states' respective starting points also influence whether respondents perceived the demonstrations as a major or more incremental change, both in terms of including LTSS in a managed care delivery model and in integrating Medicare and Medicaid services.

Key points raised by respondents about the development of state demonstration proposals include the following:

- » **Respondents see opportunities for improving the delivery of services as mostly overshadowing risks from changing the status quo, although they have some outstanding concerns about the demonstrations.**

Many respondents could identify numerous concerns about their state's demonstration, but they still expressed hope, if not optimism, that the demonstration could lead to improvements in the health care systems and in the lives of dual eligible beneficiaries. The most commonly expressed concern raised by respondents about the demonstrations is that there is not a thorough enough readiness review process in place to assess whether health plans have the competency and capacity to accept enrollment and provide services and consequently, that the state would begin enrolling vulnerable beneficiaries into a new system – sometimes even involuntarily – before the new system was ready to serve them. A related issue is respondents' fear that the demonstrations could interrupt established personal networks of care and support, without replacing them with a comparable network that is acceptable to the beneficiary, stable, and viable.

Especially where the demonstrations involve integrating LTSS into capitated financing arrangements, for which limited successful models exist, prominent concerns of respondents are that individuals retain access to their current LTSS providers and that the provider network is adequate. A national respondent said that the challenge is getting the right mix of providers to participate in plan networks and that “...there are such varying levels of experience and expertise[,]... how do we make sure that the right providers are willing to contract with managed care organizations?” Another respondent, expressing a similar perspective, said that there already is a network of community-based services providers and families acting as paid providers in various self-directed programs and that “there is no other network of people to provide these services,” observing that health plans should seek to include existing community-based LTSS providers in their networks.

Respondents acknowledged that the existing care delivery systems in their states are not perfect and do not always work well for all beneficiaries. Some respondents pointed to health disparities between people with and without disabilities in areas such as receiving preventive care and timely diagnosis of medical problems, stemming from a lack of primary care physicians who are competent to meet the needs of adults with disabilities and a lack of physically accessible medical equipment. Several respondents saw the demonstrations as offering the potential to improve access for people who are not currently receiving services or who are under-served, such as beneficiaries who need HCBS and beneficiaries with mental health diagnoses, and to include non-traditional services such as peer supports for beneficiaries with mental health diagnoses. Another respondent, however, wondered if existing problems stemmed more from gaps in the existing mental health and HCBS offerings rather than from misalignment of the Medicare and Medicaid delivery systems. Respondents also worried that combining physical, behavioral health, and LTSS into the same capitated rate could result in less behavioral health and LTSS being provided in favor of physical health services.

Respondents repeatedly identified certain populations as having both the most to gain and being the most vulnerable should the demonstrations not work effectively. For people with co-occurring mental and physical health issues, some respondents stated that Medicaid has made some progress at improving the quality of mental health services, but that the quality and adequacy of physical health services was a major concern for this population. For “medically fragile” individuals who require LTSS, respondents pointed out that gaps in services, such as if a home care worker misses a scheduled shift, could be hazardous or even life-threatening, but improved care coordination potentially could have a positive impact on quality of life and health outcomes for these beneficiaries.

A number of states have proposed exempting people with developmental disabilities (DD) from their demonstrations. An exception among states selected for these interviews is Michigan, which does plan to include beneficiaries with DD in its demonstration. (Michigan’s proposal includes a “care bridge” that would link existing care coordinators who oversee managed LTSS for people with developmental and mental health disabilities with health plans that would provide acute care services for these populations.) A respondent from Michigan who advocates on behalf of people with DD expressed concern that the remaining level of services and care delivery system outside of the demonstration could be inadequate and that the implementation of the demonstrations should not be permitted to displace the current delivery system while the demonstrations are still being tested.

» **Respondents reported that state efforts to provide opportunities for community stakeholder input in the development of the demonstrations were mostly positive, although some respondents would have preferred more opportunities for dialogue with the state.**

Most respondents reported that their state did a good job engaging community stakeholders in the development of their demonstrations, although this was not a universal view, and no respondent thought that their state’s efforts were perfect. One Ohio respondent observed that stakeholders felt that they had to be proactive about indicating that they wanted to offer input, “but once we did so, the state worked well with us.” Several respondents said that they thought that CMS had done a good job of signaling to states that stakeholder engagement was a critical part of demonstration proposal development. Even when some respondents criticized a state process, they also indicated that they had more direct engagement with the state about the financial alignment demonstration than with previous policy initiatives. Interview subjects in both Massachusetts and Washington were nearly universal in saying they thought the state did a good job at meeting with a diverse array of stakeholders during proposal development, and one respondent even emphasized that they do not normally speak so positively about the state.



Some respondents felt the states fell short in engaging dual eligible beneficiaries while designing their demonstrations, saying that the state talked to advocates but few actual beneficiaries of the programs. At the time of the interviews, a Colorado advocate said that the state was belatedly considering focus groups as a strategy for gaining input directly from beneficiaries. Another common observation among respondents is that states held numerous public meetings, but community members were not always able to ensure that their suggestions were acted upon or even gain feedback about whether the state agreed or disagreed with their input. For example, several respondents in different states described stakeholder input meetings as involving presentations by state officials followed by comments from stakeholders rather than opportunities for back-and-forth dialogue between the state and stakeholders.

- » **Respondents observed that stakeholder advocacy led to tangible policy changes in the demonstration proposals, although they noted that states did not accept all stakeholder input, particularly regarding voluntary enrollment.**

Respondents in all five states were able to point to tangible policy changes where the state had revised its demonstration proposal as a result of public input. In Colorado, the state has reportedly established an ongoing advisory council, of which half of the members are dual eligible beneficiaries. Massachusetts has included a Long-Term Supports Coordinator as part of each individual care team, and the state is requiring its demonstration health plans to contract with community-based organizations for this role, as a result of stakeholder input. Advocates in Michigan noted the state's emphasis on person-centered planning as an important change to the proposal, whereas in Ohio, the fact that the state retained existing beneficiary-friendly notice and appeals requirements was applauded. In Washington's capitated model, respondents said that the inclusion and specific listing of the full range of services in the benefits package was a significant addition to the demonstration proposal based on stakeholder feedback.

We also asked about stakeholder input on major elements that the state did not adopt. There was some universality in responses across the states on this issue. One of the most cited areas related to automatic enrollment in the demonstration, as discussed below.

## **Enrollment**

Respondents recognized that there are competing priorities in the demonstrations, namely attaining the scale needed to achieve efficiencies versus keeping the demonstration narrowly focused on testing and refining a set of core policy ideas before expanding new financing and delivery systems to larger populations. In addition to scale, there are complicated issues related to how to best help beneficiaries with complex care needs navigate the transition to a new system and make informed individual decisions about whether to participate in the demonstration and which health plan to choose. Key issues raised by respondents about the enrollment of individuals into the demonstrations include the following:

- » **Details about the passive enrollment process and how beneficiaries will be assigned to health plans are issues of concern among respondents.**

Most respondents expressed a strong preference for purely voluntary enrollment, where beneficiaries would choose to participate in the demonstration. They noted that while the status quo may not work for all beneficiaries, it does work for some who have established a functioning and efficient system of care. There is a belief among respondents that it would be unfair and in some cases risky to force such beneficiaries out of their current system and into an unproven, new system, especially where beneficiaries have providers and services on which they are relying to live

independently in the community. Respondents also pointed out that having to make an affirmative decision to enroll in the demonstration could help ensure that beneficiaries realize that the care delivery system is changing. Respondents were concerned that if beneficiaries instead were automatically enrolled in the demonstration, they may not realize that they have new arrangements required to access care until they were at a crisis point.

Failing a purely voluntary system, respondents preferred a period of voluntary enrollment lasting at least several months before any automatic (or “passive”) enrollment of beneficiaries into demonstration health plans. This option was cited by respondents as a way for plans to build provider network capacity and gain experience with serving this beneficiary population before taking on full-scale enrollment. Many respondents also emphasized that beneficiaries always should retain the ability to opt out of the demonstration. One respondent noted, however, that allowing beneficiaries to choose not to participate in the demonstrations could be a way for health plans to “cream” beneficiaries by encouraging difficult-to-serve populations to opt out.

Another issue mentioned by respondents is whether the state will attempt to consider unique beneficiary characteristics when assigning beneficiaries to a specific health plan and whether those characteristics will be effective in matching vulnerable individuals with an appropriate plan and provider network. Respondents cited concerns about how automatic plan assignment decisions will be made and whether the plans will have the capability to meet beneficiaries’ needs. A respondent from Massachusetts stated, “I am concerned that people with complex needs will be passively enrolled into [health plans] without the competency to care for them. What are the benchmarks to prove that [plans] have competency before passive enrollment?” Some respondents are most worried about nursing facility residents who are passively enrolled, asserting that these beneficiaries’ vulnerability to being poorly served could be greatly exacerbated by a poor plan assignment. Others raised similar concerns about people with intellectual disabilities not receiving accessible and effective informational materials and not having their needs fully addressed in the plan assignment process.

» **Respondents view beneficiary access to impartial in-person counseling to assess enrollment options as important.**

Ensuring that resources are available to assist beneficiaries in making a plan choice was a commonly voiced concern among respondents. Respondents emphasized the need for in-person assistance given the complexities involved in beneficiary decisions about whether to opt-out of the demonstration and which health plan to select. A respondent in Washington said they are most worried about people whose disabilities create barriers to making informed plan choices, such as some people with DD or mental health disabilities. A respondent in Colorado said that if beneficiaries simply get a letter in the mail, without access to options counseling and other supportive services, the enrollment information may be poorly received or confusing. Generally, respondents said that there should be neutral one-on-one assistance available to help people understand the significant changes that are taking place as part of the demonstration and to assist beneficiaries with making informed plan choices and other decisions. Respondents in several states were hesitant about solely relying on State Health Insurance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs) to perform this function because SHIPs and ADRCs were perceived as having more expertise in Medicare and issues affecting elderly beneficiaries and less of an emphasis on LTSS and issues affecting non-elderly beneficiaries with disabilities. Rather, respondents preferred including community-based organizations that already work with people with disabilities as neutral enrollment counselors to afford beneficiaries a choice about where to receive enrollment assistance.

## Care Coordination, Benefits, and Network Adequacy

The financial alignment demonstrations are an attempt to better integrate and coordinate the primary care medical system with the often distinct network of LTSS providers, which includes community-based providers of non-medical services that may, in some cases, be friends or family members who serve as paid providers for beneficiaries who choose to self-direct their care. This involves bridging two distinct care systems and raises benefit design questions about which services to include in a state's demonstration, whether the plans and provider networks in the demonstration will have the knowledge and expertise to coordinate and deliver both medical and LTSS, and how to instill accountability mechanisms that work in the context of these often very different types of services.

Key observations by respondents about care coordination, benefits, and network adequacy in the demonstrations include the following:

- » **Improved care coordination is often viewed by respondents as the overriding potential benefit of the demonstrations, although respondents recognize that effectively coordinating care for people with disabilities presents challenges.**

In virtually every state, respondents described two groups of beneficiaries. One has navigated a highly fragmented system and, over time and often with significant effort, has managed to piece together a network of medical and personal care providers that meets their needs. For these individuals, respondents' concern is that a new system should not be permitted to disrupt what is currently working. Another group of beneficiaries consists of people with less capacity to understand the system and navigate it on their own. For these people, respondents hope that the care coordination offered by the demonstrations will strengthen the connections between long-term care services and medical care systems in ways that both improve beneficiaries' access to and satisfaction with the services they receive and clinical outcomes. Nearly all respondents indicated that they saw improved coordination of services as a primary potential benefit of the demonstrations. Several respondents acknowledged that the care coordination offered through the demonstrations would be the first time that help in navigating the health care system would be available for some beneficiaries. However, a couple of respondents expressed that beneficiaries should control the extent of the personal medical information that is shared in the care coordination process. For example, these respondents indicated that beneficiaries with mental health disabilities may want to limit the extent to which the details of their diagnoses and medications are shared.

When asked how exactly coordination would be improved as a result of the demonstrations, there were a range of answers. In some cases, respondents were vague about how this would happen, pointing out that the care team's roles and care coordination processes are "fuzzy" in the MOUs. Respondents agreed that care coordination is an idea that "makes sense on paper," but how it will actually work is "all theoretical now" prior to demonstration implementation. In Massachusetts, respondents believe that having a Long-Term Supports Coordinator from a community-based organization that is independent of the health plan as part of the individual's care team will facilitate improved coordination and access to services. Some respondents in Ohio, which already has Medicaid managed care for certain populations without disabilities, pointed out that care coordination for people with disabilities who have chronic health needs is different than care coordination for Medicaid beneficiaries who are relatively healthy parents and children. In Colorado, where the demonstration will operate under a managed FFS model, the state has an established network of paid Regional Care Coordination Organizations (RCCOs) whose primary responsibility will be to improve coordination of services for demonstration participants and providers. Some Colorado respondents indicated that they were not worried about incentives to reduce access to existing

services, given the managed FFS nature of the demonstration, and that the demonstration could make the greatest impact in the area of service coordination. Other respondents in managed FFS demonstration states (Colorado and Washington), however, stated that there were limited financial incentives for providers to improve outcomes because they will not receive additional payments for participating in care coordination efforts (in Colorado, payments for care coordination will go to the RCCOs, not to the providers; similarly, in Washington, health home care coordination organizations, but not providers, will be reimbursed for providing care coordination services).

» **Expanding access to a variety of LTSS also is seen by respondents as a core potential benefit of the demonstrations.**

Most respondents indicated that they hoped that their states' demonstrations would lead to the provision of additional medical services outside of primary care, such as dental care, as well as more non-medical supportive services, such as transportation, medical and social case management, and prevention and wellness services. Whereas some representatives of people with mental health disabilities spoke of the need for better access to physical health care services for this population, most respondents underscored the need for increased access to LTSS and related supports, citing their states' current long waiting lists for Medicaid HCBS waivers. Respondents cited a commonly held perspective within the disability community that insurers, including Medicaid and Medicare, are more focused on providing medical services and achieving health outcomes at the expense of social supports and other services that may be higher priorities for beneficiaries or may be necessary components of a system of care that supports independent living and community integration. A respondent in Colorado captured this sentiment by saying, "We see the model of care as overly medicalized and we want more services to [help beneficiaries] maintain independence." Other respondents noted that to achieve expanded access to home and community-based LTSS, the goal of increasing and maintaining independence needs to be built into the capitated payment rates and quality measures for the demonstrations. Respondents maintained that the demonstrations lacked specific requirements to advance this goal, such as making HCBS the default choice, requiring plans to allocate a certain amount of spending to HCBS to maintain or increase current ratios of home and community-based to institutional long-term care services, and including specifics about upfront investments in HCBS by states to support expanded access. Some individuals also expressed concerns that health plans are data-driven, and there are not always solid research data underpinning the need for LTSS or linking the provision of LTSS to improving clinical outcomes. This has raised questions among respondents about whether, absent these data, plans will attempt to restrict access to critical LTSS.

» **Network adequacy, especially relating to LTSS, is a prominent concern of respondents.**

When states consider adopting capitated managed care within Medicaid, one perceived benefit is that these health plans are accountable for building an adequate network of providers. One respondent pointed out, however, that due to their specialized needs and the limited number of providers competent to meet those needs, people with disabilities do not have the same degree of choice within a closed provider network as people without disabilities do. Concerns about network adequacy encompass both primary care providers who are experienced in meeting the needs of people with disabilities and the range of specialists required by people with disabilities. There is hope among respondents that greater reliance on health plans also could increase access to LTSS. Respondents' fear, however, is that there is already an inadequate network of LTSS providers, and if health plans attempt to impose onerous new rules and requirements, the demonstrations actually could lead to a diminishment of the LTSS provider network. One respondent underscored the importance of out-of-network single case agreements for providers for people with disabilities. This person noted that some providers will be reluctant to join a health plan network because they will not be able to handle the volume of accepting all plan members. At the same time, these

providers may be important to people with disabilities who have specialized care needs. This respondent noted that Massachusetts' MOU has continuity of care provisions that enable beneficiaries to continue to see existing providers on an out-of-network basis for a limited time after demonstration is implemented, but worried that the MOU does not adequately provide for future situations when no in-network provider is able to meet the specialized needs of a person with disabilities.

Several respondents also emphasized that accessibility for people with disabilities must be part of network adequacy determinations, beyond the number of providers within a certain distance of a beneficiary's home. For example, respondents suggested assessing whether providers had physically accessible offices and examination equipment, offered sign language interpreters for deaf patients, provided extra time and flexible scheduling for people with DD, and avoided multi-layered automated phone menus to accommodate people with mental health disabilities and traumatic brain injuries.

» **Respondents have questions about the role of existing community-based organizations in some states' demonstrations, especially those organizations that are focused on meeting the needs of people with disabilities under age 65.**

Respondents noted that implementing capitated managed care would be a change not only for beneficiaries but also for community-based organizations that work with beneficiaries, especially in states where the predominant existing care delivery system is FFS. Community-based organizations that provide LTSS will have to adjust to negotiating provider agreements with multiple health plans instead of receiving reimbursements from the state Medicaid program. Some respondents worried that the capitated rates might be too low to support small community-based providers or that health plans may not seek to include such providers in their networks. In addition, beneficiaries will likely turn to existing community-based organizations who already are providing them with case management, advocacy, or other support as they try to navigate the new care delivery system. Respondents expressed concern that these organizations may not have the capacity to effectively meet this new demand without the investment of additional resources.

Respondents noted that only a couple of the approved demonstrations included a formal role for community-based organizations: Massachusetts' requirement that health plans contract with community-based organizations as independent Long-Term Supports Coordinators, and Ohio's requirement that Area Agencies on Aging (AAAs) coordinate HCBS for elderly beneficiaries. Some respondents expressed the concern that AAAs and other senior-focused organizations have more experience serving seniors than younger people with disabilities. Senior-focused organizations were perceived by some respondents as having less familiarity with home and community-based LTSS and the ability to self-direct services, and respondents worried that non-elderly beneficiaries may perceive their needs as distinct from elderly beneficiaries and therefore prefer to access services through community-based organizations that already are working and identified with people with disabilities. Respondents in Ohio also worried about which entity would coordinate HCBS for non-elderly beneficiaries since no particular organization was identified in Ohio's MOU, unlike the AAAs for elderly beneficiaries.

» **Health plans are generally believed by respondents to currently have limited experience with providing person-centered care, managing home and community-based LTSS, and administering self-directed service delivery models.**



Respondents in several states asserted that the needs and preferences of younger people with disabilities in accessing care often are different than those of older people. This was especially true in Colorado where several respondents indicated that there is a highly organized community of younger people with disabilities that expects and demands the ability to take a person-centered approach to developing care plans and is very comfortable with self-direction of LTSS. Respondents observed that there is a real benefit to better integrating and coordinating LTSS with medical services, but that there are also some risks if integration favors a “medical” model that primarily involves or favors providing treatment for illness rather than non-medical services to support independent community living. Respondents noted that non-elderly people with disabilities worry about being overly “medicalized” and treated as if they are sick. Several people expressed the view that the demonstration proposals contained positive general statements about the provision of person-centered planning and self-direction, but that actual implementation of these concepts may conflict with how health plans are accustomed to operating. Respondents expressed concern that plans may not necessarily be accustomed to viewing people with disabilities as expert in their own care, especially under a capitated model where respondents observed that a potential benefit of relying on health plans comes from their ability to efficiently deliver care by eliminating unnecessary services and limiting the pool of approved providers. Respondents also articulated concerns that plans may not fully understand the self-direction model and that plans may not have the administrative capacity and flexibility to oversee beneficiary-directed services that involve control over individual budgets and/or empowering beneficiaries to select, supervise, and dismiss personal care providers. Respondents noted that some health plans, albeit a minority, have recognized that they lack expertise in managing LTSS and have reached out to disability groups for information.<sup>16</sup>

## Financing

Part of the rationale for the financial alignment demonstrations is to attempt to establish a more efficient interface between Medicare and Medicaid to potentially save money for both the federal government and the states. CMS’s January 2012 guidance about the capitated financial alignment model requires that the capitation rate for participating plans provide upfront savings to both CMS and the state; absent savings for both payers, CMS has indicated that the demonstrations will not go forward.<sup>17</sup>

Key findings from respondents about demonstration financing include the following:

- » **Federal guidance that requires first year savings in the capitated model was viewed by respondents as unrealistic in the early phases of the demonstrations, given the need for upfront investments.**

Many respondents stated that there are several ways that the programs can save money, but they also believe that initially, there is a need for new investments in infrastructure development and to cover other upfront costs and provide adequate oversight, with savings to be realized over time.<sup>18</sup> In some cases, this means expanding access to community-based services or building the administrative infrastructure to monitor new models for delivering services. Several respondents worried that CMS’s requirement that states in the capitated model demonstrate immediate program savings did not adequately account for these upfront investments. For example, Massachusetts’ MOU with CMS initially stipulated that the state and CMS would each save one percent, two percent, and four percent, in the first, second, and third years of the demonstration, respectively. (Massachusetts subsequently has revised its savings targets to zero in 2013 and one percent in 2014, and approximately 4.2 percent in 2016 to account for the reduced savings in year one.)<sup>19</sup> Respondents noted that while the MOUs provide the required savings percentages, there is no explanation as to how that amount of savings will be reached, and respondents were not aware of any extensive analysis behind state savings projections. In Colorado, a state with a managed FFS model,



respondents reported that the state budget legislation establishing the demonstration called for seven to 12 percent savings in the first year. Respondents also observed that CMS’s method of deducting savings upfront from the federal and state baseline contributions to the capitated rate made it unlikely that program savings would be reinvested to improve and expand services, as respondents had hoped. Nonetheless, in most states, respondents confirmed that they thought the state program administrators were genuinely committed to using the demonstration to build a better program, and while saving money is a never-ending pressure point for states, it was not the sole or primary motivation for pursuing a demonstration. Some respondents suggested that a better orientation would be viewing the demonstrations as a means to spend program money more effectively as opposed to realizing savings. A couple of respondents expressed that they expected the new models to generate savings in five or ten years, which is beyond the three year initial life of the demonstrations.

Respondents indicated that state officials were focusing on achieving savings through reduced emergency room visits and hospital re-admissions, areas where respondents also generally believed there was the potential for savings. A respondent from Colorado reported that the state’s early experience with its ACO demonstration has already achieved demonstrable savings in these areas. A respondent in Massachusetts, however, questioned the level of savings that could be achieved because they believe there is a relatively small group of people responsible for high levels of hospitalizations, including highly complex populations. Respondents did not believe that states were viewing the demonstrations as a way to advance long-term care rebalancing efforts nor were states pursuing a reduction in the use of institutional care as a primary strategy for saving money.

» **At the time of the interviews, little was known about payment rates, which respondents view as a critical determinant of demonstrations’ feasibility and success.**

At the time of the interviews, respondents reported that few details appeared to be available regarding the level of payment for the range of covered services under the demonstrations.<sup>20</sup> There are two elements to respondents’ expressed concerns about payment rates. First is whether CMS and the states pursuing capitated models will pay health plans adequately to deliver the full range of services and supports encompassed in the demonstration, especially with regard to LTSS. Respondents worry that health plans may have an incentive to cut LTSS if demonstration payment rates and risk adjustment to account for plans with disproportionate shares of high cost/high need beneficiaries are inadequate. The second element relates to ensuring that the states hold health plans accountable for adequately paying LTSS providers. In Massachusetts and elsewhere, respondents raised concerns that states are shifting too much responsibility to health plans. Confirming this perspective, a respondent in Washington worried that the state was placing too much trust in health plans without building in accountability measures. When discussing the effectiveness of care coordination in Colorado’s managed FFS model, one respondent indicated that the state plans to pay the RCCOs only \$12 per member per month, a level that they believe is insufficient to improve care coordination.<sup>21</sup> Respondents also mentioned the importance of accurately risk adjusting plan payments to account for beneficiaries with disproportionately high needs.

## **Measuring Success**

Measuring “success” in the demonstrations is a function of a state’s goals and objectives, the metrics employed, and beneficiary outcomes. The development and/or adoption of quality and oversight metrics can impact the direction or focus of a state’s demonstration, and for many states hoping to incorporate LTSS-specific metrics, there are often far more data on the relative effectiveness of various clinical interventions and more consensus on key clinical metrics

than those that exist for LTSS. Beyond metrics, however, a broader set of monitoring activities will likely need to be considered to assess and build upon the experience in the demonstrations. Still, several respondents observed that a key outstanding question is “How will we determine if the demonstration is successful?”

Key findings from respondents about how to evaluate the success of the demonstrations included the following:

» **Respondents reported that not enough attention has been focused on the development of appropriate metrics.**

Several respondents told us that they had not adequately focused on metrics themselves, and they also believed that state officials also had not yet given significant attention to this topic, pointing out that many key details about this area were still described as “to be determined” in the states’ proposals and MOUs. For example, a respondent in Massachusetts noted that their state’s demonstration currently includes only one LTSS quality measure. At the same time, there are not many existing LTSS quality measures from which to choose. One national respondent said that there was a need for national indicators to minimize duplication of effort and permit comparability across states, although another respondent noted that developing a national set of HCBS measures could be difficult given the variability in state programs. Another national respondent argued for strengthening and relying on the appeals and grievance system to identify problems to be addressed. Further, several people asserted that ombudsman programs have a critical role to play in both resolving individual complaints as well as monitoring patterns of issues to provide systemic oversight of the program. A clinician from Colorado said that more clinical metrics should be introduced over time. Respondents also emphasized that clinical measures should vary by population, such as people with mental health disabilities, people with physical disabilities, and people with complex medical conditions. Several respondents suggested that measuring beneficiary satisfaction, independence, and quality of life was more important than process or disease measures.

» **Respondents believe that further work is needed to determine how to measure the success of the demonstrations, including how to assess the effectiveness of LTSS.**

Developing the right metrics to measure the success of an LTSS system is a challenge, as is integrating these metrics with clinical care metrics. A key principle for monitoring is to strive for parsimony and consistency in the number of metrics to facilitate comparisons across populations and programs. Whereas CMS already has some required metrics for the demonstrations, respondents expressed that these may not yet be fully developed to provide useful measures of the effectiveness of the demonstration. While there was no agreement on specific metrics, nearly all respondents said that developing appropriate measures is important and that metrics are needed to evaluate more than clinical outcomes. Respondents indicated that measures should assess beneficiaries’ quality of life and degree of independence. Respondents in Ohio believed that CMS could play a more active role in this developing area. A respondent in Michigan suggested looking at their state’s Medicaid § 1915(c) waiver because it has measures for response times and critical no-shows and mandates reporting when provider no-shows put someone at risk. Another respondent from Ohio gave us the most detailed suggestions for metrics by identifying several critical domains to assess, including: 1) health status; 2) functional abilities; 3) retaining beneficiaries in community settings and downsizing nursing facilities; 4) supporting independence; 5) delivery of quality care; 6) beneficiary satisfaction; 7) process outcomes, i.e., getting care in a timely manner, the extent to which beneficiaries have a say in determining the contents of their care plans; and 8) reducing health disparities across populations. Another respondent suggested that LTSS needs assessment and quality measures should include functional status (i.e., what care needs does a beneficiary have based on his or her functional limitations, and whether services are appropriate),

beneficiary capacity for independent living, and provider network adequacy standards. Respondents also pointed out the importance of collecting data about beneficiaries' functional impairments and assessing whether plans were providing an appropriate level of services to meet beneficiary needs.

» **Ongoing, real-time beneficiary oversight is viewed by respondents as critical to demonstrations' success.**

Many respondents believe that the promise of the demonstrations will be limited unless more is done to build in real-time monitoring and oversight. As stated previously, respondents were generally positive about the manner in which states worked with community stakeholders on the development of the demonstrations. Respondents also reported, however, that states have become far less engaged with stakeholders after the initial proposal was developed, particularly once the state became involved in MOU negotiations with CMS. The need for beneficiary involvement in demonstration oversight relates another respondent concern, described above, about the need for additional resources devoted to community-based organizations representing people with disabilities to monitor beneficiary experiences throughout the course of the demonstrations. Respondents suggested funding independent living centers and other community-based organizations to monitor patterns of complaints and identify access barriers as the demonstrations are implemented. For example, Massachusetts' stakeholders proposed the creation of an independent, beneficiary-led non-profit organization to focus on quality improvement and training opportunities within the demonstration. Several respondents also offered different variations on a model for regular troubleshooting meetings with health plans, providers, and beneficiary representatives.

» **Establishing a high standard for assessing state and health plan readiness before enrollment begins is a prominent concern of respondents.**

A major concern of nearly all respondents was whether their state would implement its demonstration before adequate beneficiary protections and oversight and monitoring systems are in place. Specifically, respondents expressed the desire for standardized metrics to assess the readiness of health plans to enroll any beneficiaries as well as for heightened criteria that must be met before beneficiaries are passively enrolled in a new system. Further, respondents are looking for detailed state monitoring plans to ensure that health plans are meeting their obligations under the demonstrations. Another respondent suggested that health plans should report data in a standardized way to allow for monitoring and oversight.

» **Respondents believed that physical and programmatic accessibility could be improved if standards to evaluate Americans with Disabilities Act (ADA) compliance are built into health plan readiness reviews.**

Respondents generally felt that health plan and provider compliance with the ADA could be improved, but they did not see the demonstrations as a vehicle for accomplishing this goal unless the three-way contracts with health plans provided specific criteria, and the state committed sufficient resources to monitoring and enforcement. For example, respondents pointed out that health disparities between people with and without disabilities often stem from a lack of physically accessible medical equipment. However, a respondent from a national organization noted that the demonstrations generally lack specific requirements or measures related to ADA compliance. Respondents suggested that physical and programmatic accessibility standards should be incorporated into network adequacy standards and health plan readiness reviews. National and state level respondents also believed that training of plans, providers, and care coordinators will be important in ensuring physical and programmatic accessibility for beneficiaries with disabilities.

## LOOKING AHEAD

In addition to the observations already provided, the following are overarching observations of respondents based on the interviews that we conducted:

» **The scale of the proposals raises questions among respondents about whether states are conducting a demonstration or implementing a new program.**

While respondents are optimistic, albeit cautiously, that the financial alignment demonstrations will lead to significant improvements in care coordination and delivery for dual eligible beneficiaries, many raised concerns about the scale of state demonstration enrollment plans. Massachusetts is planning to enroll 115,000 dually eligible beneficiaries into its capitated demonstration in the first year; dual eligible beneficiaries previously have not been enrolled in Medicaid managed care organizations in Massachusetts. Enrollment in the managed FFS component of Washington's demonstration is voluntary in the sense that beneficiaries retain the choice about whether to receive demonstration health home services, but respondents reported that the state estimates that half of its dually eligible beneficiaries will participate in its health homes. Ohio is enrolling all of its dual eligible beneficiaries in the demonstration in 29 counties in seven highly populous regions, for an estimated total of about 115,000 dual eligible beneficiaries out of roughly 180,000 in the state. The concern among respondents engendered by this large-scale enrollment is that it becomes a demonstration in name only and is instead the widespread implementation of an as yet unproven model of care. Many respondents said that their hopes for a true demonstration require recognizing that this is a process of trial and error, which is perhaps best effectuated by starting to implement a new model in a small geographic area, such as one county, and then refining and gradually expanding the model. Respondents said it becomes much harder to make changes if the majority of dual eligible beneficiaries already are enrolled in the new program and if the demonstration proceeds with limited data to inform future adjustments to the program.

» **Respondents view federal leadership as critical as states move toward implementation.**

The interviews we conducted were not focused on federal implementation of the demonstrations and, in fact, we did not ask respondents about the role of federal officials in this process. Nonetheless, several respondents provided feedback that underscores the important role played by CMS in shaping the state demonstrations. As previously stated, CMS is credited with reinforcing the importance of broad stakeholder engagement in developing the demonstrations. Further, respondents felt that several positive decisions they received from state officials were due, in part, to federal guidance or requirements. For example, several respondents said that their state had agreed to include an ombudsman function in their demonstration because they believed that CMS would make this a condition of establishing an MOU with the state. Going forward, respondents believe that there will likely continue to be instances where federal leadership will be instrumental in steering states to adopt policies that are considered to be best practices and critical to the successful implementation and monitoring of the demonstration.

» **Respondents indicated that ensuring ongoing stakeholder engagement that includes beneficiaries with disabilities is likely a core element of success.**

While states' efforts to engage community stakeholders in the development of the demonstrations were seen as mostly positive, there was near unanimity among respondents that the level of engagement had dropped off considerably once the initial proposal was developed. For example, in Massachusetts, several respondents mentioned that the state initially held meetings with disability community representatives that were separate from providers and other stakeholders who may otherwise dominate large public forums. While respondents were pleased with how this system worked, they were concerned that this effort stopped once the proposal was submitted

and hoped that it could be re-established. Consistent with the observation about the need for real-time oversight as the demonstration is implemented, several respondents in other states suggested that states reinvestigate their stakeholder engagement procedures throughout the implementation process. Respondents emphasized that states should include a diverse group of stakeholders and representatives of people with disabilities in such efforts and ensure that policymakers are interacting directly with demonstration participants.

» **Respondents believe that ensuring that the demonstrations evolve and adapt to success and failures is critical.**

To help ensure that the demonstrations realize their potential of designing innovative models of care, respondents maintained that states would need to create the space for trial and error. This means building in real-time evaluation, implementing consumer feedback loops, and making a commitment to adjusting course as necessary. However, respondents voiced concern about how real-time monitoring would work in practice and whether CMS and the states would be able to effectively respond to problems in a timely manner. For example, a commonly cited concern was whether or how states would suspend health plan enrollment if evidence shows there is a lack of plan capacity to provide adequate services to existing enrollees.

» **Respondents noted that beneficiary protections are key elements in demonstration implementation.**

Respondents mentioned the availability of beneficiary protections, such as independent enrollment options counseling and ombuds programs as important elements that must be included in any demonstration. Respondents also pointed to the appeals and grievance process as a way to identify systemic problems in the demonstrations. Some respondents also wondered how beneficiaries will know about alternative services that may not have been offered to them as part of their care plans and how appeals will work if the care teams, rather than the Medicare or Medicaid programs directly, are the entities that determine which services are provided. In these cases, respondents underscored the need for an effective accessible appeals process if beneficiaries do not receive the services they seek. For example, one respondent suggested that an appeals system should offer beneficiaries a second opinion at no cost because shifting financial risk to providers would change the existing incentives in which the provider typically supports a beneficiary's appeal of the care that the provider is ordering to an insurer. Several respondents noted that the demonstrations had not fully fleshed out how to integrate the Medicare and Medicaid appeals processes and underscored the complexity of this undertaking.

## CONCLUSION

Effectively meeting the diverse and complex needs of seniors and people with disabilities who receive services through both Medicaid and Medicare, while containing costs, is one of the biggest challenges facing the health care system. The financial alignment demonstrations offer a potential opportunity to make progress in developing new approaches that lead to better coordination and integration of services, increased care quality, greater beneficiary satisfaction, and improved clinical outcomes. While disability stakeholders have been engaged in the development of the financial alignment demonstrations, these interviews reveal that many important details remain unknown, which impedes a full understanding about how the demonstrations will be implemented and overseen. As the demonstrations proceed, the interview findings suggest that additional attention should be paid to issues that are important for beneficiaries with disabilities, particularly those who rely on LTSS, such as the need for increased access to HCBS, improved care coordination for people with multiple chronic conditions, network adequacy and readiness review standards that account for physical and programmatic access, adequate payment rates and risk

adjustment for high need populations, LTSS quality metrics, and beneficiary protections. In addition, there currently is a lack of consensus about how the success of the demonstrations ultimately will be determined. At this point, the demonstrations are continuing to evolve, and many important details still remain to be specified. Throughout this process, people with disabilities are critical partners in working with states, CMS, and others to maximize the lessons learned through the demonstrations.

This issue brief was prepared by Jeffrey S. Crowley of the O’Neill Institute for National and Global Health Law at Georgetown University Law Center and MaryBeth Musumeci and Erica Reaves of the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured.



# Endnotes

- <sup>1</sup> For additional background on dual eligible beneficiaries, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for Dual Eligible Beneficiaries* (April 2012), available at <http://www.kff.org/medicaid/issue-brief/medicaids-role-for-dual-eligible-beneficiaries/>; Kaiser Family Foundation, *Medicare's Role for Dual Eligible Beneficiaries* (April 2012), available at <http://www.kff.org/medicare/issue-brief/medicares-role-for-dual-eligible-beneficiaries/>.
- <sup>2</sup> *Medicare's Role for Dual Eligible Beneficiaries* at 3.
- <sup>3</sup> *Ibid.* at 6. These figures include both full benefit and partial benefit dual eligible beneficiaries.
- <sup>4</sup> *Ibid.*
- <sup>5</sup> *Ibid.*
- <sup>6</sup> *Ibid.*
- <sup>7</sup> *Ibid.*
- <sup>8</sup> *Ibid.*
- <sup>9</sup> *Medicaid's Role for Dual Eligible Beneficiaries* at 12.
- <sup>10</sup> *Ibid.*
- <sup>11</sup> *Ibid.*
- <sup>12</sup> *Ibid.*
- <sup>13</sup> For additional background on the financial alignment demonstrations, see Kaiser Commission on Medicaid and the Uninsured, *Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries* (October 2012), available at <http://www.kff.org/medicaid/issue-brief/explaining-the-state-integrated-care-and-financial/>.
- <sup>14</sup> For a summary of the approved MOUs, see Kaiser Commission on Medicaid and the Uninsured, *Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS* (July 2013), available at <http://www.kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/>.
- <sup>15</sup> See Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home and Community-Based Services Programs: 2009 Data Update* (Dec. 2012), available at: <http://www.kff.org/medicaid/report/medicaid-home-and-community-based-service-programs/>.
- <sup>16</sup> Insurance firms that contract with the Medicare and Medicaid programs recognize that “few organizations are perceived as having all of the core competences they need to effectively manage the diversity of subgroups” and that “[a]mong under-65 dual-eligible beneficiaries, different provider networks and care management techniques are likely to be needed for key subgroups, such as those with severe mental illness, developmental disabilities, and physical disabilities.” Kaiser Family Foundation, *Medicare Health Plans and Dually Eligible Beneficiaries: Industry Perspectives on the Current and Future Market* at 1 (March 2013), available at <http://www.kff.org/medicare/report/medicare-health-plans-and-dually-eligible-beneficiaries-industry-perspectives-on-the-current-and-future-market/>.
- <sup>17</sup> Kaiser Commission on Medicaid and the Uninsured, *An Update on CMS's Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees* (April 2012), available at <http://www.kff.org/medicaid/issue-brief/an-update-on-cmss-capitated-financial-alignment/> (citing CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans at 3 (Jan. 25, 2012), available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf>).
- <sup>18</sup> Similarly, insurance firms that contract with the Medicare and Medicaid programs “see some savings potential from financially integrating Medicare and Medicaid services, but believe that capturing these savings likely will require time, organizational development, and work with providers to obtain their buy-in.” Kaiser Family Foundation, *Medicare Health Plans and Dually Eligible Beneficiaries: Industry Perspectives on the Current and Future Market* at 1 (March 2013), available at <http://www.kff.org/medicare/report/medicare-health-plans-and-dually-eligible-beneficiaries-industry-perspectives-on-the-current-and-future-market/>.
- <sup>19</sup> Kaiser Commission on Medicaid and the Uninsured, *Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS* (July 2013), available at <http://www.kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/>.
- <sup>20</sup> Insurance firms that contract with the Medicare and Medicaid programs also have noted that “absence of critical details in the proposals and contracts, such as benefit specifications, rate levels, and risk adjustment methods, make it difficult to negotiate with providers or plan ahead.” Kaiser Family Foundation, *Medicare Health Plans and Dually Eligible Beneficiaries: Industry Perspectives on the Current and Future Market* at 1 (March 2013), available at <http://www.kff.org/medicare/report/medicare-health-plans-and-dually-eligible-beneficiaries-industry-perspectives-on-the-current-and-future-market/>.
- <sup>21</sup> State of Colorado Department of Health Care Financing and Policy, Proposal to the Center for Medicare and Medicaid Innovation, State Demonstration to Integrate Care for Dual Eligible Individuals (May 2012), available at <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251796448420&ssbinary=true>.



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