THE PENNSYLVANIA STATE UNIVERSITY
SCHREYER HONORS COLLEGE

DEPARTMENT OF HEALTH POLICY AND ADMINSTRATION

INSIGHT INTO THE FINANCIAL ALIGNMENT INITIATIVE: CAPITATED MODEL DEMONSTRATIONS

JONATHON T. GEORGE
SPRING 2017

A thesis
submitted in partial fulfillment
of the requirements
for baccalaureate degrees
in Finance & Health Policy and Administration
with interdisciplinary honors in Finance
& Health Policy and Administration

Reviewed and approved* by the following:

Mark Sciegaj
Professor of Health Policy and Administration
Professor-in-Charge, Bachelor of Science Degree in Health Policy and Administration
Thesis Supervisor

Caprice Knapp
Associate Professor of Health Policy and Administration
Honors Adviser

* Signatures are on file in the Schreyer Honors College

ABSTRACT

Of the estimated 11.4 million Americans dually enrolled in Medicare and Medicaid programs, these "dual eligible" beneficiaries are among the sickest and most vulnerable patients in the United States. Because of the complexity these high-risk individuals, their needs are typically overlooked by standard health systems due to a lack of service coordination across Medicare and Medicaid providers. To address the lack of coordination among other concerns, the Centers for Medicare and Medicaid Services introduced the Financial Alignment Initiative in 2011, a nationwide demonstration that seeks to improve access to quality care and coordination of services for dual eligibles. This thesis provides an integrative study and discussion on the Financial Alignment Initiative and its California and Illinois demonstrations. Through literature review and data collection by means of interviews with federal, state, and third-party officials, we argue that by emphasizing further collaboration between federal decision-makers and health plans, focusing on administrative improvements across demonstrations, and refining meaningful data collection and evaluation, results would lead to better care coordination, enrollment, and cost savings as a whole.

TABLE OF CONTENTS

LIST OF FIGURES iii

LIST OF TABLES iv

Chapter 1 Introduction 1

Chapter 2 Population Overview 3

2a. Medicare Population 3
2b. Medicaid Population 5
2c. Dual Eligible Population 6

Chapter 3 The Financial Alignment Initiative 11

3a. Overview 11
3b. Background 11
3c. State and Health Plan Requirements 16
3d. Uncertainties Across Parties 19
3e. Recent Progress 20
3f. State Identification 21
3g. California Demonstration 23
3h. Illinois Demonstration 28

Chapter 4 Study Data and Methods 30

4a. Study Data and Methods 30
4c. Key Informant Interviews 33

Chapter 5 Study Results 35

5a. Limitations 35
5b. Summary of Interview Findings 35
5s. Conclusions 38

Chapter 6 Discussion and Conclusion 39

6a. Discussion 39
6a. Conclusion 42

Appendix A Interview Guide 43

BIBLIOGRAPHY 44

LIST OF FIGURES

Figure 1. Medicare Coverage, Benefits, and Premiums Broken into Five Parts.....4

Figure 2. Dual Eligible Enrollment vs. Spending for Medicare and Medicaid, National.....8

Figure 3. Dual Eligible Enrollment vs. Spending for Medicare and Medicaid, California 9

Figure 4. Dual Eligible Enrollment vs. Spending for Medicare and Medicaid, Illinois 9

Figure 5. State Demonstrations in the United States 12

Figure 6. Dual Eligible Beneficiaries by State.....23

Figure 7. Three-Way Contract Structure: Cal MediConnect 24

Figure 8. Three-Way Contract Structure, MMAI.....29

LIST OF TABLES

Table 1. Financial Alignment Initiative Demonstrations by Model 14

Table 2. CMS Core Measurements 17

Table 3. Capitated Enrollment, Age, and Preliminary 90-day HRA Completion 18

Table 4. California DHCS Leadership 25

Table 5. Examples of Community-Based California Pilot Demonstrations 26

Table 6. Examples of Care Coordination-based California Pilot Demonstrations 27

Table 7. Key HFS Leadership 29

Table 8. Key Informants, Federal 30

Table 9. Key Informants, California 31

Table 10. Key Informants, Illinois 32

Table 11. Key Informant Interview Timeline 34

Chapter 1

Introduction

The Financial Alignment Initiative is a nationwide demonstration that seeks to improve access to quality care and coordination of benefits and services for the Medicare-Medicaid enrollee population. The Medicare-Medicaid enrollee population consists of individuals who are dually eligible for both Medicare and Medicaid, and are more commonly referred to as dual eligible beneficiaries, or "dual eligibles" for short. Furthermore, launched by the Centers for Medicare and Medicaid Services (CMS) in conjunction with the Affordable Care Act (ACA), the Financial Alignment Initiative originally proposed two models for state participation: a Capitated Model or Managed Fee-For-Service (MFFS) Model. This initiative was made possible through the collaboration of CMS's Innovation Center and Medicare-Medicaid Coordination Office.[1]

While 26 states originally submitted proposals to CMS for participation in the initiative, as of February 2017, thirteen states have finalized memorandum of understanding (MOUs) with CMS.[2] Each state has its own individualized demonstration(s), yet all states require mandatory health assessments as well as the assignment of individualized care plans for enrollees.[3] Individualized care plans vary based on the state's target demographic, but all focus on the ability to positively impact quality of care and reduce costs for these high-risk individuals.

Looking forward, this thesis starts by providing an overview of various populations across the country, including Medicare, Medicaid, and dual eligibles, to better understand how each demographic plays a role in the Financial Alignment Initiative. We then outline the history and progress of the Financial Alignment Initiative, which seeks to improve quality care and

provide financial alignment through three-way contracts with CMS, state departments, and managed care plans. In addition to outlining the progress and impact of the Financial Alignment Initiative, our focus then shifts to two individual states for further overview – California and Illinois. As of June 2016, California and Illinois' combined coverage includes 171,373 of the estimated 415,411 enrollees in the United States (more than 41%), making these states and their demonstrations important players in the Financial Alignment Initiative.[4] By outlining the California and Illinois demonstrations, we are able to determine current-state operations of each state and identify key areas of focus for our research methodology.

In this study, our objective is to understand the perspectives of individuals with broad experience in the coordination of Financial Alignment Initiative Demonstrations and further identify areas of need at the federal and state levels. Three focus groups were identified, and individuals within each group were selected for interviews. The three focus groups included federal, state, and third-party officials. Interviewees across the three groups included senior officials and professionals with a wide range of experience across the Initiative.

Interviews were conducted over the phone and were based on the following research questions: (1) What are the key drivers of success for the Financial Alignment Initiative? (2) What challenges have been experienced thus far? (3) What changes are being made to improve upon current initiatives? (4) What investments are being made to enhance relationships between each group? (5) What lessons have been learned that will help other state demonstrations and policymakers for the future? Interview findings are outlined, synthesized, and discussed in Chapter 5, and conclusions are formed to provide insight for future research, strategy, and policymaking at the federal and state levels.

Chapter 2

Population Overview

2a. Medicare Population

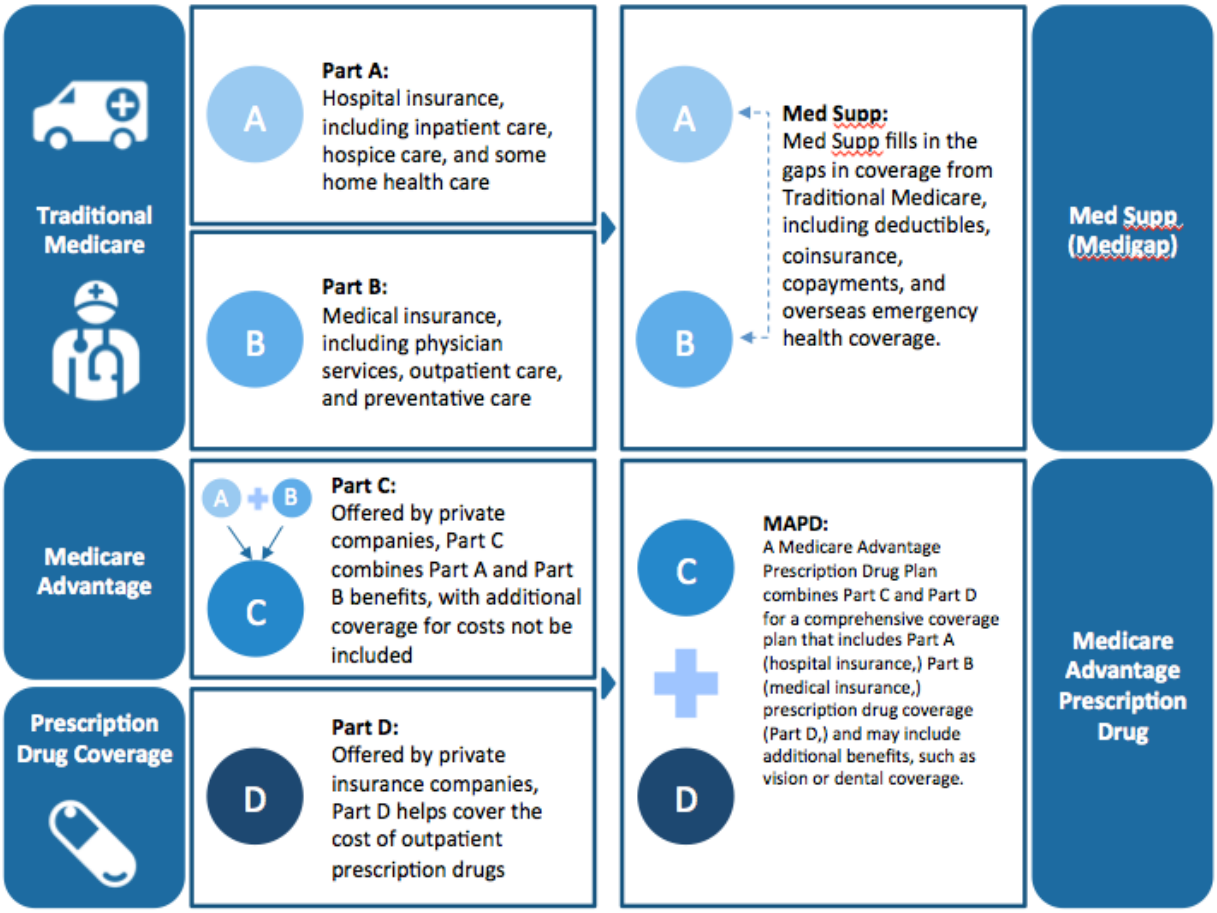
The elder population is typically much more at-risk to develop chronic diseases or medical issues than that of a younger population. Because of this, it was much harder to obtain health insurance throughout much of the 50's and 60's in the United States, especially so for those 65 years and older. This challenge was addressed by President Johnson in 1965, ultimately leading to the passing of a bill that created the Medicare program.

At that time, Medicare was a federal health insurance program established exclusively for those 65 and older to help provide coverage to this at-risk population. In 1972, Medicare expanded to include individuals with permanent disabilities and end-stage renal disease, regardless of age. Today, Medicare is under the Centers for Medicare and Medicaid Services (CMS) and covers roughly 55 million individuals in the United States.[5] In terms of spending, the Medicare program accounts for roughly 15% of total annual federal spending in the United States at more than $645 billion each year.[6]

Medicare is broken into various parts based on coverage, benefits, premiums, and other criteria. The primary parts of Medicare include: Part A, Part B, Part C (or 'Medicare Advantage Plans'), and Part D (for prescription drug coverage). Originally, Medicare was comprised of two parts: Part A and Part B. Today, Parts A and B are more commonly referred to as "Traditional Medicare," while Part C is in lieu of these traditional parts. Other Medicare plans are also

available, such as Medicare Supplemental Insurance (more commonly referred to as 'Medigap'). Medigap works to cover any gaps in coverage that traditional Medicare does not. Lastly, Part D covers beneficiaries' prescription drug plans and helps cover out-of-pocket costs for covered drugs.[7,8] Figure 1 provides a continued outline of Medicare and each Parts' coverage, benefits, and services provided.

Figure 1. Medicare Coverage, Benefits, and Premiums Broken into Five Parts



Note: Adapted from the Government Programs Training, 2016, PwC: PricewaterhouseCoopers, LLP. Copyright 2016 by PwC, LLP[9]

Traditionally, Medicare services that are also covered by Medicaid are typically paid first by Medicare. For dual eligibles as a whole, Medicare covers payments for traditional Medicare

and Part D; while payments on premiums, cost sharing, and additional benefits not covered by Medicare are supplemented through state Medicaid payments.[10] Examples of such benefits include behavioral health services and long-term services and supports (LTSS) - both of which are important needs for dual eligibles.

Historically, Medicare and Medicaid have been independent of one another, with very little coordination between the two. However, as it relates to dual eligibles, it is easy to see how financial alignment issues could arise, especially with the various State-specific options for receiving Medicare and Medicaid services across the country.

2b. Medicaid Population

Along with the establishment of the Medicare program in 1965 came Medicaid, an entitlement program that initially provided insurance to people receiving cash assistance at the time. Today, Medicaid has expanded to provide health care to eligible individuals in each state, including low-income adults, children, elderly, disabled persons, pregnant women, and those needing long-term care. Eligibility criteria is set by each state; however, there are mandatory eligibility groups in which states are required to cover. Additionally, since the expansion of the ACA, states were given the option to expand coverage to individuals at or below 133% of the Federal Poverty Line (FPL). As of December 2016, Medicaid covers 69 million individuals in the United States.[11]

Because Medicare services also covered by Medicaid are typically paid for by Medicare, Medicaid is considered the secondary payer in most situations. Secondary payments include services such as personal care, home-based care, and nursing home care. Individual benefits and

coverage vary by state, but are traditionally provided through managed care plans and fee-for-service (FFS) plans. Exceptions to this coverage include specialty plans that offer both Medicare and Medicaid benefits. An example of such is the Dual Eligible Special Needs Plan (D-SNP).[12]

Under the ACA, states have shifted away from FFS and moved towards a managed care approach towards managing costs and quality. The managed care approach delivers benefits through contractual arrangement between state Medicaid agencies and managed care organizations (MCOs). As states continue to look at ways to improve care coordination and administrative alignment for Medicaid beneficiaries beyond managed care, many have begun implementing a range of initiatives that focus on: populations with complex conditions, alignment for provider payments, and incentives based on performance.[13] As such, the Financial Alignment Initiative seeks to address and improve all of these areas, and has had a major role in the expansion of Medicaid and dual eligible care across a number of states.

Overall, the relationships between state Medicaid agencies and MCOs, as well as the relationships between the federal government and MCOs, are important components of the Financial Alignment Initiative. As such, it is important to note that the relationship between States and MCOs has been previously established, while the relationship between the federal government and MCOs is currently in the developmental stage.

2c. Dual Eligible Population

By definition, individuals dually eligible for Medicare and Medicaid are classified as part of the Medicare-Medicaid population, more commonly referred to as ‘dual eligibles.’ Of the estimated 11.4 million dual eligibles in the United States, more than two-thirds receive benefits

from both programs.[14] These beneficiaries account for much more spending than the average Medicare or Medicaid beneficiary, and present a multitude of challenges for care providers and insurers.

To fully understand the challenges that come with dual eligibles, one must understand the variety of individuals that are part of the population. For example, dual eligibles are most commonly low-income seniors and younger persons with severe disabilities. Roughly 60% of individuals have annual incomes below $10,000, and more than 33% are younger individuals with disabilities.[15] Additionally, not only are the majority of individuals older in age, but two-thirds of all dual eligibles have multiple chronic conditions, including: dementia, cognitive and mental health impairments, substance abuse, and more. Some individuals are homeless, while others reside in institutions. Others live alone and received limited or fragmented care.[16]

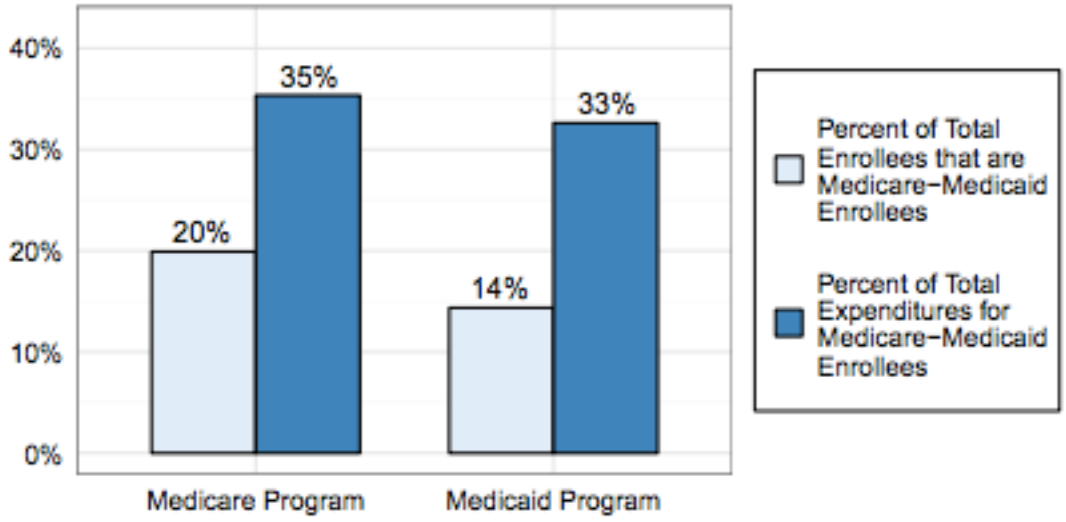
Because of the unique circumstances of these individuals, dual eligibles have greater health needs and higher utilization rates than that of the average Medicare or Medicaid beneficiary; making them of great interest to Medicare and Medicaid policymakers, as well as the governments funding the respective programs.

For an additional perspective, more than 50% of dual eligibles are considered to have 'fair or poor health,' which is twice-that of Medicare beneficiaries with fair or poor health.[17] Roughly 60% have three or more chronic conditions, requiring a greater amount of resources related to hospitalization, emergency room visits, and long-term care as a whole.[14] And dual eligibles account for more than 30% of all health care costs associated with Medicare and Medicaid per year. Clearly, large amounts of money and resources are expended annually, and recent data suggests that annual expenditures for dual eligibles are approximately $300 billion or more per year.[18]

Furthermore, because of the complexity of their health needs, dual eligibles are typically overlooked by standard health systems. This omission stems from a number of issues, but primarily comes from a lack of service coordination across Medicare and Medicaid providers.

With the difficulty in aligning programs and providers across Medicare and Medicaid, dual eligibles often receive very fragmented care from their providers. In turn, this fragmented care negatively impacts their access to areas such as behavioral health, home care management, and LTSS benefits. In the most recent report from CMS, 14% of all Medicaid beneficiaries were found to be dually eligible, yet those same individuals accounted for more than 32% of all Medicaid spending - an 18% difference. As it relates to Medicare, the numbers are not much better, standing at 20% and 35% respectively, resulting in a 15% surplus in spending.[17]

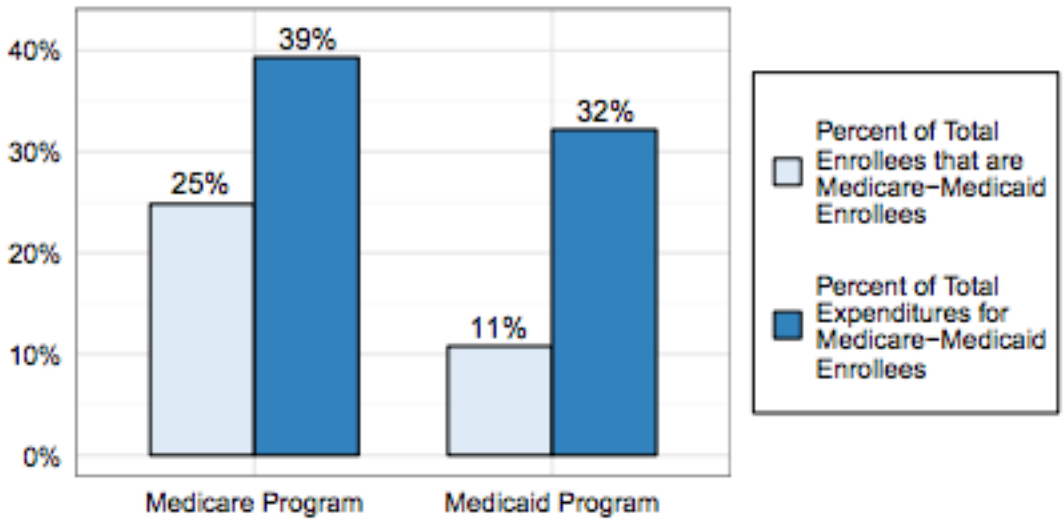
Figure 2. Dual Eligible Enrollment vs. Spending for Medicare and Medicaid, National



Note: Retrieved from Medicare-Medicaid Enrollee Information National, 2011, CMS.[17]

For another perspective, figures at the state level can be worse than the national average in some cases. California's percentage of total Medicaid enrollees and Medicaid spending for dual eligibles is reported at 11% and 33% respectively - a 21% surplus in spending.[19]

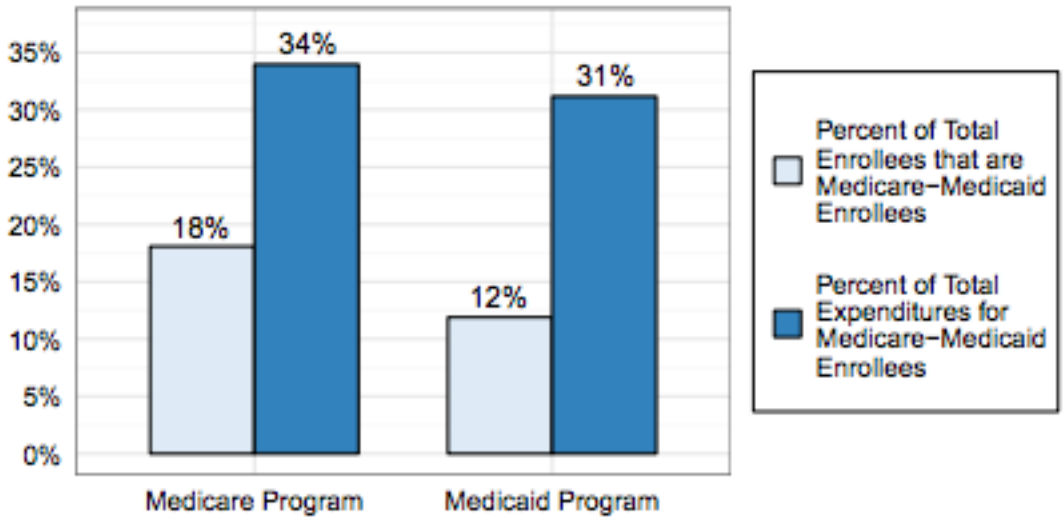
Figure 3. Dual Eligible Enrollment vs. Spending for Medicare and Medicaid, California



Note: Retrieved from Medicare-Medicaid Enrollee Information California, 2011, CMS.[19]

In Illinois, the numbers are also of concern. With a 19% surplus in Medicaid spending and 16% surplus in Medicare spending, both metrics are above that of the national average.[20]

Figure 4. Dual Eligible Enrollment vs. Spending for Medicare and Medicaid, Illinois



Note: Retrieved from Medicare-Medicaid Enrollee Information Illinois, 2011, CMS[20]

It is clear that spending and cost savings for these individuals has been, and will continue to be, an area of concern for programs as they continue to develop over time; however, it is through the improvement of coordination, integration, and collaboration of services across parties that these issues can be addressed.

Chapter 3

The Financial Alignment Initiative

3a. Overview

Signed into law in 2010, the ACA created two important entities and one important authority which now oversee the largest dual eligible program in the United States: The Financial Alignment Initiative.

Made possible through the collaboration of the CMS Innovation Center and the CMS Medicare-Medicaid Coordination Office, the Financial Alignment Initiative is designed to provide dual eligible beneficiaries with a better overall care experience through the integration of care and alignment of financial incentives across the Medicare and Medicaid programs.[1] With more than 11.4 million current Americans enrolled in both Medicare and Medicaid, cost stability and care improvement for dual eligibles is of major concern of the federal government; especially with the growing elderly population in the United States.

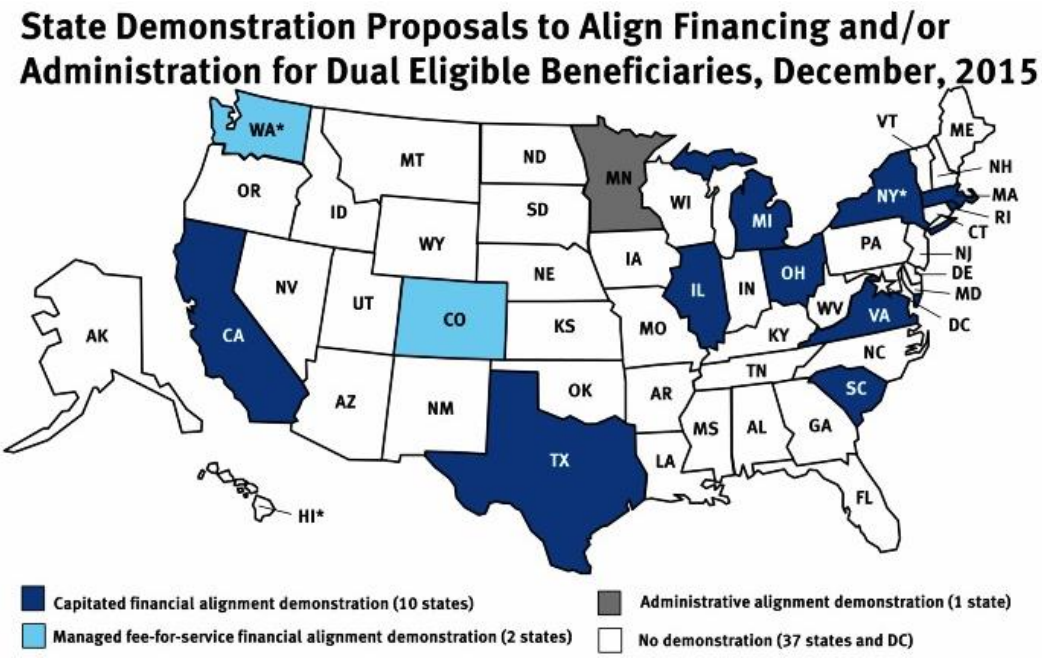
3b. Background

Through the Financial Alignment Initiative, CMS contracts with states and health plans across the country to test two models for effectiveness in achieving the goals of increased access to high quality, seamless systems of care and improved coordination of benefits and services for dual eligibles across each program. Most commonly referred to as ‘demonstrations,’ states opting to participate in the Financial Alignment Initiative have the option to choose between two

approaches: a Capitated model, or managed Fee-For-Service (FFS) model. Today, twelve states currently participate in either a capitated or FFS model, while one state has been allowed to participate in an Administrative model which excludes the financial-portion of the initiative and strictly focuses on the administrative alignment portion of the initiative.[21]

While choosing between two models seems simple, the development of a state demonstration under the Financial Alignment Initiative can be very complex, and involves various contractual agreements, negotiations, and applications between involved parties.[3] As such, 26 states initially applied to participate in the Financial Alignment Initiative but only thirteen signed official memorandum of understanding (MOUs) with CMS to solidify their demonstrations.[21]

Figure 5. State Demonstrations in the United States



Note: Retrieved from KFF Figure 1: State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiares, 2015, KFF: Kaiser Family Foundation. Copyright 2016 by KFF[21]

As part of the capitated approach, states agree to a three-way contract with CMS and exclusive health plans to coordinate the delivery of service to enrollees. In an effort to improve and expand upon the efforts of managed care on the Medicaid-side, these exclusive contracted health plans tend to be comprised of Managed Care Organizations (MCOs) within the state. These MCOs are, in turn, responsible for providing coverage pertaining primarily to Medicare Parts A, B, and D; Medicaid; as well as the alignment of administrative responsibilities across programs. In turn, CMS and the states are responsible for jointly monitoring performance and payments for these plans.[22] To spur the improvement of care coordination for dual eligibles, MCOs are given prospective blended payments for providing comprehensive, coordinated care to beneficiaries. As of June 2016, ten states have implemented capitated demonstrations, enrolling 370,371 individuals across the country.[4]

Under the FFS model, states contract with provider networks to deliver integrated primary and acute care, behavioral health benefits, and long-term services and supports (LTSS). When quality benchmarks are achieved by these providers, both the state and CMS provide health plans a retrospective performance payment based on predisposed amounts that are jointly set by CMS and the states.[23] As of 2016, two states have adopted the FFS model, enrolling 45,039 individuals in those demonstrations.[4] For the purpose of this study, we will be focusing on the capitated model demonstrations and expanding upon two target state demonstrations.

Table 1. Financial Alignment Initiative Demonstrations by Model

	States	Demonstration	State Department	Eligibility	Implementation Date
Capitated Model	**California**	*Cal MediConnect*	California Department of Health Care Services (DHCS)	Age 21 or older	Apr. 1, 2014
	Illinois	*Medicare-Medicaid Alignment Initiative (MMAI)*	Illinois Department of Healthcare and Family Services (HFS)	Age 21 or older	Mar. 1, 2014
	Massachusetts	*One Care*	Commonwealth of Massachusetts	Age 21-64	Oct. 1, 2013
	Michigan	*MI Health Link*	Michigan Department of Community Health	Age 21 or older	Mar. 1, 2015
	New York	*Fully Integrated Duals Advantage (FIDA)*	New York State Department of Health (NYSDOH)	Age 21 or older; LTSS requirements	Jan. 1, 2015
		FIDA: Intellectual and Development Disabilities (IDD)		Age 21 or older with IDD	Apr. 1, 2016
	Ohio	*MyCare Ohio*	Ohio Department of Health	Age 18 or older	May 1, 2014
	Rhode Island	*Medicare-Medicaid Alignment Integrated Care Initiative Demonstration*	Rhode Island Executive Office of Health and Human Services	Age 21 or older	June 1, 2016
	South Carolina	*Healthy Connections Prime*	South Carolina Department of Health and Human Services	Age 65 or older in enrollment community	Feb. 1, 2015
	Texas	*Dual Eligible Integrated Care Demonstration Project*	Texas Health and Human Services Commission	Age 21 or older; qualify for Medicaid HCBS	Mar. 1, 2015
	Virginia*	*Commonwealth Coordinated Care*	Virginia Department of Medical Assistance Services	Age 21 or older	Apr 1, 2014
FFS	**Colorado**	*Financial Alignment Demonstration*	Colorado Department of Health Care Policy and Financing	Age 21 or older	Sept. 1, 2014
	Washington	*Health Homes MFFS*	Washington State Health Care Authority	All ages	July 1, 2013
Other	**Minnesota**	*Dual Demo (Administrative Alignment only)*	Minnesota Department of Human Services (DHS)	Ages 18 to 64 with disabilities	Sept. 13, 2013

**In December 2017, the Virginia capitated financial alignment contract will be terminated* [4]

Furthermore, it is important to remember that Medicare and Medicaid have traditionally operated with very different providers before the installment of the Financial Alignment Initiative. Both programs also tended to vary in levels of administrative development and in the range of benefits they serve to beneficiaries.

While Medicare's national requirements serve as the base-line for each state's demonstration requirements, Medicaid's requirements vary from state to state. This variation causes additional disruption related to patient enrollment among other things. Furthermore, as it relates to enrollment, states have never traditionally been able to auto-enroll beneficiaries into their Medicare programs. This has not been the case for Medicaid beneficiaries. State Medicaid agencies have had the ability to auto-enroll Medicaid beneficiaries into their integrated care plans if they do not opt-in voluntarily.[24] As part of the Financial Alignment Initiative, CMS has given states operating under the capitated model the ability to auto-enroll beneficiaries into their exclusive contracted health plans, more commonly referred to as 'passive enrollment.' This passive enrollment of dual eligibles was a new and much debated approach as it relates to Medicare beneficiaries and providers across the country; however, CMS has argued that passive enrollment measures were a necessary component to the initiative that would ultimately aid and facilitate the creation of infrastructure and savings across demonstrations.[25]

In regards to the three-way contracts between CMS, states, and participating health plans, it is also important to note the history, experience, and working relationships between each party.

Naturally, CMS and states have had experience working together on activities related to Medicare and Medicaid directly; the same goes for state agencies working with their own state health plans and providers. This past experience is an invaluable synergy, especially as it relates to the navigation of communication, establishment of new and continued working relationships,

and implementation of changes to program policies. In regards to the relationship between CMS and health plans, however, these parties have not had much experience working together directly. While updates to federal policy and programs ultimately end up affecting health plans directly and indirectly, the lack of experience and collaboration between CMS and health plans is an important factor for the Financial Alignment Initiative. Because there were, and still are, unknown intricacies and barriers between these groups - particularly related to collaboration and joint decision making - these parties have struggled in the early years of the Financial Alignment Initiative. Especially in areas such as enrollment and data collection.[4]

With that being said, investments made towards fostering and improving these delicate relationships is an important consideration for all parties moving forward. Moreover, this is especially important for CMS and federal stakeholders responsible for major decision-making related to policy and program updates.

3c. State and Health Plan Requirements

As part of the initial agreement for the Financial Alignment Initiative, CMS outlined that "all state programs would be evaluated [by CMS] on their ability to improve quality and reduce costs." To accomplish the goal of effectively evaluating demonstrations, CMS implemented data collection requirements for participating states. These requirements involved collecting and providing cost, quality, enrollment, and utilization data within each state and their respective demonstrations.[26] This data has been collected consistently by CMS across demonstrations, and used to compare findings across groups and individuals. However, there have been many issues related to the collection of this data, causing gaps in findings that will be discussed later.

Furthermore, states participating in the capitated model have also been required to provide encounter data for program beneficiaries and report on additional quality indicators set fourth by CMS. While these added requirements were set fourth initially at the state-level, much of the implications have ended up affecting health plans, requiring providers to adapt to adjust their data collection systems to keep up with the added pressure set fourth by CMS.

Continuing upon the notion of data collection, CMS, states, and health plans have introduced the establishment of health risk assessments (HRA) across all capitated model demonstrations. These HRAs were required by all participating health plans in capitated demonstrations, and were seen as and important first-step of development towards a comprehensive, person-centered care experience in the Financial Alignment Initiative. Moreover, CMS collects "HRA completion" data, and continually requests updated data from health plans to closely monitor individual progress related to care coordination and enrollment.[27] The HRA completion rate was one of the many core measurements used to provide quality benchmarks across the Financial Alignment Initiative as a whole.

Table 2. CMS Core Measurements

Core Measures
1. Health Risk Assessments
2. Care Coordination
3. Enrollee Protections
4. Organizational Structure and Staffing
5. Performance and Quality Improvement
6. Provider Network
7. Systems
8. Utilization

Note: Adapted from Updates from the Medicare-Medicaid Financial Alignment Initiative, 2015, CMS Division of Medicare Health Plans Operations. Copyright 2015 by CMS[26]

To provide further insight into the background of HRA data, there were two additional requirements set fourth in each party's three-way contract. The first was HRA completion related to enrollment. The second was related to a continuity-of-care period, which gave patients the ability to access their old services and providers from before the implementation of their demonstration. The HRA completion period required within 90 days of patient enrollment, and the continuity-of-care period was set from 90-180 days after enrollment, or in some cases, until after the HRA was completed. While the broad requirement from CMS for HRA completion was set at 90 days of enrollment, timing for this varied across states and demonstrations.[27]

Table 3. Capitated Enrollment, Age, and Preliminary 90-day HRA Completion

	States	Participating Health Plans (June 2016)	Total Enrollees (June 2016)	Enrollees Age 65+ (%)	Preliminary Enrollees with Completed HRAs within 90 Days** (%)
Capitated Model	**California**	10	122,905	71%	**84%**
	Illinois	7	48,468	56%	**71%**
	Massachusetts	2	13,106	2%	**65%**
	Michigan	7	40,884	43%	**58%**
	New York	17	5,516	91%	**95%**
	Ohio	5	62,981	51%	**73%**
	Rhode Island	n/a*	n/a	n/a	**n/a**
	South Carolina	4	5,614	100%	**83%**
	Texas	5	42,914	68%	**85%**
	Virginia	3	27,768	49%	**88%**

**Data currently unavailable as of June 2016*
***Data collected as of March 2016*

Note: Adapted from Updates from the Medicare-Medicaid Financial Alignment Initiative, 2015, CMS Division of Medicare Health Plans Operations. Copyright 2015 by CMS[27]

3d. Uncertainties Across Parties

In an effort to expand upon some of the aforementioned uncertainties related to the Financial Alignment Initiative, it is important to understand the reservations each party had at the forefront of the program. In regards to state and health plan reservations, concerns were primarily associated with administrative functions and communication with beneficiaries; in regards to CMS, concerns stemmed from provider buy-in and the complexities of gathering dual eligible information.

Providers worried that their current enrollment processes for beneficiaries were not sufficiently equipped to handle the large volume of enrollees that CMS expected of them. Furthermore, direct and effective messaging between health plans and their respective beneficiaries, as well as having the ability to address the vast, complex needs of their populations were among other concerns.[25] Dual eligibles already receive very fragmented care as is. Adding in the fact that many of these individuals come from uneducated backgrounds can make for very ineffective communication across parties. This is especially the case when providers need to communicate negative changes to their beneficiaries' current health care.

As for CMS, reservations relate primarily to the health care providers acting in a manner of avoidance, as opposed to 'opening their doors' to the complex, high-risk population that is the Medicare-Medicaid population. Furthermore, complexities related to the dual eligible population as a whole include the diverse needs that various beneficiaries have and how gaps in accurate contact and medical information negatively impact the ability to address those needs.[26]

In regards to patient information, there are instances where basic data is readily available for providers, such as age, income, and current medical disabilities; however, when measuring

this data across large populations the ability to manage this data accurately while continuing other functions as a whole can be very challenging. Not to mention, there is also a large amount of data that is not readily available.

As we continue our study, understanding how many of these perspectives have shifted is important in understanding the overall progress of the Financial Alignment Initiative to date.

3e. Recent Progress

In terms of progress made by the Financial Alignment Initiative, we seek to understand how CMS has handled the evaluation of demonstrations across the country. Since the installment of the Financial Alignment Initiative, CMS has contracted with third parties to assist in the evaluation of data. The primary third party evaluator, RTI International, is a non-profit institute that provides research and technological services to the clients it serves, and is monitoring and evaluating four key areas of the Financial Alignment Initiative: demonstration implementation; impact on patient experiences; overall populations; and sub-populations related to medical conditions.

RTI's evaluations and reports have been limited to date, with only a handful of issue briefs made available by CMS. Publicly available issue briefs identify early findings on care coordination, insights into special population enrollees, and early findings on beneficiary experience.[28] Additionally, RTI has released a report on the Massachusetts state demonstration, One Care, but as it relates to this study, we will focus on RTI's issue brief related to early findings on care coordination across capitated models.

According to RTI International's issue brief titled, "Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative[29]:

> *A major accomplishment of the [Financial Alignment Initiative] is that large numbers of new care coordinators have been hired and trained, and the new system has been implemented. The care coordinators are providing a new service that Medicare-Medicaid enrollees generally feel is beneficial. Once enrollees become familiar with their assigned care coordinators and forge personal relationships with them, they appreciate the support and learn to ask for assistance with various challenges, including access to needed providers and durable medical equipment. States and MMPs are heavily invested in the new system and are working hard to make it succeed.*

These major accomplishments and signs of buy-in from both states and health plans have been very promising for CMS and the Financial Alignment Initiative as a whole. Additionally, CMS has noted that there have been "dramatic increases" in the number of dual eligibles participating in capitated models, more than 200,000 HRAs received and counting, and added infrastructure via the hiring of over 2,500 new care coordinators in 2014.[26]

Overall, in keeping in line with the notion that the Financial Alignment Initiative was designed to provide dual eligibles with a better care experience through the integration of care and alignment of financial incentives across programs, the above metrics have shown that these goals are being realized by many demonstrations across the initiative.

3f. State Identification

While there are currently thirteen states participating in the Financial Alignment Initiative, we chose to further outline two states in particular - California and Illinois. Key considerations used when determining our selection included: the demonstration model used; the number dual eligibles in each state; and the population characteristics of each demonstration.

When considering which demonstration model to sample from, the focus of this study has been on the capitated model approach by states; thus, both states would need to be operating under a capitated model to maintain continuity. This eliminated three of the thirteen states for our selection.

When considering the number of dual eligible beneficiaries in the state, we assumed that selecting a state with a larger dual eligible population as a portion of the total population lead to larger, more intricate demonstrations that would be of importance to CMS and other stakeholders at a national level; furthermore, we assumed this importance would subsequently provide us with more readily available data, which would help us to form meaningful insight when discussing our findings and suggestions for CMS and others.

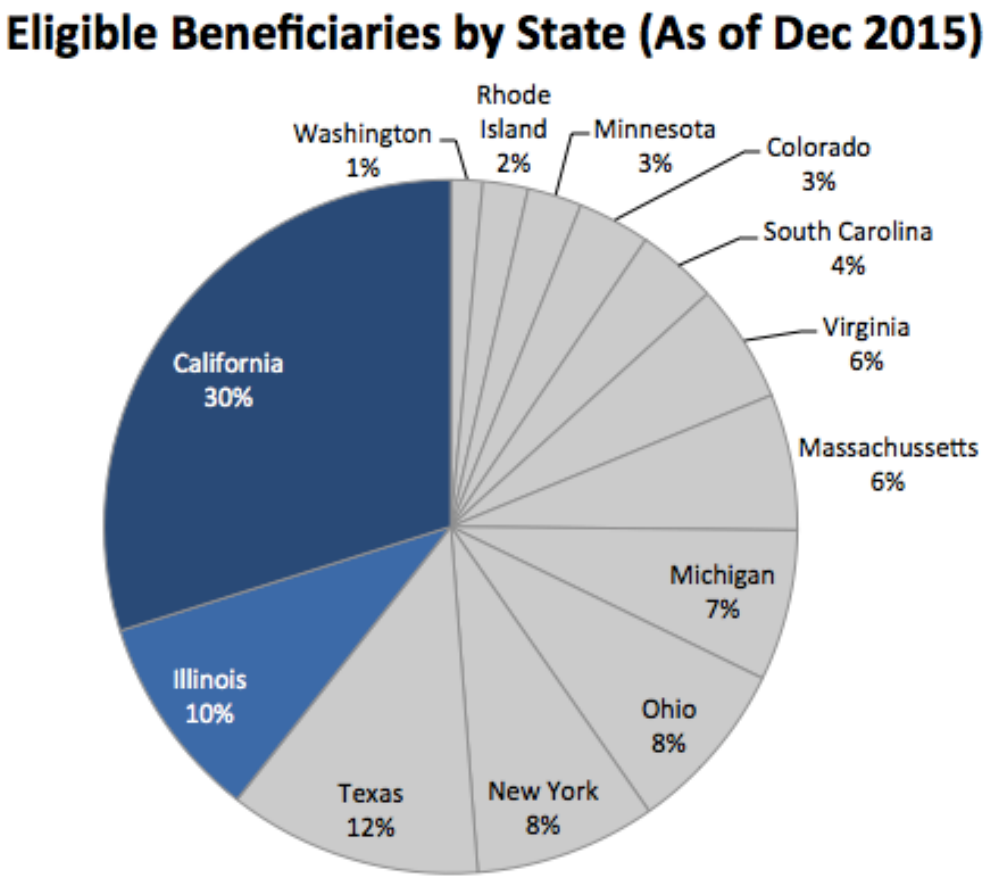
When considering the population characteristics for each demonstration, we felt that selecting states with a more diversified group of target beneficiaries would provide us with a more robust outline of experiences and lessons learned to aid in the discussion and recommendations for future research.

Overall, the California and Illinois demonstrations both operate under the capitated model, and account for more than 40% of all dual eligible beneficiaries in the United States, combined. California has the largest dual eligible population, accounting for roughly 30% of all dual eligible beneficiaries. Illinois is third-largest, accounting for roughly 10% of all beneficiaries in the United States.[21]

In terms of population characteristics, both California's and Illinois' programs have eligibility requirements of being 21 years or older, while also containing a large majority of individuals over 65 years of age. Some state demonstrations target strict populations, such as only enrolling beneficiaries under 65 or older than 65 (Massachusetts and South Carolina,

respectively), but California and Illinois were found to have a much more diverse mix of individuals across their populations.[4,27]

Figure 6. Dual Eligible Beneficiaries by State



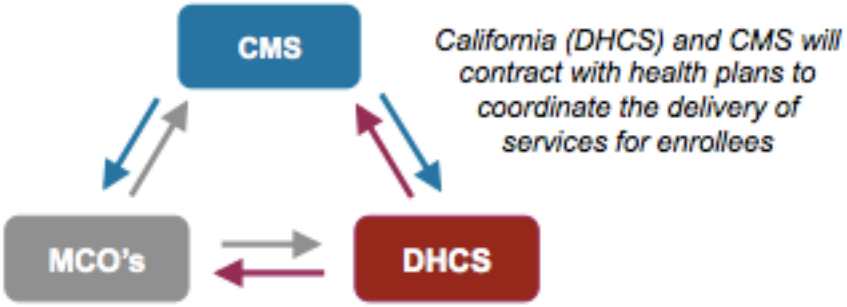
Note: Retrieved from KFF Figure 1: State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiares, 2015, KFF: Kaiser Family Foundation. Copyright 2016 by KFF[21]

3g. California Demonstration

The Financial Alignment Initiative currently has one demonstration for dual eligibles in California: Cal MediConnect. Under the three-way current agreement between the Department of Health Care Services (DHCS), CMS, and participating health plans, all Cal MediConnect

beneficiaries are entitled to Medicare and Medicaid services from MCOs, but requires use of specified 'in network' provider health plans. Eligibility for Cal MediConnect requires prior eligibility for both traditional Medicare as well as the state Medicaid program, Medi-Cal.[4] Data from 2010 suggests that $4.8 billion was spent on dual eligibles through FFS payments, and $632 million was spent on capitated payments in California.[30] Additionally, Cal MediConnect operates out of eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Figure 7. Three-Way Contract Structure: Cal MediConnect



In an effort to enhance health and satisfaction for California health care beneficiaries, California Governor Edmund "Jerry" Brown began the Coordinated Care Initiative (CCI) in July of 2012.[31] The CCI worked to provide savings to providers while shifting the delivery of services from institutional care to home and community-based care – both important facets of the Cal MediConnect program and will be later outlined in greater detail. The financing for Cal MediConnect is a key component of the CCI, however, as of January 2017, Jerry Brown released his proposed 2017-2018 budget which eliminated the CCI. While funding for CCI will be dissolve, included in the budget proposal was an extension of Cal MediConnect through the end

of 2019, citing estimated savings of $20 million and improvements in health outcomes for dual eligibles.[32]

Table 4. California DHCS Leadership[33]

Name	Title	DHCS Office
Jennifer Kent	*Director*	Office of the Director
Mari Cantwell	*Chief Deputy Director*	Health Care Programs
Anastasia Dodson	*Associate Director of Policy*	Health Care Programs
Michelle Villados	*Deputy Director*	Civil Rights
Jared Goldman	*Deputy Director and Chief Council*	Legal Services

Today, California has the largest number of dual eligible beneficiaries in the country, as well as the largest number of homelessness persons in the country. Providing dual eligibles with quality, coordinated care is extremely important, but because of the high number of homelessness individuals - who tend to also have behavioral health concerns - residing in California, Cal MediConnect has placed an added focus on helping homelessness dual eligibles in the communities it serves.

As noted in the 2016 Annual Homelessness Assessment Report, California accounts for 44% of all homeless individuals in the US and has the highest number of total homeless individuals at 118,142. To put this number in perspective, the two next closest states have 109,911 total homelessness persons, combined.[34] Cal MediConnect has sought to provide positive impact by providing increased access to community housing resources, improvements to

care coordination across behavioral and physical health services. To provide these services and more, Cal MediConnect has introduced a number of pilot demonstrations across the state.

In terms community housing resources, examples of various community-based pilot demonstrations are outlined in Table 5.

Table 5. Examples of Community-Based California Pilot Demonstrations[4]

	Pilot Program	Overview
Community Focus	**Medi-Cal 2020 Demonstration**	State-wide pilot demonstration that offers homeless dual eligible individuals the opportunity to receive quality care through a combination of public and private entities across the state
	Project 25	San Diego-based pilot demonstration that works to improve health outcomes for homeless dual eligibles through the procurement of housing opportunities. On average, Project 25 has achieved over $2 million in savings per year
	L.A. Care	Los Angeles-based pilot demonstration that connects homeless dual eligibles with social services and housing. L.A. Care's target population has experienced success in reducing readmission rates in the region

As for behavioral and physical health services in California, it is important to note that specialty mental health services have traditionally been managed by separate counties in California. However, through the Financial Alignment Initiative, MCOs and mental health programs have now been given the opportunity to receive incentive payments by achieving quality standards for coordination of services.[4] As such, behavioral health services will continue to be financed and administered through county agencies in California, with an added emphasis on CMS funding for these initiatives looks to be an area for growth for in the future.

In addition to these various pilot programs, telehealth initiatives are also being explored to seek improvements in care services and coordination of care, and many health plans view these initiative as positive tools to expand the number of individuals assisted. Furthermore, as noted in RTI International's issue brief on early stage care coordination findings, California is currently working to develop a tool to provide a more cohesive assessment of Cal MediConnect as a whole, with hopes of a stateside implementation in the coming months.[28]

Table 6. Examples of Care Coordination-based California Pilot Demonstrations[4]

	Pilot Program	Overview
Care Coordination Focus	**Community Care Settings**	San Mateo pilot demonstration that aims to reduce fragmented, institutional care through partnerships with state housing resources and external housing databases. An example includes state-coordination with the Los Angeles Homeless Services Authority
	Multiple Admitter Project	San Diego pilot that helps forms partnerships between health plans and home health/hospice agencies to provide care and reduce readmissions
	CalOptima	Orange County pilot demonstration working to address nursing facility issues in the area. To date, CalOptima has experienced increased awareness of benefits through outreach to nursing facilities.

As it relates to reservations about the Cal MediConnect program, a group of stakeholders from the state of California, led by the Los Angeles Medical Association, filed a lawsuit against DHCS and the Cal MediConnect program in 2014. The lawsuit was filed in the state Superior Court, noting that Cal MediConnect had "caused vast confusion among [dual eligible] patients," and that DHCS and state officials had superseded statutory authority through the implementation of CCI to implement Cal MediConnect and passively enroll beneficiaries into the program.

Citing California state requirements of health plans needing to provide a choice form 'at or below a sixth-grade reading level,' as well as clear opt-out choices for beneficiaries, the plaintiff argued that these requirements were not being met.[35] The lawsuit requested an injunction to halt the implementation of the passive enrollment, but was denied by Superior Court on the basis that the Los Angeles Medical Association did not prove that Cal MediConnect would harm patients.[36]

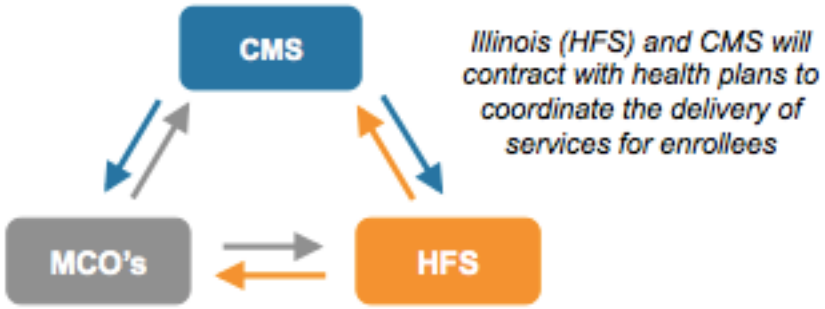
Overall, although Cal MediConnect received initial pushback from providers in the early stages of development, the ability to capitalize and improve upon care coordination and cost savings have since shifted provider perception. As CMS and DHCS continue to update and improve upon current progress, it is evident that increased collaboration and buy-in from health plans and providers is a necessary component of future program success.

3h. Illinois Demonstration

The Financial Alignment Initiative currently has one demonstration for dual eligibles in Illinois: the Medicare-Medicaid Alignment Initiative (MMAI). All MMAI beneficiaries are entitled to Medicare and Medicaid services from MCOs, including prescription drugs. Eligibility for MMAI in Illinois requires prior eligibility for both traditional Medicare, and Medicaid.[4]

Illinois received approval from CMS to participate in the Capitated Financial Alignment Initiative Model in February of 2013, thus creating MMAI. Upon approval from CMS, a 281-page contract was created which established a partnership between CMS and Illinois' Department of Health and Family Services (HFS). This contract outlined responsibilities for all participating parties, financial and payment provisions, and extensive details that would allow a third-party contractor (MCO) to participate.[37]

Figure 8. Three-Way Contract Structure, MMAI



As it relates to MMAI enrollees, passive enrollment adjustments were recently made by HFS to protect dual eligibles that choose to opt-out of their MMAI plan. These adjustments require beneficiaries who voluntarily opt out of MMAI after May 2016, and were previously receiving Long Term Services and Supports (LTSS), to enroll in an MLTSS program under Medicaid. These individuals will be given the choice to choose their own MLTSS plan for a period of time, or be auto enrolled if a choice is not made. This advancement is working to close the gap for uninsured, high-risk individuals.[38]

Table 7. Key HFS Leadership[39]

Name	Title	Office
Felicia F. Norwood	*Director*	Office of the Director
Ray Marchiori	*Chief of Staff*	Office of the Director
Mollie Zito	*Chief of General Council*	General Council
Shawn McGrady	*Chief of Legislative Affairs*	Legislative Affairs
Teresa Hursey	*Chief of Medical Programs, Acting*	Medical Programs

Chapter 4

Study Data and Methods

4a. Study Data and Methods

Qualitative data for this study came from interviews with key informants across three focus groups: Federal, California, and Illinois officials. All individuals selected had experience or involvement with the Financial Alignment Initiative and demonstrations.

Individuals from the federal group consisted of leaders with experience in overseeing the Financial Alignment Initiative from a nation-wide perspective. These individuals were part of CMS, as well as the Kaiser Family Foundation (KFF), a large, non-profit organization that provides insight and information related to national health issues and global health policy.[40]

Table 8. Key Informants, Federal

	Interviewee	Organization	Title
Federal	**Tim Engelhardt**	*CMS*	Director
	Sara Vitolo	*CMS*	Deputy Director
	Lindsay Barnette	*CMS*	Director, Duals
	Melissa Seeley	*CMS*	Deputy Director, Duals
	Marybeth Musumeci	*Kaiser Family Foundation*	Associate Director

The California group consists of leaders with experience in overseeing the Cal MediConnect demonstration. These leaders come from the California Department of Health Care Services (DHCS), Justice in Aging, and PricewaterhouseCoopers (PwC). DHCS is the California

agency responsible for coordinating with CMS on their three-way contracts, and is also responsible for administering various federal and state health care programs to the California population.[41] DHCS currently handles the financing or organization of health care services to approximately one-third of California's population. Additionally, Justice in Aging is a large, non-profit organization that focuses on legal advocacy, covering health care programs such as Medicare, Medicaid, Social Security, and Supplemental Security Income.[42] Lastly, PwC is a professional services firm that provides audit, tax, and consulting services to organizations in a number of industries, including healthcare.[43]

Table 9. Key Informants, California

	Interviewee	Organization	Title
California	**Felicia Norwood**	*DCHS*	Director
	Mari Cantwell	*DCHS*	Chief Deputy Director
	Carol Gallegos	*DCHS*	Deputy Director
	Jared Goldman	*DCHS*	Deputy Director
	Amber Christ	*Justice in Aging*	Senior Staff Attorney
	Angelina Payne	*PricewaterhouseCoopers*	Director

The California group consists of leaders with experience in overseeing the MMAI demonstration. These leaders come from CMS, the Illinois Department of Healthcare and Family Services (HFS), and PwC. HFS is the Illinois agency responsible for coordinating with CMS on their three-way contracts, and is also responsible for providing coverage to adults and children who quality for Medicaid and Child Support Services in the state of Illinois. HFS currently finances or administers health care service to approximately one-fourth of Illinois' population.[44]

Table 10. Key Informants, Illinois

	Interviewee	Organization	Title
Illinois	**Tobey Oliver**	*CMS*	IL State Lead
	Jennifer Kent	*HFS*	Director
	Ray Marchiori	*HFS*	Chief of Staff
	Mollie Zito	*HFS*	Director, MMAI
	Laura Phelan	*HFS*	Manager, MMAI
	Katherine Kohatsu	*PricewaterhouseCoopers*	Principal

In our study, we identified a number of individuals across the three focus groups, and interviewed them to gather insight into their experiences with the Financial Alignment Initiative and/or their experience with the California or Illinois demonstrations.

Interviewees were contacted via telephone and email to conduct interviews voluntarily. More specifically, interviews with participants sought to understand each person's experiences with the Financial Alignment Initiative and its demonstrations. Our research focuses on three key questions: (1) what drives the success of the Financial Alignment Initiative?; (2) what have been the major challenges of the initiative?; and (3) what key lessons have been learned?

Interviews were conducted by telephone or email, with all follow-up inquiries submitted via email. Ten interviews were completed over a 4-week period ending in March 2017, and consisted of five voluntary interview questions:

Interview Questions:

(1) What have been the key drivers of success for the Financial Alignment Initiative?

(2) What challenges and pain points have been experienced thus far?

(3) What specific changes should be made to improve upon current initiatives?

(4) What investments are being made to enhance relationships between each group?

(5) What lessons have been learned that will help other state demonstrations and policymakers for the future?

After conducting interviews and summarizing our findings, we will present our conclusions as they relate to the qualitative data collected. Once those conclusions are made, we will continue upon our study by integrating those deductions with our information related to the literature analysis in Chapter 3 to form our discussion section below.

4c. Key Informant Interviews

Five key informants were identified for the federal group, all of which opted to participate in voluntary interviews. Four interviews were conducted telephonically, while one was conducted over email. Additionally, six key informants were identified for the California group. Two of which opted to participate in interviews, two declined interviews, and two did not respond when inquiring over the course of the study. The two California interviews were conducted telephonically. Lastly, six key informants were identified for the Illinois group. Three of which opted to participate in interviews, one declined, and two did not respond. The full outline of interviewee focus groups and the interview timeline in outlined in greater detail in Table 11.

Table 11. Key Informant Interview Timeline

	Interviewee	Organization	Title	Interview Type	Interview Date
Federal	**Tim Engelhardt**	*CMS Federal Coordinated Health Care Office*	Director	Phone	March 10, 2017
	Sara Vitolo		Deputy Director	Phone	March 20, 2017
	Lindsay Barnette	*CMS Models, Demonstrations, and Analysis Group*	Director	Phone	March 30, 2017
	Melissa Seeley		Deputy Director	Phone	March 23, 2017
	Marybeth Musumeci	*Kaiser Family Foundation*	Associate Director	Email	March 20, 2017
California	**Felicia Norwood**	*DCHS*	Director	Email	n/a
	Mari Cantwell	*DCHS*	Chief Deputy Director	Email	n/a
	Carol Gallegos	*DCHS*	Deputy Director	Email	n/a
	Jared Goldman	*DCHS*	Deputy Director	Phone	n/a
	Amber Christ	*Justice in Aging*	Senior Staff Attorney	Phone	March 24, 2017
	Angelina Payne	*PricewaterhouseCoopers*	Director	Phone	March 23, 2017
Illinois	**Tobey Oliver**	*CMS*	IL State Lead	Phone	March 27, 2017
	Jennifer Kent	*HFS*	Director	Email	n/a
	Ray Marchiori	*HFS*	Chief of Staff	Email	n/a
	Mollie Zito	*HFS*	Director, MMAI	Email	n/a
	Laura Phelan	*HFS*	Manager, MMAI	Phone	March 15, 2017
	Katherine Kohatsu	*PricewaterhouseCoopers*	Principal	Phone	March 10, 2017

Chapter 5

Study Results

5a. Limitations

Limitations of the study related to interviews include a lack of response from interviewees in the California and Illinois groups. If we had been able to interview all of our selected individuals, further insight could have been made related to those state demonstrations. This limitation had minor implications to our discussion section, but did not skew our results to the point that our conclusion would have drastically changed. Additionally, it is important to note that some interviewees opted to not answer individual questions. Only three of the ten interviewees chose to omit questions, resulting in 5 total omitted questions in our study.

Additionally, as we continue into the discussion in the subsequent chapter, there were various limitations related to literature and cost-saving data for the Financial Alignment Initiative and its individual state demonstrations. This gap in data and information made it difficult to identify documented savings for states and health plans. While one full-evaluation report has been released by CMS on the Massachusetts demonstration, there has been a minimal amount of tangible data related to cost reduction or savings achieved for other demonstrations.

5b. Summary of Interview Findings

Upon conclusion of interviews, findings were outlined into five groups, by question. Interview findings are outlined below, and conclusions were formed to summarize our findings.

Key drivers of success

Findings related to the success of the Financial Alignment Initiative and its demonstrations include a number of drivers and outcomes. These areas of success include: member engagement, the offering of a single market for enrollees, improvement to utilization and care coordination across demonstrations, and the implementation of HRAs. However, the most common response from interviewees focused on collaboration between CMS, states, and health plans as the key driver for success.

In California specifically, successes were related to improved collaboration and establishment of a single market for enrollees. As it relates to Illinois, responses were centered around collaboration and member engagement. At the federal level, interviewee responses related to the implementation of HRAs, improved utilization, and improvements to care coordination.

Primary challenges faced

Findings related to the challenges included poor enrollment systems, difficulty with data collection, communication barriers, unrecognized savings, false claims from CMS, difficulty in navigating new relationships, and sub-optimal beneficiary experiences. Overall, the most common responses centered around challenges related to provider and beneficiary engagement and 'buy-in.'

With California particularly, challenges were related to administrative cost savings, specifically with Medicaid, as well as difficulty in managing the new degree of partnership between state agencies and CMS. Additionally, there was little to no systems testing before the roll out of the demonstration, and passive enrollment caused a large amount of disruption for health plans and the state. For Illinois, challenges were centered around communication, as well

as HRA data collection and provider resistance. At the federal level, results showed a range of challenges, including patient and provider vulnerability, enrollment issues, and data collection.

Changes and updates

Findings and areas of focus for changes being made to the programs varied greatly across interviewees, but enrollment and provider outreach were the most common responses during interviews. Additionally, other areas of change being made included communication and education for beneficiaries, addressing the grievance and appeals process across states, collaboration during contract updates, and an improvement in customer service and government oversight.

Overall, California's respondents placed emphasis on administrative alignment and provider outreach, while Illinois' were centered around enrollment. The federal findings consisted of improvements for provider engagement, federal oversight, and improved data collection and collaboration.

Investment in relationships

Overall, responses related to investments being made for relationships most commonly related to investments in care coordination. Other responses related to increasing collaboration through monthly meetings and calls, as well as establishing relationships with nursing facilities and quasi-medical entities.

For California, the focus was with skilled nursing facilities to improve care for homeless and low-income beneficiaries, while Illinois was related to monthly calls and meetings, as well as involving providers in payment reconciliation decisions. The federal respondents focused primarily on investments in relationships between the government and health plans to improve care coordination as a whole.

Lessons learned

The most common key lesson learned across all interviewees was establishing relationships related to care coordination and administration at the easy stages of demonstration development. Other lessons included planning systems testing before implementing demonstrations, as well as focusing on provider engagement and limiting passive enrollment.

As it relates to California specifically, results focused on implementing strict systems testing, building strong relationships with providers, focusing on administrative alignment, and limiting passive enrollment. Illinois findings related to administrative alignment and engaging states early on. Federal interviewees focused on building trust between groups, encouraging provider buy-in, and focusing on areas that would provide meaningful evaluation of care coordination early on.

5s. Conclusions

Overall, it is evident that care coordination plays a large factor in the successes, challenges, and lessons learned across interviewees. Establishing relationships between all parties have been a key driver of success, but also a big challenge, especially related to providers. While changes and investment in relationships continue to address these challenges, it is evident that focusing on care coordination and administration should be the focus moving forward; and as for lessons that can be taken away from our study, the establishment of relationships related to care coordination and administration should be of the upmost importance as states develop programs within the Financial Alignment Initiative.

Chapter 6

Discussion and Conclusion

6a. Discussion

Through a combination of literature review and interviews with stakeholders across state and federal focus groups, we argue that by increasing emphasis on the improvement of relationships between federal decision-makers and health plans, administrative functions across demonstrations, and meaningful data collection and evaluation, results would lead to better results for all parties involved.

To improve upon current progress made at all levels of the Financial Alignment Initiative, both state and federal stakeholders should continue to invest in collaborative relationships with health plans to provide additional opportunities for providers to participate in major decision-making; especially since said decision-making ultimately ends up impacting the providers and beneficiaries directly. This increased collaboration would not only help to improve upon major challenges, such as poor provider engagement and buy-in, but would improve enrollment across demonstrations as a whole. Less turmoil and resistance at the health plan level would result in positive encouragement from providers and less dis-enrollments across demonstrations. In turn, increases in enrollment would subsequently lead to a larger number of dual eligibles receiving quality, coordinated care, especially in well developed demonstrations. Without collaboration with health plans, issues will continue to arise as providers and beneficiaries consistently resist change to their compensation and care management. Again, one

of the major issues we found throughout our study was that, although states and CMS have been receptive to the large changes being made to the coordination of care, such changes have been met with major reservations from the providers and beneficiaries actually receiving, arguably, the most important benefit of the program: improved care coordination. If CMS and state agencies are better able to communicate and engage providers in their decision making, especially in a way that is conductive to positive provider buy-in, more beneficiaries would receive the care they truly need; in turn, while states and CMS subsequently achieve their goals of cost savings and alignment across programs.

In terms of improvements related to administrative functions, we argue that the emphasis should be placed on updates to enrollment processes and communication of benefits across demonstrations. As we found in our study, there have been a number of issues related to enrollment across demonstrations. Particularly as it relates to the systems in which states choose to enroll beneficiaries, and passive enrollment as a whole. Because there are a number of demonstrations that opted to utilize the ability to passively enroll individuals, disruption ensued across providers and beneficiaries as a whole. As prescription drugs and care providers changed without clear notice from the state and federal levels, beneficiaries were reluctant to such change, which resulted in dis-enrollment in many cases. Based on our study, we found this issue to stem from a lack of clear communication of benefits to providers and beneficiaries, which caused further separation across parties. By improving the means of communication of said benefits, and educating the members in which these benefits are directly impacting, CMS and states will be able to re-gain the trust of health plans across demonstrations. In conjunction with the idea of improving relationships, the improvement of said administrative functions would serve to improve enrollment and care coordination as a whole.

Lastly, a large focus should also be placed on meaningful data collection and evaluation across all parties, specifically related to CMS and state agencies. Overall, because there has been a discrepancy between CMS and state-specific enrollment systems, this separation has led to a lack of coordination and data-sharing across demonstrations. When considering the core measurements initially set fourth by CMS, the lack of system coordination has ultimately led to a number of problems while collecting and evaluating up-to-date data – specifically with enrollment, HRAs, and utilization. If systems that are responsible for data collection and collaboration across parties are not properly aligned, measurements can become inaccurate. This inaccuracy ultimately affects the ability to meaningfully evaluate progress being made; and furthermore, this inaccuracy negatively affects the ability to pinpoint areas of growth and development across demonstrations. While CMS continues to operate under their older systems, and states look to continue adapting their systems and data collection to fit individual needs, progress will remain stagnant if collaboration does not ensue. By improving these systems and providing meaningful data collection and evaluation, all parties serve to benefit from the improvements.

Overall, while the Financial Alignment Initiative offers opportunities to improve coordination, costs, and quality across demonstrations, it is important to remember that vulnerability of patients also increases as well. By improving relationships between federal decision-makers and health plans, emphasizing administrative alignment across demonstrations, and refining approaches to data collection and evaluation, all parties within the Financial Alignment Initiative demonstrations serve to benefit.

6a. Conclusion

In summary, our study provides insight into the Financial Alignment Initiative and its capitated model demonstrations by means of outlining the populations being served, progress across demonstrations, and research across contemporary literature and interviews conducted with federal, state, and third-party officials. By outlining and discussing our findings, we hope that this study provides valuable insight for future planning, development, and policy making related to the Financial Alignment Initiative in the United States.

Appendix A

Interview Guide

THESIS INTERVIEW GUIDE

Interviewer: Jonathon George
Interviewee: *[Insert Name]*
Date: *[Insert Date]*

Pre-Interview Questions:

Name:
Department:
Position:
Experience:

Interview Questions:

(1) What have been the key drivers of success for the Financial Alignment Initiative?

Notes:

(2) What challenges and pain points have been experienced thus far?

Notes:

(3) What specific changes have been made to improve upon said challenges?

Notes:

(4) What investments are being made to enhance working relationships between groups?

Notes:

(5) What lessons have been learned?

Notes:

BIBLIOGRAPHY

1 Financial Alignment Initiative for Medicare-Medicaid Beneficiaries (2017, March). Retrieved from https://innovation.cms.gov/initiatives/Financial-Alignment/

2 State Medicaid integration tracker (2017, February). Retrieved from http://nasuad.org/sites/nasuad/files/State%20Medicaid%20Integration%20Tracker%20February%202017%20.pdf

3 State Medicaid Director's letter describing the models (2011, July). https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

4 Philip, A. M., Kruse, A., & Soper, M. H. (2016, June). ACAP Medicare-Medicaid plans and the Financial Alignment Demonstrations: Innovations and lessons. Retrieved from http://www.chcs.org/media/ACAP-Medicare-Medicaid-Plans-and-the-Financial-Alignment-Demonstrations.pdf

5 An overview of Medicare (2016, April). Retrieved from http://kff.org/medicare/issue-brief/an-overview-of-medicare/

6 NHE fact sheet (2017, March). Retrieved from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

7 What's a Medicare Advantage Plan? (2015, April). Retrieved from https://www.medicare.gov/pubs/pdf/11474.pdf

8 Explaining Medicare (2017). Retrieved from https://www.medicareinteractive.org/get-answers/introduction-to-medicare/explaining-medicare

9 Kohatsu, K. (2016). PricewaterhouseCoopers, LLP. Retrieved from [slide 7] Government Programs Training

10 Dual eligible beneficiaries under the Medicare and Medicaid programs. (2016). Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

[11] December 2016 Medicaid and CHIP enrollment data highlights (2017). Retrieved from https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[12] Dual Eligible special needs plans (2016, August). Retrieved from https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/D-SNPs.html

[13] Managed care (2017). Retrieved from https://www.medicaid.gov/medicaid/managed-care/index.html

[14] People enrolled in Medicare and Medicaid (2017, March). Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf

[15] Medicaid's role for dual eligible beneficiaries (2013, August). Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/08/7846-04-medicaids-role-for-dual-eligible-beneficiaries.pdf

[16] The role of Medicaid for people with behavioral health conditions (2012, November). Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_bhc.pdf

[17] Medicare-Medicaid enrollee information, national (2011). Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2011NationalProfile.pdf

[18] Dual Eligibles in the U.S.: Statistics and facts. (2013, October). Retrieved from http://www.tn-elderlaw.com/blog/october_2013/dual_eligibles

[19] Medicare-Medicaid enrollee information, California (2011). Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2011StateProfilesCA.pdf

[20] Medicare-Medicaid enrollee information, Illinois (2011). Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2011StateProfilesIL.pdf

21 Musumeci, M. (2015, December). Retrieved from http://kff.org/medicaid/issue-brief/financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-states-with-memoranda-of-understanding-approved-by-cms/

22 Capitated model (2016, November). Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/CapitatedModel.html

23 Managed fee for service model (2016, August). Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ManagedFeeforServiceModel.html

24 Medicaid MCO auto-enrollment policies in effect (2015, October). Retrieved from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf

25 Walsh, E. G. (2015, October). Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf

26 Castleberry, Susan (2015, November). Updates from the Medicare-Medicaid Financial Alignment Initiative. Retrieved from http://www.iceforhealth.org/podcast/20160105_08_DualsDemoPanel.pdf

27 FAI enrollment report (2016, June). Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAIEnrollmentHRAJun2016.pdf

28 New research shows efforts to improve Medicare and Medicaid programs are working (2017, March). Retrieved from https://www.rti.org/news/new-research-shows-efforts-improve-medicare-and-medicaid-programs-are-working

29 Greene, A. M. (2017, March) Early findings on care coordination in capitated Medicare-Medicaid plans under the Financial Alignment Initiative. Retrieved from https://innovation.cms.gov/Files/reports/fai-carecoordination-issuebrief.pdf

30 Medi-Cal's Dual Eligible population demographics, health characteristics and costs of health care services (2010, April). Retrieved from http://www.dhcs.ca.gov/Documents/Dual Eligibles Summary California Data.pdf

31 Frequently asked questions (2017). Retrieved from http://www.calduals.org/background/faq/

32 Taylor, M. (2016, November). The 2017-2018 budget: California's fiscal outlook. Retrieved from http://www.lao.ca.gov/reports/2016/3507/Fiscal-outlook-111616.pdf

33 Department of Health Care Services Contacts (2017). Retrieved from http://www.dhcs.ca.gov/Pages/dhcs_contact.aspx

34 The 2016 Annual Homeless Assessment Report to Congress (2016, November). Retrieved from https://www.hudexchange.info/resources/documents/2016-AHAR-Part-1.pdf

35 Abrams, S. (2014,July). Los Angeles Country doctors sue state over Cal MediConnect program. Retrieved from http://www.dailynews.com/general-news/20140708/los-angeles-county-doctors-sue-state-over-cal-mediconnect-program

36 Ruling: California judge allows Cal MediConnect to continue amidst physicians' objections (2014). Retrieved from http://calrheum.org/cra/app/document/3535051

37 Approved demonstrations – signed MOUs (2015, November). Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html

38 Medicaid Managed Long Term Service and Supports implementation (2016, June). Retrieved from http://www.ageoptions.org/documents/FINALMMWMLTSSWebinarSlides.6.2.16.pdf

39 HFS executive staff (2017). Retrieved from https://www.illinois.gov/hfs/About/Pages/ExecutiveStaff.aspx

40 Kaiser Family Foundation (2017). Retrieved from http://kff.org/about-us/

41 Department of Health Care Services (2017). Retrieved from http://www.dhcs.ca.gov/Pages/AboutUs.aspx?utm_source=Resources&utm_medium=SideBar&utm_campaign=AboutDHCS

42 Justice in Aging (2017). Retrieved from http://www.justiceinaging.org/about-us/

43 PricewaterhouseCoopers, LLP (2017). Retrieved from http://www.pwc.com/us/en/about-us.html

44 Healthcare and Family Services (2017). Retrieved from https://www.illinois.gov/hfs/About/Pages/default.aspx

Academic Vita: Jonathon George

3 Marlboro Drive
Greensburg, PA 15601

Jxg5293@psu.com | 724.972.8615

EDUCATION

Pennsylvania State University, **Schreyer Honors College**

Schreyer Honors College, B.S. Health Policy & Administration 5/17

Smeal College of Business, B.S. Finance, Concentrations in Accounting and Economics 5/17

PROFESSIONAL EXPERIENCE

PWC STRATEGY&, Chicago, IL 6/16 – 8/16

Intern, Healthcare Deals Group

- Strategic Operating Model Transformation for Leading Health Payer – Operational Assessment and Redesign
  - Performed operational due diligence in a team of 5 to define and construct current- and future-state operating models
  - Assisted the design of a detailed future-state operating model across government and operational entities, generating a comprehensive reporting, governance, and communication structure
  - Operating Models were presented directly to Executive Leadership
- Government Programs Workshop – Presentation and Implementation
  - Created, developed and presented a viable future-state operating model to Executive Leadership and Senior Staff

VERALON STRATEGY, Philadelphia, PA 6/15 – 8/15

Intern, Healthcare M&A

- M&A Due Diligence and Financial Analysis - $400M Acquisition of Health System by $1.7B Market Leader
  - Performed due diligence, financial modeling, and financial impact analysis for a large healthcare provider
  - Projected the client's Balance Sheet, Income Statement, and Inpatient/Outpatient volume impact alongside a Senior Associate; results presented directly to client's Board of Directors

PENN STATE DANCE MARATHON (THON), University Park, PA 4/16 – 4/17

Executive Committee

- Directed the largest student run philanthropy in the world, consisting of 16,500 Penn State student volunteers
- Raised over **$10M in 2017**, directly benefitting children and families battling childhood cancer
- Director of Communications, responsible for collecting, coordinating, and disseminating all of THON's vital information to the 16,500+ THON Volunteers, 28,000+ THON Supporters, and 450+ Organization Presidents

LEADERSHIP & SERVICE

Schreyer Consulting Club | President

- Led all activities of the Schreyer Consulting group; educating, preparing, and placing 95% of our students

Beta Sigma Beta Fraternity | Executive Board

- Led a fraternity of 100+ brothers, raising over $260,000 in two years as Head of Philanthropy

LifeLink PSU | Student Mentor

- Mentor for local ASD special-needs students to provide positive social and academic growth

Camp Kesem Central PA | Unit Leader

- Led the organization of free summer camps for children affected by a parent's cancer