



December 2015

# MEDICARE AND MEDICAID

## Additional Oversight Needed of CMS's Demonstration to Coordinate the Care of Dual-Eligible Beneficiaries

# GAO Highlights

Highlights of [GAO-16-31](#), a report to congressional requesters

## Why GAO Did This Study

The Medicare and Medicaid programs spent an estimated \$300 billion on dual-eligible beneficiaries—those individuals who qualify for both programs—in 2010. These beneficiaries often have complex health needs, increasing the need for care coordination across the two programs. In 2013, CMS began the Financial Alignment Demonstration, with the goal of integrating Medicare and Medicaid services and financing and improving care coordination. Thirteen states are participating.

GAO was asked to examine care coordination under the demonstration. GAO examined (1) how integrated care organizations—which are health plans or other entities—are implementing care coordination and (2) what, if any, challenges organizations have encountered in implementing care coordination and the extent to which CMS oversees these care coordination activities. GAO interviewed officials from CMS and, during site visits to a nongeneralizable sample of the first five states to implement the demonstration, interviewed state officials, organizations, advocacy groups, and providers. GAO also reviewed CMS guidance outlining CMS's oversight role and the measures it uses to monitor the demonstration.

## What GAO Recommends

GAO recommends that CMS develop new comparable measures and align existing measures to strengthen oversight of care coordination. HHS proposed actions that it plans to take in response to GAO's recommendations, as discussed in the report.

View [GAO-16-31](#). For more information, contact Kathleen M. King at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov).

December 2015

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### Additional Oversight Needed of CMS's Demonstration to Coordinate the Care of Dual-Eligible Beneficiaries

## What GAO Found

Due to the flexibility that states have in designing their Financial Alignment Demonstrations, the integrated care organizations that GAO interviewed in California, Illinois, Massachusetts, Virginia, and Washington implemented care coordination for dual-eligible Medicare and Medicaid beneficiaries in a variety of ways. For example, these organizations assigned care coordinators to beneficiaries using different approaches, such as assigning them by geographic proximity to the beneficiary or to the beneficiary's primary care provider. Care coordinators also used a range of interactions with beneficiaries in order to coordinate care, including by mail, e-mail, telephone, or in person.

The organizations GAO interviewed described facing challenges that affected their ability to coordinate care, such as difficulties in locating beneficiaries. Specifically, organizations noted that certain characteristics of dual-eligible beneficiaries, such as high levels of transience, can make it challenging to coordinate their care—one of the key goals of the demonstration. GAO's interviews with beneficiary advocacy groups and providers raised questions about the extent to which care coordination is actually occurring.

The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), collects information that assesses the extent to which care coordination is occurring, but not all of this information is comparable across the states. To inform its oversight, CMS has established a framework of monitoring activities, and one key component of this oversight is the monitoring of core and state-specific measures for each of the two demonstration models that states can implement: (1) the capitated model, where organizations receive a capitated payment to provide integrated care, and (2) the managed fee-for-service (MFFS) model, where states are eligible for retroactive savings resulting from initiatives to integrate care with existing fee-for-service providers. CMS collects different sets of core measures from the capitated and MFFS model states. Two out of 10 core measures in the capitated model provide information on the extent to which care coordination is occurring, while no core measures in the MFFS model examine this area. The states in our review had state-specific measures that explored aspects of care coordination, but they were not comparable across the states or both demonstration models. In addition, CMS added comparable, demonstration-specific questions to the Consumer Assessment of Healthcare Providers and Systems, a survey that CMS requires all organizations for the capitated model, and states for the MFFS model, to complete annually. While the results of the surveys are still forthcoming, information from these questions may be able to provide CMS with important information about whether beneficiaries are meeting with their care coordinators across both models. Federal internal control standards state that monitoring should be designed to help an agency accomplish its goals. Because not all of the information that CMS collects to examine the extent to which care coordination is occurring is comparable, CMS does not fully know whether it has achieved its goal of providing coordinated care to dual-eligible beneficiaries. Establishing additional measures that would allow CMS to obtain these data could help it better understand the reasons why care coordination is or is not occurring and thus help the agency to strengthen the demonstration.

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### Abbreviations

CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare & Medicaid Services
CMT	contract management team
D-SNP	dual-eligible special needs plans
EDCD	Elderly or Disabled with Consumer Direction
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
HOS	Health Outcomes Survey
ICP	individualized care plan
ICT	interdisciplinary care team
MACPAC	Medicaid and Children's Health Insurance Program Payment and Access Commission
MFFS	managed fee-for-service
SNP	special needs plans

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December 18, 2015

Congressional Requesters

About 10 million of Medicare’s approximately 50 million beneficiaries are also eligible for Medicaid, a joint federal-state program that finances health insurance coverage for certain categories of low-income or disabled people.<sup>1</sup> Dual-eligible beneficiaries accounted for less than one-fourth of each program’s population but over one-third of each program’s spending—more than \$300 billion—in 2010, the most recent year available.<sup>2</sup> Dual-eligible beneficiaries are often in poorer health and require more care compared with other Medicare and Medicaid beneficiaries. They typically receive their benefits through each program separately, which can lead to fragmented care because the programs have different rules for provider reimbursement and benefits and may have conflicting financial incentives. For example, incentives may exist for providers to shift beneficiaries from one type of service to another to increase their payments. These types of program misalignments can result in unnecessary hospitalizations, which can reduce quality of care and increase costs. Recently, the federal government, states, researchers, and advocates have focused increased attention on care coordination for dual-eligible beneficiaries as a key strategy for improving the quality of care while simultaneously reducing costs.<sup>3</sup>

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<sup>1</sup>Medicare is the federally financed health insurance program for persons 65 years of age or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare fee-for-service includes Medicare Parts A and B. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance, which covers hospital outpatient, physician, and other services and requires a monthly premium. Medicare Part B beneficiaries have the option of enrolling in a Medicare Advantage plan—a private plan alternative to Medicare fee-for-service that operates under Medicare Part C—to receive their Parts A and B benefits. In addition, all Medicare beneficiaries may opt to receive prescription drug coverage under Medicare Part D either through a separate Part D plan or through a Medicare Advantage plan.

<sup>2</sup>Medicare Payment Advisory Commission and Medicaid and Children’s Health Insurance Program Payment and Access Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (Washington, D.C.: January 2015).

<sup>3</sup>Care coordination is the process of integrating all medical, behavioral health, and long-term services and supports to ensure the proper providers and services are in place to meet the beneficiaries’ needs.

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Specifically, beginning in 2013, the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) began implementing the Financial Alignment Demonstration through its Medicare-Medicaid Coordination Office, which will integrate Medicare and Medicaid services and financing and improve care coordination for dual-eligible beneficiaries.<sup>4</sup> Ultimately, CMS believes the Financial Alignment Demonstration will reduce spending and improve the quality of care for dual-eligible beneficiaries. The demonstration allows states, through contracted integrated care organizations, to test models of care that emphasize care coordination, including care coordinators, health risk assessments, individualized care plans (ICP), and interdisciplinary care teams (ICT).<sup>5</sup> CMS is required by law to evaluate the quality of care furnished under these models. In addition, the Secretary of Health and Human Services may, through rulemaking, expand the duration and scope of a model under specified conditions. As of August 2015, CMS had approved 13 states to participate in the 3-year demonstration, and the agency estimates that approximately 441,000 beneficiaries are enrolled.<sup>6</sup>

You asked us to examine care coordination under CMS's Financial Alignment Demonstration. Specifically, we examined

1. how integrated care organizations are implementing care coordination for beneficiaries in the Financial Alignment Demonstration and
2. what, if any, challenges the organizations have encountered in implementing care coordination and the extent to which CMS oversees these care coordination activities.

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<sup>4</sup>The Financial Alignment Demonstration is also sometimes referred to as the Financial Alignment Initiative.

<sup>5</sup>For this report, integrated care organizations—which we refer to as organizations—include health plans or other qualified entities participating in the Financial Alignment Demonstration. In addition, for this report, a care coordinator is the person responsible for facilitating the coordination of services for the beneficiary. A health risk assessment examines a beneficiary's needs. The ICP is a plan of care that includes the beneficiary's goals and strategies toward meeting those goals. The ICT is a team of providers, including the care coordinator, that works closely with the beneficiary to implement and maintain his or her ICP.

<sup>6</sup>In July 2015, CMS gave states the option to extend their demonstrations for an additional 2 years.

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To describe how integrated care organizations are implementing care coordination for beneficiaries in the Financial Alignment Demonstration, we reviewed CMS guidance. We also selected a nongeneralizable sample of five states—California, Illinois, Massachusetts, Virginia, and Washington—and examined their demonstration planning documents. We selected these states because they were the first five states to begin enrolling beneficiaries on or before September 1, 2014.<sup>7</sup> Because the demonstration parameters are complex and involve many requirements, we focused our review on the four care coordination requirements for the demonstration, which are specified in CMS and state guidance: (1) a care coordinator, (2) a health risk assessment, (3) an ICP, and (4) an ICT. We also interviewed officials from CMS’s Medicare-Medicaid Coordination Office about the care coordination requirements in CMS guidance and how these requirements were being implemented by states involved in the demonstration. We conducted site visits to each state and interviewed state agency officials; officials from the CMS regional office; staff at integrated care organizations, including care coordinators; staff from beneficiary advocacy groups; and primary care providers. We selected 11 integrated care organizations to interview within the five states<sup>8</sup> (2 in Illinois, Massachusetts, Virginia, and Washington, and 3 in California) by identifying organizations that had the highest level of enrollment in the demonstration as of August 2014 (except for Washington, where we used

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<sup>7</sup>Of the five states we selected, the state with the earliest implementation date started enrollment in July 2013 and the state with the latest implementation date started enrollment in July 2014.

<sup>8</sup>One of the organizations we interviewed in Massachusetts dropped out of the demonstration early, on September 30, 2015, noting that its participation was not economically sustainable. In addition, while Washington’s 3-year demonstration was initially planned to end after December 31, 2016, the approved 2015-2017 Washington state budget did not authorize any funding for the demonstration after December 31, 2015. However, as of November 2015, the state of Washington decided to continue participating in the demonstration until at least June 2016.

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enrollment data as of February 2015).<sup>9</sup> At most of the organizations in our review, we also observed ICT meetings conducted by organization staff. To obtain the perspective of beneficiaries, we asked officials from the five states to identify one beneficiary advocacy group that was a stakeholder in developing each state's demonstration, and we interviewed staff at that group. In addition, we spoke with seven primary care providers located in California, Illinois, and Massachusetts about their experiences with the demonstration.<sup>10</sup> We developed structured interview protocols to gather consistent information from CMS, the states, integrated care organizations, beneficiary advocacy groups, and primary care providers about their perspectives in implementing care coordination in the demonstration. Our findings are limited to the five states in our review and are not representative of all states and integrated care organizations participating in the Financial Alignment Demonstration.

To determine what, if any, challenges the organizations have encountered in implementing care coordination and the extent to which CMS oversees these care coordination activities, we interviewed staff at integrated care organizations located in the five states in our review about challenges they have encountered. We also interviewed CMS officials from the Medicare-Medicaid Coordination Office about the agency's oversight and monitoring of selected states' demonstrations. In addition, we reviewed CMS guidance about the agency's role and responsibility for demonstration oversight, as well as CMS guidance describing the

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<sup>9</sup>Unlike the other state demonstrations in our review, after beneficiaries in Washington are automatically enrolled in the state's demonstration, care coordination services are not provided unless an enrollee elects to receive them. If an enrollee elects to receive services, Washington's demonstration considers the beneficiary to be "engaged." Since the enrollment numbers reported by the organizations in Washington only reflected the total number of beneficiaries enrolled and not the number of engaged beneficiaries who were actually receiving services, we also examined the total number of engaged beneficiaries to inform our selection of organizations in that state. We found that the two organizations with the highest number of enrollees as of February 2015 also had the highest number of engaged enrollees. In the other state demonstrations in our review, care coordination services were included among the services provided under the demonstration upon a beneficiary's effective enrollment date.

<sup>10</sup>The staff we interviewed at organizations in California, Illinois, Massachusetts, and Virginia gave us a list of primary care providers in their respective networks that cared for enrollees in the demonstration. We contacted several providers in each state—18 in all. Of these, 7 responded to our requests for an interview. We did not contact providers in Washington because, unlike the other state demonstrations in our review, the providers in Washington's demonstration provide care to beneficiaries on a fee-for-service basis through existing Medicare and Medicaid service delivery systems.

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measures that CMS regularly requires organizations and states to report as part of the agency’s monitoring. We determined whether these measures assessed the extent to which care coordination is occurring in the demonstration—that is, whether care coordinators are meeting with beneficiaries, health risk assessments are being completed, ICPs are being developed, and ICT meetings are occurring. We compared these oversight activities to CMS’s goals for the demonstration and the standards described in *Standards for Internal Control in the Federal Government*.<sup>11</sup> We did not evaluate whether the demonstration had achieved cost savings or improved the quality of care.

We conducted this performance audit from June 2013 to December 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

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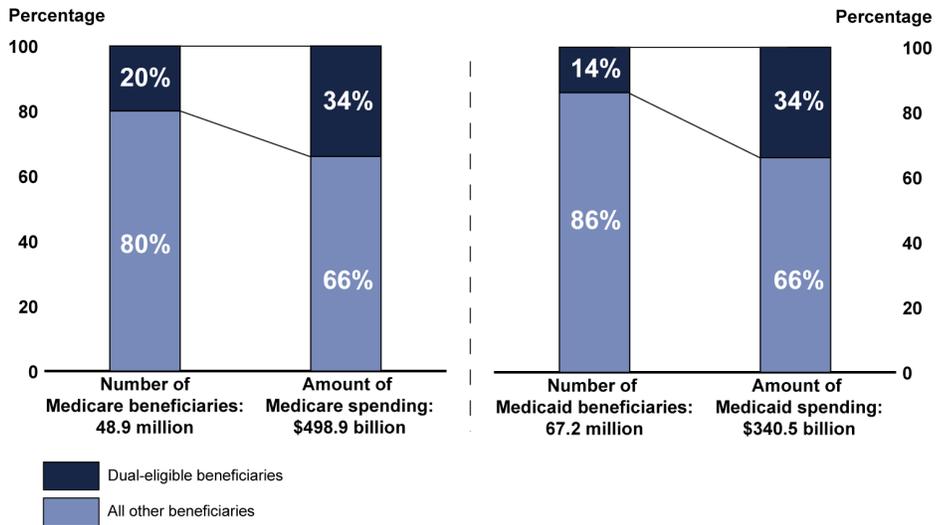
### Characteristics of Dual-Eligible Beneficiaries

Dual-eligible beneficiaries are a particularly vulnerable group. In general, these individuals are among the poorest and sickest beneficiaries enrolled in Medicare and Medicaid. For example, compared to other Medicare beneficiaries, they are more likely to be disabled; report poor health status and limitations in their activities of daily living, such as bathing and toileting; and have cognitive impairments, mental disorders, and certain chronic conditions, such as diabetes and pulmonary disease. Therefore, dual-eligible beneficiaries tend to have higher rates of service use and consequently, higher spending, compared to other Medicare and Medicaid beneficiaries. (See fig. 1.)

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<sup>11</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

**Figure 1: Dual-Eligible Beneficiaries as a Share of Medicare and Medicaid Enrollment and Spending, Calendar Year 2010**



Source: Medicare Payment Advisory Commission and the Medicaid and Children's Health Insurance Program Payment and Access Commission. | GAO-16-31

Although dual-eligible beneficiaries have a higher rate of service use compared to other Medicare and Medicaid beneficiaries, as a group, they vary in terms of their need for health care services, reflecting differences in the prevalence of disabilities and other health conditions. Under Medicare, dual-eligible beneficiaries have coverage for most acute care services, such as care provided by physicians or inpatient hospitals, post-acute skilled nursing facility care, and prescription drugs. Under state Medicaid programs, dual-eligible beneficiaries also have coverage for long-term nursing facility care and home and community-based services. These beneficiaries may also qualify for payment of Medicare premiums and cost sharing. Medicaid is the health care payer of last resort, meaning that Medicare pays to the extent of its liability before Medicaid makes any payments. Because dual-eligible beneficiaries receive care through separate programs with different benefits and payment processes, they are likely to be treated by many different health care providers that may not coordinate their care, which can lead to increased costs and poorer patient outcomes.

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## Past Initiatives to Coordinate Care for Dual-Eligible Beneficiaries

Prior to the implementation of the Financial Alignment Demonstration in 2013, the Medicare and Medicaid programs were separately responsible for covering certain services for most dual-eligible beneficiaries, and there may not have been an incentive for one program to help control costs in the other program. As we previously reported, any savings that were achieved often resulted from services that were largely paid for by Medicare, such as reductions in the number and length of hospital stays, and therefore accrued to the Medicare program.<sup>12</sup> Therefore, state Medicaid programs did not have an incentive to better coordinate care or reduce spending since they did not benefit from any savings that were achieved. However, increasingly there have been efforts to try to improve integration of care between these two programs. For example, one specific effort to integrate care for dual-eligible beneficiaries was the establishment of dual-eligible special needs plans (D-SNP) in 2003.<sup>13</sup> D-SNPs are a type of Medicare Advantage plan exclusively for dual-eligible beneficiaries that provide specialized services targeted to the needs of their beneficiaries, including a health risk assessment and an ICT for each enrolled beneficiary. About 1.9 million of the dual-eligible population was enrolled in D-SNPs in 2014.<sup>14</sup>

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## Financial Alignment Demonstration: Design and Implementation, Care Coordination, and Sources of Potential Savings

### Design and Implementation of the Demonstration

CMS's goal for the Financial Alignment Demonstration is to integrate Medicare and Medicaid services and financing and improve care coordination for beneficiaries, therefore resulting in improved care and

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<sup>12</sup>See GAO, *Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance*, [GAO-12-864](#) (Washington, D.C.: Sept. 13, 2012).

<sup>13</sup>Special needs plans (SNP), including D-SNPs, have been reauthorized several times since their establishment was first authorized in 2003. Dual-eligible beneficiaries may also choose to enroll in other types of SNPs for which they are eligible, including institutional SNPs for individuals residing in nursing facilities or institutions, and chronic condition SNPs for individuals with severe or disabling chronic conditions.

<sup>14</sup>See [GAO-12-864](#).

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savings to Medicare and Medicaid. CMS gave the states flexibility in designing their demonstrations because of the different needs of their target populations, the geographic coverage areas, and the number of eligible beneficiaries. For example, while Massachusetts chose to limit its target population to dual-eligible beneficiaries from age 21 through 64, California, Illinois, and Virginia chose to include all dual-eligible beneficiaries aged 21 and older as their target populations. CMS required states to involve dual-eligible beneficiaries and other stakeholders, such as beneficiary advocacy groups, in the development of their demonstrations to help design a person-centered system of care.

Before any state's demonstration becomes operational, CMS oversees a multistep approval process of the state's demonstration design. First, states interested in participating in the demonstration submit proposals to CMS that provide a description of the demonstration's design. CMS then reviews the proposals and works with the states to develop a memorandum of understanding that further outlines the parameters of the demonstration, which both the state and CMS sign.

As part of their proposals, states generally opted to test one of two models—the capitated or managed fee-for-service (MFFS) models.<sup>15</sup> Under the demonstration's capitated model, following CMS approval of the memorandum of understanding, the states work with CMS to select qualified integrated care organizations to participate in the demonstration. Then, the state, CMS, and an integrated care organization enter into a three-way contract, and the integrated care organization receives a prospective blended capitated payment, which includes both Medicare and Medicaid payments, to provide coordinated care across both programs. CMS reduces payment rates to organizations up front each year based on a predetermined Medicare and Medicaid savings estimate, with the amount of savings increasing each year, typically from 1 percent in the first year to 4 percent in the third year of the demonstration. For example, in Massachusetts, contracted managed care health plans provide care coordination services and integrate care between the two

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<sup>15</sup>Four of the five states in our review—California, Illinois, Massachusetts, and Virginia—are implementing a capitated model that will rely on qualified organizations, such as health plans, to provide integrated care to dual-eligible beneficiaries under the demonstration. The remaining state—Washington—is implementing an MFFS model that will rely on health homes, which are the organizations responsible for integrating care under the demonstration.

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programs and receive one combined payment from both Medicare and Medicaid for each enrollee. For states opting for the MFFS model, following CMS approval of the memorandum of understanding, the state and CMS enter into an agreement by which providers continue to receive fee-for-service reimbursement for both Medicare and Medicaid services. The state is then eligible for a portion of any retroactive savings resulting from state initiatives designed to improve quality and reduce spending for dual-eligible beneficiaries. One state, Washington, is using Medicaid health home agencies to coordinate Medicare and Medicaid services among existing fee-for-service providers for dual-eligible beneficiaries.

The organizations in the capitated model, and the states in the MFFS model, then undergo a CMS review to ensure they are prepared to begin enrolling dual-eligible beneficiaries. Once they have passed CMS's review, they can begin enrolling beneficiaries. In general, under the capitated model, eligible beneficiaries—those dual-eligible beneficiaries who meet the state's age, geographic residency, and other requirements for the demonstration—can enroll voluntarily into the demonstration and choose a participating integrated care organization. Dual-eligible beneficiaries who choose not to enroll voluntarily can be assigned by the state Medicaid agency to a participating organization, in a process known as "passive enrollment." Once a beneficiary is enrolled into the demonstration, the state will send the beneficiary's contact information to the relevant integrated care organization. The state or CMS may also provide Medicaid or Medicare claims data, medical history, hospitalizations, and pharmacy use for the beneficiaries. The organization then typically assigns a care coordinator and begins coordinating the beneficiary's care. In the MFFS model, beneficiaries are automatically enrolled in the demonstration, and following enrollment, the care coordinator will perform outreach to the beneficiary and give the beneficiary the option to elect to receive care coordination services. Under both models, beneficiaries can opt out of the demonstration at any time.

Implementation of the Financial Alignment Demonstration began in July 2013 when the first state, Washington, began enrolling beneficiaries. Since then, CMS has approved 12 other state demonstrations and all but one of these states has begun enrolling beneficiaries. Two states—Connecticut and New York—had proposals pending approval from CMS

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as of September 2015.<sup>16</sup> (See fig. 2 for a demonstration map.) The agency is no longer accepting new proposals from states.

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<sup>16</sup>CMS has approved New York's capitated demonstration model, which targets dual-eligible beneficiaries over the age of 21 who are receiving nursing facility or community-based long-term services and supports, but its second demonstration proposal, which targets dual-eligible beneficiaries with developmental disabilities, is pending approval from CMS. In addition to New York, California, Illinois, Massachusetts, Michigan, Ohio, Rhode Island, South Carolina, Texas, and Virginia are pursuing a capitated model. Colorado and Washington are pursuing an MFFS model. Minnesota is pursuing an alternative administrative alignment model, which will maintain its existing payment and delivery system arrangement but will allow organizations to integrate Medicare and Medicaid payments and improve coordination among different types of services.



Care Coordination under the Demonstration

One of the key goals of the demonstration is to improve care coordination for beneficiaries using a person-centered care delivery model based on the preferences and needs of the beneficiary, which CMS anticipates will improve the quality of care and reduce costs. CMS requires states and organizations participating in the demonstration to incorporate a care coordinator role, a health risk assessment, an ICP, and an ICT into their care delivery model for the demonstration. (See table 1.)

**Table 1: Required Care Coordination Components for the Centers for Medicare & Medicaid Services' (CMS) Financial Alignment Demonstration for Dual-Eligible Beneficiaries**

Required component of care delivery model	Component description based on the five state demonstrations in our review <sup>a</sup>
Care coordinator	<ul style="list-style-type: none"> <li>Typically, upon enrollment, beneficiaries are contacted by their assigned care coordinator, who is a clinician or other trained professional employed by the organization and responsible for coordinating the beneficiary's care.</li> <li>Among other responsibilities, the care coordinator is responsible for facilitating care coordination services, such as conducting (or participating in) the health risk assessment, developing the beneficiary's individualized care plan, and leading or facilitating the interdisciplinary care team meetings.</li> </ul>
Health risk assessment	<ul style="list-style-type: none"> <li>Once enrolled, each beneficiary is assigned to a risk category (such as low-risk, moderate-risk, or high-risk) based on his or her health history and needs.<sup>b</sup></li> <li>Each beneficiary receives a health risk assessment, administered by the integrated care organization, to identify needs.</li> <li>The assessment tool is a screening questionnaire that can vary by state, but must assess a beneficiary's different needs, such as medical, psycho-social, functional, and cognitive.</li> </ul>
Individualized care plan (ICP)	<ul style="list-style-type: none"> <li>The ICP is a plan of care required for each beneficiary, and the format can vary by state. It is typically developed by the care coordinator or the interdisciplinary care team in collaboration with the beneficiary.</li> <li>The ICP, which is usually developed following the health risk assessment, includes the beneficiary's goals and strategies toward meeting those goals.</li> <li>The beneficiary's interdisciplinary care team typically works with the beneficiary to implement the ICP, which is updated annually or when the beneficiary has a change in health status or goals.</li> </ul>
Interdisciplinary care team (ICT)	<ul style="list-style-type: none"> <li>Each beneficiary is to have access to an ICT that is built on the beneficiary's preferences and needs.</li> <li>The ICT, often led by a care coordinator, is a team of providers that works with the beneficiary to implement and maintain his or her ICP.<sup>c</sup></li> <li>The ICT typically consists of the primary care provider, the care coordinator, the beneficiary, any other relevant specialist providers, and any other members the beneficiary chooses to include. Beneficiary participation in ICT meetings is optional.</li> </ul>

Source: GAO analysis of CMS guidance and state planning documents for the CMS Financial Alignment Demonstration. | GAO-16-31

Notes: For this report, integrated care organizations—which we refer to as organizations—include health plans or other qualified entities participating in the Financial Alignment Demonstration. The states in our review used different terminology for the care coordinator role, health risk assessment, ICP, and ICT.

<sup>a</sup>The five states in our review were California, Illinois, Massachusetts, Virginia, and Washington.

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Sources of Potential Savings under the Demonstration

<sup>b</sup>In general, states categorize higher risk beneficiaries as those that have multiple health conditions and a higher risk of hospitalization and they categorize lower risk beneficiaries as those that have few or no health needs.

<sup>c</sup>Washington's state planning documents do not indicate that the ICT works with the beneficiary to implement his or her ICP.

Under the demonstration, any savings will be shared equally by Medicare and Medicaid, regardless of whether the savings were achieved primarily by Medicare or Medicaid. Although CMS projects that approximately 60 to 70 percent of savings from the demonstration will come from reductions in costly Medicare-covered services, such as fewer hospital admissions (including readmissions), and approximately 1 to 5 percent of savings will come from fewer emergency room visits, the agency requires that as part of a more integrated approach, both the Medicare and Medicaid programs adjust their payment rates to plans based on aggregate savings percentages.<sup>17</sup>

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Organizations Participating in CMS's Financial Alignment Demonstration Implemented Care Coordination in a Variety of Ways

Organizations in the five states in our review used state- and CMS-required care coordinators, health risk assessments, ICPs, and ICTs to coordinate care. Due to the flexibility states have in designing these elements in their demonstrations, implementation varied among the organizations in these five states.

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Care Coordinator

Staff from organizations in our review reported different ways that they assigned care coordinators to beneficiaries. Some organizations assigned care coordinators on the basis of geographic proximity to the beneficiary or the beneficiary's primary care provider. Others assigned care coordinators a mix of low-, moderate-, and high-risk beneficiaries, or assigned care coordinators based on the coordinator's qualifications and areas of expertise.

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<sup>17</sup>See Centers for Medicare & Medicaid Services, *Joint Rate-Setting Process for the Capitated Financial Alignment Model* (Baltimore, Md.: August 2013).

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Care coordinators varied in their qualifications and backgrounds, and in the types of care they coordinated. Organization staff said care coordinators had degrees or licensures in fields such as nursing, social work, or behavioral health. Staff from the organizations said they hired care coordinators with backgrounds in care management and assessment, and who were comfortable reaching out to and engaging with beneficiaries. In addition, some organizations had separate care coordinators assigned to handle medical needs versus behavioral health needs, but others had care coordinators who were responsible for coordinating care across medical, behavioral, and social realms.

Care coordinators for the organizations in our review reported interacting with beneficiaries, using a range of methods and in a variety of settings, to conduct health risk assessments, develop ICPs, and lead ICTs. Care coordinators we spoke with reported interacting with beneficiaries by mail, e-mail, telephone, and in person, but most care coordinators said they interacted with beneficiaries by telephone or in person. Some care coordinators told us they interacted by telephone regardless of a beneficiary's risk level, while others used a mix of telephone and in person methods depending on the beneficiary's risk level and needs. Some care coordinators in the latter group used in person interactions for higher-risk beneficiaries and telephone interactions for low-risk beneficiaries. Locations of the in-person visits also differed; while in-person visits were often conducted in a beneficiary's home, care coordinators described meeting beneficiaries in other settings as well, such as parks, libraries, homeless shelters, clothing drives, and provider's offices.

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## Health Risk Assessment

The organizations in the five states we reviewed differed in how they conducted the health risk assessment. For example, they differed in how they identified high- and low-risk beneficiaries, a process that typically occurs when the beneficiary is enrolled in the demonstration, but before the health risk assessment is conducted. Staff at some of these organizations said they confirm or adjust the initial risk category assigned by the state through the health risk assessment process. Conversely, staff at organizations in states that do not assign an initial risk category said they begin their health risk assessment process by identifying high- and low-risk beneficiaries through an initial health screening and then administering the health risk assessment.

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Additionally, based on our interviews, we found that organizations in the five states varied in their methods for conducting the assessment. Not all of these organizations used their own staff and instead contracted with a vendor to conduct the assessments. For the organizations conducting their own assessments, the staff responsible also differed depending on the organization. For example, some organizations had the beneficiary's care coordinator conduct the assessment, while others used other types of staff, such as assessment coordinators.

The organizations we reviewed also used different health risk assessment tools. For example, the Illinois demonstration required organizations to use a tool that must assess the beneficiary's medical, psycho-social, functional and cognitive needs, and medical and behavioral health, while the Massachusetts demonstration required organizations to use a tool that not only assesses these needs but also assesses needs related to housing, employment status, and food security. Staff at some of these organizations also said they used a supplemental assessment in addition to the health risk assessment to further identify the needs of their beneficiaries.

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## ICP

Based on our interviews, we found that the ICP templates varied by organization in the five states and therefore differed in length, complexity, and focus. Some organizations used ICP templates from the state and others developed their own templates. The ICPs varied in length, from shorter plans containing three to five goals to longer plans containing many goals. Staff who used the shorter ICPs explained they did so to avoid losing the beneficiary's interest. The complexity of the ICP also depended on the organization. For example, staff at some organizations described ICPs that contained goals for the beneficiaries as well as strategies, timelines, and barriers to meeting those goals. Additionally, some organizations created ICPs with a mix of short- and long-term goals, while other organizations said their ICPs contained a small number of meaningful and achievable goals. Some organizations tailored their ICPs to focus on the risk level of the beneficiary, with ICPs for low-risk beneficiaries containing basic educational information on common health issues such as asthma or diabetes, while ICPs for high-risk beneficiaries were tailored to identify gaps in their care. Staff at one organization said the ICPs were not clinical plans but focused on home and community-based services, such as referrals to transportation services.

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Care coordinators said they developed the ICP with the beneficiary either in conjunction with the health risk assessment or after the completion of the health risk assessment.<sup>18</sup> Some care coordinators used a standard ICP outline auto-populated with results from the beneficiary's health risk assessment as the basis for developing the ICP with the beneficiary.

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## ICT

We also found that implementation of the ICT process varied by organization in the five states. Specifically, these organizations said that the frequency and format of ICT meetings depended on the needs of the beneficiary. Some meetings took place only once, when a beneficiary first enrolled in the organization, while others took place on a regular basis for on-going health needs or only in the case of acute events such as hospitalizations. Additionally, staff from some organizations in our review said that ICT meetings do not occur for every beneficiary, particularly low-risk beneficiaries, because their health needs may not be complex and thus they may not need to meet with their ICT. Staff also commented that communication and meetings among ICT members took place in different ways. For example, staff at one organization told us they consider conversations between the organization's medical director and the beneficiary's primary care provider to be a form of ICT communication, and staff at another organization said ICT meetings can take place between the care coordinator, the beneficiary, and the beneficiary's primary care provider during the beneficiary's medical appointments. While we observed some ICT meetings that included the care coordinator, the beneficiary, and another member of the care team, we also observed group meetings that covered multiple beneficiaries, which the organizations also considered to be ICT meetings. Staff from organizations in our review said that these regularly scheduled in-person group meetings discussed recently hospitalized beneficiaries or beneficiaries with health issues, and they typically involved the organizations' medical directors, care coordinators, social workers, pharmacists, and network operations staff. During these types of ICT meetings, care coordinators summarized a beneficiary's health status and

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<sup>18</sup>Some care coordinators we spoke with said that, unlike the health risk assessment, the ICP is a chance for the beneficiary to provide input on their care. They told us that clinical goals are not always the goals of the beneficiary, and often nonmedical needs, like housing, take priority. Many care coordinators said they focus on these needs first, before focusing on more difficult goals or health issues. Some care coordinators said it can take several visits to develop the plan depending on the beneficiary's availability and willingness to engage.

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meeting participants provided input on how to address the beneficiary's needs.

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## Organizations Described Challenges in Coordinating Care, and the Extent to Which Care Coordination Occurs in the Demonstration Is Not Fully Known

Organization staff in the five states in our review described challenges that affected their ability to coordinate care for beneficiaries. Specifically, these organizations reported challenges related to locating beneficiaries, engaging beneficiaries and primary care providers, and communicating with beneficiaries about the demonstration. CMS has established an oversight framework for the demonstration that includes monitoring activities. However, while the agency collects information that assesses the extent to which care coordination is occurring in the demonstration, not all of this information is comparable.

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## Organizations Described Challenges That Affected Their Ability to Coordinate Care

### Locating Beneficiaries

Organization staff said it was a challenge locating beneficiaries to initiate care coordination services because the characteristics of some dual-eligible beneficiaries make it difficult to develop and maintain accurate contact information. Some dual-eligible beneficiaries are transient because they are homeless or live in temporary accommodations, such as a hotel or with relatives. Many may be unreachable by telephone because they have no or limited access to a telephone. Additionally, staff told us that behavioral health issues, such as substance abuse, are prevalent and may affect an individual's ability to remain in touch with providers or organizations. Further, organizations have difficulty locating beneficiaries if the states do not have accurate beneficiary contact

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information.<sup>19</sup> Staff from some organizations in our review also told us that dual-eligible beneficiaries enrolled via the passive enrollment process were harder to locate, and some beneficiaries were unaware they were enrolled. Organization staff told us they devoted time and staff resources trying to locate beneficiaries, some increasing staff or hiring a vendor to help locate beneficiaries. Furthermore, some organization staff told us they conducted outreach efforts to community-based organizations that have prior relationships with dual-eligible beneficiaries and know how to locate them. Some organizations reported that they had developed strategies for finding beneficiaries. CMS and some states have discussed and developed best practices for finding beneficiaries.

When organizations are unable to locate beneficiaries, it can be challenging for the organizations to coordinate their care, which is one of the key goals of the demonstration and one that CMS views as essential to the successful integration of care between Medicare and Medicaid. For example, staff at some organizations in California told us that, in order to address the challenge of coordinating services for the beneficiaries they could not reach, they used a standard ICP outline auto-populated with any information they had about the beneficiary.<sup>20</sup> We also found that advocacy groups in four of the five states we reviewed had concerns about the extent to which care coordination is being provided in the demonstration. These advocacy groups noted that some of the beneficiaries with whom they interacted said that they had not been assigned a care coordinator, participated in an ICT meeting, or worked with their care coordinator to develop an ICP. One advocacy group told us that it had worked with a high-risk beneficiary who had been enrolled in the demonstration for a year but had not yet been contacted by a care coordinator. Our findings are consistent with the results of a 2015 study by the Medicaid and Children's Health Insurance Program Payment and

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<sup>19</sup>CMS officials told us that states and organizations could also obtain beneficiary contact information from CMS to help them locate unreachable beneficiaries. States and organizations previously had to request this information separately for each beneficiary. However, in August 2015, CMS announced that states and organizations could request beneficiary contact information from CMS for groups of beneficiaries upon enrollment. According to CMS, this new capability provides an additional source for beneficiary contact information and can help both the states and organizations obtain contact information for newly enrolled beneficiaries if state data are not yet available.

<sup>20</sup>CMS officials said they do not prohibit organizations from creating care plans for beneficiaries they cannot reach; however, they do not believe this practice fulfills CMS's vision of a beneficiary-driven ICP development process.

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Engaging Beneficiaries and  
Primary Care Providers

Access Commission (MACPAC), which found that many of the beneficiaries who participated in focus groups across three capitated model states said they did not have a care coordinator and had not experienced these required components of care coordination.<sup>21</sup>

Organization staff in the five states in our review said that it is a challenge to engage beneficiaries to coordinate their care in the demonstration. Care coordinators pointed out that the demonstration requires effort on the part of the beneficiary—a willingness to engage with the care coordinator to use the services available. However, beneficiaries may not understand how the demonstration can benefit them, and may not be aware of services available. A beneficiary advocacy group in Massachusetts said that one goal of the demonstration is to have a beneficiary-driven care system, but if beneficiaries cannot advocate for themselves, or are not aware of their options, then they cannot benefit from the demonstration. Additionally, organization staff said that some beneficiaries are not interested, while others may be distrustful of the health care system in general and not comfortable answering questions about their health from individuals they do not know. Lack of engagement and understanding of available care options can affect the provision of care coordination services, including participation in ICTs. For example, staff we spoke with at a few organizations said that not all beneficiaries want to participate in their ICT because, for example, they are not comfortable having their health care discussed in a team setting. CMS officials said that ICTs are built on the health needs and specific preferences of the beneficiary and that, while all beneficiaries are to have access to an ICT, there are no requirements for beneficiaries to participate in ICT meetings. During our observations of ICT meetings, we found that not all beneficiaries participated. Specifically, over 17 beneficiaries were discussed during the 9 ICT meetings we observed and only 8 beneficiaries joined the meetings by phone. CMS officials said that

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<sup>21</sup>MACPAC is a nonpartisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of Health and Human Services, and the states on issues affecting Medicaid and the Children's Health Insurance Program. Specifically, MACPAC conducted seven focus groups with beneficiaries enrolled in the capitated model in California, Massachusetts, and Ohio. In general, most of the participants said they had not seen or received a personal care plan. Some of the focus group participants also said they had not yet experienced a team-based approach to care coordination services. See Medicaid and Children's Health Insurance Program Payment and Access Commission *Experiences with Financial Alignment Initiative Demonstration Projects in Three States* (Washington, D.C.: May 2015).

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the beneficiary does not need to be involved every time ICT members communicate, but should at least be aware of the meetings if he or she is not participating in them.

Organization staff we spoke with said that engaging primary care providers in the demonstration has also been a challenge. While primary care providers are considered a core member of the ICT in the demonstrations, six of the seven providers we interviewed had never participated in an ICT meeting and two had never reviewed an ICP. Organization staff we spoke with said that the busy schedules of primary care providers, and their varying levels of interest in the demonstration, made it difficult to engage them in the ICTs. In fact, in many of the ICT meetings we observed, the beneficiary's primary care provider was not present; however, the organization's medical director was present and was an active participant in the discussion. Organization staff also said that a provider's knowledge of the demonstration can affect his or her willingness to engage with care coordination activities. Organization staff and primary care providers said that providers caring for a beneficiary with multiple health issues are more likely to engage with care coordinators. Staff of some organizations said they were trying to increase provider engagement through provider education and provider incentives, as well as by sending them completed ICPs and results of ICT meetings, and by scheduling ICT meetings to accommodate providers' schedules.

## Communicating with Beneficiaries about the Demonstration

Some organizations and beneficiary advocacy groups we spoke with said that beneficiaries have had difficulty with communication about the demonstration. Some organizations and beneficiary advocates said enrollment materials that beneficiaries received from the state were overwhelming for the beneficiary because of the volume of information in the materials and because the information was not easy to understand. Additionally, some organizations and advocates said that enrollment materials sent by mail often do not get opened. CMS officials said that in response to this challenge states have attempted to streamline their enrollment materials by focusing on which materials are most applicable to beneficiaries in that state. CMS officials added that they are encouraging the states to test their enrollment materials with a sample of beneficiaries before distributing them to all beneficiaries, and several states have opted to do so.

Additionally, staff we spoke with at some organizations said that the information beneficiaries receive from outside of the organization creates confusion and anxiety, and may lead to some beneficiaries opting out of

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the demonstration. An organization in California said that private entities sponsored newspaper advertisements that encouraged beneficiaries to opt out of the demonstration, which created confusion among beneficiaries. Staff at some organizations said they would like to reach out to beneficiaries before their effective enrollment date to communicate with them about the demonstration.

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### CMS Has Established a Framework of Monitoring Activities to Oversee the Demonstration

To oversee the coordination of care provided in the demonstration, CMS has established a framework of monitoring activities. The agency has established contract management teams (CMT) in the capitated states that are responsible for monitoring the demonstration on a day-to-day basis by providing technical assistance and overseeing contract compliance. These teams allow for collaboration between CMS and the states and comprise, at a minimum, officials from the CMS central office, the CMS regional office, and the state Medicaid office, but may include other entities, depending on the state. CMTs have a number of required responsibilities outlined in CMS guidance to ensure that organizations comply with their contracts, such as monitoring the organizations' performance in meeting measures and tracking complaints. In addition, the CMTs are required to meet regularly with participating organizations to discuss various topics including compliance, enrollment, and beneficiary issues. If an organization is found to be out of compliance with its contract, the CMTs can impose a range of enforcement actions increasing in severity from an initial notice of noncompliance to a warning letter, and finally to a formal corrective action request.<sup>22</sup>

According to CMS officials, the key difference in oversight provided is that CMS primarily oversees the organizations under the capitated model while it oversees the states under the MFFS model. Specifically, in states using an MFFS model, the state itself is primarily responsible for the day-

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<sup>22</sup>For less serious violations, CMTs may work informally with an organization to improve a particular area of performance by requesting the organization create a performance improvement plan. For more serious violations, CMTs can issue a notice of noncompliance, which notifies an organization that it is out of compliance and requests that it correct the problem. A warning letter notifies organizations that one or more specific areas of performance is unacceptable and further noncompliance will lead to more stringent actions. Warning letters are used for repeated noncompliance or for more serious instances of noncompliance. A corrective action request is issued when CMS identifies an area of concern that requires a formal plan to resolve. Corrective action requests are issued for organizations that have not provided a satisfactory response to a warning letter or if the issue is of a very serious nature.

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to-day monitoring of the demonstration, and the CMS regional office is responsible for overseeing the state's compliance with the terms of its demonstration as well as tracking its required data reporting for the demonstration.

One key component of CMS's oversight is monitoring of core and state-specific measures that the organizations, for the capitated model, and states, for the MFFS model, are contractually required to report. The measures include established quality measures from organizations like the National Quality Forum, as well as demonstration-specific measures developed by CMS, in collaboration with the states, to assess the demonstration.<sup>23</sup> The organizations in the capitated states use a common set of core measures. Similarly, the MFFS states adhere to a common set of core measures. However, the sets of core measures differ between the two models.<sup>24</sup> (See table 2.) CMS officials said that they did not deliberately design the two models to have different sets of core measures, but that the differences were the result of data that organizations and states collected prior to the demonstration. Specifically, they said that many of the demonstration-specific measures in the capitated states were adapted from existing Medicare Part C and Part D measures; in contrast, the MFFS states were not collecting these types of measures prior to the demonstration. In both capitated and MFFS model states, CMS supplements these core measures with required, state-specific measures. (See app. I for the state-specific measures for the five states that we reviewed.)

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<sup>23</sup>The National Quality Forum is a nonprofit organization established in 1999 that fosters agreement on national standards for measurement and public reporting of health care performance data.

<sup>24</sup>CMS officials told us that while the sets of core measures differ between the MFFS and capitated models, they tried to develop some measures that examined similar concepts between the two models. For example, both the capitated and MFFS models have measures assessing the percentage of beneficiaries screened for clinical depression with documentation of a follow-up plan and the percentage of beneficiaries for whom a transition record was transmitted to a health care professional within 24 hours of discharge.

**Table 2: Core Measures for Capitated and Managed Fee-for-Service (MFFS) Models Required by the Centers for Medicare & Medicaid Services' (CMS) Financial Alignment Demonstration for Dual-Eligible Beneficiaries**

<b>Core measures for the capitated model</b>
1. Percentage of beneficiaries with a health risk assessment completed within 90 days of enrollment <sup>a</sup>
2. Percentage of beneficiaries with an annual health risk reassessment
3. Percentage of beneficiaries for whom a transition record was transmitted to a health care professional within 24 hours of discharge
4. Number of grievances and appeals filed <sup>b</sup>
5. Care coordinator-to-member ratio
6. Establishment of consumer advisory board or inclusion of consumers on a preexisting governance board consistent with contractual requirements <sup>a</sup>
7. Percentage of beneficiaries screened for clinical depression and who had documentation of a follow-up plan
8. Percentage of clean claims for long-term services and supports paid within 30, 60, and 90 days <sup>c</sup>
9. Number of behavioral health-related emergency room visits
10. Nursing facility diversion <sup>d</sup>
<b>Core measures for the MFFS model</b>
1. Percentage of hospital readmissions within 30 days of discharge
2. Percentage of hospital admissions attributable to an ambulatory care-sensitive condition <sup>e</sup>
3. Percentage of emergency department visits for conditions that were either preventable or treatable in a primary care setting
4. Percentage of beneficiaries hospitalized for mental illness who received follow-up care
5. Percentage of beneficiaries screened for clinical depression and who had documentation of a follow-up plan
6. Percentage of beneficiaries for whom a transition record was transmitted to a health care professional within 24 hours of discharge
7. Percentage of beneficiaries who were screened for fall risk
8. Percentage of beneficiaries with alcohol or other drug dependence who initiated treatment

Source: Capitated and MFFS model reporting requirements in the CMS Financial Alignment Demonstration. | GAO-16-31

Note: CMS requires organizations in the capitated model to report additional state-specific measures, not included in this table. The capitated model measures were effective as of January 2014 and updated in January 2015, and the MFFS model measures were effective as of July 2013 and updated as of July 2015.

<sup>a</sup>This was a quality withhold measure for the first year of the demonstration, meaning CMS and the state's Medicaid department will each withhold a percentage of the organization's capitated rate.

<sup>b</sup>The organizations are responsible for tracking grievances and appeals. Beneficiaries can file grievances, such as complaints, with the organizations. Beneficiaries can also appeal decisions regarding their care, such as denial of payment for certain services.

<sup>c</sup>This measure examines clean claims—that is, claims that include all of the required information needed for processing—for long-term services and supports, which include different types of services that can help beneficiaries meet their daily assistance needs.

<sup>d</sup>Nursing facility diversion is an effort to provide assistance in arranging community-based care for beneficiaries who are at risk of admission to nursing facilities. This measure examines the percentage of beneficiaries living in the community who require an institutional level of care but who did not reside in a facility for more than 100 continuous days in both the previous and current reporting periods.

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<sup>e</sup>This measure includes admissions for one of the following ambulatory care-sensitive conditions: (1) diabetes with short-term complications, (2) diabetes with long-term complications, (3) uncontrolled diabetes without complications, (4) diabetes with lower-extremity amputation, (5) chronic obstructive pulmonary disease, (6) asthma, (7) hypertension, (8) heart failure, (9) angina without a cardiac procedure, (10) dehydration, (11) bacterial pneumonia, or (12) urinary tract infection.

CMS designated a subset of the core and state-specific measures for the capitated states as quality withhold measures, meaning that, on an annual basis, CMS and a state's Medicaid program each withhold a percentage of an organization's capitated rate, which is later adjusted and repaid based on the organization's performance. Two of the 10 core measures were quality withhold measures during this first year of the demonstration, with additional state-specific measures also designated as quality withhold measures in each state. The CMTs in the capitated states are required to review an organization's performance on the remaining core and state-specific measures, provide feedback to the organizations, investigate any areas of poor performance, and issue enforcement actions if organizations are out of compliance. Of the 11 organizations in the four capitated states that we reviewed, 1 had received a formal enforcement action—a notice of noncompliance—from CMS related to its performance on core measures, as of April 2015.<sup>25</sup> In contrast, MFFS states can earn a retrospective performance payment annually that is based, in part, on their performance compared to benchmarks for all of their core and state-specific quality measures, which is intended to incentivize high performance. States receive a portion of their total performance payment if they meet the minimum performance threshold and can qualify to receive additional payments based on how well they performed on individual measures. Therefore, poorly performing MFFS states that do not meet the minimum threshold would not earn a performance payment. The timing of our review was too early in the implementation process for CMS to have paid a retrospective performance payment to either of the two MFFS states, but one of the states—Washington—had recently submitted its first set of annual data.

These core and state-specific measures are outlined in CMS technical guidance, which includes specific instructions for how organizations and

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<sup>25</sup>Some of the organizations in our review had received a performance improvement plan request from CMS, however, related to their performance on core performance measures.

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the states should report the data to CMS.<sup>26</sup> The organizations in the capitated states are to generally submit their data to CMS on a quarterly, semiannual, or annual basis, depending on the measure, through a contractor-administered website. CMS officials told us the contractor then synthesizes the data and shares them with CMS headquarters and the CMTs for further analysis. The CMTs may then discuss the results during regular meetings with the organizations. In contrast, in the MFFS model, states are responsible for collecting data from the integrated care organizations annually and submitting it to CMS through a contractor-administered website.

In addition, CMS requires organizations, for the capitated model, and the states, for the MFFS model, to report data annually from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which is a patient survey developed by another HHS agency, the Agency for Healthcare Research and Quality. Agency officials told us in early November 2015 that they expect to receive CAHPS results by the end of the month for the first capitated states that implemented the demonstration, and they expect to complete their analysis of the results and make them available by spring 2016. The MFFS states—Washington and Colorado—completed the survey by November 2015, and CMS anticipates the results will be available in spring 2016. CMS officials told us that they worked with a contractor to adapt a version of the CAHPS survey for the MFFS states, which is different from the CAHPS survey used by the organizations in the capitated states. Specifically, the organizations in the capitated states use the survey that must be completed by all Medicare managed care plans. In commenting on our draft report, HHS provided us with new information indicating that CMS had added 10 demonstration-specific supplemental questions to the capitated CAHPS survey. In addition, because the organizations in the capitated model are also Medicare managed care plans, they must report data annually from the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS, which is developed by the National Committee for Quality Assurance and helps consumers compare the performance of health plans in providing selected services, and the Medicare Health Outcomes Survey (HOS), which is a patient-reported outcomes survey, are measures that must also be reported by Medicare managed care

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<sup>26</sup>These measures are generally described in the memoranda of understanding and the contracts, with additional technical details provided in guidance released annually by CMS.

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plans to CMS.<sup>27</sup> Agency officials told us they received the first HEDIS results in November 2015 and they expect HOS results in spring 2016. Organizations in the capitated states are also required to regularly report encounter data to CMS, which contain information on the services and items furnished to beneficiaries.

CMS has also hired a contractor—RTI International—to assess the implementation of the demonstration and evaluate its impact on beneficiary experience, quality, utilization, and cost.<sup>28</sup> RTI International will conduct annual and final aggregate evaluations of each state’s demonstration program, as well as an overall evaluation across the states that will use both qualitative and quantitative data analysis. Specifically, the contractor will analyze enrollment, encounter, and claims data and conduct site visits, focus groups, and interviews.<sup>29</sup> CMS officials said that the first annual state evaluation is anticipated to be completed in winter 2016 and the final aggregate evaluation is expected in 2018, at the earliest.

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<sup>27</sup>The National Committee for Quality Assurance, established in 1990, is a private, nonprofit organization dedicated to improving health care quality.

<sup>28</sup>Edith G. Walsh and Norman Brangan, *Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals: Aggregate Evaluation Plan* (Waltham, Mass.: RTI International, Dec. 16, 2013). RTI International is an independent, nonprofit institute that provides research, development, and technical services.

<sup>29</sup>The contractor collects some quantitative data, such as information on eligibility and enrollment, on a quarterly basis, and CMS officials told us the contractor shares the results with CMS headquarters and the CMTs.

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**CMS Collects Information that Assesses the Extent to which Care Coordination Is Occurring in the Demonstration, but Not All of This Information is Comparable**

CMS collects different sets of core measures for the capitated and MFFS model states. Two out of 10 core measures in the capitated model provide information on the extent to which care coordination is occurring, while no core measures in the MFFS model examine this area.<sup>30</sup> The core measures for the capitated states examine the percentage of health risk assessments completed within 90 days of enrollment and the percentage of reassessments that are completed annually.<sup>31</sup> CMS does not collect any other core measures in either the capitated states or the MFFS states that assess key aspects of care coordination, such as whether care coordinators were meeting with beneficiaries, whether ICPs were being developed, or whether ICT meetings are occurring—components of the demonstration that, like the health risk assessments, are required by CMS under the demonstration.<sup>32</sup>

CMS also collects some state-specific measures that examine the extent to which care coordination is occurring; however, these measures are not collected consistently across the states, or for the two types of models in the demonstration. For example, Washington (an MFFS state), Massachusetts (a capitated state), and Illinois (a capitated state) have state-specific measures that examine whether beneficiaries have completed an ICP within 90 days of enrollment.<sup>33</sup> While the other two

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<sup>30</sup>Measures that reflect the extent to which care coordination is occurring include whether care coordinators are meeting with beneficiaries, health risk assessments are being completed, ICPs are being developed, ICT meetings are occurring, and other aspects of care coordination that CMS requires organizations in the demonstration to provide to beneficiaries. CMS has other core and state-specific measures that may assess whether existing care coordination is effective at improving beneficiaries' overall health outcomes, but these measures were outside the scope of our review.

<sup>31</sup>The health risk assessment completion rate was designated a quality withhold measure in the first year of the demonstration. The Medicaid offices in all but one of the four capitated states in our review said that many of the organizations had difficulty completing timely health risk assessments primarily because the organizations have faced challenges locating enrollees.

<sup>32</sup>The capitated states are required to report a core measure that assesses the care coordinator to member ratio, which is a ratio of the total number of care coordinators on an organization's staff to the total number of beneficiaries in the organization. According to CMS officials, this measure does not provide information on individual care coordinators' caseloads.

<sup>33</sup>Two of these states had data available at the time of our review. These data showed that, in the third quarter of 2014, which was the most recent data available at the time of our request, 2 of the 3 organizations in one state and 2 of the 8 organizations in another state had an ICP completion rate of less than 35 percent.

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capitated states in our review have a similar measure, they differed from the ICP measures in Washington, Massachusetts, and Illinois. For example, while California has a state-specific measure assessing whether an ICP was completed, there is no time period specified for doing so, and it has additional measures that separately examine whether high- and low-risk beneficiaries had an ICP completed within 30 working days of their health risk assessment.<sup>34</sup> We also noted that all the capitated states in our review had a state-specific measure that examined whether beneficiaries had a documented discussion of care goals, but the MFFS state in our review, Washington, did not have this measure.

In addition, CMS officials told us they plan to assess care coordination through the forthcoming results of the CAHPS survey (for both the capitated and MFFS models).<sup>35</sup> CMS adapted the CAHPS survey for the demonstration in the MFFS states and, in commenting on our draft report, HHS provided us with new information indicating that CMS had added demonstration-specific supplemental questions to the CAHPS survey in the capitated states. These surveys contain two questions specific to care coordination that are consistent across all states in the demonstration. Specifically, the MFFS and capitated CAHPS surveys both contain questions about whether anyone from the organization helped to coordinate the beneficiaries' care and how satisfied beneficiaries were with the help they received to coordinate their care. While the results of the capitated and MFFS surveys are still forthcoming, these questions may be able to provide CMS with important information about whether beneficiaries are meeting with their care coordinators. However, while the MFFS CAHPS survey also contains questions related to developing an

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<sup>34</sup>Similarly, Virginia has a state-specific measure that assesses whether an ICP was completed within 90 days of enrollment, and this measure also stratifies the ICP completion rate by risk level.

<sup>35</sup>CMS officials told us that they also plan to assess care coordination through the forthcoming results of the HEDIS survey (for the capitated model). However, the HEDIS survey is a standardized survey that collects data from all Medicare managed care plans and does not contain measures specific to care coordination under the Financial Alignment Demonstration. In addition, while RTI International's evaluation will assess many different aspects of the demonstration using both quantitative and qualitative data, RTI International will not be collecting any quantitative data that provide information on the extent to which care coordination is occurring in the demonstration. However, RTI International will be collecting qualitative data that may explore this area, such as requiring organizations to report whether or not care coordination procedures were implemented as expected. Further, CMS will be collecting encounter data, but these data will not provide information on the extent to which care coordination is occurring.

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ICP and meeting with an ICT, these questions are not included in the capitated CAHPS survey.<sup>36</sup> There were no questions on either survey related to the completion of the health risk assessment.

We and others have noted the importance of a common set of comparable measures across the states. In a 2012 report, we recommended that CMS systematically evaluate performance in its D-SNP program for dual-eligible beneficiaries and noted that without standard measures it would not be possible for CMS to fully evaluate the relative performance of the D-SNPs.<sup>37</sup> In addition, the Commonwealth Fund noted that, while varying the Financial Alignment Demonstration's quality measures from state to state may be necessary because the demonstrations differ across all the states, researchers and policymakers will need a common set of comparable measures in order to make useful cross-state comparisons.<sup>38</sup> While CMS has developed two core measures related to care coordination that are consistent across the capitated states in the demonstration, these measures are not core measures in the MFFS model and are therefore not comparable across both demonstration models. Moreover, while CMS collects some state-specific measures that examine this area, they are not comparable across the states. However, CMS has included two questions in its CAHPS survey that are consistent across the demonstration states in both the capitated and MFFS models, and the agency anticipates using these forthcoming results to assess care coordination.

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<sup>36</sup>In addition, the MFFS CAHPS survey includes a question about whether someone from the beneficiaries' ICT spoke with them about specific health goals. There is also a question related to whether, in the last 6 months, the beneficiary was helped by someone on his or her health care team to make a treatment plan that he or she could carry out in daily life. Similarly, there is a question related to how often the beneficiary was helped by someone on his or her health care team to plan ahead and take care of his or her condition, even in hard times.

<sup>37</sup>See [GAO-12-864](#).

<sup>38</sup>The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable. The authors also noted that CMS needs to strengthen measures related to quality of life and long-term services and supports. See Sabiha Zainulbhai, Lee Goldberg, Weiwen Ng, and Anne H. Montgomery; *Assessing Care Integration for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative*, The Commonwealth Fund, no. 1734, vol. 2 (March 2014).

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Internal control standards for the federal government specify that monitoring should be designed to help an agency accomplish its goals.<sup>39</sup> Because not all of the information that CMS collects to examine the extent to which care coordination is occurring is comparable across the demonstration, the agency does not fully know whether it has achieved its goal of improving care coordination for dual-eligible beneficiaries. Further, CMS does not have all of the data necessary to identify and correct potential problems in the demonstration. CMS officials told us that any issues related to care coordination would be identified in the forthcoming results of the CAHPS survey and discussed during the regular CMT meetings with the organizations.<sup>40</sup> CMS officials also noted that some of their existing core measures would indicate whether care coordinators are effectively coordinating care for patients, such as a core measure in the capitated model examining nursing facility diversion, that is, the percentage of beneficiaries living in the community who require an institutional level of care but who did not reside in a nursing home for more than 100 days. CMS officials told us that they believe these types of outcome-oriented measures provide more valuable information than process-oriented measures because they assess whether care coordination is effectively improving the health of beneficiaries. While we believe outcome measures are important for assessing care coordination in the demonstration, process measures are also needed to determine whether the demonstration is being implemented as intended. If process measures are not in place across the states participating in the demonstration to identify and correct potential problems, we believe that outcome measures cannot be reliably assessed.

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## Conclusions

CMS's Financial Alignment Demonstration has the potential to improve the quality of care for dual-eligible beneficiaries and to reduce spending in the Medicare and Medicaid programs. A growing consensus suggests that coordination of care is an important strategy for achieving these goals. Dual-eligible beneficiaries, who often have extensive health care needs, typically receive their benefits separately through the Medicare

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<sup>39</sup>[GAO/AIMD-00-21.3.1](#).

<sup>40</sup>For example, the CMT in one state in our review learned that two organizations had not scheduled ICT meetings for their beneficiaries and—for one of these organizations—had not developed ICPs for their beneficiaries, as required by contract. The CMT required the organizations to submit performance improvement plans describing how they planned to resolve these issues.

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and Medicaid programs. Improving care coordination is a key goal for CMS's demonstration and will ultimately influence whether the program is successful. Our work identified multiple challenges in locating and communicating with beneficiaries as well as difficulties in engaging providers in fundamental care coordination activities. Similarly, our interviews with beneficiary advocacy groups and providers called into question the extent to which care coordination is occurring in the demonstration.

CMS collects information about the extent to which care coordination is occurring in the demonstration, but not all of this information is comparable across the states. Therefore, it cannot reasonably determine whether health risk assessments are being completed, ICPs are being developed, and ICT meetings are occurring—all aspects of care coordination that CMS requires organizations to provide to beneficiaries. By not having data that are consistently available from all states across the demonstration that examine these aspects of care coordination, CMS does not fully know whether it has achieved its goal of providing coordinated care to dual-eligible beneficiaries. CMS has included measures in its CAHPS survey for both the capitated and MFFS states that examine whether beneficiaries have had their care coordinated among different health care providers. However, we believe that establishing additional measures that would allow CMS to obtain these data from all states and organizations participating in the demonstration could help it better understand the reasons why care coordination is or is not occurring and thus help the agency to strengthen the demonstration. Given the potential for the demonstrations to be expanded across the United States, it is important that CMS expediently collect this information to inform whether it is achieving its goal.

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## Recommendations for Executive Action

To strengthen oversight of the provision of care coordination services in the Financial Alignment Demonstration, we recommend that the Secretary of Health and Human Services direct the Administrator of CMS to take the following two actions:

- Expediently develop and require organizations in the capitated model, and the states in the MFFS model, to report comparable core data measures across the demonstration that measure the following:
  - the extent to which ICT meetings are occurring, and

- 
- for MFFS states, the extent to which health risk assessments are completed.
  - Align CMS's existing state-specific measures regarding the extent to which ICPs are being developed across the capitated and MFFS states to make them comparable and designate them as a core reporting requirement.

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## Agency Comments and Our Evaluation

HHS reviewed a draft of this report and provided written comments, which are reprinted in appendix II. In its comments, HHS did not specifically state whether it agreed or disagreed with our first recommendation, but it concurred with our second recommendation. HHS also provided us with technical comments, which we incorporated in the report as appropriate.

Regarding our first recommendation that HHS require organizations to report comparable core data measures across the demonstration, HHS provided us with new information that it had not previously provided, which caused us to reconsider one of our findings and a related recommendation. Specifically, HHS noted that the CAHPS surveys for both the capitated and MFFS models contain supplemental questions for the demonstration that are specific to care coordination, whereas they had previously provided us with information indicating that only the MFFS model CAHPS survey contained these questions. Given the new information HHS provided, we updated our report to reflect CMS's plan to use the forthcoming results of the CAHPS survey to assess care coordination across the demonstration. In addition, we modified the recommendation contained in our draft report that CMS require organizations in the capitated model, and the states in the MFFS model, to report comparable core data measures across the demonstration regarding the extent to which care coordinators are meeting with beneficiaries. In addition, HHS noted in its comments that it has comparable risk assessment completion rate measures in both the MFFS and capitated models and said the variances between the health risk assessment measures in the two demonstrations reflect different design elements. However, we found that there were no core measures in the MFFS model examining the health risk assessment completion rate. HHS also described steps that it has been taking that may, in the future, help to address the findings in this report. For example, HHS noted that it is developing a set of care coordination measures to supplement data obtained from the CAHPS surveys. HHS also stated that the timeline for measurement development may not align with the current three-year demonstration period, such that the inclusion of any additional new

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measures would have to be considered for potential future extension or expansion of the initiative. Given the potential for the demonstrations to be expanded across the United States, we believe it is important that CMS expediently collect this information to inform whether care coordination in the demonstration is being implemented as intended. HHS stated that it recently entered into a contract to support measure development, which should better equip HHS to evaluate the extent to which care coordination is occurring in the demonstration, among other things.

HHS concurred with our second recommendation to make CMS's existing state-specific measures comparable and designate them as a core reporting requirement. HHS stated it would examine the feasibility of designating ICPs as a core reporting requirement as the demonstration progresses. However, it noted that it currently monitors the timely completion of ICPs in both models using different state-specific measures rather than uniform core reporting measures in order to reflect differences in the demonstration parameters across the states. We believe that aligning existing state-specific measures regarding ICP development to make them comparable and designating them as a core reporting requirement would help CMS better understand the extent to which care coordination is occurring across the demonstration and thus help the agency strengthen the demonstration as it progresses.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.



Kathleen M. King  
Director, Health Care

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*List of Requesters*

The Honorable Frank Pallone, Jr.  
Ranking Member  
Committee on Energy and Commerce  
House of Representatives

The Honorable Gene Green  
Ranking Member  
Subcommittee on Health  
Committee on Energy and Commerce  
House of Representatives

The Honorable Sander B. Levin  
Ranking Member  
Committee on Ways and Means  
House of Representatives

The Honorable Jim McDermott  
Ranking Member  
Subcommittee on Health  
Committee on Ways and Means  
House of Representatives

# Appendix I: Centers for Medicare & Medicaid Services' (CMS) State-Specific Measures for the Financial Alignment Demonstration, by State

State-specific measure	California	Illinois	Massachusetts	Virginia	Washington
<b>Access</b>					
• Adults' access to preventive/ambulatory health services		X			
<b>Assessment</b>					
• Behavioral health risk assessment and follow-up		X			
• Moderate- and high-risk members with a health risk assessment completed within 90 days of enrollment		X <sup>a</sup>			
• Community Well members with a health risk assessment completed within 90 days of enrollment				X <sup>a</sup>	
• Vulnerable subpopulation members, Elderly or Disabled with Consumer Direction (EDCD) waiver members—those individuals also participating in Virginia's CMS-approved Medicaid waiver, which provides services to help individuals live in their own homes or communities instead of a nursing home—and nursing facility members with a health risk assessment completed within 60 days of enrollment				X <sup>a</sup>	
<b>Care coordination</b>					
• Members with individualized care plans (ICP) within 90 days of enrollment	X <sup>b</sup>	X	X	X <sup>a,c</sup>	X <sup>d</sup>
• High-risk members with an ICP within 30 working days after the completion of a timely health risk assessment	X				
• High-risk members with an ICP within 30 working days after the completion of a health risk assessment	X				
• Low-risk members with an ICP within 30 working days after the completion of a timely health risk assessment	X				
• Low-risk members with an ICP within 30 working days after the completion of a health risk assessment	X				
• Members with documented discussion of care goals	X <sup>a</sup>	X <sup>a</sup>	X <sup>a</sup>	X <sup>a</sup>	
• Members with long-term services and supports needs who have an independent living long-term services and supports coordinator			X <sup>a</sup>		
• Members receiving Medi-Cal specialty mental health services receiving coordinated care plans as indicated by having an ICP with the primary mental health provider	X <sup>a</sup>				
• Members with first follow-up visit within 30 days after hospital discharge	X			X	X <sup>e</sup>
• Members who have a care coordinator and have at least one care team contact during the reporting period	X <sup>a</sup>				
• Ambulatory care follow-up with a provider within 14 days of emergency department visit		X			
• Ambulatory care follow-up with a provider within 14 days of inpatient discharge		X			
• Movement of members within service populations		X <sup>f</sup>		X <sup>f</sup>	
• Transitions between hospitals, nursing facilities, and the community				X	

**Appendix I: Centers for Medicare & Medicaid Services' (CMS) State-Specific Measures for the Financial Alignment Demonstration, by State**

<b>State-specific measure</b>	<b>California</b>	<b>Illinois</b>	<b>Massachusetts</b>	<b>Virginia</b>	<b>Washington</b>
<b>Enrollee protections</b>					
• The number of critical incident and abuse reports for members receiving long-term services and supports	X	X	X	X	
• Policies and procedures attached to the memorandum of understanding with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing	X <sup>a</sup>				
<b>Organizational structure and staffing</b>					
• Americans with Disabilities Act compliance		X <sup>a</sup>		X	
• Care coordinator training for supporting self-direction under the demonstration		X	X		
• Organizations with an established physical access compliance policy and identification of an individual who is responsible for physical access compliance	X <sup>a</sup>				
• Care coordinator training for supporting self-direction under the demonstration	X			X	
• Licensure/certification requirements for new EDCD waiver providers				X	
• Continuing licensure/certification requirements for EDCD waiver providers				X	
• Non-licensed/noncertified EDCD waiver provider enrollment				X	
<b>Performance and quality improvement</b>					
• Adherence to antipsychotic medications for individuals with schizophrenia		X			
• Cervical cancer screening		X			
• Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications		X			
• Comprehensive diabetes care		X			
• Medication monitoring for patients with psychotic disorders		X			
• Annual monitoring for patients on persistent medications		X			
• Use of high-risk medications in the elderly		X			
• Mental health recovery measure			X		
• Screening and brief counseling for unhealthy alcohol use			X		
• Tobacco use: screening and cessation			X		
• Medication reconciliation post-discharge			X		
• Care for adults			X		
• Members with severe mental illness receiving primary care services				X	
• Recovery-oriented measures for persons with severe mental illness receiving mental health services				X	
• Adjudicated clean claims				X <sup>a</sup>	

**Appendix I: Centers for Medicare & Medicaid Services' (CMS) State-Specific Measures for the Financial Alignment Demonstration, by State**

<b>State-specific measure</b>	<b>California</b>	<b>Illinois</b>	<b>Massachusetts</b>	<b>Virginia</b>	<b>Washington</b>
<b>Utilization</b>					
• Reduction in emergency department use for seriously mentally ill and substance use disorder members	X				
• Readmissions of short- and long-stay nursing facility residents after hospitalization for diabetes, chronic obstructive pulmonary disease, or any medical diagnosis	X				
• Coronary artery disease		X			
• Heart failure admission rate		X	X		
• Unduplicated members receiving home and community-based services and unduplicated members receiving nursing facility services		X			
• Average length of receipt of home and community-based services		X		X	
• Long-term care urinary tract infection admission rate and bacterial pneumonia admission rate		X			
• Long-term care prevalence of hospital-acquired pressure ulcers		X			
• Inpatient hospital 30-day readmission rates		X			
• Chronic obstructive pulmonary disease or asthma in older adults admission rate			X		
• EDCD waiver members who used consumer-directed services				X	
• EDCD waiver members who experienced an increase or decrease in authorized personal care hours or respite care hours				X	
• Unduplicated members receiving home and community-based services and unduplicated members receiving nursing facility services				X	
<b>Systems</b>					
• Integrated care organization centralized enrollee record			X <sup>a</sup>		
• Plan enrollee medical record				X	
<b>Other</b>					
• The percentage of Health Home Coordinators serving participating demonstration-eligible Medicare-Medicaid clients who have taken the standardized state training on the reported elements of the Health Action Plan					X
• The average change in Patient Activation Measure score for participating demonstration-eligible Medicare-Medicaid clients who initially were least activated					X
• The percentage of demonstration-eligible Medicare-Medicaid member months where client received home and community-based services and support					X
• The percentage of demonstration-eligible Medicare-Medicaid member months where client received residential nursing home services					X

Source: Capitated and Managed Fee-for-Service model reporting requirements in the CMS Financial Alignment Demonstration. | GAO-16-31

Note: We reported these measures as they were reported in CMS guidance. California's measures were effective as of April 1, 2014, and were updated August 24, 2015. Illinois' measures were effective as of March 1, 2014, and were updated August 7, 2015. Massachusetts' measures were

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**Appendix I: Centers for Medicare & Medicaid Services' (CMS) State-Specific Measures for the Financial Alignment Demonstration, by State**

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effective as of January 1, 2014, Virginia's measures were effective as of April 1, 2014, and Washington's measures were effective as of July 1, 2013.

<sup>a</sup>This was a quality withhold measure for the first year of the demonstration, meaning CMS and the state's Medicaid department will each withhold a percentage of the organization's capitated rate.

<sup>b</sup>In California, the state-specific measure assesses whether an ICP was completed and does not specify a required time period.

<sup>c</sup>In Virginia, the state-specific measure assesses whether beneficiaries categorized as Community Well, vulnerable subpopulations, EDCD, and nursing facility had a Plan of Care completed within 90 days of enrollment.

<sup>d</sup>In Washington, the state-specific measure assesses the percentage of enrolled demonstration-eligible Medicare-Medicaid clients with Health Action Plans within 90 days of enrollment.

<sup>e</sup>In Washington, the state-specific measure assesses the percentage of hospital discharges among demonstration-eligible Medicare-Medicaid clients with first follow-up visit within 30 days of hospital discharge.

<sup>f</sup>In Illinois, the state-specific measure assesses movement of members within service populations. In Virginia, the state-specific measure assesses the transition of members between community, waiver, and long-term care services.

# Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

NOV 13 2015

Kathleen King  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicare and Medicaid: Greater Oversight Needed of CMS's Demonstration to Coordinate the Care of Dual-Eligible Beneficiaries*" (GAO-16-31).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICARE AND MEDICAID: GREATER OVERSIGHT NEEDED OF CMS'S DEMONSTRATION TO COORDINATE THE CARE OF DUAL-ELIGIBLE BENEFICIARIES (GAO-16-31)**

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to making sure Medicare-Medicaid enrollees, also known as dual eligible individuals, have full access to seamless, high quality health care and to making the health care system as cost-effective as possible.

HHS's Medicare and Medicaid programs, states, and stakeholders all play a critical role in achieving one of the Affordable Care Act's (ACA) goals: providing Medicare-Medicaid enrollees full access to seamless, high quality health care. HHS designed the Medicare-Medicaid Financial Alignment Initiative (Initiative) to better align the financing of the Medicare and Medicaid programs and integrate primary, acute, behavioral health, and long-term services and support for Medicare-Medicaid enrollees. The ultimate goals of the Initiative are to improve health outcomes, improve beneficiary experience, and promote independence in the community while reducing cost increases over time. Through this Initiative, HHS has partnered with states to establish demonstrations using the capitated and managed fee-for-service (MFFS) models.

HHS is using a wide range of measures from numerous sources to monitor and evaluate progress toward the goals of the Initiative. Assessing the delivery of care coordination is part of that broader strategy. In addition, HHS evaluates the overall impact of the demonstrations including changes in person-level health outcomes and experience of care, and changes in patterns of care to analyze whether or not HHS and demonstration participants can make further improvements to the demonstrations. HHS will examine historical data, including data from the years immediately preceding the demonstrations, and data generated during the demonstration period.

Where relevant existing measures are available, such as the Medicare Parts C and D measures and the Consumer Assessment of Health Providers and Systems (CAHPS) survey currently used for Medicare Advantage plans, we are using those measures as part of the monitoring and evaluation strategy for the Initiative. HHS established core measures based on recommendations from the National Quality Forum (NQF), including the core measure set outlined in the June 2012 report Measuring Healthcare Quality for the Dual Eligible Beneficiary Population.

HHS is contracting with the National Committee for Quality Assurance (NCQA) to develop a set of consensus-based measures aimed at assessing care coordination by Medicare Advantage plans to supplement the data on care coordination that to date has been obtained from CAHPS surveys on beneficiaries' experience of care. HHS has also recently entered into a contract with Mathematica Policy Research to support measure development. The purpose of this contract is to take a holistic look at the programs and develop de novo, maintain, reevaluate and/or refine existing quality measures across program areas, while prioritizing measures that are more aligned, meaningful, outcomes-based and not burdensome or duplicative of currently available measures. The development of additional measures through this contract should better equip HHS to evaluate the extent to which care coordination is occurring and improving outcomes in capitated and fee-for-service settings.

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE AND MEDICAID: GREATER OVERSIGHT NEEDED OF CMS'S DEMONSTRATION TO COORDINATE THE CARE OF DUAL-ELIGIBLE BENEFICIARIES (GAO-16-31)**

HHS selected measures across both the capitated and MFFS models and across individual demonstrations to reflect differences in demonstration parameters, such as the eligible population or geography, as well as different demonstration requirements (e.g. some capitated model demonstrations require longer continuity of care periods or faster assessment completion). The measure framework for each model is designed to equip HHS to monitor progress toward the agency's goals as tested through both the capitated and MFFS models.

It is important to keep in mind that the demonstrations under the Initiative are currently being tested over a period of three years. While we have engaged a contractor to support potential development of measures, HHS will want to coordinate that process to avoid duplication or development of measures that are not aligned with other measurement efforts for the Medicare-Medicaid enrollee population. In addition, the timing of developing and implementing such measures will reflect the anticipated burden and opportunity cost for federal, state, and Medicare and Medicaid program demonstration participants to report and analyze results. As a result, the inclusion of any additional new measures would have to be considered for potential future extension or expansion of the Initiative.

HHS's responses to GAO's recommendations are below.

**GAO Recommendation**

To strengthen oversight of the provision of care coordination services in the Financial Alignment Demonstration, GAO recommends that the Secretary of HHS direct the Administrator of the Centers for Medicare & Medicaid Services (CMS) to expediently develop and require organizations, in the capitated model, and the states, in the MFFS model, to report comparable core data measures across the demonstrations that measure the following:

- The extent to which care coordinators are meeting with beneficiaries;
- The extent to which interdisciplinary care team meetings are occurring; and
- For MFFS states, the extent to which health risk assessments are completed.

**HHS Response**

Currently, HHS requires the completion of CAHPS beneficiary surveys in both the capitated and MFFS model demonstrations. The capitated model demonstrations use the version of the CAHPS survey that is required for the Medicare Advantage program, with the addition of supplemental questions added for the Medicare-Medicaid Financial Alignment Initiative. These supplemental questions include questions about care coordination and related topics such as ease of accessing certain types of services. The MFFS model demonstrations use a version of the CAHPS survey that was based on the survey used for adult Medicaid beneficiaries and modified for these demonstrations, including the addition of questions that align with the supplemental questions added to the CAHPS survey for the capitated model demonstrations.

HHS is working to develop a set of consensus-based measures aimed at assessing care coordination by Medicare Advantage plans to supplement the data on care coordination that to date has been obtained from CAHPS surveys on beneficiaries' experience of care and specific care coordination

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE AND MEDICAID: GREATER OVERSIGHT NEEDED OF CMS'S DEMONSTRATION TO COORDINATE THE CARE OF DUAL-ELIGIBLE BENEFICIARIES (GAO-16-31)**

activities. Once available, these measures could also be used in the evaluation of plans in an extension or expansion of the Financial Alignment Initiative, but the timeline for measurement development may not align with the demonstration period. Additionally, HHS collects measures that allow comparison of health risk assessment completion in the two MFFS model demonstrations. The variances between the measures in those two demonstrations reflect different design elements between the two demonstrations.

**GAO Recommendation**

To strengthen oversight of the provision of care coordination services in the Financial Alignment Demonstration, GAO recommends that the Secretary of HHS direct the Administrator of CMS to align CMS's existing state-specific measures regarding the extent to which ICPs are being developed across the capitated and MFFS states to make them comparable and designate them as a core reporting requirement.

**HHS Response**

HHS concurs with this recommendation. We will examine the feasibility of designating of Individualized Care Plans (ICPs) as a core reporting requirement as the Initiative progresses.

HHS currently monitors timely completion ICPs for all capitated and MFFS model demonstrations. As noted above, this activity is measured in all demonstrations using a "state-specific" measure rather than a core measure because while it is used across the demonstrations, the measure specifications reflect differences in the demonstration parameters across states.

HHS balances the need for care coordination against the need to measure in ways that reflect different model environments. The differences in the parameters of these state-specific measures do not impede the agency's ability to assess progress toward its goals; however, we will explore ways to improve comparability of measures across demonstrations.

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Kathleen M. King, (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov)

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## Staff Acknowledgments

In addition to the contact name above, Catina Bradley, Assistant Director; Giselle Hicks; Maggie Holihan; Sarah-Lynn McGrath; Beth Morrison; Ann Tynan; and Emily Wilson made key contributions to this report.

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