

THE CALIFORNIA CARE INITIATIVE:
A COMPARATIVE ANALYSIS OF THE FINANCIAL AND ADMINISTRATIVE
ALIGNMENT OF MEDICARE AND MEDICAID

A Thesis

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by

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Department of Public Policy and Administration

Abstract
of
THE CALIFORNIA CARE INITIATIVE:
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California is the most populous and one of the most racially diverse states in the country. To avert the potential problem of not covering enough medical services for the entire population, California integrated the services of Medi-Cal and Medicare and developed the Coordinated Care Initiative. California wishes to provide amalgamated and adequate health care options to its eligible beneficiary population. This prompts an important public policy question: is the California Coordinated Care Initiative the most efficient (cost effective) way to do this?

To answer the above question, I drew on evaluations conducted by Research Triangle Institute, or RTI International (RTI). RTI contracted with Centers for Medicare and Medicaid Services (CMS) prior to implementation and is the basis for all evaluations and the official evaluator of the CMS Demonstrations. One of the advantages of the RTI evaluations is that they utilize the exact same surveys and observations for each state, as the core method to gather information from the programs.

In addition to analyzing evaluations by RTI, I include responses from stakeholders I interviewed, based on my findings in the analysis. The individuals I had the pleasure of talking with include: Amber Christ, Senior Staff Attorney with Justice in Aging, Christian Griffith, Chief Consultant of the California State Assembly Budget Committee, Andrea Margolis, Consultant of California State Assembly, and two individuals who wished to remain anonymous, with combined experience in working in the non-profit sector as a health care advocate, and in state government in finance and legislation.

My analysis illustrates that it is possible to successfully integrate health plans only if there is ample time to plan, put policies in place, and inform those affected prior to implementation. Based on discussions with those who work with the program or understand its components, as well as evaluations done on the integrated programs, if some parts of the integration had been handled differently, the CCI program may not have suffered such catastrophic issues with implementation.

_____, Committee Chair
Robert W. Wassmer, Ph.D.

Date

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I finally made it to the end of my educational career, and this thesis is the result of the blood, sweat, and tears I have invested in my human capital. In the beginning, I asked myself if it was worth all the late nights, endless coffee, and no social life with my family and friends. Now that I have made it to this point, I can honestly say...yes. Yes, it was worth every memo I had to write and every presentation I had to give. It was worth having to spend 15 hours on a 2-page memo to make sure I got it right. It was worth receiving B+'s instead of A-'s because that drove me to do better.

I would like to take this moment to express my gratitude to the most amazing people in my life, who supported me and provided guidance through this entire program when I needed it most. First, to Rob Wassmer and Ted Lascher, for their support and assistance with this thesis, sticking with me and helping me see it through. I would not have made it this far without you. I would like to include the staff and the rest of the faculty in the Public Policy and Administration Department. Each of you provided guidance, tolerated, and answered all my mundane questions. Thank you for all that you did for me, and for everything you do for the program.

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through the trials and tribulations all the way to the finish line. You are my everything; I love you.

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CHAPTER 1

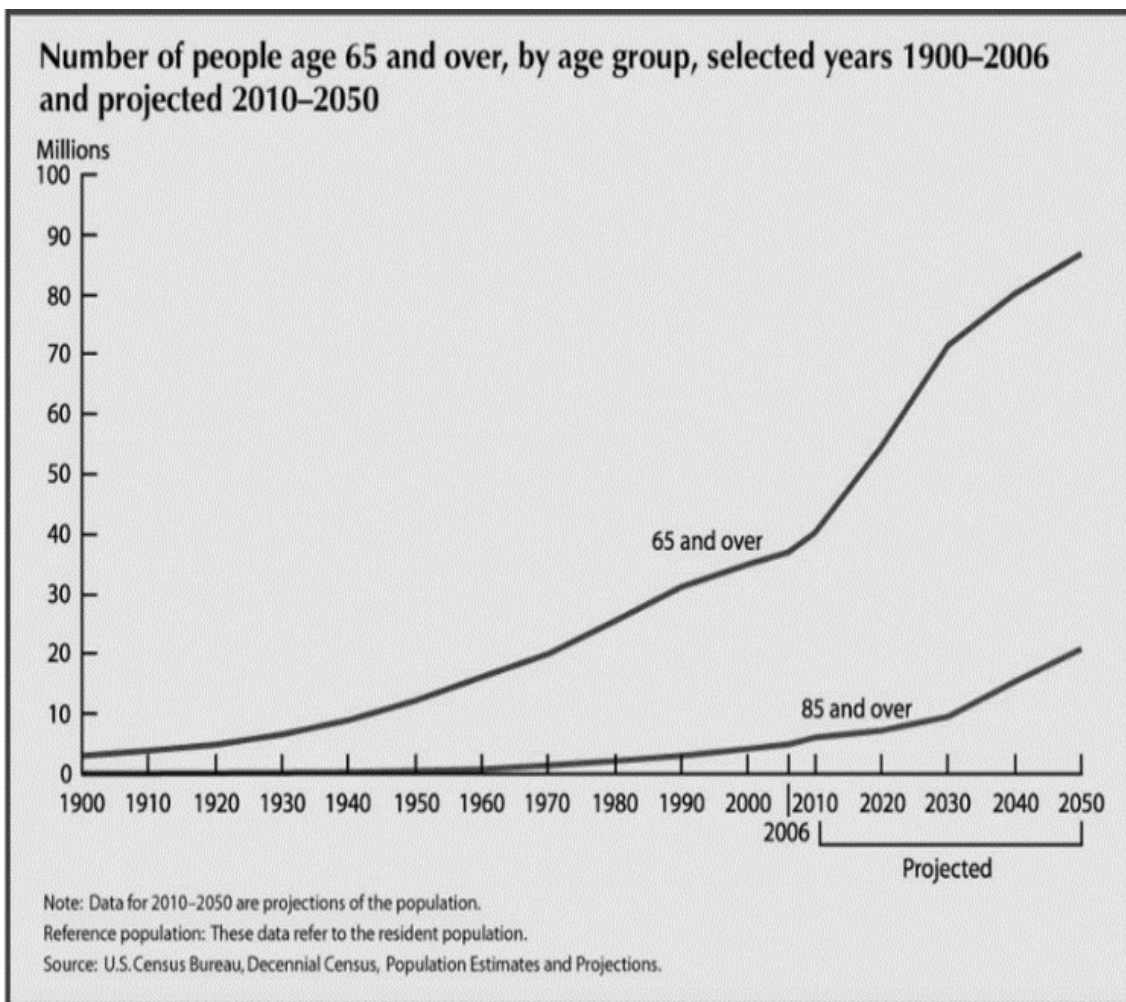
INTRODUCTION

The Baby Boomer generation, born between 1946 and 1965 and recently called the “Silver Tsunami” due to the striking realization that the aging generation is dramatically increasing in size daily, began turning 65 years old in 2011 (WJSchroer, 2015). With the advancement of medical knowledge and technology, people are living longer, with the life expectancy increasing from 47 in 1900 to 72 years in 2001 (Blackburn & Barrett, 2010). According to Lecovich (2014), the population of those over 100 years of age in the United States will increase from 343,000 in 2004 to 3.2 million by the year 2050. As shown in Figure 1.1, America is entering a gray period: the increasingly aged population is putting a strain on an already overburdened and fragmented health care system, while the millions of seniors living below poverty level are unable to afford the rising health care costs.

California is one of the most populated and racially diverse states in the country, which leads to some concern about the efficiency and sustainability of the health care system and its ability to handle the explosive growth of the aging population (Blackburn & Barrett, 2010). To avert the potential problem of not covering enough medical services for the entire population, California integrated several health care programs through Medicare and/or Medi-Cal (California’s Medicaid program). For example, the design of the Coordinated Care Initiative provides comprehensive health care by integrating the services of Medi-Cal and Medicare. However, each of these coordinated programs supports different populations and may only cover certain services. The specific question

I address in this thesis is: *Given that California wishes to provide amalgamated and adequate health care options to its eligible beneficiary population, is the California Coordinated Care Initiative the most efficient (cost-effective) way to do this?*

Figure 1.1: Projected Increase of Aging Population 65+ and older in the U.S. (Media Relations, 2016)



In the next section of this chapter, I explain in more detail what Medicare and Medicaid are, the issues that originated from having health plans financed and managed by two different governmental entities, and what took place to organize them. In the remaining

sections on the Medicare-Medicaid Financial Alignment Project and the California Coordinated Care Initiative, I provide an overview of the initiation of the dual-eligible demonstration project, and what California proposed to do to increase coordination of health care services to dual-eligible residents of the state.

Medicare and Medicaid

Medicare is a federal insurance program that is the principal source of health care coverage for beneficiaries who are dual-eligible, meaning that they qualify for coverage under both Medicare and Medicaid. Dual-eligible beneficiaries are usually poorer, over age 65, and have a broad range of conditions and health care needs (Jacobson, Neuman, & Damico, 2012). Their health and cognitive limitations may require assistance with activities of daily living (ADLs), such as toileting and eating. Additionally, those who are dual-eligible, make up a considerable portion of beneficiaries in facilities such as mental health hospitals or nursing homes. In fact, nearly three-quarters of beneficiaries who have coverage under Medicare reside in long-term care facilities.

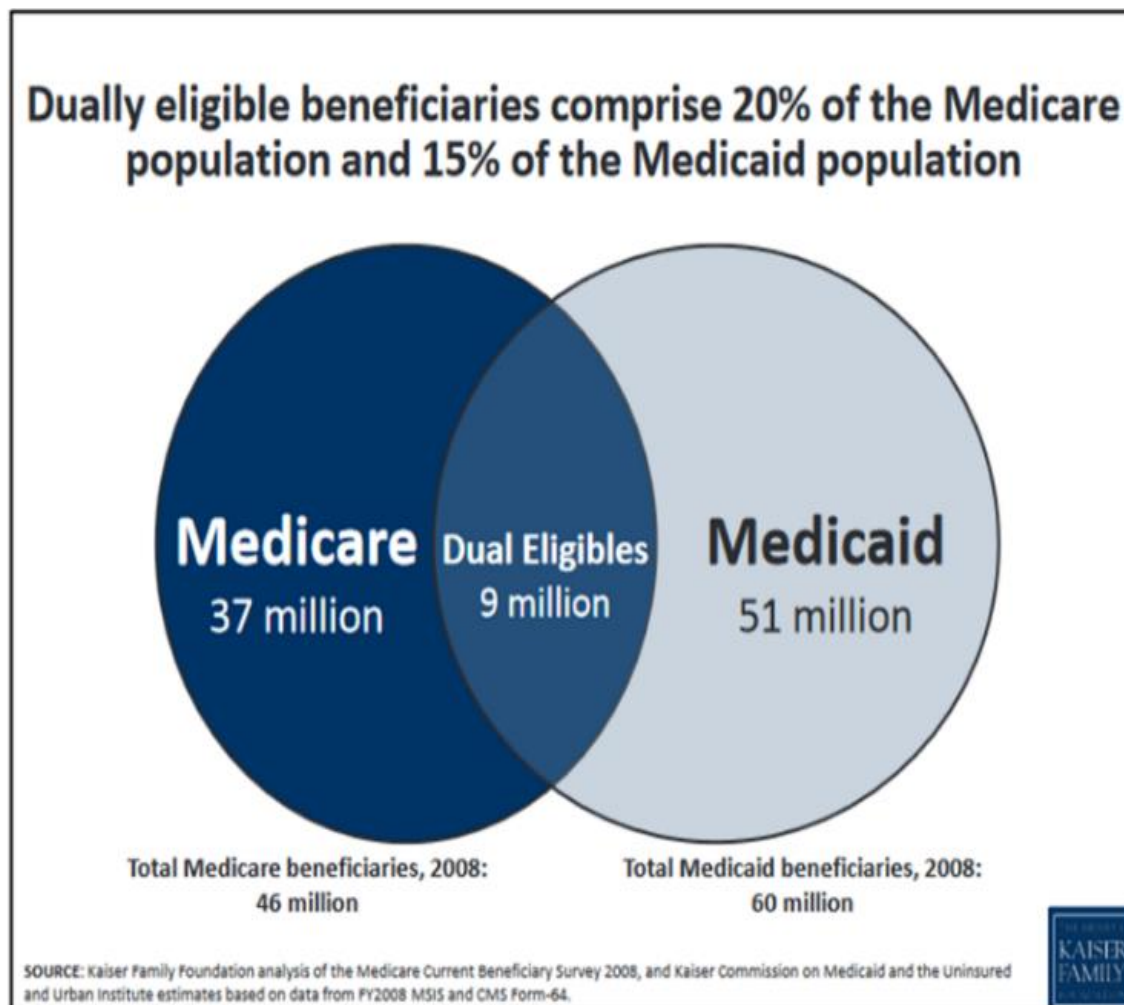
Medicaid is a need-based insurance program funded by state governments, for pregnant women, children, seniors and those with disabilities who meet the eligibility criteria set by states within minimum federal standards (Medicaid.gov, 2011). Medicaid is responsible for supplementing services not covered by Medicare such as long-term services and supports (LTSS), hearing, vision, dental, and coverage of Medicare's premiums and cost-sharing requirements (Young, Garfield, Musumeci, Clemans, & Lawton, 2013). Since its inception, the Medicaid program uses the Federal Medical Assistance Percentage (FMAP) which is a formula to determine the share-of-cost of

specific services that the federal government will pay to each state's Medicaid program (Foundation, 2012). The FMAP rate for California in 2006-07 was fifty percent. Moreover, for each dollar that the state contributed to a qualified social or medical program between 2006 and 200, the federal government contributed by matching the dollar (Peters, 2008). The problem with the FMAP model is that it has been relatively unchanged since 1965, and there are issues with the variable in the formula. It inadequately measures total resources that finance health and long-term care for the states. It also does not effectively measure poverty levels in a state's population. Lastly, the formula does not take in account potential economic recessions; it accounts for future growth in Medicaid but not of revenue during periods of economic downturn (Foundation, 2012). These issues point to the possible disadvantages in using Medicaid, such as overspending or not providing enough services.

Dual eligible beneficiaries are responsible for a disproportionate share of expenditures in both Medicaid and Medicare due to high utilization. Each program receives funding separately, which promotes coordination issues in spending and delivery of health care services. In 2008, over nine million individuals had coverage under both programs (Jacobson et al., 2012). See Figure 1.2. Per Jacobson et. al (2012), the spending for Medicare in 2008 was 1.8 times greater for dual eligible beneficiaries than for others covered by Medicare only (\$14,169 versus \$7,933), with spending for dual eligibles totaling \$132 billion. In fact, spending for dual eligibles who resided in a facility averaged \$22,366 in comparison to the average cost of \$12,915 for dual eligibles who still resided in the community. In addition to Medicare, Medicaid paid a total \$129

billion, with sixty-nine percent of that cost going towards LTSS. Since 2008, the increase in dual eligible spending has grown much faster than for non-duals. By 2011, spending per dual beneficiary substantially grew by thirty-two percent to \$19,113 while spending for non-duals increased only eleven percent, to \$8,865 (MedPAC, 2015). In the same year, total Medicaid spending per dual-eligible equaled \$16,904, with a total expenditure of \$247,050 million (Foundation, 2011).

Figure 1.2: Number of Dual Eligibles in Medicare and Medicaid in 2008 (Jacobson et al., 2012)



In addition to excessive spending, beneficiaries must navigate two health care systems to obtain the services they need, which can cause frustration and extended periods between services received, resulting in the mismanagement of personal health. Additionally, the health care systems have different eligibility requirements, enrollment procedures, benefits, financial systems, and physician networks that can cause coordination issues (Jacobson et al., 2012).

The federal government attempted to reform the fragmented health care system since the early 1900's, by implementing a variety of health care laws (Cass, 2012). By the early 2000's, the system continued to experience heavy scrutiny from both legislators and citizens as health care costs increased, while employer-sponsored health care coverage decreased and more people found themselves uninsured or filing bankruptcy due to the inability to pay for medical bills (White & Reschovsky, 2012). The compounding issues just described were some of the primary motivators of the March 23, 2010, signing into law by President Barack Obama of the Patient Protection and Affordable Care Act (ACA) (ASPA, 2015). The ACA established initiatives that identified and tested new health care payment models that focused on reducing costs and increasing the quality of care for beneficiaries, while minimizing spending and increasing coordination between health care systems.

The Medicare-Medicaid Alignment Project

Under the authority of the ACA, the Centers for Medicare and Medicaid Services (CMS) released a letter in 2011, proposing the development of two demonstration models. States participating in the demonstration could choose either a capitated model or the managed fee-for-service model (Musumeci, 2015; Summer, O'Malley-Watts, & Musumeci, 2015). The capitated model is a commercial design in which health plans receive a lump sum payment for services rendered during a specified period for each beneficiary. The fee-for-service model has an unbundled service design, and health plans receive payment for each service separately. Both designs intended to improve access to

care, promote independence in the community and align financing between Medicaid for States and Medicare through coordination.

CMS selected fifteen states to design the new delivery models and offered up to \$1 million as an incentive to facilitate the development and implementation of the financial alignment (Walls et al., 2013). Thirteen states, including California, signed Memorandum of Understanding (MOU) to establish a partnership between two organizations and are participating in the dual demonstration project. See Table 1.1 for a list of participating states and designated financial alignment model.

Under the demonstration program, instead of driven by the health care system, a case worker or manager initiates services and manages care for both the state Medicaid and Medicare system, called the “person-centered” method, through existing managed care plans. In California, managed care plans must establish a 3-way contract with CMS and Medi-Cal, which will pay the health plans a blended rate for each dual eligible. The blended rate comes from Medicare payments as well as Medi-Cal payments to cover all costs incurred by each beneficiary. The capitated rate covers one person per month, unlike fee-for-services that only provide payment for each service rendered. Overall, CMS expects that the financial alignment will succeed in significant savings and higher quality of care.

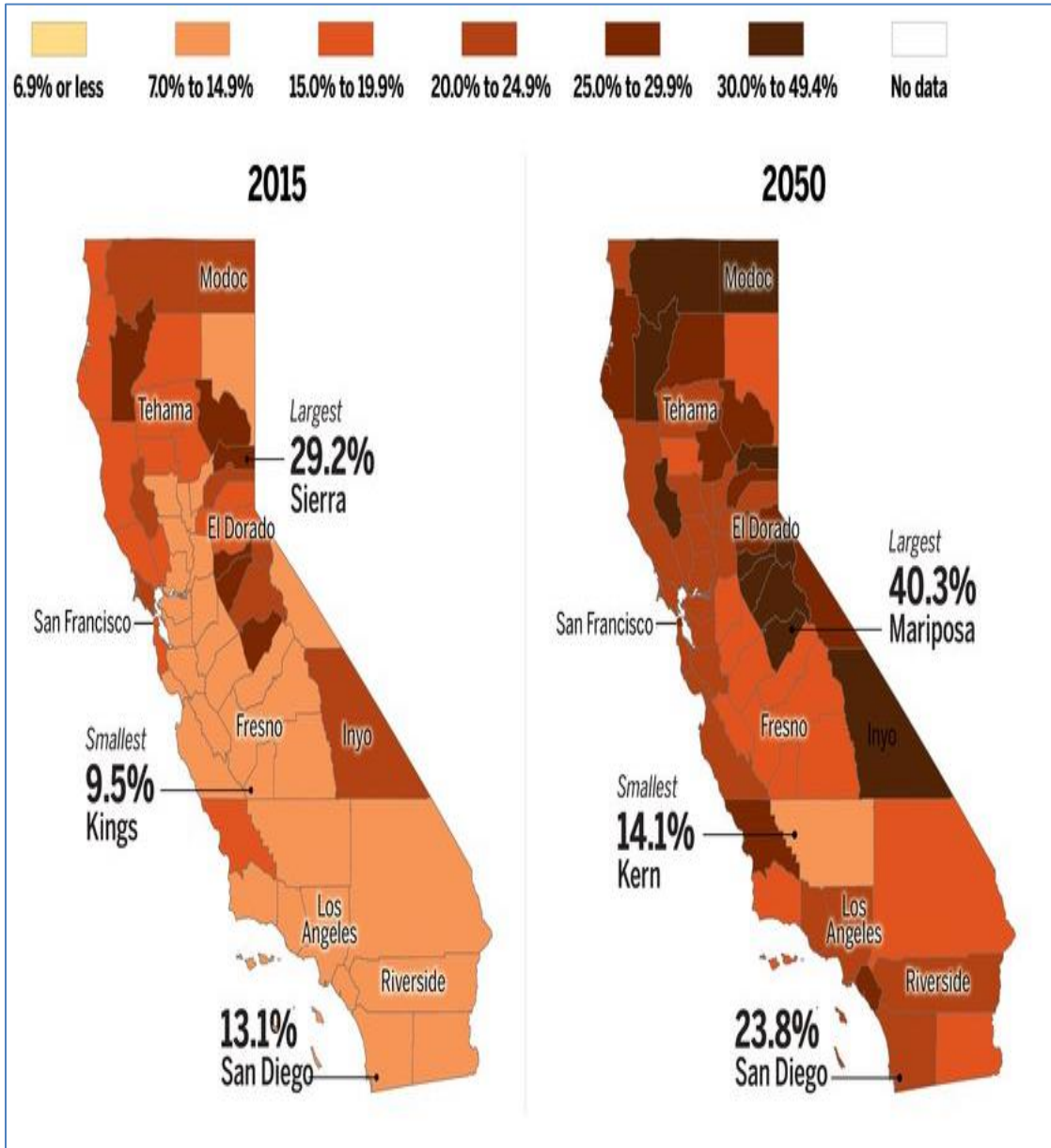
The California Coordinated Care Initiative

With California’s population of seniors over the age of 65 expected to double by the year 2050 (see Figure 1.3) the demand for medical services, assisted living and nursing home facilities will increase (Beck & Johnson, 2015; Gilchrist, 2016). Since Medi-Cal

and In-Home Supportive Services (IHSS) cover LTSS, it is likely that there will be direct budget implications to the state. The increase in costs will require the state to look at alternative options for providing care to low-income seniors who are at risk of needing nursing home care, without reducing the quality of care received.

Figure 1.3: Percentage of California Population 65 years of age or older by county.

(Gilchrist, 2016)



In a proposal called the *California Demonstration to Integrate Care for Dual Eligible Beneficiaries* delivered to CMS on May 31, 2012, California announced its interest in participating in the dual eligible demonstration program (E. G. Brown, Lightbourne, W., Douglas, T. Connolly, L., 2012). The proposal outlined the background, the care model overview, stakeholder engagement, financing, expected outcomes, infrastructure, feasibility, and sustainability. Nearly a year later, March 27, 2013, the California Department of Health Care Services (DHCS) entered into an MOU with CMS and chose to participate in the demonstration using the capitated financial model (CMS.gov, 2015).

The California demonstration model, referred to as the Coordinated Care Initiative (CCI) is currently active in seven counties: Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino, and Santa Clara (CalDuals, 2012). The counties used existing Medi-Cal managed care plans and developed a new “duals” product called Cal MediConnect (CMC) (DHCS, 2016a). CMC covers all LTSS services, including institutionalization (nursing homes, rehab centers) and home- and community-based services (HCBS) (adult daycare, or in-home care) for eligible beneficiaries aged 21 and older. Before the passive enrollment into the CCI program began in April 2013, there was an estimated amount of 424,000 dually eligible beneficiaries in the target area, with approximately seventy-one percent over the age of 65, see Table 1.1.

Table 1.1: List of demonstration project states, eligible beneficiaries on the onset of the program, target population, effective date, and financial model (Musumeci, 2015)

Earliest Effective Date	State	Target Population and Geographic Area	Estimated Number of Eligible Beneficiaries	Financial Model
July 2013	WA	High cost/high risk adult dual eligible beneficiaries statewide except in 2 urban counties	21,000	Managed FFS
September 2013	MN	Dual eligible beneficiaries age 65 and older enrolled in the Minnesota Senior Health Options program statewide	36,000	N/A
October 2013	MA	Non-elderly adult dual eligible beneficiaries in 1 partial and 8 full counties	90,240	Capitated
March 2014	IL	Adult dual eligible beneficiaries in 21 counties grouped into 2 regions	135,825	Capitated
April 2014	CA	Adult dual eligible beneficiaries in 7 counties	424,000	Capitated
April 2014	VA	Adult dual eligible beneficiaries in 104 localities grouped into 5 regions	78,600	Capitated
May 2014	OH	Adult dual eligible beneficiaries in 29 counties grouped into 7 regions	115,000	Capitated
September 2014	CO	Adult dual eligible beneficiaries statewide	48,000	Managed FFS
January 2015	NY (1)	Adult dual eligible beneficiaries in 8 counties who require nursing facility or nursing facility diversion and transition home- and community-based waiver services or more than 120 days of community-based LTSS	100,000	Capitated
February 2015	SC	Dual eligible beneficiaries age 65 and older statewide who live in the community at the time of enrollment	53,600	Capitated
March 2015	TX	Adult dual eligible beneficiaries with disabilities who qualify for SSI or Medicaid waiver HCBS in 6 counties	168,000	Capitated
April 2015	MI	Adult dual eligible beneficiaries in 25 counties grouped into 4 regions	100,000	Capitated
December 2015	RI	Adult dual eligible beneficiaries statewide	30,000	Capitated
April 2016	NY (2)	Adult dual eligible beneficiaries in 9 counties who are eligible for state DD services and an ICF/DD level of care (must be enrolled in DD waiver if receiving waiver services)	20,000	Capitated

The implementation of the financial alignment in California faced challenges, requiring the integration of multiple systems and sometimes-contradictory policies between Medicare and Medicaid. The process required extensive upfront costs, time, and resources to implement the demonstrations, which exceeded the original estimation (Walsh, 2014).

Three years after implementation only 120,971 dual eligible beneficiaries are in the CCI program, with approximately 85,000 over the age of 65 (DHCS, 2016a). Unfortunately, when Governor Jerry Brown presented the 2017-2018 fiscal year budget for California in January 2017, he stated that the CCI Program might not continue, as it is not cost-effective. In fact, Gov. Brown stated that the IHSS component of the Cal MediConnect program would be eliminated. This change would shift costs back to the counties by as much as \$600 million (Admin, 2016). Furthermore, the announcement included that the Department of Finance miscalculated the costs of the Medi-Cal program, creating an additional setback by \$1.9 billion in the previous year, meaning even more potential program cuts, but it was not the reason for the changes to the CCI program. Despite the news, some of the underlying language suggested that part of the Cal MediConnect program would continue to exist for dual eligible beneficiaries. What this means for the State of California will be included in the discussion in Chapter 4.

Remainder of Thesis

I base my answer to the thesis question posed earlier on a review and comparison of dual-eligible demonstration programs currently in progress in California, Massachusetts,

Ohio, Minnesota, and Washington. This review forms the basis of my analysis to determine the possible differences in efficiency and sustainability between the programs. My goal is to draw from this analysis and recommend possible reforms to California's program, so that California seniors continue to receive high quality, low-cost health care.

In Chapter 2 I explore and discuss past literature regarding the brief history on policy issues that emerged due to the increasing aging population, prior attempts at integration, and current demonstrations developed by federal and state programs which provide comprehensive care to individuals over the age of 65. The chapter includes a review of the facts that point to why the aging population is at risk of not receiving adequate health benefits. It also includes an assessment of the public policy basis for why this problem deserves further attention by California's policymakers.

The purpose of Chapter 3 is to detail the methodology I use to analyze prior studies and results of the Medicare-Medicaid Financial Alignment. I will peruse qualitative and quantitative information to determine whether there are differences in institutional design between states which are active in the program, and explore the impact of any variances on specific results (Mintrom, 2012). Using the comparative analysis methodology, I expect to use the information to explain the differences between current policies. I expect to find that the CCI is not the only program that is experiencing high opt-out rates, and that there may be other underlying issues not yet determined.

Chapter 4 presents key findings from my research and analysis of prior evaluations of data and quality measures from the CCI and other state programs as a comparison. I

compare the outcomes to the literature in Chapter 2 and discuss any improvements or failures in the system. I foresee that I will find some correlations with past attempts at integrating health care systems and will discover that while there have been some improvements; the system is still largely fractured, and future expansions of the demonstration program may not occur.

Chapter 5 concludes the thesis by discussing the results of my research of the financial alignment of the Medicare and Medi-Cal programs. I anticipate that my results will demonstrate that there are issues with the existing services, enrollment process, collaboration, as well as financial and organizational problems that could lead to the failure and potential overhaul of the CCI program (Bardach, 2012). The results might assist California health agencies by providing the necessary tools to make a more informed decision and consider revising the CCI program for future utilization and expansion.

CHAPTER 2

REVIEW OF LITERATURE ON HEALTHPLAN INTEGRATION

In this chapter I explore earlier attempts at the integration of medical services through the Medicare's Coordinated Care Demonstration of 2002 (MCCD) and beneficiaries' experiences through a ten-year experiment (Chen, Brown, Archibald, Aliotta, & Fox, 2000). The purpose of doing this review is to identify the specific challenges that California continues to experience in attempting the integration of Medicare and Medi-Cal. Based upon previous research, I offer evidence as to why institutionalization does not work, how long-term stays in nursing home facilities hinders the ability for a patient to heal from mental and/or physical impairment, and how the costs for long-term care will only rise in the future.

Next, I review alternative means for offering health care for aging seniors who are at risk of long-term nursing home care. To achieve this, I divided the remainder of this chapter into sections that covers previous literature on the following three topics: reducing health care costs, reducing institutionalization, and successes and failures of streamlining two complex health care systems. I chose these topics because they are pertinent to the discussion of why it is important that the financial and administrative alignment of Medicare and Medicaid succeed in their integration process.

Lastly, I explain the evaluation process developed by RTI International, contracted by the Centers of Medicare and Medicaid Services (CMS), to evaluate and analyze data

gathered on the integration development, implementation, and ongoing performance of the demonstrations.

The information given in the literature review will provide the reader with the tools to understand why health care costs are so high for those who utilize both Medicare and Medicaid, why inpatient utilization is high, and what we need to do to reduce both. It is important not only for taxpayers who pay into the system, but also for the beneficiaries who utilize it.

Prior Coordinated Care Attempts

Historically, beneficiaries enrolled in Medicare fee-for-service (FFS) plans accounted for a disproportionate share of expenditures. These individuals, most of them over age 65, usually had a diagnosis with one or more chronic illnesses, and due to their high usage of hospital services, required repeated costly medical care. Stated previously, as the population of chronically ill beneficiaries grew, it was the expectation of most people that the Medicare and Medicaid program costs would rise dramatically inciting an increased interest of integrating health plans to promote cost-savings and higher quality of care (R. S. Brown, Peikes, Peterson, Schore, & Razafindrakoto, 2012).

With the realization that health care costs could exponentially increase, the Centers for Medicare and Medicaid Services (CMS) implemented a coordinated care demonstration to provide services to elderly and disabled persons with medical, functional, social, and emotional issues, which could increase their risk for adverse health events. The Medicare Coordinated Care Demonstration (MCCD) of 2002 addressed

those needs through self-care education, improvement of medical treatment, and integration of the health care system. The demonstration, authorized by the 1997 Budget Enforcement Act (BEA), required that targeted beneficiaries were eligible for both Medicare Parts A and B, with listed chronic conditions such as congestive heart failure, diabetes, chronic lung diseases, and other chronic conditions, and on a Medicare FFS plan. The BEA also required that the payment methodology be budget neutral, meaning that there would be no additional costs or revenue produced by the program. Once implemented, CMS planned to conduct formal evaluations every two years and report the findings to Congress. The evaluations were to assess the outcomes of the beneficiary's health, overall satisfaction of the care received, and the project's cost-effectiveness. After a four-year period, CMS would review the evaluations to determine if the integration resulted in cost-savings and if it should continue and/or expand as a permanent program.

CMS chose fifteen states to participate in the demonstration including California. The first evaluation of the MCCD found that medical providers experienced very little communication across the plans; however, there was a measurable reduction of hospital use and costs (Chen et al., 2000). The study also stated that while there was potential to reduce utilization while maintaining or refining quality of care, there was also uncertainty regarding the true cost-savings if the program expanded throughout the country.

A second evaluation came a year after implementation of the MCCD program. The purpose of the evaluation was to test whether the integrated programs could achieve

equivalent results in the FFS population, and demonstrate that quality of care was sustainable while reducing costs (R. S. Brown et al., 2012). While a year did not produce significant data to review, the report did focus on three subject areas: types of programs the beneficiaries enrolled in, changes the programs applied, and whether the patients and providers liked the program(s). Some of the results of the study showed that while small-scale coordination could take place in various organizations, lack of enrollment was one of the notable problems (Burwell, 2014; Peterson, Zurovac, Mutti, Stepanczuk, & Brown, 2015). The programs that reported having success in enrolling beneficiaries already had close relationships with providers before the start of the demonstration. Over the life of the demonstration, all the programs opted not to continue their participation, with one exception. CMS extended one program called Health Quality Partners (HQP), and ten years later produced a final report (Peterson et al., 2015). The analysis found that between 2002 and 2010, the HQP did not significantly reduce expenditures or hospital utilizations. The program experienced a shorter patient tenure, especially in the first three years. Based on earlier providers and HQPs performance, there was a lack of confidence that the FFS model developed by the MCCD could result in reduced Medicare expenditures as well as improved quality of care. Thus, the Medicare Coordinated Care Demonstration ended without much success.

The review of these evaluations on the prior attempt at integrating care for Medicare show that there are still many different obstacles to overcome. While CMS has identified a need to integrate the administrative functions as well as coordinating care to offer

beneficiaries a higher, more efficient quality of care, there still seems to be fragmentation in the system that hinders the attempt to be successful. In the next section, I discuss the issue of institutionalization and why we should reduce this practice as much as possible, and promote a better health care delivery model

Reducing Institutionalization

Prior reports on the Medicare and Medicaid programs show that many beneficiaries are over the age 65, and are primary utilizers of both systems. The same reports show that these individuals generate the highest costs, especially those who reside in nursing homes or other long-term facilities, also known as institutionalization.

Institutionalization of an aging adult happens when the sources of support become unbalanced; otherwise, most prefer to live out the remainder of their years in their own home, or with a family member capable of taking care of them (Noel-Miller, 2010).

Two separate studies investigated reasons behind why so many elderly persons ended up moving to a nursing home, and the results were surprising. In the first study, individuals that experienced the loss of a spouse, and either lost or did not have any children were at the highest risk of entering a nursing home. In fact, the risk of nursing home admission increased once a person reached a certain, or unknown, cognitive, or physical threshold (Gaugler, Duval, Anderson, & Kane, 2007). The second study followed one hundred individuals admitted to a skilled nursing facility (SNF), though only sixty-eight were willing to participate in the survey; thirty-two were too ill. Within the first six months, nineteen of the participating sixty-eight passed away and of the

thirty-two who were already ill, fourteen of them died (Scocco, Rapattoni, & Fantoni, 2006). The analysis resulted in finding that institutionalization did not improve health or help stabilize existing medical conditions. On the contrary, quality of life and physical and cognitive functions declined rapidly.

Engelhardt (2006) argued that care at the end of a person's life experienced fragmentation, often because different health care providers are giving care in different settings. He also stated that more than seventy-three percent of Americans will die after age 65, and the age group will only grow as the boomer generation ages. To verify his assumption, he reviewed a program called Advanced Illness Coordinated Care Program (AICCP), to see how effective care coordination was at the end of a person's life. The sample included two-hundred seventy-five random individuals, and of those, only one-hundred eighty-six patients completed the study. AICCP delivered health care and support through physician support, health literacy, care coordination, prevention, and emotional and social support (Engelhardt et al., 2006). The outcomes of the study, which took place at enrollment, three-month, and six-month intervals, revealed that patients and their families were more satisfied with the end-of-life (EOL) preparation and coordinated care, as well as experienced lower per-case expenditures. While this supported the promise of improving healthcare, the number of participants and brief period limited the study. Providing coordinated EOL care may allow more chronically ill individuals to live at home instead of institutionalizing them, improving the quality for the rest of their life, as well as reducing overall healthcare costs.

More indicators for a need of coordinated care, point to those people who exhibit multiple chronic conditions (MCCs), which involves highly specialized care. Revisiting a prior statement, those over age 65 who are eligible for both Medicare and Medicaid are the costliest patients (Kelley AS, 2012). They were also most likely to have more than one chronic condition, requiring specialized routine care and medications. To verify this, Lehnert and colleagues (2011) completed a study on health care utilization and health care costs among the elderly diagnosed with multiple chronic conditions. They performed a computerized search, and reviewed twenty-one surveys. They hypothesized that a person with co-morbidities should have a stronger impact on health care use (Lehnert et al., 2011). Reports specified that the prevalence of MCC's among persons 65 and older exceed sixty-five percent. Findings of the study supported that people over age 65 did have more frequent physician visits. Additionally, the researchers noticed that with each additional diagnosed chronic illness, hospital utilization increased. In fact, those who experienced adverse events, such as a heart attack, were more than ninety times as likely in comparison to those with four or more chronic conditions to require hospitalization, suggesting that self-care arrangements were not as sufficient or right for some of the patients that had MCC's. In contrast, a prior study using 952 patients over the age of 40 with MCC's produced evidence showing that medical interventions specifically designed for heterogeneous groups of chronically ill patients were successful in reduced hospitalizations and improved health behaviors (Lorig KR, 1999).

As you can see, institutionalization generally does not benefit those who utilize it. In fact, as per the literature, those who go into a hospital, or nursing home for long-term services or EOL services tend to decline in health rapidly, while those who can receive health care at home usually live longer, or enjoy a better quality of life towards the end of their life. In addition to the health implications of facility utilization, costs for long-term health care services are usually high.

Encouraging Aging-In-Place

In addition to prior attempts at care coordination reform, some policymakers opted for building community-based medical care, referred to as ‘aging-in-place.’ Simply defined, it means that aging or disabled individuals who have multiple chronic illnesses or diseases, are at risk for nursing home admittance or other long-term care facility, and have community and family support, will opt to stay in their own home and receive home-based medical care that is equivalent to nursing home care (Russo, 2009). This has been an ongoing delivery method of care for quite some time. For example, the first official PACE Model offering in-home services opened in the 1970’s. PACE, which stands for Programs of All-Inclusive Care for the Elderly, currently serves state certified individuals over the age of 55, who are at risk of needing nursing home care (NPA, 2014). PACE is currently active in 31 states, has 119 programs, and continues to grow on a yearly basis (Bloom, 2016).

With an abundant amount of evidence that individuals over the age of 65 are going to dramatically increase health care costs due to the baby boomer generation doubling and

tripling in size, increasing the demand for nursing home level of care due to loss of community support, or increasing in the number of chronic conditions requiring increased specialized care, it is imperative that we consider reforming our healthcare system in order to keep up with and adequately care for the aging population (Alemayehu B, 2004; Parker & Thorslund, 2007). CMS believed that there needed to be other methods of health care delivery as well, and have been diligently working towards the development of several demonstrations (pilot programs) to attempt the integration of care and financial reform for those who utilize both Medicare and Medicaid plans the most.

While aging-in-place is not a new practice, policy makers are pushing to expand the idea in every state. In the last few decades, evidence-based evaluations have surfaced in various reports evidencing how successful aging-in-place is. Among California's many health care programs, the option to age at home while receiving nursing home level of care is one of them. This demonstrates that California agrees that this option is one to pursue not only for the beneficiaries' benefit, but also to reduce costs to taxpayers. In the next section, I will address the reason federal and state governments should consider realigning and integrating Medicare and Medicaid, for the benefit of those who use both programs.

Why We Should Consider Integrating the Medicare and Medicaid Programs

Not only is the population of seniors increasing at a rapid rate, they are also living longer (Parker & Thorslund, 2007). This is possible by the improvements in medical technology, increased health awareness, and better control of diseases. Communities in the 1970's through early 2000's revealed they were not equipped to handle caring for the elderly in the home, driving sick and disabled seniors towards living in facilities (Scharlach, 2009). After the ACA passed, more health care providers encouraged those over 65 to remain at home, where they could receive treatment (Parker & Thorslund, 2007). Allowing those to age in their own home could potentially save money over time, and reduce the pressure on two separate health systems attempting to coordinate the care required for an aging senior.

To recap from before, dual eligible beneficiaries accounted for forty percent of spending by Medicaid, and twenty-five percent of Medicare spending as of 2008 (Group, 2008). The projection stated that the total spending on duals by 2024 would surpass \$775 billion, with per capita spending approaching \$80,000 (Meyer, 2012). CMS had previously attempted to integrate care through the Medicare Coordinated Care Demonstration of 2002; however, it did not produce considerable evidence for increased quality of coordinated care, in addition to cost savings. Thus, affordable and quality healthcare remained difficult to find.

Once the demonstration ended, policymakers continued to ask whether a realignment of Medicare and Medicaid would benefit the dual eligible population. Reviewing prior

records and evaluations, CMS considered it a possibility, that if executed correctly, the integration could still take place. The previous demonstrations used a FFS setting resulting in higher-than-expected costs, so for the new project, CMS presented the possibility of using a capitated model. In consideration of potential future pilot programs, a report by The Lewin Group (2008) focused on two key areas that would need to be addressed. First, to roll the dual eligible population from a FFS system into a capitated model, they would need to figure the financial implications on a comprehensive scale. Second, they would need to consider the significant design features, as well as public policy matters that could potentially influence the capitated model setting. The results of the report indicated that large-scale savings could emerge once Medicaid and Medicare successfully completed their financial alignment and utilized the capitated model. The initial savings beginning CY2010 would be three percent per year, climbing up to six percent per year by CY2024. While these percentages seem small, due to the large baseline of the per-person spending on dual eligibles, this would transform into very large dollar amounts. For example, Ohio could see close to \$10 billion in savings over the fifteen-year period, while California could see close to \$41 billion (Group, 2008). A potential barrier to savings included that some savings would accrue to the Medicare program, and the states would not have access to those funds. Additionally, dual eligible individuals may have little motivation to enroll voluntarily in the MCO programs.

Supporting The Lewin Group analysis, Bella and Palmer (2009) also encouraged the idea of integration, in suggesting that aligning the funding streams could improve the

value, management, and cost-effectiveness of care for this high-risk population, and reduce rule conflict between the two programs. The purpose of the paper offered the rationale for health care integration, and why it has not yet taken place. They identified issues that duals contend with, such as two medical providers, benefits, and multiple ID cards (Bella & Palmer, 2009). This can lead to missed appointments, duplicative services, and unnecessary care. Not only that, beneficiaries may become frustrated and be at risk to stop seeking medical treatment all together. Financial alignment is also a concern, as beneficiaries must work with two different health plans and determine who is paying for what services (ACAP, 2011).

Other challenges they identified included low enrollment possibilities, as well as the ability to develop and bring model programs to scale. Bella and Palmer (2009) introduced potential vehicles for integrating Medicare and Medicaid through new alternative delivery models. The first model, referred to as Gainsharing Demonstrations, intended to use an alternative payment program using FFS. The second model, The Medicaid Duals Demonstration, charges states with managed care organizations the responsibility of assuming risk, by managing the Medicare and Medicaid benefits, providing a medical home, and coordinating care for the duals in addition to adopting a capitated rate payment plan.

Understanding that integration of care, as well as the target populations, would vary by state or region, the models should include the following as part of their standard services: patient-centered care, multidisciplinary care team, and a comprehensive

medical provider network. These services would guarantee to meet the target population's needs, including those utilizing long-term supports and services programs, and medical and behavioral services. Even though states across the country are interested in participating in the integration program, there are several challenges to overcome before the program could launch. There are potential administrative, operational, and financial obstacles, which include rule conflict between the two organizations, goal ambiguity, and encounter reporting issues.

Even with the failure of prior integration attempts, there is a realization among policy makers that coordinated care would benefit everyone. Seeing the evidence from prior studies that integration is needed and encouraged, the only next step is to pursue it. In the next section, I will introduce the subsequent and current attempt at coordination of care, by discussing the Administrative and Financial Alignment of Medicare and Medicaid.

CMS's Administrative and Financial Alignment of Medicare and Medicaid

Signed in 2010 by President Obama, the Patient Protection and Affordable Care Act, or ACA, represents the most significant attempt to overhaul the United States health care system (Services, 2010). The purpose of the law was to improve health outcomes using technology, improving affordability, and offer a better delivery of care to everyone. Section 2602 of the ACA created the Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office (CMS, 2011). CMS had authority

under the law to develop new health care delivery models and expand access to all dually eligible beneficiaries to integrated programs (Bella, 2012).

In order to begin enrollment as soon as 2013, Melanie Bella (2012) directed all health plans interested in the integrated health plan to follow guidance provided in a memo. There were several key areas covered, such as Payment Principles, which described the development process of capitated payment rates, as well as how to achieve savings for both Medicare and Medicaid Programs. Approval process dates, as well as plan selection days described in detail, provided clear direction for the health plans on the next steps for pursuing coordinated care. The guidance also included a notice of intent questionnaire form in which health plans could submit their interest to offer a proposal for the demonstration program (Bella, 2012). In response, twenty-six states eagerly indicated their interest to CMS by submitting proposals and of those, CMS selected fifteen states to participate in the administrative and financial alignment (CMS, 2011). By July 2013, six states received approval to begin the implementation.

An early review of the design and implementation process by Crowley, Musumeci, and Reaves (2013) focused on the states that began the design and implementation of the demonstrations first (Colorado, Massachusetts, Michigan, Ohio, and Washington). They were most interested in the common issues and potential solutions found in the beginning stages of the design process, and completed an evaluation to determine concerns for beneficiaries over age 65 who utilized LTSS services the most. The review included 26 interviews with national and state disability stakeholders, including representatives from

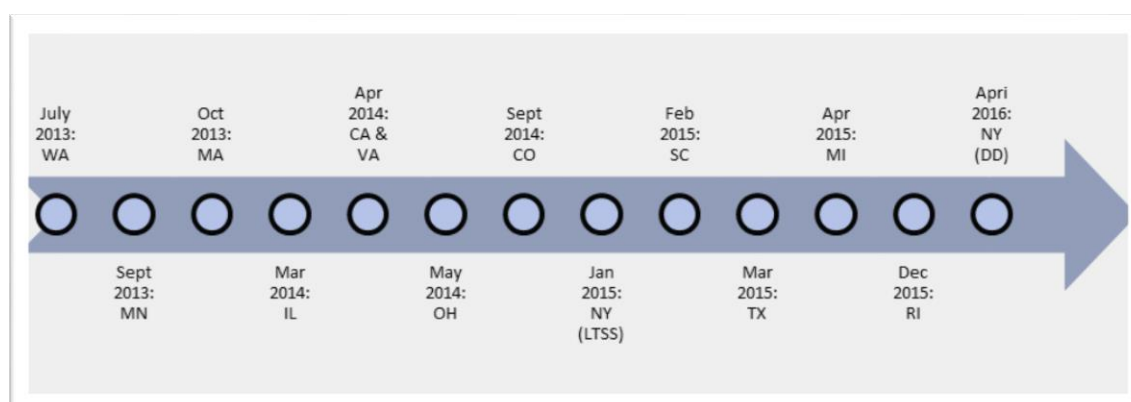
associations and organizations who represented people with physical, mental, and developmental (Crowley, Musumeci, & Reaves, 2013).

The results of the review completed by Crowley, Musumeci, and Reaves (2013) found many strengths and concerns with the coordinated care and financial alignment integration. Respondents indicated that they believed that care coordination could improve health outcomes, as well as reduce disparities in care, and increase access to home- and community-based services (HCBS); however, they shared concern about enrollment process for the beneficiaries, and increased focus on expenditure of funds instead of on the savings goals. Due to the vulnerability of most of the eligible beneficiaries, the respondents preferred voluntary enrollment. However, if that failed, voluntary enrollment followed with automatic/passive enrollment would be used instead (Crowley et al., 2013). The respondents also suggested that the first-year savings gained from implementation of the program was unrealistic due to the upfront costs required to build capacity and monitor new processes. Respondents instead felt that it was more important to spend money prudently, at least in the beginning of the demonstrations.

Per the respondents, there was a lack of consensus on the demonstrations utility. Moving forward with limited information and as the design of the demonstrations progressed, additional focus would need to be paid to those issues concerning beneficiaries who rely on LTSS services, such as increased access to HCBS, improved care coordination, system capability, and best-practices standards that account for physical and programmatic access (Crowley et al., 2013).

The enrollment process began in 2013 for the newly approved states, and initially the demonstration program had a three-year approval timeline. At that time, there were over 9.6 million seniors and disabled individuals eligible for enrollment in the programs, and estimated that over 2 million would participate. In July 2015, CMS announced that the states involved could extend their pilot programs an additional two years (Musumeci, 2015). By November 2015, close to four-hundred thousand beneficiaries in nine states enrolled in coordinated care plans, which mostly had capitated financial arrangements. By December 2015, thirteen states had signed MOU's with their managed care organizations and CMS to proceed with implementing the coordinated care program (Musumeci, 2015). Below is a timeline of all thirteen states and their beginning enrollment periods:

Figure 2.1: Earliest Effective Enrollment Dates in Financial/Administrative Alignment Demonstrations for Dual Eligible Beneficiaries (Musumeci, 2015).



One of the selected states, California, entered its MOU agreement with CMS in March 2013, expecting the total savings to reach a maximum of 5.5% by year three of the

program, making it among the highest projected savings among the approved demonstrations (Foundation, 2015). In December of 2013, the selected managed care plans signed a three-way contract with the state and CMS to begin the process of providing LTSS care to the aging population, as well as those who need mental health and other disability services. In April 2014, passive enrollment officially began in San Mateo County, while opt-in enrollment began in Los Angeles, Riverside, San Bernardino, and San Diego Counties (CMS, 2015).

The early reviews of the integration show that there are still obstacles to overcome, regardless of the expected outcome. While coordinated care is predicted to improve the quality of health care provided, low enrollment rates coupled with voluntary enrollment plague the systems attempting to improve the process. How can the plans reduce or eliminate problems associated with these obstacles? In the next section, I discuss the plan CMS put forth to evaluate the programs that signed up for the demonstration.

The Evaluation Process of the Alignment Initiative

Once enrollment began across the country in the approved states, CMS considered ways to measure success and failure of the demonstration programs, and contracted with RTI International to develop and employ an evaluation plan for all active coordinated care programs (Musumeci, 2014). All states evaluated included areas of implementation, beneficiary experiences and utilization, access and quality of care, cost, and health disparities among the populations. Federal and state policy makers and stakeholders had considerable interest in the results of the evaluations, as it would affect the future of

health care coordination, and determine whether the demonstration programs will expand to the rest of the population.

RTI International (RTI) conducted evaluations at regular intervals, which included quarterly, annual, and final reports, as well as comprehensive final analyses. The evaluations included both qualitative and quantitative research methodologies based on site visits, interviews, and focus groups. Qualitative datasets were from analysis of claims, encounter data, quality reporting, and utilization and cost data. Delivery methods were another focus in the evaluation, which reviewed beneficiary experiences, access, and quality of care, as well as costs (Musumeci, 2014).

As part of the analysis, RTI planned to complete two site visits per state, using two-person teams, with the first site visit six months after the start of enrollment. Additionally, each state had four focus group meetings throughout the demonstration, which comprised of eight to ten people, including family members and beneficiaries. Lastly, as part of the evaluation process, RTI conducted stakeholder interviews, held quarterly either in-person during site visits, or by telephone. Within the first six months, there were eight phone interviews in each participating state, and up to eight in-person or telephone interviews per state, per year (Musumeci, 2014).

RTI intended to review each state's health care delivery system as part of the analysis, prior to the start of the demonstration, and determine what each state intended to change. The analysis would compare later evaluations and ascertain if and what changes occurred, and then compare them to outcomes of other states. Design features included

the integrated delivery system, financing and payment systems, case management, coordinated care, benefits, enrollment and access to care, as well as beneficiary involvement (Musumeci, 2014).

The evaluation process will continue over several years as the demonstrations proceed. Moreover, as part as the evaluation process, The Department of Health Care Services (DHCS) gives monthly updates on the status of the CCI, as well as provides evaluations to the public. If the demonstrations show any signs of failure, the public can then submit requests to the State, challenging them to end the pilot programs. Only time will tell if the CCI is a sustainable program for the dual eligible beneficiaries in California.

Conclusion

For over fifteen years, CMS attempted to integrate care in Medicare and Medicaid several times, without much success. Prior studies have shown that integration is challenging and faces many obstacles for success. The literature presented only shows a small portion of actual results from the demonstrations as many of the sample sizes were small, and did not cover a long specific period, except for the final report for the MCCD of 2002, which covered ten years. The California Care Initiative began as a pilot program in 2013, with enrollment beginning in April 2014, which only affords the state with just over two years of evaluations. The evaluations are important to the success of the Medicare-Medi-Cal integration in California and allow for future expansion of the program. As of today, The Coordinated Care Initiative, as well as the other participating

states have gone through many evaluations, with the most recent in December 2016 for Minnesota, and they all continue to receive evaluations (CMS, 2016).

My thesis builds off and complements the earlier analyses of the most recent efforts to integrate Medicare and Medicaid. More specifically, in Chapter 3 I review the evaluation design plans and compare the development and implementation, and ongoing progress of demonstration programs for the states of California, Massachusetts, Ohio, Minnesota, and Washington using prior and current evaluations to determine feasibility and sustainability of the CMS financial and administrative alignment of Medicare and Medicaid. I then present the findings from the evaluations I review in Chapter 4.

CHAPTER 3

METHODOLOGY

For Chapter 3, I review the method and process of analysis for my research. In Section 1: Design and Method, I review in more detail the methodologies I considered for this project, and the method I use to summarize the information principles used in the evaluations to compare the various coordinated care programs in the CMS financial and administrative alignment. In Section 2: Source of Evaluations and Categories Used, I explain why I chose to review the programs in California, Massachusetts, Ohio, Minnesota and Washington, focusing on California. In Section 3: What's Next, I conclude with an explanation on why the given evaluations can help us understand the countless challenges of health care plan integration not only for the managed care plans, but also for Medicare and Medicaid.

Section 1: Design and Method

A research project requires a method of inquiry. For this thesis, I reviewed potential methodologies that would best fit the information I collected and analyzed. I considered a criteria-alternative matrix (CAM) analysis to determine the tradeoff between efficiency, equity, and sustainability among the different approaches; however, due to the variety among the states, I decided it would not be a practical method to accurately measure success and or failures across the programs (Mintrom, 2012). In addition, I considered a regression analysis using data on beneficiaries, starting with those who were originally eligible, and searching by different variables such as age, geographic location, and

ethnicity. I would have compared them to the most recent number of beneficiaries now enrolled in the Coordinated Care Initiative, and attempt to compare them to other states taking part in similar demonstration programs. Due to the difficulty and potential failure of obtaining the data I would need to complete the research, I decided that it was best not to pursue that particular method. As my review and analysis will be based on prior and current evaluations of five states participating in the CMS Demonstration, I chose to do a comparison analysis on the demonstration evaluations as my methodology (Munger, 2000)

Performing a comparative analysis as my method of research is beneficial for this kind of study, especially since multiple states are still early in the problem assessment phase (Mintrom, 2012). Mintrom (2012) suggests that when policies are working elsewhere, it is possible to borrow those ideas to create new policies to solve current problems. Reviewing the evaluations will help me identify and sharpen the details of the problems facing integrating health care programs, and attempt to draw solutions and recommendations based on the experiences of other programs to apply to current problems facing California's CCI program.

Mintrom (2012) describes a comparative analysis as a useful tool that can contribute to identifying and defining a policy issue and can "clarify links between formal rules, structural arrangements, actions and collections of individuals, as well as social and economic outcomes." Because some research in policy analysis is particular, Mintrom

suggests using a guideline of steps to conduct this type of analysis. Suggested steps in Mintrom's comparative policy analysis are as follows:

Step 1 - Select and refine analytical questions: Selection and refinement of an analytical question require a thorough investigation of the problem's background. In the first step of a comparative analysis, a policy analyst should identify and define the policy problem and describe the settings that the problem was observed. Per Mintrom (2012), these institutional settings include current policies, practices, rules/laws, and structure. In Chapter 1 of this thesis, I provided a thorough background of the problem I researched, and identified my research question as: ***Given that California wishes to provide amalgamated and adequate health care options to its eligible beneficiary population, is the California Coordinated Care Initiative the most efficient (cost effective) way to do this?***

Step 2 - Develop a research design, and select cases or criteria: Once the research question/problem is identified, the analyst begins developing the process for finding and collecting information needed to perform the analysis (Mintrom, 2012). In this process, the analyst should look for successful or failed policy changes where the problem is observed. Mintrom (2012) suggests that the analyst look for cases that are similar but have differences in the actual treatment of the policy problem. For this step, I began my search using the knowledge I already had of the California Coordinated Care Initiative, reviewed latest evaluations, and then traced backwards from that point to the beginning of the program. In the process, I learned that CMS had employed several other states to

participate in similar but different programs, presenting an opportunity to review potential policy issues. The discovery fueled my interest in completing a comparison analysis, to see if California's program is more successful than that of the other states, and if not, what can be done differently. One of the things I found was many of the demonstrations experience high enrollee opt-out rates which could ultimately affect the sustainability of the programs, which in turn could cause the integration of Medicare and Medicaid to fail, presenting a potential policy solution if it works.

For the purpose of my study, I chose Massachusetts, California, Ohio, and Minnesota since they were the first states to propose a capitated payment model and began enrollment for beneficiaries the earliest. These four states will have the most evaluations available for analysis. I also chose Washington State, as it was also an early adopter of the demonstration, but chose to enter a managed fee-for-service payment model.

Step 3 - Collect and analyze the relevant information; compare alternatives: Per Mintrom (2012), once the analyst chooses the method of study, the next step is to review information and begin gathering relevant facts and data. Chapter 2 of this thesis appropriately offers a review of literature related to the subject matter and research question. As part of my analysis, I developed a matrix to assist with organizing the work and identifying problems as suggested, as it helped to make sure that I collected the most vital facts (Mintrom, 2012). Bardach (2012) adds to this by suggesting obtaining information from participants or others who might be considered subject matter experts. I plan to use information from ongoing updates I receive from the Department of Health

Care Services, providing the most current information pertaining to the Coordinated Care Initiative.

Step 4 - Isolate the relationships between institutional choice and observed

outcomes: For Step 4 of the analysis process I review the facts drawn from the literature and compare the outcomes that the current policy has on the various demonstration programs; results are presented in Chapter 4 of this thesis. Reviewing all information to ensure outcomes are driven by the same policies will aid in eliminating possible external issues that are not related to those policies. The evaluations I use to complete my analysis come from organizations such as RTI International (RTI), The SCAN Foundation, Field Research Corporation, the State Health Departments for California, Massachusetts, Ohio, Minnesota and Washington, and various public or private organizations contracted to perform evaluations for the programs. They use several methodologies for gathering information including focus groups, telephone interviews, surveys, direct observations, and quantitative data analysis. I develop and include a matrix of key categories that each evaluation focuses on to ensure that I collect the relevant facts (See Table 3.1).

Step 5: Present your findings, and make recommendations: The final step in doing a comparative analysis pulls from the final outcomes of the analysis and results in forming the basis for potential policy recommendations. In Chapter 5, I present the findings taken from the analysis completed in Chapter 4, laying out the comparisons of successful policies. Additionally, I include responses from interviews I conducted with stakeholders

who had knowledge or experience in working with the CCI, based on the findings from my analysis, and conclude with recommendations on solving failed policies

Section 2: Source of Evaluations and Categories Used in Them

While each state completes an evaluation based on its own needs for improving problems as they arise, RTI International (RTI) is the basis for all evaluations and the official evaluator of the CMS demonstrations. The evaluations conducted by RTI utilize the exact same surveys and observations for each state, as their core method to gather information from the programs. RTI contracted with CMS prior to implementation and developed a readiness review to determine each program's ability to pull off the integration process. From this they developed a more comprehensive analysis based on data and surveys completed by the various state demonstrations. For the first six months, then in ongoing evaluations, RTI focuses on seven key categories: Eligibility and Enrollment, Care Coordination, Beneficiary Experience, Stakeholder Engagement, Financing and Payment, Service Utilization, and Quality of Care. These categories are listed as the main headings in Table 3.1, and are the basis for evaluations of the different demonstration programs in all the participating states. Each evaluator performs an assessment based on the listed categories using various methodologies, and then summarizes the outcomes in their reports. Table 3.1 (below) breaks down the categories and briefly defines what each evaluator is looking for, which intends to illustrate the similarities among the different evaluations. The outcomes rely on the specific policies in place for each individual demonstration program.

Table 3.1: Evaluation Design Features and Measurement Categories:

Research Evaluation Organization	Eligibility and Enrollment	Care Coordination	Beneficiary Experience	Stakeholder Engagement	Financing and Payment	Service Utilization	Quality of Care
All States: RTI International	Integrated enrollment and access to care.	Assessment process. Service planning process.	Beneficiary overall satisfaction.	Approach for engaging stakeholders.	Financing model: capitation or managed fee for service.	Trends in use of LTSS for dual eligibles. Home health care utilization.	Core measures to assess quality of services.
California: Field Research Corporation, The SCAN Foundation with The California Department of Health Care Services (DHCS)	Beneficiary transition Education on enrollment Opt out and disenrollment	Access to care Ability to get appointments, medications	Overall experience with care and satisfaction	Regular stakeholder meetings by DHCS	Capitated payment model	LTSS Coordination management	Success and failures of program
Massachusetts: The Henry J. Kaiser Family Foundation	Focus on non-elderly population	Design and implementation of care	Involvement of beneficiaries and families	Involvement of stakeholder groups	Capitated Payment Model	Access to LTSS services	Ongoing quality of care
Ohio: The Ohio Department of Medicaid	Integrated enrollment and access to care.	Providing seamless transition between settings and programs.	Overall experience with care and satisfaction	Involvement of stakeholder groups	Capitated financial model	Long-term care, behavioral health, and physical health services	Quality of care received from providers
Washington: Washington State Department of Social and Health Services	Focus on individuals seniors and disabled individuals who are dual eligible	Providing seamless transition between settings and programs.	Involvement of beneficiaries and families Overall experience with care and satisfaction	Forums conducted including focus groups	Managed fee for service financial model	Access to community supports and services	Ongoing quality of care

In the rest of this chapter, I review and define each individual category included in the matrix, and discuss in more detail the method each evaluator uses to obtain the information, if available. I conclude with an explanation of the final steps for the analysis process.

Eligibility and Enrollment

Evaluation of eligibility and enrollment focuses on several areas. First, the program must decide what population to serve by the demonstration. The population can include non-elderly people with disabilities, people over the age of 65 with multiple chronic conditions, or other combinations of individuals with needs. State health programs want to reduce institutionalization by the highest-costing utilizers in their state. By studying the populations, a state can determine which program(s) would be most effective and/or efficient at achieving their goal.

It is important to note that enrollment is a concern for most health programs. A majority of (elderly) individuals are not open to change, especially when it comes to their health care, and are not as eager to change programs (Secker, Hill, Villeneuve, & Parkman, 2003). This component of the study will be one of the major factors in helping to determine if the programs will be sustainable over time. Specific interests include how many are eligible to participate, how many were passively enrolled, and who opted out of the demonstration.

Care Coordination

Care coordination begins at the moment of program implementation (Leichsenring, 2004). Several features of care coordination include the success rate of the proposals that were implemented and documentation of coordination activities between MMPs and their surrounding community-based organizations. Aligning services to meet the need of the targeted groups will take most of the program period to iron out any issues to make sure health care options are available and accessible to all beneficiaries. Measures to ensure care coordination takes place include successful transition of health benefits for beneficiaries and ability to access care for their own specific needs.

Beneficiary Experience

Another key component to the demonstrations is the overall beneficiary experience. The project's success weighs on how beneficiaries utilize the programs and if they are ultimately happy with their experience. Improving the beneficiary experience by improving access to care, promoting person-centered planning, and ultimately regaining independence in their community is one of the top-most goals of the demonstration (Walsh, 2014). Measuring successful experiences stems from multiple interviews via telephone or in-person, and mail surveys. Many of the surveys utilized a Likert-scale style measurement to determine strong satisfaction or strong dissatisfaction in services received.

Stakeholder Engagement

Stakeholder engagement is an integral part of success for many programs, as it allows a body of individuals such as subject matter experts, health advocates, even beneficiaries themselves to partake in meetings and voice their concerns or explain what works with the programs. Public agencies frequently put together stakeholder meetings for the very purpose of finding out exactly what works or does not work for people, suggestions for change, or how to keep things the same. These meetings provide results on how effective stakeholder involvement is by illustrating success rates on changes made due to the decisions stakeholders make.

Financing and Payment

When CMS decided to open options for the Financial and Administrative alignment, it offered two potential payment models: capitated and managed fee-for-service. States chose which payment model to go with during the planning stage of their demonstration project. Depending on the population, and how many organizations participated, some states chose the capitated model while others chose the managed fee-for-service model. Throughout the demonstration, changes in payment methodology took place, which caused challenges among the MMPs and providers (Walsh, 2014).

Service Utilization

Dual eligible individuals are high-utilizers of long-term health care (Shugarman & Whitenhill, 2012). They are responsible for increased costs for inpatient acute care,

skilled nursing facility use, home health care, and other home- and community-based services (Beck & Johnson, 2015). Service utilization goes together with providing the right access to care, ensuring to meet all the beneficiaries needs.

The goal is to reduce the number of actual primary care visits, reduce the need for inpatient facility stays, and increase the number of services available on an outpatient or in-home basis. The analysis includes several reporting measures, which will look at these components to figure out if a reduction in institutionalization occurred with the implementation of care coordination.

Quality of Care

A set of quality measures for determining the overall quality of care, is largely utilization based. Several factors for quality of care combine the prior mentioned key components along with other measurements of quality. Several of the concepts to measure the quality of care include readmission rates, vaccines, preventable emergency room visits, and other screenings. Telephone interviews, surveys, and focus groups provide the basis for data collection on this part of the evaluation.

Section 3: What's Next

While some evaluations have not yet been completed, there is plenty of data to review and compare with all the states taking part in the demonstration. In Chapter 4, I focus deeper on the main key components of the evaluations, and analyze and compare the results side by side. I review the findings and explain the similarities and differences

in the results for each of the individual key components described in this chapter, based on demographics and specific program designs for the various states. In Chapter 5, I conclude this thesis with a discussion of the results of the analysis, responses from stakeholders involved with the CCI program, and recommendations for future policy changes if any.

CHAPTER 4

A COMPARISON OF STATES

In this chapter, I present individual analyses based on the evaluations of five states participating in the CMS financial and administrative alignment. I begin with Massachusetts, and give an overview of all seven key components discussed in the rubric I developed in Chapter 3. I then do the same for Washington, Ohio, California, and Minnesota. In the remainder of Chapter 4, I give a brief summary of the outcomes of the states, including similarities; however, I focus especially on the differences across states and how those outcomes affected the demonstration's progress in each state.

Massachusetts – One Care

The state of Massachusetts wished to improve coordination of services between Medicare and Medicaid, while also improving quality of care and reduce overall health care costs (Walsh, 2016a). Massachusetts was the first to express interest in taking part in the demonstration, signed an MOU with CMS in August of 2012, and by October 2013, began enrollment of eligible beneficiaries in nine chosen counties in a program referred to as One Care (Barry, Riedel, Busch, & Huskamp, 2015). The first preliminary evaluation by the Henry J. Kaiser Foundation (HJKF), published on May 2015, revealed an optimistic but cautious report. In Table 4.1 below, the seven key components previously discussed are shown at the top, with the outcomes listed in the HJKF report under each category.

Table 4.1: Massachusetts evaluation summary from the Henry J. Kaiser Foundation

(Barry et al., 2015)

Eligibility and Enrollment	Care Coordination	Beneficiary Experience	Stakeholder Engagement	Financing and Payment	Service Utilization	Quality of Care
* Focus on non-elderly population, ages 21-64 * Utilizes passive-enrollment (with opt-out options) and active-enrollment strategy * Only 18.4% of eligible beneficiaries enrolled in the first 17 months	Initial assessment, followed by integration of services headed by a care coordination team: care coordinator, primary care, behavioral health, LTSS providers and coordinator, peer support/counseling, and any other needed specialists	Noted that MA benefited from care coordination. *** having no Rx co-pay was an incentive for voluntary enrollment **Ombudsman program established to address concerns and complaints	Active stakeholder group, involved in all stages of implementation, made up of beneficiaries, providers and advocacy groups to provide ongoing feedback	OneCare is financed through a per member-per month capitated rate which is intended to cover ALL costs incurred by each beneficiary. 3 monthly payments: *payment by CMS for Medicare parts A & B *payment by CMS for part D *payment by MassHealth	Noted that the integration allowed beneficiaries access to new services and range of new care coordination functions	Not measured

The first key component, Eligibility and Enrollment, shows only eighteen percent of total eligible beneficiaries enrolled in the first seventeen months; the target population included non-elderly individuals who were 21 to 64 years of age. The state used an enrollment strategy that required passive enrollment period every quarter. The strategy provided the first challenge by overwhelming the system, and caused a backlog due to initial health assessments that needed completion for the new beneficiaries (Barry et al., 2015). Due to enrollment struggles, many potential beneficiaries opted-out of the program, and held a “wait-and-see” approach. Stakeholders in the HJKF report expressed valid concern over the passive enrollment strategy. Changing the process to passively enroll on monthly basis instead of lump sum basis each quarter may help the workload and reduce the pressure in completing the initial assessments.

The other issue with passive enrollment had to do with available contact information for beneficiaries. To solve the issue of inconsistent data, CMS allowed MassHealth to bypass InfoCrossing, a program that validates a beneficiary’s Medicare eligibility, to passively enroll beneficiaries who are eligible for Medicaid (Walsh, 2016a). The RTI International report (RTI) suggested that another tactic observed assisted with the enrollment process. MassHealth contracted with an organization called Maximus, an enrollment broker, to handle customer service issues relating to enrollment, caused by increased administrative workloads. Maximus representatives completed specialized training, and developed processes to work with and resolve enrollment issues. Maximus

sends informational packages and provides notification to One Care plans on status of enrollees (Walsh, 2016a). Table 4.2 below provides a brief synopsis of RTI's evaluation.

Table 4.2: Massachusetts evaluation summary from RTI (Walsh, 2016a)

Eligibility and Enrollment	Care Coordination	Beneficiary Experience	Stakeholder Engagement	Financing and Payment	Service Utilization	Quality of Care
Information completed by utilizing surveys. Enrollment was limited by a ratings category. Eligible individuals were hard to locate do to inconsistencies in data	Information completed by utilizing phone conversations. Beneficiaries were connected to new services through care coordination. The design of the LTS coordinator role was widely supported, although lacked clarity at first. Sharing behavioral health info across providers have been a challenge.	Information completed by utilizing focus groups and surveys. Having a coordinator available to speak to and assist to resolve problems reduced stress and anxiety. Beneficiaries, once enrolled, expressed satisfaction with the services and care they received with One Care.	Information completed by utilizing key informant interviews. High level of collaboration was demonstrated among stakeholders. It was noted that plans needed to earn the trust of the beneficiaries. There is still too much confusion regarding coordination roles.	Information completed by utilizing phone conversations. One Care is under a capitated rate financial model. Three separate payments are used to cover the capitated monthly rate for each individual person enrolled in the demonstration.	Information completed by utilizing phone conversations. Quantitative analysis completed utilizing data from several sources such as enrollees, those receiving LTSS benefits, and those receiving behavioral health care.	Information completed by utilizing phone conversations. Robust set of core measures developed by CMS and MassHealth to measure care. Attention will be paid to structural issues in the beginning, then transfer to clinical outcomes.

Under care coordination, the report carefully outlined the development of the “coordination care team” and the representatives who make up the team. At the head of the team are the care coordinator, then primary care, behavioral health, peer support/counseling, and any other specialists needed. However, stakeholders expressed concern that a much-needed component to the team, LTSS, was not built initially into the financial costs of the planned team and created a challenge to the aspect of early implementation of the care coordination team. To solve this issue, a position called the LTS coordinator was developed to work with One Care enrollees to ensure that their LTSS needs receive attention (Walsh, 2016a). While the LTS coordinator role was widely supported, stakeholders felt that there were too many “coordinators” and could potentially create duplication of services (Barry et al., 2015). Some enrollees expressed confusion at having multiple coordinators and what their roles were (Walsh, 2016a). Overall, results of the evaluation show that despite the challenges One Care faced, the Care Coordination component delivered benefits to many enrollees, and is viewed as a valuable service to offering access to new areas of health care. Instead of navigating a fragmented system, they enrollees are getting the attention and care they desperately need (Walsh, 2016a).

The HJKF report covered both the beneficiary experience and stakeholder engagement components. Two separate groups put together evaluated experiences both on a beneficiary and stakeholder level. Both groups spent most of the time meeting with pre-arranged focus groups and interviewing beneficiaries and providers to ascertain

experiences and allow for feedback to the state and CMS on the progress of the demonstration (Barry et al., 2015). The report suggested that the state did benefit from coordinated care initially, that having no co-pays for prescription medications provided an incentive for beneficiaries to voluntarily enroll into the program, as well as improving overall quality of life (Barry et al., 2015). RTI offered comparable results from focus group meetings and surveys. Through the established stakeholder group, ongoing meetings provided critical beneficiary feedback during and after implementation (Walsh, 2016a). The evaluation provided evidence that beneficiaries, once enrolled, expressed satisfaction with the services and care they received with One Care. Having a coordinator available to speak to and assist to resolve problems reduced stress and anxiety among the enrollees (Walsh, 2016a). While there is room for improvement on quality and access to care, the program appears to be well designed.

OneCare designed and implemented a capitated rate financial model. This means that for each member, each month, the state receives a lump-sum payment which intended to cover all costs completely. Per the report, OneCare received three different payments. The first two payments both came from CMS: one to cover parts A and B for Medicare which is risk adjusted based on the enrollees profile (Walsh, 2016a). The other payment covers part D of Medicare, adjusted to use the existing Part D for prescription drug coverage. The third payment sent by MassHealth (combined by Medicaid and the Children's Health Insurance Program), covers the state costs, equivalent to Medicaid. These three amounts combine to create the full capitated payment (Barry et al., 2015).

Stakeholders expressed ongoing concern over capitated rates and their adequacy. While it was noted that there were high sunk costs, the initial projections for savings may have been too optimistic, and not be indicative of savings in the long-run (Walsh, 2016a).

The HJKF report on service utilization suggested that in the preliminary stages of implementation, care coordination introduced new services to beneficiaries and provided an increased range of care functions that had not been available before (Barry et al., 2015). The purpose of evaluating service utilization, per RTI, is to understand the trends that occur overtime in the demonstration. The results could be compared to other groups so that CMS, the participating state, and stakeholder groups can see the patterns of use (Walsh, 2016a). Some preliminary findings from the RTI analysis showed emergency room visits declined, while visits to primary care doctors increased, indicating that care coordination, and the added services provided, worked.

MassHealth experienced successes and challenges in the beginning of implementation of the demonstration program. CMS worked with MassHealth, the One Care plans and stakeholders collaboratively to solve problems relating to locating eligible beneficiaries for enrollment. While some progress was noted in the RTI report, there was a sizeable percentage of enrollees still unaccounted for, as high as twenty-eight percent (Walsh, 2016a). Finding a solution to handle the large volume of enrollees, making sure enrollees had access and information to new health care options, and solving the issue of multiple coordinators became the most important priorities.

In the next section, I give an overview of the State of Washington's approach which uniquely focuses on a Health Home program and fee-for-service payment model. I chose Washington for comparison due to the different program model and payment system that state chose to work with for their demonstration. I include the analysis and results of evaluations completed on eligibility, care coordination, beneficiary and stakeholder experiences, payment model, service utilization, and quality of care, since implementation of their program.

Washington – Health Homes

Washington State opted to join into the CMS demonstration starting with the enrollment of beneficiaries in July 2013, with all but two counties participating (Walsh, 2016c). As part of their agreement with CMS, Washington opted to utilize fee-for-service payments for its existing home health model that targets dual eligible individuals suffering from chronic health conditions (CMS, 2013). What this means, is that the Washington Health Homes demonstration did not integrate with Medicare's enrollment system, due to the enrollees assigned to a Medicaid health home and not enrolled into a new Medicare benefit (Walsh, 2016b). The purpose for integration in Washington is to offer services to the highest-risk, highest-using dual eligible beneficiaries to reduce costs and improve services. CMS contracted with RTI to provide regular reports on the process from implementation of the program, to determine the sustainability during the demonstration period.

The first report RTI presented in January 2016, represents the demonstration period of July 2013 through December 2014. The second report, which was the first annual report presented to the CMS office, became available July 2016. Table 4.3 below provides a brief synopsis of the key points of both evaluations completed by RTI, based on the seven-component rubric I developed in Chapter 3. In the rest of this section, I provide an overview of the analyses of both reports, and include successes, challenges, and important findings.

**Table 4.3: Summaries of HealthPlan Washington evaluations by RTI International
(Walsh, 2016c)**

Eligibility and Enrollment	Care Coordination	Beneficiary Experience	Stakeholder Engagement	Financing and Payment	Service Utilization	Quality of Care
Reported on the first 6 quarters of enrollment. All ages. Dual eligible. Chronic conditions.	Care coordination appeared to succeed. Hospitalization rates declined, as well as behavioral health and primary health visits.	More than half of the beneficiaries interviewed claimed they experienced a significant improvement in their quality of life.	Not collected.	Chose a MFFS model. CMS offered an incentive for states who use this model will be eligible for performance payments based on savings and quality requirements.	Some reported difficulties with access to certain specialists, and limited choices for behavioral health professionals.	Not collected.
As of June 2015, 16,772 out of 20,541 eligible beneficiaries were enrolled. Meaning 82% were still enrolled. Participation by all ages, except for two counties. All eligibles are auto-enrolled into a health home by the state, but have the option to opt-out	State enrolls the beneficiary, then assigns them to specific Community Care Organization (CCO), needs addressed/identified through PRISM. First visit, results in health action plan (HAP), and results are shared with providers to develop goals. Care Coordinators address gaps in care and maintain communication	Focus groups report that significant improvements in health or quality of life. Reduced emergency department use, weight loss, increased exercise, smoking cessation, and even overcoming depression.	Multiple strategies used to engage stakeholders. Home Health Advisory Team - consists of many associations, agencies and care coordinators. State has had a difficult time communicating to stakeholders the concept of health home services.	Information not yet provided. Will be addressed in next evaluation.	Differences in utilization and spending patterned were noticed. There was a dramatic increase in vaccinations during the demonstration period. Admission rates fell, however preventable ED visits increased.	Quality of care increased. Due to higher utilization of some programs, admission rates decreased, as in behavioral health.

Health Homes is not a new idea. In fact, some states, such as California, have a Health Homes program (DHCS, 2016b). In Washington, Health Homes offers person-

centered care, with access to any choice of providers without limiting availability to services. While enrollees are passively enrolled, they have the option to opt-out of the coordinated service. The target population includes all ages, dually eligible for Medicare and Medicaid with no other insurance plans, and reside in a county that is participating in the demonstration (Walsh, 2016c). The state was careful to consider how the large number of passively enrolled beneficiaries would affect their system, so Washington controlled the number of enrollees, by basing it on the assessment of the capacity of the health homes, and gave priority to those enrollees who had higher acuity levels. Health Homes utilized the program Predictive Risk Intelligence System (PRISM), which was a predictive modeling tool to assist with targeting eligible beneficiaries (Walsh, 2016b). The preliminary evaluation noted that at the end of the analysis period, the number of enrolled beneficiaries increased steadily, with few beneficiaries dis-enrolled from the demonstration (Walsh, 2016c). In fact, over eighty-one percent of eligible beneficiaries were enrolled in the program as of June 2015 (Walsh, 2016b). The only challenges noted were some minor technical issues during the first quarter of enrollment, and finding incorrect information on some enrollees. This resulted in staff having to focus more on outreach than actual engagement. These findings suggest that the Washington Health Homes demonstration was successful in the early integration period.

When beneficiary become eligible they are enrolled automatically (passively) into the Health Home program, assigned to a specific health home, and then matched with a community care organization (CCO). Once beneficiaries contact their coordinator they

go through an assessment which is shared with all their assigned providers. The assessment procures a health action plan (HAP) which outlines the health goals for the beneficiary and providers. Per the evaluation, this process established new principles for providing coordinated care to the most at-risk individuals. The most challenging aspect of care coordination has been to have enough care coordinators to handle the growing need for developing plans and encouraging the achievement of goals (Walsh, 2016b). While the goal for the program is to integrate care, and improve quality of life for eligible beneficiaries, the results of the analysis for the care coordination key component shows that it is widely varied due to the differences in the health homes and the actual services provided based on beneficiaries needs. However, Washington State Officials, health home participants and stakeholders seem to agree that the process is working. While the evaluation only reviews the first year of operation, there is an optimistic attitude that future evaluations will yield even better results (Walsh, 2016b).

The RTI evaluation on beneficiary experience also yielded positive results. From streamlining the process of securing housing, to being able to manage chronic conditions, care coordinators reported success as more beneficiaries accessed more services, while beneficiaries set their own health goals, changed their behavior and attitude towards their own health and services received (Walsh, 2016b). With only a few challenges, such as having difficulty telling apart their care coordinators and case managers, and the lack of knowledge of what service care coordinators could provide, more than half of the beneficiaries interviewed in the focus groups reported a significant improvement in

quality of life because of the services they received from the health home. The evaluation reported that there was a decrease in emergency department use, while physical activity and weight loss increased. Beneficiaries reported having quit smoking, and even needed less behavioral health services, as they were receiving much higher quality of care. Beneficiaries were more engaged in their health care and goals, were very happy with the number of services available to them, and worked well with their coordinators (Walsh, 2016b).

As part of the integration process, the State initiated a stakeholder group called the Health Home Advisory Team, consisting of advocacy groups, State and county agencies, and home care workers. Initially the State had difficulty finding willing stakeholders to join the team, so they conducted forums throughout the different regions to provide information to the enrollees, but also to reach out to and invite potential stakeholders to participate. The team worked together to build a successful plan to implement and sustain the Washington Health Homes program. RTI found that stakeholder engagement was successful in offering input to positively improve the health homes and overcome challenges (Walsh, 2016b).

While Health Homes intended to target the highest utilizers of the costliest health care, RTI found that even though preventative care seemed to improve, emergency department visits trended upwards. Initially the integration process was slow in finding eligible enrollees and developing HAPs. Unfortunately, this delayed coordination services for many eligible enrollees, and by the end of the demonstration period, only ten

percent of all enrollees had a completed HAP (Walsh, 2016b). The report showed that hospital utilization such as inpatient admissions, and emergency department utilization was similar between those beneficiaries who utilized Health Homes, and those who did not. In addition, there was no report of change in utilization of skilled nursing facilities (SNFs), showing over one percent (Walsh, 2016b). RTI reported that among the LTSS population, there were no noticeable trends regarding inpatient admissions and stays, and there was a small decline in the utilization of SNFs.

The Washington Health Homes demonstration project experienced its own successes and challenges. At the end of the evaluation period, it was determined that stakeholders and State officials found value in the program, and believed that the coordinated care model could effectively aid enrollees in obtaining the best health care options available (Walsh, 2016b). The analysis also states that Case Managers are very supportive of the Care Coordinators two roles (finding gaps in coordination, and keeping track on the enrollee's health needs), and see them as an added compliment to the process (Walsh, 2016b). Future and final evaluations will identify the progress and success/failure of the improved enrollment process, as well as the fiscal impact.

In the next section, I provide an overview of the evaluation on the State of Ohio. Ohio's program closely resembles California's demonstration program, by following the capitated model; however, Ohio's target population is any dually eligible beneficiary over the age of 18. The analysis includes a review of enrollment, care coordination,

beneficiary and stakeholder experiences, financing, and results of evaluations completed since the start of implementation.

Ohio – MyCare

In April of 2012, the Ohio Department of Medicaid submitted a Request for Application to contract with health plans in order to provide integrated services to dually eligible beneficiaries in the state. After two years of agreements, enrollment officially began in May 2014 (McCarthy, 2014). The first evaluation by the Ohio Department of Medicaid did not have substantial information, as it was completed only 6 months after the initial implementation. The report demonstrated that by December 2015, dual eligible individuals over the age of 18 represented only fifty percent, or 91,000 out of 182,000 enrolled into the program (McCarthy, 2016; Stephan, 2015). Table 4.4 provides a summary of all evaluations completed by the Ohio Department of Medicaid from 2014 through 2016.

MyCare planned to move forward with a managed care approach, which is a type of system in which patients only visit specific doctors or facilities and serves as a way of reducing costs. Care coordination through MyCare includes long-term services and supports, behavioral health, and organized to focus on patient-centered care (McCarthy, 2014; Stephan, 2015). Each beneficiary is to have only one coordinator, and one plan to manage all health care needs.

The State of Ohio encouraged potential beneficiaries to engage in forums and stakeholder meetings to discuss their experiences in the implementation process (McCarthy, 2014). The results of these ongoing meetings demonstrated to the state the areas that could receive help from improvements were related to communication from the Care Coordinators (Stephan, 2015). The report suggests that there has been some success in the integration process in providing better services to beneficiaries resulting in overall satisfaction.

From implementation, MyCare enjoyed a fully involved stakeholder group, with over 17 organizations willing to participate. Community engagement thrived, and through focus groups, surveys, regional meetings, and forums, they worked together to solve issues that developed through implementation of the program (McCarthy, 2014). By the end of 2015, community meetings and area forums continued to offer beneficiaries and providers ongoing information about the future of MyCare (Stephan, 2015). Based on these brief findings, the stakeholder groups appear to have success in

working together on prominent issues and allowing beneficiaries to give input regarding what works and what does not.

The State chose to use the fully capitated model for MyCare Ohio, to reduce overall costs of care for both the eligible beneficiaries and managed care plans. One difference reported was that the program utilized two separate payment structures. One structure focused on those who were eligible for both Medicare and Medicaid, while the other focused only on Medicaid beneficiaries (McCarthy, 2014).

As of the current date, RTI International has not yet released an official evaluation based on the key components being analyzed offered in the rubric. The most recent report suggests that there may be issues relating to enrollment, such as high opt-out rates, but the issue has not yet been addressed.

Minnesota – Senior Health Options

Unlike other states participating in the Medicare-Medicaid alignment, Minnesota has a working model of an integrated system that has been in place since the mid-1980's (Greene, 2016). The program is known as Minnesota Senior Health Options, or MSHO. Though the program has mostly been successful, there were still administrative challenges to overcome, and CMS provided the opportunity with the financial and administrative alignment demonstration. Minnesota signed an MOU with CMS in September of 2013, with the following goals in mind: enhance quality of care, improve coordination of services, offer simplified program administration rules and materials, identify ways to reduce administrative burdens, and reduce and control costs for both the

State and the Federal government (Greene, 2016). In the fall of 2016, RTI published the first annual evaluation, which is summarized in Table 4.6 below.

Table 4.5: Summaries of Minnesota Senior Health Options (Greene, 2016)

Eligibility and Enrollment	Care Coordination	Beneficiary Experience	Stakeholder Engagement	Financing and Payment	Service Utilization	Quality of Care
Program has already been running since 1997 for people over age 65. Voluntary program, individuals opt-in. Early in 2003, enrollment was at 4,875. Enrollment in 6/2015 was 35,272 (72% of eligible beneficiaries).	Each MSHO enrollee is assigned a care coordinator. Care coordinators are encouraged to develop ongoing personal relationships with enrollees. Coordinators may work for the health plan or the care system, clinic or county, depending on the particular clinical model employed by the health plan.	48 percent less likely to have a hospital stay, and those who were hospitalized had 26 percent fewer stays; 6 percent less likely to have an outpatient emergency department visit, and those who did visit an emergency department had 38 percent fewer visits; and 13 percent more likely to receive home and community-based long term	The stakeholder groups conducted extensive engagement activities, by holding 56 workgroup meetings, trainings, or presentations. A website was also established for the public's benefit. Quarterly meetings are held which includes progress on the demonstration and allows for input of planned activities.	In MSHO, the payment design aligns financial incentives between both programs. Medicare and Medicaid payments are capitated. CMS makes Medicare payments directly to the health plans. Health plans receive Medicaid capitation payments from the state.	Utilization of service for integrated programs remained stable. Some nursing home, and hospital visit trends declined after implementation.	Quality of care remained stable for the demonstration period. 30-day followup appointments for mental illness hospitalizations increased. Preventable hospital visits among enrollees declined.

Minnesota began a demonstration program in 1997 which integrated care for dually eligible individuals as a step forward to providing better health care options and reduced costs (Kane, Weiner, Homyak, & Bershadksy, 2001). As it turns out, many early enrollees were nursing home residents, and the target population for enrollees was those over the age of 65. By 2015, total enrollment equated to 35,272, accounting for approximately seventy-two percent of eligible beneficiaries (Greene, 2016). Per the evaluation report, the enrollment retention remained stable and higher than nearly all participating states. RTI also noted that success in enrolling beneficiaries as well as retaining them in the program might have been due to enrollment being a voluntary option only.

MSHO brought care coordination to the forefront by ensuring that each enrollee had only one coordinator to work with. The care coordinators develop ongoing personal relationships with enrollees. They may work for the health plan or the care system, clinic or county, and could be an RN or social worker. Per the RTI report, there seems to be a high level of satisfaction among enrollees, and their families (Greene, 2016). A possible explanation may be due to the greater exposure to programs and better overall coordination of services.

Since the MSHO program began before the implementation of the financial and administration alignment, many beneficiaries already enjoyed the benefits of integration. In fact, as of the RTI evaluation, there was evidence of a decline in hospital stays and emergency department visits; forty-eight percent of all enrollees were less likely to stay

overnight in a hospital, and were six percent less likely to return to the emergency department. Thirteen percent were more likely to receive home- and community-based care or long-term services and support (Greene, 2016). The report suggests that most beneficiaries are satisfied with the care they receive and are happy with the coordination efforts of the health plans.

Before implementation of the demonstration program, MSHO initiated a stakeholder workgroup program to bring together providers, beneficiaries, legislators, and others to provide insight into a health care program intended to benefit everyone. The stakeholder groups conducted extensive activities, one of which was organizing over fifty meetings, training seminars or presentations for the public (Greene, 2016). In addition, the group published a website, to provide more information on how to enroll or plan information to the public. The stakeholders established a quarterly meeting schedule, which allowed everyone who participated to witness the progress of the program and allow feedback on how to improve services.

Prior to the CMS implementation the MSHO already established a payment plan that closely resembles the capitated payment model that CMS proposed for the demonstration. Due to the success that the MSHO experienced using their current payment model, they selected to keep it instead of utilizing the capitated or fee-for-service model that CMS proposed (Kane et al., 2001). Through the challenges of setting up offices and hiring and retaining administrative staff needed to collect reporting data, RTI reported that by bringing some of the work “in-house” provided over \$50,000 in

savings the first year. State Officials hope that the savings will increase in the future once they have the needed staff in place, as well as the data collected to analyze and show how the program benefits the State.

Both service utilization and quality of care remained stable before, during, and after implementation of the demonstration. The RTI evaluation determined that there seemed to be some improvements, such as thirty-day follow-up appointments for mental health patients increased, and preventable hospital visits declined (Greene, 2016). There was also an indication that nursing home admission rates declined as well, with the increase in utilization of home- and community-based programs. However, due to MSHO focusing on administrative issues, RTI did not provide a detailed report regarding service utilization.

In the next section, I discuss California's attempt at aligning Medicare and Medicaid, the successes and challenges faced, and what work is continuing. The purpose for reviewing California's program is to determine what policy is not working, and what the state could potentially do to provide quality care to millions of people, while reducing costs for both the beneficiary and the state, a win-win scenario. The analysis includes a review of enrollment, care coordination, beneficiary experiences and stakeholder engagement, payment model, service utilization, quality of care and results of evaluations completed since the start of implementation.

California – Coordinated Care Initiative (CCI)

California's Medi-Cal program and the federal Medicare program collaborated with local health plans and CMS to create a three-year demonstration project to promote integrated care for low-income seniors and people with disabilities who are dually eligible for both Medicare and Medicaid (Watkins, 2012). The capitated financial model, named The Coordinated Care Initiative (CCI), includes seven counties: Los Angeles, San Diego, Santa Clara, Orange, San Mateo, Riverside, and San Bernardino (Graham et al., 2016). Alameda County initially was to join the demonstration but due to changes in the enrollment timeline in order to move forward in implementation, the county dropped from participating. CCI developed two separate programs to serve the target population. The first program, Cal MediConnect (CMC), is a program for dual-eligible beneficiaries, which provides coverage for coordinated medical, behavioral health, long-term care, and home- and community-based care (Graham et al., 2016). The second program, known as the Medi-Cal Managed Long-Term Supports and Services (MLTSS), services all Medi-Cal only beneficiaries.

Field Research Corporation along with DHCS, UC Berkeley, and UC San Francisco completed an evaluation of the CCI since implementation to demonstrate progress through the three-year program. While CMS contracted with RTI International to complete a full annual evaluation for all participating states, RTI has not yet completed an evaluation for the state of California. Table 4.5 below provides a brief summary of evaluations completed to date, on the California Care Initiative.

Table 4.6: Summaries of California Coordinated Care Initiative (DiCamillo, Alkema, & Williams, 2015a, 2015b; Graham et al., 2016; Hollister et al., 2016)

Eligibility and Enrollment	Care Coordination	Beneficiary Experience	Stakeholder Engagement	Financing and Payment	Service Utilization	Quality of Care
Elderly and disabled individuals. Approximately 450k people are eligible to enroll.	The beneficiaries who remained enrolled, stated nothing changed regarding their health care, and reported a seamless transition.	Beneficiaries reported lower out-of-pocket expenses. They liked having only "one" insurance organization to deal with.	Not reported.	Not reported.	Beneficiaries had easier access to care, resulting in higher utilization of services. Behavioral health services were improved.	Quality of care is described as good. Beneficiaries are satisfied overall with the program, and liked the care they were getting from all of their providers.
Not reported.	Up to 85% of enrollees were satisfied with the care they received.	Beneficiaries expressed "fear of change" as the reason why they opted out.	Not reported.	Not reported.	Not reported.	Not reported.
Factors for opting out: want to maintain current provider. Did not want to change coverage. Had negative outlook regarding government-run programs.	Not reported.	Not reported.	Not reported.	In CY2010, dual eligible population accounted for 8 out of 10 dollars Medi-Cal spent on LTC services.	Not reported.	Not reported.
By May 2016, 120k eligible beneficiaries enrolled. Opt-out rates vary per region and also by language spoken	Per the report, health plans stated they were better able to integrate the services and coordinate care. Incited better collaboration between health plans and services.	Beneficiaries informal caregivers were encouraged to become IHSS workers. Plans attempted to identify care workers.	Education efforts are encouraged to be continued, and find ways to reach and locate eligible beneficiaries.	Challenges with establishing and managing contracts, adjusting to provider payment rates, and adapting to lags in cash-flow.	Best practices should be identified so that beneficiaries could avoid unnecessary utilization of medical services.	Incentives provided in improve quality of care, reporting metrics included. Quality withholds seemed to be working with how quality of care is conducted.

Enrollment into the CCI passively began in April 2014, with the potential to enroll over 450,000 eligible people. The program allowed for individuals to opt-out before enrollment occurred, or dis-enroll at a later time (Graham et al., 2016). To inform the beneficiaries of the program, notification letters were sent to alert eligible beneficiaries that they were enrolled in the program, and provide basic information. Not anticipated, however, was the high rate of those who chose to opt-out. Over half of the eligible population opted out prior to enrolling, and another ten percent dis-enrolled. When asked why, some beneficiaries reported that the entire process confused them and felt that they did not have a choice, or they did not receive any information or notification prior to enrollment. However, in contrast, the report by Graham (2016) suggested that perhaps the opt-out rates occurred due to various language and ethnic barriers, and medical advice given to those individuals. The most recent reports maintain that the main complaint is that beneficiaries were not given any information pertaining to the CCI, the enrollment process, or even notifying them that they had been enrolled; they found out when they reordered prescriptions, or tried to make an appointment with their physician. One beneficiary recommended that a stronger attempt to contact individuals would have been preferable, instead of a general letter that was mailed out (Graham et al., 2016). By May 2016, only 120,971 eligible beneficiaries were enrolled into the CCI program (Hollister et al., 2016).

In response to the feedback given by stakeholders, DHCS announced that they would halt passive enrollment, and switch to a voluntary enrollment strategy, or opt-in

enrollment, which would begin in July 2016. The new process intended to reorganize the process by providing more and complete information to the eligible beneficiaries, as well as allow freedom to choose to enroll. As of December 2016, DHCS reported that only a total of 113,000 individuals retained enrollment (DHCS, 2016a). This figure includes any new enrollees since July 2016.

In Graham's (2016) report, enrolled beneficiaries claimed to have a high satisfaction level when it came to actual care coordination. The process was organized, and helpful in finding solutions for conditions that needed medical attention. Once introduced to a coordinator, the process appeared to run more smoothly. Questions were answered, and beneficiaries received detailed information about services they did not know were covered. Going forward, stakeholders suggested that an assessment should be included in the care coordination process in order to more accurately arrange for proper medical services. In agreement, DHCS included the Health Risk Assessment (HRA) as part of the care coordination process, which provide questions to assist the coordinator in providing referral options for the beneficiaries (CalDuals, 2012).

Beneficiaries reported lower out-of-pocket expenses in comparison to their health care services prior to participating in the CCI program. While many were satisfied with their experiences using care coordination, some said they were unhappy with other issues, such as some medications were not covered, or not happy being forced to switch doctors (Graham et al., 2016). Some beneficiaries stated they had a challenging time seeing the specialists they needed, or that certain services were not provided, especially better

access to LTSS services. However, the Field Research Corporation found that for those enrolled in CMC, up to eighty-five percent expressed satisfaction with the services they received for their health care needs (DiCamillo et al., 2015b).

The CCI has a robust and active stakeholder group which participates in monthly conference calls and regular meetings. The purpose is to engage beneficiaries, health plans, and participating state departments to brainstorm and develop potential solutions to problems during the demonstration. Through a work group process, the State seeks ongoing feedback regarding beneficiary notification and enrollment, program operations, benefits, access to services, and other consumer protections. To date, the workgroups have successfully built toolkits to assist beneficiaries with the plan selection process and to provide more information about the CCI, as well as toolkits for health plan providers to help educate them regarding the process of transitioning beneficiaries into the CCI program, as well as the services provided.

The CCI program struggled in the beginning of implementation to adapt to the administrative burden due to the attempts to integrate the health care programs. Health care stakeholders reported a significant increase in workload due to the result of the CMC's required data collection and reporting requirements to maintain costs. While the billing system was considered simple, there were reported challenges managing contracts, working with variable procedures across health plans, as well as adjusting to individual provider rates (Hollister et al., 2016). There was doubt in 2015-2016 that the CCI program would continue through the year 2017 due to potential funding issues.

California's managed care organization (MCO) tax expired in June 2016, and a new funding source needed to be agreed upon in the Legislature so that funding could continue. In response, the Legislature introduced a bill that would reform the MCO tax to conform to federal requirements, it passed in 2016 (LAO, 2015)

Health care spending in California is extremely high, which is no surprise as the state boasts the largest population in comparison to other states. Early reports suggest that beneficiaries had easier access to health care services after implementation; however, there were notes of potential over-utilization. Over-utilization can lead to confusion to the beneficiaries, as well as higher costs, defeating the purpose of the integration project (Graham et al., 2016). The California Health Care Foundation estimated that in 2014-15, Medi-Cal beneficiaries who had more than one chronic condition visited the ER five-and-a-half times, and spent approximately \$44,916 annually (Shewry, Rodriguez, Goldstein, & Sandoval, 2015).

Quality of care at the health care level illustrates either how ineffective or efficient services provided to beneficiaries can be. Health plans who have successfully integrated their services to not only reduce confusion, and un-needed physician visits, may also provide a higher quality of care. Early reports for the CCI program show that beneficiaries are satisfied with their quality of care (Graham et al., 2016). They conveyed that they liked the care they received from their coordinator, as well as their physicians and specialists. A report by DHCS (2013) suggested that the improved quality of care is a direct result of incentives provided to health plans, such as requiring reporting

on specific metrics, or performing a “quality withhold”, which is when funds are withheld until quality performance has been proven.

California’s Coordinated Care Initiative is just over three-years old as of December 2016; however, it is struggling to keep individuals enrolled in the program. While those who are currently enrolled claim they are happy with their benefits and satisfied with the care they received, it does not seem to be enough to encourage others to stay enrolled. With only a twenty-six percent rate of retention, it does not seem realistic that the program could continue sustainability in the future. As an answer to this, Governor Jerry Brown announced in January 2017, that the CCI program might not continue in the fiscal year of 2017-2018 (Admin, 2016). In the budget that was presented to the public, Governor Brown proposed instead the extension of the Cal MediConnect program, and perhaps keeping some of the pieces of the CCI program that were found to be cost effective, and provide improved quality of care for those already enrolled.

Conclusion

The general conclusion I have gathered from these evaluations is that many the programs suffered challenges when it came to enrollment and beneficiary satisfaction. Throughout this chapter, enrollment was an important key component of the success of integration. I found that out of the five states analyzed, California’s program appeared to be experiencing the most challenges, the biggest dealing with enrollment and retention of beneficiaries, while Washington and Minnesota had the highest retention rate for enrollees. Since these demonstration programs serve the costliest users of both Medicare

and Medicaid, one of the most important aspects is to make certain that eligible beneficiaries enroll, but also remain in the program, in order to achieve cost-savings. Although, other cost-savings occur when there a reduction in utilization of un-needed services, so ensuring care coordination works effectively would also result in cost-savings.

In Chapter 5, I provide a summary of Chapters 1 through 4, and offer conclusions based on the analysis and findings given in Chapter 4. I discuss in more detail the issues that the California Care Initiative faces, explain what the results mean, and present potential policy implications that could improve the program. In addition, I offer insight and opinions from eight individuals who have personally worked with the CCI, the stakeholder groups, or know of the program and all aspects of it. I believe their input will be interesting and help with understanding the future of the CCI.

CHAPTER 5

CONCLUSIONS AND IMPLICATIONS

The focal point of this thesis examined the California's Coordinated Care Initiative (CCI) program and most of its success and challenges to date, and compared the results to four other states also participating in the Centers for Medicare and Medicaid Services (CMS) financial and administrative alignment of Medicare and Medicaid. The examination was aimed at responding to the question I posed at the start of this thesis: *California wishes to provide amalgamated and adequate health care options to its eligible beneficiary population; however, is the California Coordinated Care Initiative the most efficient (cost effective) way to do this?*

Chapter 1 introduced the projected problem of the Baby Boomer generation doubling and tripling the number of elderly in the United States, effectively overwhelming the nation's health care systems. It also explained why we need to consider integrating the two largest health plans, and offered an overview of both Medicare and Medicaid programs and services they provide. Chapter 2 provided insights to what we already know about health plan integration, focusing on prior CMS integration attempts to identify potential challenges that the current demonstration might face. Additionally, I described other issues such as the salience of reducing institutionalization, and why we should expect health care costs to rise dramatically in the future. Chapter 3 explained the comparative analysis methodology used in this thesis, and detailed the steps taken to complete my research. Included in chapter 3 is a matrix I developed for the purpose of

completing the analysis of the evaluations. Chapter 4 analyzed the successes and challenges five states faced in planning and implementing the financial and administrative alignment of Medicare and Medicaid. I completed this by reviewing the ongoing evaluations completed by RTI International and other entities which also completed evaluations on the alignment project.

In this chapter, I present the findings from the research and analysis I discussed throughout this thesis, and determine from the results if the CCI is in fact, sustainable and cost-effective. The body of this chapter is divided into multiple sections in which I consider more specific aspects of the CCI. For the planning and implementation section, I focus on California's problems that stemmed from the lack of available planning time, to implementation. For eligibility and enrollment, I look at how the different states are recruiting their beneficiaries, and how enrollee retainment is holding up in comparison to other states. The stakeholder engagement section looks at how stakeholder groups affect the advancement of the integration and finally, financing and payment reviews the payment model that the states used, and how cost-effective the programs are in their respective states. I include responses from individuals I interviewed regarding the CCI program on these specific categories. The individuals I had the pleasure of talking with include Amber Christ, Senior Staff Attorney with Justice in Aging, Christian Griffith, Chief Consultant of the California State Assembly Budget Committee, Andrea Margolis, Consultant of California State Assembly, and two individuals who wished to remain anonymous (Anonymous One and Anonymous Two). Anonymous One has experience

working in the non-profit sector as a health care advocate. Anonymous Two has experience working in the state government in finance and legislation. I conclude this chapter with suggestions on future research and recommendations for policy changes relating to similar health care programs.

Planning and Implementation

CMS contracted with RTI international to complete evaluations for all states participating in the CMS financial and administrative alignment of Medicare and Medicaid. In addition, other public and private third party organizations also agreed to complete their own analyses of the demonstrations. The evaluations thoroughly reviewed the programs by ways of data analysis, interviews, surveys, and focus groups. As part of my investigation, I reviewed evaluations for California, Massachusetts, Minnesota, Ohio, and Washington State. In this Planning and Implementation section, and the following sections, I discuss findings relating to the CCI program in California, and the challenges discovered prior and during the demonstration.

During my analysis, I was surprised to discover that Minnesota was one of the first states which integrated Medicare and Medicaid into a single health plan, long before CMS presented with the Financial and Administrative alignment opportunity. The state worked to perfect the program since the 1997 implementation, prior to CMS's attempt at the Medicare's Coordinated Care Demonstration in 2002. While most of the enrollees they served in the beginning were nursing home residents, they still had high enrollment

and retention rates. In fact, some of the evaluations I analyzed showed that of the enrollees:

- There was evidence of an overall decline in hospital stays and emergency department visits;
- Forty-eight percent of all enrollees were less likely to stay overnight in a hospital, and were six percent less likely to return to the emergency department.
- Thirteen percent were more likely to receive home- and community-based care or long-term services and support.

Early planning and implementation, and allowing the program to run for a prolonged period appeared to help Minnesota improve upon the services they provided to their beneficiaries. While they expected most of their services to remain stable, they did experience additional improvement after participating in the CMS administrative and financial alignment.

As part of my research, I explored the challenges California suffered during the planning and implementation of the CMS demonstration. California began the planning stage in 2011, with the start of enrollment in early 2013. A report by UC Berkley (2016) suggested that it was a challenge to complete the necessary organizational changes due to the timeframe given to implement the program. To examine this, I inquired among my interviewees regarding the planning and implementation process by asking if they believed there was enough time to implement the CCI program in the timeframe given.

Amber Christ, with Justice in Aging, stated that the Department of Health Care Services needed more time in order to effectively develop materials, notices, conduct outreach, test systems, and develop policies. She informed me that Justice in Aging submitted a letter to DHCS in February 2014 requesting a delay in implementation due to the lack of readiness of the program. Due to the brief period between planning and implementation, there just was not ample time to conduct a thorough systems-testing, which resulted in issues through implementation. Christ also said that policies were not fully developed, and if the Department granted more time for planning, then implementation would have gone smoother.

In agreement, Christian Griffith, with the Assembly Budget Committee, believed that the entire effort to integrate the two programs was driven by a desire to reduce costs, rushing the process at the expense of a thoughtful and orderly process. He also stated that DHCS lacked the talent and leadership to execute the planning and implementation of the programs. Anonymous One agreed; however, she added that it is possible that the rollout of the implementation could have been staged, based on readiness. She stated San Mateo County prepared and was ready to implement far sooner than other counties and it may have made things go a bit smoother, if counties had the time they needed to put their plans in place prior to implementing the program.

Eligibility and Enrollment

For a health plan to remain stable, an organization would need to have enough patients enrolled in order for the plan to be cost-effective, for both the health plan, and

patient both. If not enough individuals enroll into a plan, it would not be feasible for the program to continue. In this section, I review potential issues relating to the enrollment of beneficiaries in the program, such as enrollment strategies, opt-outs, and retainment of enrollees.

Utilizing my current knowledge about health care in California, I recognize that the State struggles with maintaining enrollment of beneficiaries in the Coordinated Care Initiative. During monthly stakeholder meetings, the stakeholders frequently discuss opt-out rates and what could be driving people to leave the program that so many other current enrollees express satisfaction with. In my analysis, I was not surprised to discover that states such as Massachusetts suffered high opt-out rates. And several states, including California, utilized a passive enrollment strategy. In contrast, Minnesota used a voluntary-only enrollment option, resulting in high enrollment rates over several years. What's more, seventy-two percent of eligible beneficiaries over the age of 65 remain enrolled in their program.

In comparison, I found that Washington State chose to enhance an active program, Health Homes, which targets an all-ages population dually eligible for Medicare and Medicaid with no other insurance plans. While Washington State officials used a passive enrollment strategy, they also utilized a third party organization to assist with targeting eligible beneficiaries. This method assisted the state to successfully enroll over eighty-one percent of eligible beneficiaries.

California's CCI program suffered significant challenges in enrolling and retaining beneficiaries since the beginning of implementation. Intrigued with the issue, and why California did not consider other methods when it was clear that the strategy utilized did not work, I questioned my interviewees on their thoughts of the issue of enrollment and retaining beneficiaries. Christian Griffith, of the California State Assembly Budget Committee, believed that the passive enrollment strategy did not cause the struggles of enrollee retention. However, Amber Christ, of Justice in Aging offered several reasons why she believes that the process was a significant issue:

1. It is confusing,
2. Passive enrollment versus active choice fosters distrust and undermines a program that is supposed to be person-centered,
3. Passive enrollment caused disruption. Many beneficiaries did not know they were enrolled in a plan until they sought services and received a denial; once disruption was experienced, many people dis-enrolled,
4. Health plans put in a lot of effort to find beneficiaries who were passively enrolled. They did not receive accurate contact data, so had thousands and thousands of enrolled members that they could not conduct health risk assessments on. They spent money and time finding these enrollees just to have them dis-enroll when they found out they were in a plan they did not choose.

While Christ agrees with Griffith that passive enrollment was not the reason the CCI struggled to enroll participants, she does think it resulted in a “very huge cost.” Anonymous2 believes, however, if the CCI used voluntary enrollment, the numbers would have been lower at first, but over time those numbers would have increased.

Stakeholder Engagement

Stakeholder involvement is very common amongst large-scale programs for both non-profit groups, as well as governmental entities. Through these groups, individuals with various and relevant backgrounds can provide input on policies and procedures to assist in moving an organization towards success. It is for this reason that I was interested in the stakeholder process in relationship to the demonstration projects, to see how important stakeholder groups were to the planning phase and implementation of the programs in the various states. In this section I review involvement among stakeholder groups for the various states, mainly for the CCI program, and how that involvement influences changes within the program.

Each state pulled stakeholders together to work collaboratively and solve potential issues as they arise. Minnesota’s workgroup conducted extensive outreach by holding meetings, presentations, even training. Ohio held collaborative meetings and regional forums to bring information out to the beneficiaries and providers. California has held roundtables since 2014 and other presentations and meetings for beneficiaries, as well as monthly stakeholder calls. In most cases, stakeholder engagement seemed to provide a

lot of insight to the issues each stated faced. However, in California's case, some people expressed frustration at the stakeholder group that not enough was done. Due to the issues California faced, I was interested to see if this was the case. I asked my interviewees if they felt that the CCI stakeholder group did enough to provide clear and up-to-date information to the beneficiaries and health plans.

Per Amber Christ, Senior Staff Attorney with Justice in Aging, California's CCI program has a robust and active stakeholder group, which has been waning over time (Christ, 2017). The reason for the reduction in stakeholder engagement is multiple delays in the program implementation and how recommendations and feedback were received and acted upon by DHCS and CMS. Additionally, the state conducted its stakeholder group meetings via webinar, which does not allow for the same level of engagement that a face-to-face meeting offers. Instead, an oversight/implementation council formed of state officials, stakeholders, and consumers could have been assembled to monitor and discuss issues with CCI implementation (One, 2017).

Financing and Payment

The dual eligible population is looked upon as the costliest and highest utilizers of health care services. With the capitated model, Medicare-Medicaid Plans provide all Medicare Part A, B, and D and Medicaid services in return for a capitated payment that blends Medicare and Medicaid funds and provides a new savings opportunity for both the state and CMS. Managed fee-for-service models leverage existing state infrastructure such as primary care case management, Medicaid health homes, accountable care

organizations (ACOs), and related programs. Most of the programs I reviewed utilized the capitated rate payment model, while Washington chose to fund their Health Homes program with the fee-for-service model. In this section, I discuss the financial changes that California faces due to budget constrictions for the 2017-2018 Fiscal Year, as well as review the cost-effectiveness of the program.

California's CCI program utilized a capitated rate model, which expected to provide cost savings for the state over time. In January of 2017, California's Governor Jerry Brown announced that there would be changes to the CCI program beginning in January 2018. The reason for the change was that the program was not cost-effective and that the in-home supportive services (IHSS) component will be eliminated from the program. There apparently was a clause in the implementation legislation, that allowed the governor to choose to cancel the CCI program, in event that it proved to not save money for California (Walters, 2017). In response to these announcements, I questioned my interviewees on the cost-effectiveness of the CCI program, and whether they believed that the CCI program could be saved.

Per Amber Christ, (2017), savings for the CCI program were immediately realized through the rates the health plans received, although these cost savings may have been overlooked due to the high administrative costs in order to implement the program. Christ believes, as well as Griffith, that over time the CCI will prove cost-effective as the program matures. Christ explained, using an example regarding San Mateo county, how the program demonstrated significant savings by decreasing avoidable nursing home

admissions, and discharging beneficiaries back into their communities with support, and no longer needing nursing home level of care. Since the only meaningful change to the CCI is the financing and removal of the IHSS program, the Cal MediConnect and MLTSS programs will continue operating (One, 2017). However, the state will no longer be using the universal assessment tool, thought to be a core component of integration. In addition, with IHSS removed from the CCI, it will be critical to ensure that care coordination between health plans and the counties is maintained (One, 2017). Anonymous2 (2017) added that the future of the program is uncertain, primarily due to the chaos at the federal level, but it seems to be that it holds great promise if given enough time.

Future of the Affordable Care Act and How it Will Affect the CCI Program

The Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA) or Obamacare, is currently being challenged by the current presidential administration, under President Donald Trump (Wikipedia, 2016c). The purpose of the ACA, developed by President Obama, was to encourage hospitals and physician offices to transform their practices fiscally, technologically, and clinically to drive better health outcomes, reduce health care costs, and improve their methods of health care delivery and accessibility. It also aimed to allow many uninsured and low-income individuals to obtain health care for themselves and their families.

The Trump Administration is in the process of remodeling the ACA, in which currently, will cause millions of individuals to lose their health care coverage. If the

effort is successful (and that is uncertain at this point), it no doubt will affect millions of Californians, as well as the 100k individuals who are enrolled in the CCI program, as most of them are low-income seniors and individuals with disabilities. The IHSS component, which is what Governor Brown believes to cost the most money, will be cut from the CCI program, forcing the participating counties to fit the bill for IHSS workers. This will no doubt cause more issue for the counties, as federal requirements now state that IHSS workers could receive payment for overtime hours, as well as meet a minimum wage hike, which was something overseen by the Obama Administration. Historically, IHSS received funds from federal, state, and local funds, delivered primarily as a Medi-Cal benefit. With changes at the federal level looming over the country, California could see even more cuts to its already austere programs, as the federal government provides fifty percent of the IHSS program costs (Taylor, 2017). To aid the counties in the financial transition, the Legislative Analyst Office suggests either a one-time General Fund relief payment or a gradually decreasing amount of General Fund relief over a few years (Taylor, 2017). It is unknown exactly how the counties will fare if they return to the 1991 realignment cost-sharing ration for IHSS.

Conclusion and Opportunities for Future Research

California has suffered some setbacks in the process of integration. In my analysis and based on discussions with those who work with the program or understand its components, I have found that if some parts of the integration had been done differently, the outcomes might have been much better. The CCI program suffered in part due to

poor planning prior to implementation. The state should have taken time to clearly write policies, prepare and offer materials to beneficiaries prior to the start of the CCI, and meet with beneficiaries to gain insight to what they needed. Instead, the planning part was rushed and pushed through, with limited materials and information to provide to both beneficiaries and health plans. As a result, uninformed enrollees removed themselves from the program, due to fear of change, losing their providers, and not knowing the process or what was going on with their services and health plans. The total number of enrollees dropped each month, despite the number of individuals who were passively enrolled. As late as 2016, the Department of Health Care Services responded to the concern of the lack of information provided to beneficiaries, by developing a “tool kit” of information to help them understand Cal MediConnect and what kind of services are offered through the program (DHCS, 2016a).

Regardless of the setbacks, the integration of Medicare and Medicaid is still the preferred option for health plans working with dual eligible beneficiaries. The outcomes based on my analysis point to the fact that time was the biggest issue in relating to implementation failure; there was not enough time to plan prior to implementing the CCI program. This, I believe is why the CCI suffered many impediments and why California is still having problems enrolling and retaining beneficiaries.

Future research should consider the following questions: Why are we continuing to utilize two separate health care programs? And what would be considered a long enough timeframe to attempt a large-scale integration of two health plans? My research has

underscored the critical importance of sufficient time and preparation for an integration of this kind. I hope that future research can build on this finding to offer specific guidance regarding time and resources necessary for implementation success.

APPENDIX A

INTERVIEW QUESTIONS

Overview

RTI international and other public / private third party organizations agreed to completed evaluations on the different states participating in the CMS Financial and Administrative Alignment of Medicare and Medicaid. I reviewed evaluations for five states including California, Massachusetts, Minnesota, Ohio, and Washington State. The questions below are based on my findings in comparing the five states in the following categories: planning and implementation, eligibility and enrollment, stakeholder engagement, and financing and payment.

Planning and Implementation

California began planning in 2011, and enrollment began in in 2013. A report suggested that it was a challenge to complete the necessary organizational changes due to the timeframe given to implement the program.

1. Do you believe there was enough time to plan, implement, and improve the CCI program in the time frame given?
2. If the CCI had more time, say 5 years to plan and implement, do you think that the State would have had more success in the implementation process?
Why or why not?

Eligibility and Enrollment

I understand that California struggled with the enrollment of beneficiaries in the Coordinated Care Initiative which resulted in high opt-out rates.

3. Is it possible that part of the CCI's struggles are due to utilizing a passive enrollment strategy? Why or why not?
4. Do you think that if CCI started with voluntary-only enrollment, the number enrolled would have been higher?
5. Do you think the CCI program could have benefitted from using a third party to locate the enrollees, and perhaps provide information about the program to encourage more voluntary enrollments?

Stakeholder Engagement

Each state pulled stakeholders together in order to work collaboratively and solve potential issues as they arise. California has held roundtables since 2014 and other presentations and meetings for beneficiaries, as well as monthly stakeholder calls.

6. Do you believe that the California Stakeholder group did enough to provide clear and up-to-date information to the beneficiaries and health plans? Why or why not?

Financing and Payment

It is known that the dual eligible population is looked upon as the costliest and highest utilizers of health care services, and that the California's demonstration intended to reduce costs for both beneficiaries and state and federal government.

7. Do you believe that the CCI program has been cost-effective for the state?

Why or why not?

In FY 2015-16 the California budget showed that CCI would have a General Fund savings in the amount of \$176.1 million, attributed to the MCO tax. Funding issues and Federal requirements required the Legislature to vote in a new law to replace the MCO tax in 2016.

8. Going forward, with Governor's Brown's new proposed budget for the 2017-2018 year announcing cuts for the CCI program, do you believe that the important aspects of the program could be saved or moved to enhance a current program, such as Health Homes?

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