

# GAO Highlights

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

## Why GAO Did This Study

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

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

## What GAO Recommends

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

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

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## MEDICARE AND MEDICAID

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

## What GAO Found

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

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

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