Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare

Medicaid and Medicare together provide health coverage for approximately 10 million low-income seniors and people with disabilities who are dually eligible for both programs (CMS 2016a). These individuals are among the poorest and sickest individuals covered by either Medicaid or Medicare, and account for a disproportionate share of Medicaid and Medicare spending (MedPAC and MACPAC 2016).

Medicaid and Medicare generally operate as separate programs. Medicare is the primary payer for services such as physician visits, hospital stays, post-acute skilled care, and prescription drugs. State Medicaid programs wrap around this coverage by providing financial assistance with Medicare premiums and cost sharing, as well as covering additional benefits not covered by Medicare, such as long-term services and supports (LTSS). While both sources of coverage are important for dually eligible beneficiaries, having multiple sources of coverage may mean that beneficiaries have to navigate multiple sets of requirements, benefits, and plans. In addition, differing coverage and payment policies between the two programs may create incentives to shift costs back and forth between the states and the federal government, leading to underutilization of services in some cases and overutilization in others. Lack of coordination between the programs may also result in fragmented care which can lead to high costs and poor outcomes.

In order to improve coordination between these two programs, Section 2602 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) created the Federal Coordinated Health Care Office within the Centers for Medicare & Medicaid Services (CMS). The office is charged with improving care and reducing costs for dually enrolled beneficiaries, and rationalizing administration between Medicaid and Medicare. This includes testing new strategies to improve coordination between the two programs, one of which is the Financial Alignment Initiative: a demonstration project to test models of integrated care and payment.[1] Two models are being tested: (1) the capitated model in which CMS, a state, and health plans enter into a three-way contract agreeing to a blended capitated rate for participating plans for the full continuum of Medicaid and Medicare benefits for dually eligible beneficiaries; and (2) the managed fee-for-service (FFS) model, in which states provide the up-front investment in care coordination and are then eligible for a retrospective performance payment if they meet the established quality thresholds and if Medicare achieves a target level of savings. States may also propose an alternative model.

As of April 2016, 13 states participate in the demonstration (10 under the capitated model and 3 under a managed FFS or an alternative model). There are a total of 14 demonstrations in 13 states because New York is operating two programs (CMS 2016b).[2] Each state model is unique with different target populations, benefits, care coordination services, and payment frameworks.

At this time, it is too early to determine the financial viability of these models and their effect on quality of care. However, stakeholders have raised concerns about certain aspects of the Financial Alignment Initiative. Beneficiaries and advocacy groups have voiced concerns regarding the health plan selection process as well as plans' enrollment of and communication with beneficiaries. Plans have reported their own challenges, such as

incorrect participant contact information from CMS and states, inadequate payment rates, and low provider participation. Providers have voiced concerns regarding provider rates, passive enrollment, service authorizations, claim submissions, and provider credentialing processes (Summer and Hoadley 2015, Watts 2015). The Commonwealth of Virginia and multiple plans across the states participating in the demonstration intend to (or already have) dropped out of the demonstration.

CMS has contracted with RTI International for a comprehensive evaluation of the beneficiary experience, budgetary and access to care effects, quality of care, and health outcomes. CMS published preliminary results on seven demonstrations, including information on enrollment, care coordination models, beneficiary safeguards, and stakeholder engagement, in January 2016. Additionally, CMS has released one state level report examining the first year and half of the Washington State managed FFS demonstration program. MACPAC, among others, has examined beneficiaries' early experiences (MACPAC 2015a) and will continue to monitor the demonstration.[3] (Overview of examinations to date is discussed in further detail below.)

This issue brief describes the overall design of the Financial Alignment Initiative, and compares key provisions of state approaches in the 11 capitated model demonstrations currently underway. We have not included the managed FFS models underway in Colorado and Washington, or an alternative model in Minnesota in our analysis.

Participation in the Financial Alignment Initiative

State participation

CMS issued a solicitation for design contract grants on December 10, 2010. The award, issued six months later, provided up to $1 million in funding to 15 states to support the upfront costs and infrastructure needed to design innovative service delivery and payment models for dually eligible individuals (CMS 2011a, FBO 2010). On July 8, 2011, CMS issued a State Medicaid Directors Letter requesting letters of intent from states interested in participating in the demonstration (CMS 2011b). By October 2011, 37 states and the District of Columbia (including all 15 states that were awarded design contracts) submitted letters of intent (CMS 2011c and Table 1). As of April 2016, 26 states followed through with a proposal (CMS 2011c, CMS 2015a).

Subsequently, 16 states fully withdrew and 2 states partially withdrew citing concerns about the payment methodology, rate setting mechanisms, carve-out allowances, and limited health plan interest (State of Tennessee Department of Finance and Administration 2012, New Mexico Department of Human Services 2012, Idaho Department of Health and Welfare 2014). For example, the director of Tennessee's Medicaid program, TennCare, noted that participating plans would receive lower capitation rates than Medicare Advantage plans even though they would be held to higher standards for quality and care coordination (State of Tennessee Department of Finance and Administration 2012).

New Mexico withdrew its proposal after CMS did not approve its proposed carve-out of LTSS (New Mexico Department of Human Services 2012). After one of two health plans in Washington State withdrew from the capitated demonstration, the state announced in February 2015 that it cancelled its capitated model demonstration while continuing its managed FFS model demonstration (Washington State Health Care Authority 2015). In California, Alameda County has dropped out of the demonstration due to the financial difficulties of the county's only participating plan, Alameda Alliance for Health (Atlantic Information Services Health 2015).

As of April 2016, 13 states have signed a formal memorandum of understanding (MOU) with CMS. Ten states are participating in the capitated model, two are participating in the managed FFS model, and one state (Minnesota) is participating in an alternative form of the demonstration, testing the integration of administrative functions without financial alignment (CMS 2016a).

In July 2015, CMS sent a letter to state Medicaid directors participating in the demonstration allowing them to extend the scheduled end dates for the demonstration by two years. In this letter, CMS noted that the evaluation of the demonstration did not coincide with state budget planning cycles, which extended beyond the scheduled end dates for the demonstrations. The letter also noted that assessments on the overall successes and limitations of the demonstration were not yet available (CMS 2015b).

All 13 states participating in the demonstration submitted a letter extending the demonstrations. Since then, Ohio and CMS published an updated three-way contract that extends the demonstration for an additional two years. Other states are currently determining if the demonstration will proceed. For example, in the 2016—2017 state budget the Governor of California identifies that the program will continue in 2016, but if the program is not cost effective it will end in 2017 (Brown 2016).

Virginia now intends to end the demonstration. In January 2016, Virginia submitted a Section 1115 waiver to implement a Medicaid managed long-term services and supports (MLTSS) program; the waiver request indicated that Virginia's Financial Alignment Initiative will end in December 2017, and the MLTSS program will operate as a fully integrated program model that includes physical health, behavioral health, home and community-based services (HCBS), and institutional services for eligible beneficiaries, which include those currently enrolled in the Financial Alignment Initiative (Virginia Department of Medical Assistance Services 2016).

Other states have made programmatic changes to support the future of their demonstrations.

- For example, Illinois is rolling out a MLTSS program, and with the roll out of its MLTSS program the state is stressing the importance of the demonstration program in coordinating Medicare and Medicaid services, including LTSS. Dually eligible beneficiaries who do not enroll in the demonstration will be enrolled in Medicare coverage, a Medicaid managed care plan, and a separate Medicaid LTSS managed care plan. The demonstration provides an opportunity for these beneficiaries to receive streamlined Medicare and Medicaid benefits without having a separate MLTSS plan.
- In November 2015, New York created another program under the Financial Alignment Initiative for individuals with intellectual and developmental disabilities, called Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD). This four-year demonstration program shares the same goals New York's Fully Integrated Duals Advantage (FIDA) Demonstration, targets individuals with intellectual and developmental disabilities, only uses a voluntary enrollment process, and provides benefits to enable these beneficiaries to live in the community.

TABLE 1. State Interest in the Financial Alignment Initiative

State	Received design contract award	Submitted letter of intent	Submitted proposal	Withdrew proposal	Signed MOU	Exiting demonstration
Alaska		X				
Arizona		X	Capitated	X		
California	X	X	Capitated		X	
Colorado	X	X	FFS		X	
Connecticut	X	X	FFS	X		
Delaware		X				
District of Columbia		X				
Florida		X				
Hawaii		X	Capitated	X		
Idaho		X	Capitated	X		
Illinois		X	Capitated		X	
Indiana		X				
Iowa		X	FFS	X		
Kansas		X				
Kentucky		X				
Maine		X				
Maryland		X				
Massachusetts	X	X	Capitated		X	
Michigan	X	X	Capitated		X	
Minnesota[1]	X	X	Other	X	X	
Missouri		X	FFS	X		
Montana		X				
Nevada		X				
New Mexico		X	Capitated	X		
North Carolina	X	X	FFS	X		
New York[2]	X	X	FFS and capitated	X	X	
Ohio		X	Capitated		X	
Oklahoma[3]	X	X	Other	X		
Oregon	X	X	Capitated	X		

TABLE 1. (continued)

State	Received design contract award	Submitted letter of intent	Submitted proposal	Withdrew proposal	Signed MOU	Exiting demo
Pennsylvania		X				
Rhode Island		X	Capitated		X	
South Carolina	X	X	Capitated		X	
Tennessee	X	X	Capitated	X		
Texas		X	Capitated		X	
Vermont	X	X	Capitated	X		
Virginia[4]		X	Capitated		X	X
Washington[5]	X	X	FFS and capitated	X	X	
Wisconsin	X	X	Capitated	X		
Total	**15**	**38**	**26**	**16 fully withdrawn, 2 partially withdrawn**	**10 capitated, 2 FFS, and 1 other**	**1**

Notes: MOU is memorandum of understanding. FFS is fee for service. States that did not submit a letter of intent or a proposal are not included in this table.

[1]Minnesota withdrew its proposal, but signed a separate MOU with CMS that focuses on aligning administrative aspects of Medicaid and Medicare.

[2]New York initially proposed testing both the managed FFS and capitated models. However, it withdrew its managed FFS proposal. In November 2015, New York announced that it would operate another program under the demonstration, FIDA-IDD, to focus on individuals with intellectual and development disabilities. (These individuals are not eligible for enrollment in New York's other Financial Alignment Initiative demonstration, FIDA.)

[3]Oklahoma's proposal consisted of a three pronged approach in implementing the demonstration which includes care coordination, a partnership with the University of Oklahoma, and integrating care based on the PACE model.

[4]Virginia's Financial Alignment Initiative will end in December 2017.

[5]Washington was approved to participate in both models. However, in February 2015 it withdrew its plan to test the capitated model.

Sources: Barnett, L., CMS 2015, CMS 2016b, CMS 2015a, CMS 2015c, CMS 2011a, CMS 2011c, Integrated Care Resource Center 2014, KFF 2012.

Health plan participation

As of April 2016, 61 plans were participating in capitated models in the nine states actively enrolling and serving beneficiaries (Table 2). The number of participating plans ranges from 1 plan in Rhode Island and the New York FIDA-IDD program to 17 plans in the New York FIDA program. Not all plans are offered in every participating county or region. For example, California has 10 participating plans in the demonstration statewide, but only the Health Plan of San Mateo serves the demonstration population in San Mateo County.

Plans are responsible for beneficiary enrollment and communications, as well as care coordination and delivery of benefits. Plans were first selected by the state and then had to meet CMS application requirements. Some states used existing Medicaid managed care contracts in their selection process, while others issued a procurement specific to the demonstration. Plans selected by CMS then had to pass a readiness review in order to move forward (Barnett, L., CMS 2015).

Some plans have dropped out due to dissatisfaction with the capitated rates (California Department of Health Care Services 2014, Gutman 2013). These include Fallon Total Care, which announced in June 2015 it would exit

the Massachusetts demonstration effective September 30, 2015 because continued participation was not economically sustainable (Dickson 2015). Four plans have dropped out of the New York FIDA demonstration—Amerigroup New York, LLC (Empire BlueCross BlueShield HealthPlus FIDA Plan), Catholic Managed Long-term Care, Inc. (ArchCare), Health Insurance Plan of Greater New York (EmblemHealth), and Integra MLTC, Inc..[4] Some of these plans had significantly low enrollment while participating in the demonstration. Over the course of the demonstration, ArchCare and EmblemHealth had no more than 80 enrollees during a given month (CMS 2016c). Additionally, in Illinois, the Health Alliance Medical plan has dropped out of the demonstration.

Participating plans had varied experience serving dually eligible beneficiaries (Table 2). For example, all of the health plans participating in the California demonstration, but none of those in Illinois, New York FIDA-IDD, South Carolina, Rhode Island, or Virginia, had prior experience serving dually eligible beneficiaries in Medicaid managed care. Some had served dually eligible beneficiaries in other states (CMS 2015d). Most of the plans participating in California, Massachusetts, Michigan, Ohio, Texas, and the New York FIDA program had experience serving beneficiaries in a Medicare Advantage dual eligible special needs plan (D-SNP), compared to fewer than half of those in South Carolina and Virginia, and none in the New York FIDA-IDD program and Rhode Island (CMS 2014a).

TABLE 2. Participating Plans with Prior Experience Serving Dually Eligible Beneficiaries

State	Number of plans	Participating plans with prior experience serving dually eligible beneficiaries in state		Participating plans with no prior experience serving dually eligible beneficiaries in a D-SNP or Medicaid managed care plan in state
		D-SNP plan in state prior to demonstration (December 2014)[1]	Medicaid managed care plan in state prior to demonstration (July 2013)[2]	
California	10	• Anthem Blue Cross (including CareMore) • CalOptima (Orange County Health Authority) • CareFirst • Community Health Group • LA Care • HealthNet • Health Plan of San Mateo • Inland Empire Health Plan • Molina	• Anthem Blue Cross (including CareMore) • CalOptima (Orange County Health Authority) • CareFirst • Community Health Group • LA Care • HealthNet • Health Plan of San Mateo • Inland Empire Health Plan • Molina • Santa Clara Family Health Plan	• None
Illinois[3]	7	• Cigna-HealthSpring of Illinois • Humana • Meridian • Molina Healthcare of Illinois[4]	• None	• Aetna Better Health • Blue Cross Blue Shield of Illinois • IlliniCare Health Plan (Centene)
Massachusetts[5]	2	• Commonwealth Care Alliance • Tufts Health Plan-Network Health	• Commonwealth Care Alliance[6] • Tufts Health Plan-Network Health[6]	• None
Michigan	7	• Fidelis SecureCare of Michigan • HAP Midwest Health Plan • Meridian	• HAP Midwest Health Plan • Meridian • Molina • Upper Peninsula Health Plan	• Aetna Better Health of Michigan, Inc. • AmeriHealth Michigan, Inc.

TABLE 2. (continued)

State	Number of plans	Participating plans with prior experience serving dually eligible beneficiaries in state: D-SNP plan in state prior to demonstration (December 2014)[1]	Participating plans with prior experience serving dually eligible beneficiaries in state: Medicaid managed care plan in state prior to demonstration (July 2013)[2]	Participating plans with no prior experience serving dually eligible beneficiaries in a D-SNP or Medicaid managed care plan in state
Michigan (continued)		• Molina • Upper Peninsula Health Plan		
New York FIDA (continued)[7]	17	• Agewell New York, LLC • AlphaCare of New York, Inc. • CenterLight Healthcare, Inc. • Elderplan, Inc. • GuildNet, Inc. • Managed Health, Inc. • MetroPlus Health Plan, Inc. • New York State Catholic Health Plan, Inc. • Senior Whole Health of New York, Inc. • VNS Choice • Wellcare of New York, Inc.	• CenterLight Healthcare, Inc.[8] • Elderplan, Inc. • Elderserve Health, Inc.[8] • GuildNet, Inc. • Independence Care System, Inc.[8] • Managed Health, Inc. • MetroPlus Health Plan, Inc. • New York State Catholic Health Plan, Inc. • Senior Whole Health of New York, Inc. • Village Senior Services Corp. dba VillageCareMAX[8] • VNS Choice • WellCare of New York, Inc.	• Aetna Better Health of NY, Inc.[9] • Centers for Health Living, LLC[9] • North Shore-LIJ Health Plan, Inc.[9]
New York: FIDA-IDD	1	• None	• None	• Partners Health Plan
Ohio	5	• Buckeye Community Health Plan, Inc. • CareSource • Molina Healthcare of Ohio, Inc. • United Healthcare Community Plan of Ohio, Inc.	• Buckeye Community Health Plan, Inc.[10] • CareSource[10] • Molina Healthcare of Ohio, Inc.[10] • United Healthcare Community Plan of Ohio, Inc.[10]	• Aetna Better Health, Inc.
Rhode Island	1	• None	• None	• Neighborhood Health Plan of Rhode Island[12]
South Carolina	4	• Select Health[11]	• None	• Absolute Total Care[11] • Advicare • Molina
Texas	5	• Amerigroup • Cigna-HealthSpring • Molina • Superior • United	• Amerigroup • Cigna-HealthSpring • Molina • Superior • United	• None
Virginia	3	• Humana	• None	• Anthem[13] • VA Premier[13]

Notes:
[1]Unless otherwise noted, data on plans serving dually eligible beneficiaries through a D-SNP are from CMS SNP Comprehensive Report (CMS 2014a).
[2]Unless otherwise noted, data on plans serving dually eligible beneficiaries in Medicaid managed care are from CMS, Medicaid managed care enrollment report for 2013. Data for each plan is as of July 2013 (CMS 2015d).
[3]Health Alliance Medical Plans left the Illinois Financial Alignment Initiative on December 31, 2015 (Pressey 2015).
[4]In December 2014, Molina Healthcare of Illinois had a D-SNP plan, but no data were reported on the number of individuals enrolled in the plan.

[5]On June 17, 2015, Fallon Total Care announced it would drop out of the Massachusetts demonstration effective September 30, 2015 (Dickson 2015). Fallon is not included in the above table.
[6] In Massachusetts, all three participating plans served dually eligible beneficiaries through the Senior Care Options program. This program authorizes, delivers, and coordinates all services currently covered by Medicaid and Medicare for certain dually eligible beneficiaries over the age of 65.
[7]The four plans that have dropped out of the New York FIDA demonstration (ArchCare, EmblemHealth, Integra, and Empire BlueCross BlueShield HealthPlus) are not included above.
[8]Denotes plans that served dually eligible beneficiaries in a Medicaid long-term-care only plan.
[9]All plans participating in the New York demonstration must have met all requirements to become a managed long-term care plan and must have received a certificate of authority to operate an MLTC plan in the state by May 14, 2013. These plans met this requirement.
[10]By July 2014, Ohio had moved all Medicaid beneficiaries, including those who were dually eligible for Medicare, into Medicaid managed care. Plans identified as having prior experience serving dually eligible beneficiaries have served Ohio dually eligible beneficiaries since at least July 2014.
[11]As of July 2013, Select Health and Absolute Total Care both served South Carolina Medicaid-only beneficiaries through their Medicaid managed care plan, but neither plan included dually eligible beneficiaries (CMS 2015d).
[12]As of July 2013, Neighborhood Health Plan of Rhode Island served Medicaid-only beneficiaries living in Rhode Island through its Medicaid managed care plan, but did not included dually eligible beneficiaries (CMS 2015d).
[13]As of July 2013, Anthem and VA Premier both served Virginia Medicaid-only beneficiaries through their Medicaid managed care plan, but neither plan included dually eligible beneficiaries (CMS 2015d).
Sources: CMS 2015d, CMS 2014a, Massachusetts Executive Office of Health and Human Services 2015a, MI Health Link 2015, MyCare Ohio 2014, New York Legal Assistance Group 2014, Pressey 2015, State of Illinois Department of Healthcare and Family Services 2012, Texas Health and Human Services Commission 2015, Virginia Department of Medical Assistance 2015.

Enrollment

Over 1.3 million full benefit dually eligible beneficiaries are eligible to enroll in the 10 states that are participating in the capitated model of the Financial Alignment Initiative. Since the launch of the first capitated demonstration in October 2013, enrollment in the initiative has grown from approximately 323 enrollees in October 2013, to over 368,000 enrollees in April 2016. Enrollment peaked in September 2015 with over 397,000 individuals enrolled across the capitated models (CMS 2016b, CMS 2016c).

Target groups

States may target enrollment to specific groups of beneficiaries and may limit enrollment to specific geographic areas (Table 3). For example, South Carolina and Rhode Island are testing the capitated model statewide, but target different age groups in the dually eligible population (CMS 2015c, CMS 2013a). The eight other participating states limit enrollment to specific regions and focus on populations defined by age or degree of service need. For example, Massachusetts targets dually eligible beneficiaries age 21–64 living in nine participating counties (CMS 2012a). The New York FIDA demonstration targets dually eligible beneficiaries age 21 and over who require more than 120 days of community-based LTSS, live in New York City or Nassau County, and are not receiving inpatient mental health services (CMS 2013b).[5] The New York FIDA-IDD targets a completely different group of full benefit dually eligible beneficiaries: individuals with intellectual and developmental disabilities (CMS 2016d).

Enrollment process

Typically, states participating in the capitated model provide an opt-in enrollment period during which beneficiaries can select a plan to provide both their Medicare and Medicaid services (Table 3). This opt-in period is followed by a passive enrollment period during which remaining beneficiaries are automatically assigned to a plan. In California, beneficiaries in Santa Clara and San Mateo County were automatically enrolled in the demonstration without an initial opt-in enrollment period (CalDuals 2014).[6]

Enrollees can opt out of the demonstration at any point and if they do opt out, they typically enroll in FFS or managed care for their Medicare benefits. However, California, Illinois, New York, Ohio, and Texas require all dually eligible beneficiaries to participate in Medicaid managed care (KFF 2014).Ohio recently moved all Medicaid

beneficiaries, including those who are dually eligible for Medicare, into Medicaid managed care. As a result, all eligible beneficiaries are enrolled in a MyCare Ohio plan for Medicaid services, and have the opportunity to decide whether to have Medicare services provided through the same plan (Ohio Department of Medicaid 2014).

The New York FIDA-IDD is only using voluntary enrollment (CMS 2015e). In December 2015, the New York FIDA program suspended passive enrollment into the demonstration, and all newly eligible beneficiaries—or eligible beneficiaries who had not been passively enrolled—will have to voluntarily enroll in the program to participate. The state is currently developing new rules to help increase enrollment into the FIDA program (New York State Department of Health 2015).

In May 2016, California announced that it would also suspend passive enrollment into the program beginning July 2016. Eligible beneficiaries will be able to voluntarily enroll into the program and also be mandatorily enrolled into a Medicaid MLTSS program (California Department of Health Care Services 2016a).

When Fallon Total Care dropped out of the Massachusetts demonstration, most of its 5,000 participants were put back into Medicare and Medicaid FFS. At the same time, Commonwealth Care Alliance (the plan with the largest demonstration enrollment in Massachusetts) announced it would stop accepting new enrollees into the demonstration.[7] Tufts Health Plan, the other remaining health plan in the Massachusetts demonstration, has limited enrollment to approximately 2,500 demonstration participants.

Currently, opt-out rates are only available for a few states. As of January 2016, approximately 56 percent of all eligible beneficiaries for the New York FIDA program opted out of the demonstration (New York State Department of Health 2016). As of May 2016, 50 percent of all eligible beneficiaries in California opted out of the demonstration (California Department of Health Care Services 2016b). As of April 2016, approximately 29 percent of all eligible beneficiaries living in Massachusetts opted out of the demonstration (Massachusetts Executive Office of Health and Human Services 2016).

High opt-out rates may reflect beneficiary preferences and pressure from providers. For example, Virginia nursing homes and Illinois durable medical equipment providers were reported to have discouraged beneficiaries from participating in the demonstration (Dickson 2011, Gutman 2014).

Implementation

Massachusetts was the first state to enroll individuals into the program. Its opt-in enrollment began in October 2013 and passive enrollment began in January 2014. New York's FIDA-IDD program is the most recent demonstration program and it is expected to begin voluntary enrollment into the program to later than April 2016 (CMS 2015e). As of April 2016 Rhode Island has not yet begun passively enrolling individuals into the demonstration. It is expected to begin passive enrollment into its demonstration in July 2016 (Neighborhood Health Plan of Rhode Island 2015).

In the capitated model, enrollment start dates have frequently been delayed to provide more time to discuss enrollment options with eligible beneficiaries, allow plans to prepare for enrollees, and make changes to state enrollment systems (Atlantic Information Services Health 2013, Benson 2014, Gorn 2014). In Suffolk and Westchester counties in New York; and Orange County, California, delays occurred because plans did not meet network adequacy standards (Atlantic Information Services Health 2015, Nahmias 2015, Douglas 2014). In South Carolina's passive enrollment was initially delayed due to pending budget language considered by the South Carolina state legislature.

TABLE 3. Capitated Model: Eligible Beneficiaries, Timeline, and Enrollment

State	Demonstration	Eligible beneficiaries	MOU signed	Opt-in start dates[1]	Passive enrollment start dates[1]	Enrollment April 2016[2]	Estimates of number eligible to enroll
California	Cal MediConnect	• Full benefit dually eligible; • Age 21 and older; • Living in participating county; and, • Not enrolled in certain HCBS waivers, not residing in certain institutions, and meets certain continuous eligibility requirements	March 27, 2013	April 1, 2014–July 2015	Suspended[3]	125,050	424,000
Illinois	Medicare-Medicaid Alignment Initiative	• Full benefit dually eligible; • Age 21 and older; • Living in participating region; and, • Not enrolled in certain HCBS waivers or certain programs	February 22, 2013	March 1, 2014	June 1, 2014	49,256	154,000
Massachusetts	One Care	• Full benefit dually eligible; • Age 21 through 64; • Living in participating county; and, • Not enrolled in HCBS waivers, not residing in certain institutions	August 22, 2012	October 1, 2013	January 1, 2014	12,417	101,000
Michigan	MI Health Link	• Full benefit dually eligible; • Age 21 and older; • Living in participating county; and, • Had not previously disenrolled from Medicaid managed care due to special disenrollment, elect hospice services, have CSHCS services	April 3, 2014	March 1, 2015–May 1, 2015	May 1, 2015–July 1, 2015	33,161	105,000
New York FIDA	Fully Integrated Duals Advantage (FIDA)	• Full benefit dually eligible; • Age 21 and older; • Living in participating region; and, • Require more than 120 days of community-based LTSS or be eligible for but not already receiving facility-based or community-based LTSS (“New to Service”), who are not receiving inpatient services in an Office of Mental Health facility, and are not residing in certain institutions or receiving certain services	August 23, 2013	January 1, 2015	Suspended[4]	5,819	100,000
New York FIDA-IDD	Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD)	• Full benefit dually eligible; • Age 21 and older; • Living in participating region; and, • Eligible for Office for Persons with Developmental Disabilities (OPWDD) services, eligible for intermediate care facilities for individuals with IDD level of care, receiving Section 1915(c) waiver services as an alternative to ICF-IDD placement, or enrolled in the Section 1915(c) OPWDD waiver	November 5, 2015	April 1, 2016	No passive enrollment	N/A	20,000

MACPAC

TABLE 3. (continued)

State	Demonstration	Eligible beneficiaries	MOU signed	Opt-in start dates[1]	Passive enrollment start dates[1]	Enrollment April 2016[2]	State estimates of number eligible to enroll
New York FIDA-IDD (continued)		services as an alternative to ICF-IDD placement, enrolled in the Section 1915(c) OPWDD comprehensive waiver					
Ohio	MyCare Ohio	• Full benefit dually eligible; • Age 18 and older; • Living in participating region; and, • Who do not have developmental disabilities who are served through an ICF/DD or waiver, and are not enrolled in PACE or the Independence at Home demonstration	December 11, 2012	May 1, 2014	January 1, 2015	62,507	93,000
Rhode Island	Integrated Care Initiative Demonstration	• Full benefit dually eligible; • Age 21 and older; • Living in Rhode Island; and, • Not residing in certain institutions or receiving certain services	July 30, 2015	May 1, 2016	July 1, 2016[5]	N/A[6]	30,000
South Carolina	Healthy Connections Prime	• Full benefit dually eligible; • Age 65 and older; • Living in South Carolina; and, • Not enrolled in certain HCBS waivers, and not residing in certain institutions	October 25, 2013	February 1, 2015	April 1, 2016[7]	6,170	50,000
Texas	Texas Dual Eligibles Integrated Care Demonstration Project	• Full benefit dually eligible; • Age 21 and older; • Living in a participating county; and, • Qualify for SSI benefits or Medicaid HCBS STAR+PLUS waiver services, and not enrolled in certain HCBS waivers, and not residing in an ICF/ID	May 23, 2014	March 1, 2015	April 1, 2015	46,119	165,000
Virginia	Commonwealth Coordinated Care	• Full benefit dually eligible; • Age 21 and older; • Living in a participating county; and, • Not enrolled in certain waivers, and not residing in certain institutions or receiving certain services	May 21, 2013	April 1, 2014	July 1, 2014	27,909	67,000
Total						**368,408**	**1,309,000**

Notes: CSHCS is Children's Special Health Care Services. HCBS is home and community-based services. ICF/ID is intermediate care facility for the intellectually disabled. ICF/DD is intermediate care facility for the developmentally disabled. LTSS is long-term services and supports. PACE is Program of All-Inclusive Care for the Elderly. SSI is Supplemental Security Income.

Estimates of number eligible were obtained from the Medicare Payment Advisory Commission's June 2016 Report to Congress and CMS Press Releases (CMS 2016d, CMS 2016m, MedPAC 2016)

[1]California and Michigan have a range of opt-in and passive enrollment start dates. These states had varying opt-in and passive enrollment start dates, which differed by county or region.

[2]Enrollment numbers are derived from the CMS Medicare Advantage Monthly Enrollment by Plan, April 2016 dataset (CMS 2016c).

[3]Passive enrollment into the California demonstration will end in July 2016. Beginning in July 2016, eligible beneficiaries can voluntary enroll in the demonstration and will also be mandatorily enrolled into a MLTSS program (California Department of Health Care Services 2016a).

[4]In December 2015, the New York FIDA program suspended passive enrollment into the demonstration.

[5]The Rhode Island three-way contract identifies that passive enrollment will occur in five waves. The first phase is scheduled to begin on July 1, 2016. The following waves will occur between August 1, 2016–November 1, 2016.

[6]Enrollment data are not available for the Rhode Island demonstration.

[7]Passive enrollment in South Carolina had been on hold pending consideration by the state legislature but the first wave of passive enrollment is now scheduled to begin in April 2016, and the second wave will begin in July 2016 (Barnett, L., CMS 2015, South Carolina Healthy Connections Medicaid 2016).

Sources: CMS 2016a, CMS 2016c, CMS 2016d, CMS 2016e, CMS 2016f, CMS 2016g, CMS 2016h, CMS 2016i, CMS 2016j, CMS 2016k, CMS 2016l, CMS 2016m, MedPAC 2016, New York Health Access 2016, South Carolina Healthy Connections Medicaid 2016, Barnett, L., CMS 2015, CMS 2015c, CMS 2015e, Massachusetts Executive Office of Health and Human Services 2015, Neighborhood Health Plan of Rhode Island 2015, CMS 2014b, CMS 2014c, CMS 2014d, CMS 2014e, CMS 2014f, CMS 2014g, CMS 2014h, CMS 2014i, CMS 2014j, CMS 2013a, CMS 2013b, CMS 2013c, CMS 2013d, CMS 2013e, CMS 2013f, CMS 2013g, CMS 2013h, CMS 2012a, CMS 2012b, CMS 2012c, and CMS 2012d.

Payment Framework in the Capitated Model

CMS and the state jointly develop capitation rates encompassing both Medicare and Medicaid services as part of their contract negotiations. Participating plans receive prospective capitated payments that consist of three amounts: one from CMS for Medicare Parts A and B services, another from CMS for Medicare Part D services, and a third from the state for Medicaid services. Payment rates are established by 1) projecting baseline costs, 2) applying savings percentages, 3) applying risk adjustments, 4) applying additional risk mitigation techniques, and 5) applying withhold percentages (CMS 2012e, Brandel and Cook 2013). However, throughout the course of the demonstration CMS and the states have made changes to these elements in order to keep the program financially sustainable for plan participation. The elements of payment rates and changes to these elements are described below.

Projecting baseline costs

Baseline spending is an estimate of what would have been spent in the payment year if the demonstration had not existed, and is established prospectively on a year-by-year basis for each demonstration at a county level. Baseline spending does not include unmet needs of beneficiaries enrolled in the demonstration.

Medicaid baseline. Each state develops a projection of baseline Medicaid spending in the absence of the demonstration, which must be approved by CMS. In states that enroll dually eligible beneficiaries in managed care, the baseline projection reflects the projected capitation rate. In others, the baseline projection represents historical FFS enrollment projected to the time period of the demonstration (CMS 2012e, Brandel and Cook 2013).

Medicare baseline. While the Medicaid methodology varies from state to state, the Medicare methodology is consistent across all states (CMS 2012e, Brandel and Cook 2013). To project what baseline Medicare spending would have been in the absence of the demonstration, CMS calculates the Medicare Part A and B capitation rate in each county based on the projected share of enrollees in Medicare FFS versus Medicare Advantage. The component associated with beneficiaries currently in Medicare FFS is based on the published county-level FFS payment rates, which reflect historical costs of the Medicare FFS population. Similarly, the component associated with those enrolled in Medicare Advantage is based on estimated payments to Medicare Advantage plans in which members would have enrolled in the absence of the demonstration (CMS 2013i, Brandel and Cook 2013).

The baseline capitation rate for Medicare Part D is set at the national average monthly bid amount. Plans in the demonstration are also subject to the same payment methodologies as other Part D plans (CMS 2013i, CMS 2012e, Brandel and Cook 2013).

Savings percentages

The Financial Alignment Initiative is intended to reduce spending over time through better care coordination and by reducing unnecessary utilization of high-cost services, such as emergency room visits, hospitalizations and

long-term stays in nursing and post-acute care facilities. Under the capitated model, states and CMS establish savings percentages for the demonstration which are deducted up front from Medicaid and Medicare payments to plans. These percentages, established by CMS and each state, are applied equally to the baseline projections for Medicare Parts A and B and Medicaid (CMS 2013c). Savings percentages are not applied to the Medicare Part D component of the rate (CMS 2013i).

CMS examines existing evidence of the effect of care management on health care use to inform the rate-setting process and develops models to predict changes in utilization patterns and a range of potential savings in each state (Brandel and Cook 2013, CMS 2013i).[8] CMS and the states then work together to establish aggregate savings percentages for each year of the demonstration (Table 4). These can vary by state due to factors such as target population, covered services, managed care penetration, and trends in use of services (CMS 2012c, Brandel and Cook 2013). States may also vary target savings percentages by region. Most states expect savings percentages to increase each year.

In Massachusetts, savings percentages have been amended twice from the original MOU reflecting lower savings than originally anticipated (Barry et al. 2015, Barnett, L. CMS 2015). Originally savings percentages in year 2 and year 3 of the Massachusetts demonstration were 2 percent and 4 percent, respectively. In December 2014, CMS and the state adjusted the savings percentages in year 2 to 0.5 percent, and in year 3 to 2 percent. In December 2015, CMS and the state adjusted the savings percentages again—changing both year 2 and year 3 savings percentages to 0 percent (CMS 2015f).

TABLE 4. Medicare and Medicaid Savings Percentages for Capitated Payments, by State and Demonstration Year

State	Year 1	Year 2	Year 3
California[1]	Ranges from 1 to 1.47%	Ranges from 2 to 3.5%	Ranges from 4 to 5.5%
Illinois	1%	2%	5%
Massachusetts[2]	Year 1a: 0% Year 1b: 1%	0%	0%
Michigan	1%	2%	4%
New York FIDA	1%	1.5%	3%
New York FIDA-IDD[3]	0.25%	0.5%	1%
Ohio	1%	2%	4%[4]
Rhode Island[5]	1%	1.25%	3%
South Carolina	1%	2%	4%
Texas[6]	Year 1a: 1.25% Year 1b: 2.75%	3.75%	5.5%
Virginia	1%	2%	4%

Notes:

[1]In California, minimum savings percentages were established by the state but each county has specific interim savings percentages added to the state's minimum (CMS 2013e). The rates above show the range across counties.

[2]Massachusetts did not apply any savings percentages to the Medicare or Medicaid capitated rate during the first six months of year 1 of the demonstration. During the last six months of year 1, Massachusetts applied a 1 percent savings percentage to the Medicaid and Medicare capitated rate. In addition, Massachusetts amended the savings percentages proposed in its original MOU. The table reflects the December 2015 revised savings percentages for years 2 and 3. Originally, these were 2 percent in year 2 and 4 percent in year 3.

[3]The New York FIDA-IDD demonstration is 4 years long. Savings percentages in year 4 are 1 percent.

[4]Saving percentages for demonstration years 4 and 5 for the Ohio Financial Alignment Initiative are 4 percent (CMS 2016n).

[5]The Rhode Island MOU and three-way contract note that if plans experience annual losses in demonstration year 1 exceeding 3 percent of revenue in the aggregate of all regions in which the Medicare-Medicaid plan participates, the savings percentage for demonstration year 3 will be reduced to 1.5 percent. The three-way contract also notes that in Rhode Island demonstration is four years long and year 4 savings percentages are 3 percent (CMS 2016o).

[6]Texas defines demonstration year 1 as Year 1a (March 1, 2015–December 31, 2015) and Year 1b (January 1, 2016–December 31, 2016).

Sources: CMS 2016n, CMS 2016o, Barnett, L., CMS 2015, CMS 2015c, CMS 2015e, CMS 2014b, CMS 2014c, CMS 2013a, CMS 2013b, CMS 2013c, CMS 2013d, CMS 2013e, CMS 2012a, CMS 2012b.

Risk adjustment

Risk adjustment modifies payments to health plans to reflect the differing health needs of enrollees, paying more for members who need more care than average and less for those who need less, ensuring that plans drawing a sicker (or healthier) than average group of enrollees are not under or overpaid. Risk adjustments are applied separately to Medicare Parts A, B, and D and the Medicaid components of capitated payments.

Medicare risk adjustment. The Medicare components of the rate are risk adjusted based on the risk profile of each enrollee. The CMS Hierarchical Condition Category and the CMS Hierarchical Condition Category End Stage Renal Disease risk adjustment models are used to calculate risk scores for Medicare Parts A and B; the Prescription Drug Hierarchical Condition Categories model is used to calculate risk scores for Medicare Part D.

Medicaid risk adjustment. States may distribute the Medicaid component of the capitated rate into rating categories for groups of beneficiaries based on CMS-approved methodology, or risk adjust the Medicaid component at the beneficiary level. States can use different adjustment models so long as they provide incentives for community alternatives to institutional placement; have clear operational rules; have a process to assign beneficiaries to a rate category that is compatible with the beneficiary's risk level and profile; and are budget neutral to Medicaid after application of savings percentages (CMS 2012e, Brandel and Cook 2013, Commonwealth of Massachusetts).

Each state classifies eligible beneficiaries into subgroups in an attempt to capture differences in risk among dually eligible beneficiaries. These rating categories are based on level of care and functional assessment, and are specified by the state in their MOUs and three-way contracts.[9] The specific categories and methods for grouping enrollees across plans vary by state (Table 5). For example, Texas uses three rating categories—home and community-based services (HCBS), other community care, and nursing facility—while South Carolina enrollees are classified in four different rate categories—nursing facility-based care, two different categories for HCBS, and one for those in the community.

TABLE 5. Medicaid Rating Categories and Requirements by State

State	Number of rating categories	Rating categories	Rating category definitions
California	4	Institutionalized	Beneficiaries who reside in a long-term care facility for 90 or more days.
		Home and community-based services high	Beneficiaries who are high users of home and community-based services (HCBS), who receive community-based adult services, are part of Medicare Shared Savings Programs (MSSP), or receive in-home supports and services (IHSS) or classified under the IHSS program as severely impaired.
		Home and community-based services low	Beneficiaries who are low users of HCBS. They receive IHSS but are not classified as severely impaired.
		Community well	Beneficiaries who do not reside in long-term care facilities and do not use community-based adult services, MSSP, or IHSS.
Illinois	4	Nursing facility	Beneficiaries residing in a nursing facility on the first of the month in which the payment is made.
		Waiver	Beneficiaries enrolled in a qualifying HCBS waiver as of the first of the month in which the payment is made.
		Waiver plus	Beneficiaries moving from a nursing facility to a qualifying waiver.
		Community	Beneficiaries who do not meet the state's nursing home level of care criteria and do not reside in a nursing facility or qualify for an HCBS waiver.

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TABLE 5. (continued)

State	Number of rating categories	Rating categories	Rating category definitions
Massachusetts[1]	6	Facility-based care (F1)	Beneficiaries who have been identified by MassHealth as having a stay exceeding 90 days in a skilled nursing facility or nursing facility or a chronic hospital, rehabilitation hospital, or a psychiatric hospital
		Community tier 3—high community need (C3B)	Individuals who have a daily skilled need, have two or more activities of daily living (ADL) limitations, and have three days of skilled nursing need, and individuals with four or more ADL limitations, and who also have certain diagnoses (e.g., quadriplegia, muscular dystrophy and respirator dependence) leading to costs considerably above the average for current C3
		Community tier 3—high community need (C3A)	Individuals who have a daily skilled need, have two or more activities of daily living (ADL) limitations, and have three days of skilled nursing need, and individuals with four or more ADL limitations, and who do not have a diagnoses that classifies them as C3B
		Community tier 2—community high behavioral health (C2B)	Beneficiaries who do not meet F1 or C3 criteria, and their most recent home care assessment indicates one or more of the behavioral health diagnoses that indicate high level of service need, and who also have a co-occurring diagnoses of substance abuse and serious mental illness
		Community Tier 1– Community Other	Beneficiaries who do not meet F1, C2, or C3 criteria
Michigan	3	Tier 1	Beneficiaries who meet the nursing facility level of care as determined by the Michigan Nursing Facility Level of Care Determination (NFLOCD) on the first day of the month, and occupy a nursing facility bed certified for both Medicaid and Medicare
		Tier 2	Beneficiaries who meet the nursing facility level of care as determined by the Michigan NFLOCD tool on the first day of the month, live in any setting other than that referenced in Tier 1, and are enrolled in the integrated care organization 1915(c) waiver
		Tier 3	Beneficiaries who do not meet the criteria for Tier 1 or Tier 2 on the first day of the month
New York FIDA	2	Nursing home certifiable	Beneficiaries who meet the Nursing Home Level of Care (NHLOC) standard
		Community non-nursing home certifiable	Beneficiaries who require more than 120 days of community-based long-term services and supports (LTSS), but who do not meet an NHLOC standard
New York FIDA-IDD	2	Dual Eligible Adults, Age 21 to < 50	Beneficiaries who are age 21 or older and less than 50 years of age
		Dual Eligible Adults, Age 50 and Over	Beneficiaries who are age 50 and older
Ohio	2	Nursing facility level of care (NFLOC)	Beneficiaries who meet an NFLOC as determined initially through waiver enrollment or 100 or more consecutive days in a nursing facility
		Community well	Beneficiaries who do meet the NFLOC standard
Rhode Island[2]	5	Community non-LTSS	Enrollees eligible to receive community or not receiving LTSS
		Community LTSS	Enrollees residing in the community and receiving LTSS
		Facility LTSS	Individuals receiving LTSS in a nursing facility and have been in a nursing facility for more than 90 consecutive Days
		Intellectual/developmental disabilities (I/DD)	Enrollees with intellectual/developmental disabilities
		Severe and persistent mental illness (SPMI)	Enrollees with severe and persistent mental illness

TABLE 5. (continued)

State	Number of rating categories	Rating categories	Rating category definitions
South Carolina	4	NF1: Nursing facility-based care	Beneficiaries who identified as having a nursing facility stay of more than 3 months and meeting Medicare skilled nursing criteria or Medicaid NFLOC
		H1: Home and community-based services	Beneficiaries who do not meet NF1 criteria, and meet the level of care requirements for nursing facility placement or applicable HCBS waiver
		H2: Home and community-based services plus	Beneficiaries moving from the NF1 rate cell to a qualifying HCBS waiver for the first 3 months of transition
		C1: Community tier—community	Beneficiaries who do not meet NF1, H1, or H2 criteria
Texas	3	Nursing facility	Beneficiaries who receive state plan services only, and reside in a nursing facility
		Other community care	Beneficiaries who receive state plan services only, and do not reside in a nursing facility
		Home and community-based services	Beneficiaries who receive state plan services, as well as Section 1115(a) HCBS STAR+PLUS waiver services, and elderly or adults with disabilities who qualify for NFLOC, but do not reside in a nursing facility
Virginia	4	Nursing facility level of care: age 21-64	Beneficiaries age 21-64 meeting an NFLOC standard through waiver enrollment or currently in a nursing facility for 20 or more consecutive days
		Nursing facility level of care: age +65	Beneficiaries age 65 and older meeting an NFLOC standard through waiver enrollment or currently in a nursing facility for 20 or more consecutive days
		Community well: age 21-64	Beneficiaries ages 21-64, who do not meet an NFLOC standard, or meet NFLOC standard and are currently in a nursing home for fewer than 20 days
		Community well: age +65	Beneficiaries age 65 and older who do not meet an NFLOC standard, or meet an NFLOC standard and are currently in a nursing home for fewer than 20 days

Notes:

[1] After calendar year (CY) 2013 enrollees in the Community Tier 3—High Community Need (C3) group were further classified into two subcategories (Community Tier 3—Very High Community Need (C3B) and Community Tier 3—High Community Need (C3A)). In addition, after CY 2013 enrollees in the Community Tier 2—Community High Behavioral Health (C2) group were further classified into two subcategories (Community Tier 2—Community Very High Behavioral Health (C2B) and Community Tier 2—Community High Behavioral Health (C2A)). The table shows all six of the current rating categories.

[2] Rating categories for Rhode Island reflect the rating categories listed in its three-way contract.

Sources: CMS 2016o, CMS 2015c, CMS 2015e, CMS 2014b, CMS 2014c, CMS 2013a, CMS 2013b, CMS 2013c, CMS 2013d, CMS 2013e, CMS 2012a, CMS 2012b.

The rating categories ultimately determine the Medicaid rate the plan receives for enrollees. Plans receive a higher Medicaid rate for individuals with greater need. The Medicaid rates also vary within state based on geographic location. For example, in 2015, for Community Tier 1 – Community Other (C1) enrollees, plans received $109.08 for those living in Franklin County, MA and $115.72 for those living in Norfolk County, MA. For facility-based care (F1) enrollees, plans received $7,689.41 for those living in Franklin County, MA and $8,871.88 for those living in Norfolk County, MA (Massachusetts Executive Office of Health and Human Services 2015b).

Risk mitigation

Demonstrations in some states include additional risk mitigation techniques to share risk between plans and the state, including medical loss ratio (MLR) requirements, risk pools and risk corridors.

Medical loss ratio. Medical loss ratio refers to the share of premium revenues that a health plan spends on patient care and quality improvement activities as opposed to administration and profits. Seven states in the demonstration have a minimum MLR; Illinois, Michigan, New York FIDA, Rhode Island and South Carolina set a targeted MLR at 85 percent, and Ohio and Virginia set a targeted MLR at 90 percent. Plans that fail to meet the standard are required to pay any excess back to CMS and the state, or are required to pay a fine to the state. Some states also require a corrective action plan.

Risk pools. Risk pools are made up of large groups of individual entities (either individuals or employers) whose medical costs are combined in order to calculate premiums (AAA 2009). Such pools mitigate health plan risk if a disproportionate number of high-need individuals enroll in a certain plan (i.e., adverse selection).

Massachusetts is the only state with a capitated model using a high-cost risk pool. High-cost enrollees are defined based on spending for select Medicaid LTSS and certain rating categories. The state withholds a portion of the Medicaid component of the capitated rate for enrollees who have high-cost needs and puts it in a risk pool. The funding in the risk pool is divided across participating plans based on their share of total costs above the threshold amount associated with the high-cost members (CMS 2012a). According to Massachusetts' final rate report for CY 2015 of the demonstration the risk pools were eliminated for the first 2 years of the demonstration but will be in place for the third year of the demonstration (Massachusetts Executive Office of Health and Human Services 2015b).

Risk corridors. Risk corridors, which limit plan gains and losses, are used to protect plans against uncertainty in rate setting when they lack data on health spending for potential enrollees (AAA 2011). Michigan applies risk corridors for the first year of its demonstration, and Massachusetts and California apply risk corridors in all three years. In these states, participating plans receive a payment from CMS and the state if their losses exceed a certain threshold, or the plans pay CMS and the state if their gains exceed a certain threshold (AAA 2013, CMS 2014c, CMS 2013e, CMS 2012a). The New York FIDA-IDD demonstration will apply risk corridors to the first 3 years of the demonstration, and following demonstration year 2, CMS and the state will evaluate the need to continue a risk corridor arrangement for demonstration year 4 based on the assessment of the plan's financial experience (CMS 2015e). Rhode Island will also apply risk corridors in its demonstration (CMS 2015c).

Quality measures and withholds

CMS and states also withhold a portion of the capitation payments that plans can earn back if they meet certain quality thresholds. Some quality measures are consistent across all the demonstrations and are drawn from the Healthcare Effectiveness Data and Information Set, Health Outcomes Survey, Consumer Assessment of Healthcare Providers and Systems, and existing Part D measures.[10] State-specific measures include those related to LTSS, utilization, coordination, transitions, and waiver requirements (CMS 2012f).

Typically, quality withhold measures in the first year are process-based including health risk assessment completion. Withholds are 1–3 percent. If quality measures are met each year, the withhold amount is returned (CMS 2012c, Brandel and Cook 2013).

In November 2015, CMS announced it plans to develop a star rating system for the plans participating in the Financial Alignment Initiative. The star rating system will build off of the Medicare Advantage and Part D star rating system, but also measure quality across the full spectrum of Medicare and Medicaid services, including LTSS and treatment of behavioral health and substance abuse. CMS recognizes that with the limited

demonstration time frame and the lead time necessary for development of new LTSS measures means a comprehensive star rating system for these plans would not be possible until after the demonstrations are currently scheduled to end. CMS intends to start working on developing the star rating system now, so it can be used if the program extends after the demonstration ends. Starting in 2016 CMS proposes to post plan quality outcomes on its website as the star rating system is in development (CMS 2015g).

Benefits and Care Delivery

All participating plans are required to cover all services included in the Medicaid state plan, and all medically necessary Medicare Part A and B services (Table 6). They must also meet all Medicare Part D requirements, including benefits and network adequacy (CMS 2012c). Even so, the benefits offered and delivered through the Financial Alignment Initiative are not uniform either within or across states. Some capitated models require plans to offer additional benefits. California offers expanded vision coverage and South Carolina allows enrollees who have a serious, chronic, or life-limiting illness and who do not qualify for hospice care to receive new palliative care benefits (CMS 2015j, Walsh et al. 2014). The New York FIDA-IDD has expanded inpatient and outpatient psychiatric services through the demonstration. The MOU identifies that this initiative will cover inpatient mental health over 190-day Medicare lifetime limit, intensive psychiatric rehabilitation treatment programs, intensive behavioral services, and substance abuse program services.

Plans may also contract with community-based entities to help provide benefits. For example, Massachusetts requires plans to contract with community-based organizations for coordination of LTSS. The LTSS coordinator helps ensure person-centered care, counsels potential beneficiaries, provides communication and support needs, and acts as an independent facilitator and liaison between the beneficiary, plan, and providers (CMS 2012a). In Ohio, plans must contract with area agencies on aging to coordinate services for enrollees over the age of 60 (CMS 2012b).

Some demonstrations carve out certain benefits from the capitated model. For example, in California, although plans are financially responsible for all Medicare behavioral health services, some Medicaid specialty mental health services that are not covered by Medicare and certain Medi-Cal drug benefits are not included in the capitated payment.[11] These services are financed and administered by county agencies under the state's Medicaid managed care waiver and its state plan.[12] California requires plans to contract with county mental health and substance use agencies to ensure that enrollees have access to these services (California Department of Health Care Services 2013).

TABLE 6. Selected Benefits Offered in Capitated Financial Alignment Model States

State	Expanded state Medicaid plan benefits	Carved out benefits[1]	Required community involvement
California	• Vision • Non-medical transportation	• Behavioral health[2] • Hospice	• Not specified in memorandum of understanding (MOU)
Illinois	• None	• Intermediate Care Facilities for Individuals with Mental Retardation	• Not specified in MOU
Massachusetts	• Dental • Personal care assistance with cueing and monitoring • Durable medical equipment	• Targeted case management services • Rehabilitation option services • Medicare hospice	• Plans are required to contract with a community organization to provide enrollees long-

TABLE 6. (continued)

State	Expanded state Medicaid plan benefits	Carved out benefits[1]	Required community involvement
Massachusetts (continued)	• Diversionary behavioral health • Community support services	•	term services and supports coordinator
Michigan[3]	• Home and community-based (HCBS) waiver services and items • Adaptive medical equipment and supplies • Community transition services • Fiscal intermediary • Personal emergency response system • Respite	• Mental health and substance use services	• Not specified in MOU
New York FIDA	• HCBS waiver items and services	• Hospice • Out-of-network family planning services • Directly observed therapy for tuberculosis • Methadone maintenance treatment	• Not specified in MOU
New York FIDA-IDD	• Section 1915(c) OPWDD comprehensive waiver items and services • ICF-IDD services • Inpatient mental health over 190-day Medicare lifetime limit • Intensive psychiatric rehabilitation treatment programs • Intensive behavioral services • Individual directed goods and services • Transportation • Substance abuse program services • Other supportive services the interdisciplinary team determines necessary	• Hospice	• Participating plans must contract with an adequate number of community-based LTSS providers to allow participants a choice of at least two providers of each covered community-based LTSS service within a 15-mile radius or 30 minutes from the participant's ZIP code of residence
Ohio	• None	• Hospice	• Plans are required to contract with area agencies for aging to coordinate waiver services for individuals over the age of 60
Rhode Island	• None[4]	• Dental • Hospice • Non-emergency transportation services • Residential services for enrollees with intellectual and developmental disabilities • Opioid treatment program health homes	• Not specified in MOU

TABLE 6. (continued)

State	Expanded state Medicaid plan benefits	Carved out benefits[1]	Required community involvement
South Carolina	• Palliative care	• Hospice • Non-emergency transportation	• Not specified in MOU
Texas	• HCBS	• Hospice	• Not specified in MOU
Virginia	• None	• Targeted case management services • Dental • Case management services for participants of auxiliary grants	• Not specified in MOU

Notes:
[1]Although the participating plan does not cover these services, beneficiaries have access to them through Medicare or Medicaid fee for service.
[2]In California, plans are financially responsible for all Medicare behavioral health services, but some Medicaid specialty mental health rehabilitative and targeted case management services and non-Medicare drug services are not included in the capitated payment. These services are financed and administered by county agencies under the provisions of the state's Medicaid managed care waiver and its regular Medicaid state plan.
[3]In Michigan, home and community-based waiver services and items are only available to enrollees who meet an NFLOC and for whom these services are included in the enrollee's care plan. Supplemental benefits detailed above are included in the enrollee's care plan if he or she meets established criteria.
[4]The Rhode Island MOU and three-way contract identify that state and CMS may consider adding certain supplemental benefits (e.g., integrated pain management program, Screening, Brief Intervention and Referral to Treatment, and non-medical transportation) to the required demonstration benefit package in demonstration years 2 and 3 (CMS 2016o, CMS 2015c).
Sources: CMS 2016o, CMS 2015c, CMS 2014b, CMS 2014c, CMS 2013a, CMS 2013b, CMS 2013c, CMS 2013d, CMS 2013e, CMS 2012a, CMS 2012b.

Care Coordination

The capitated model is designed to coordinate medical, behavioral health, and LTSS through a single health plan. Each demonstration program specifies different levels of care coordination, which can include health assessments, individualized care plans, interdisciplinary care teams, and methods for ensuring care continuity.

Health assessments

All plans are required to conduct a comprehensive health assessment of each enrollee that covers medical and behavioral health needs, chronic conditions, disabilities, functional impairments, need for assistance in ADL, and cognitive status, including dementia. The specific components of the assessment and the timeline are spelled out in the state's MOU or the three-way contract. In Massachusetts each health plan must complete the comprehensive assessment tool for each new enrollee within 90 days of enrollment. Massachusetts also requires the assessment to be completed in person, by a registered nurse, and in a convenient location for the enrollee (CMS 2012a). In Illinois, plans must administer an initial health risk screening within 60 days. Those designated as moderate or high risk must receive an additional assessment within 90 days of enrollment (CMS 2013d).

Concerns have been raised about beneficiaries receiving health assessments in a timely manner (PerryUndem 2015, Summer and Hoadley 2015, Watts 2015, Barry et al. 2015). Plans face challenges in reaching out to eligible and enrolled beneficiaries, both because frail and disabled enrollees are typically hard to reach but also due to receipt of incorrect contact information for those who were passively enrolled (Dickson 2014, Engelhardt 2015).

Individualized care plans

Plans also must develop an individualized care plan for each enrollee that includes both health goals and measurable objectives and timetables to meet medical, behavioral health, and LTSS needs. Plans must develop and share the care plan with the enrollee, as well members of the enrollee's care team. The structure and time line for putting care plans into action are dependent on either the state's MOU or the three-way contract. In Texas, the

individualized care plan must include enrollee's health history; a summary of current, short-term LTSS and social needs, concerns, and goals; and a list of required services, their frequency, and a description of who provides such services. The care plan must also be in place within 90 days of enrollment or upon receipt of all necessary eligibility information from the state, whichever is later. In Michigan, plans must develop the care plan with the enrollee and his or her care team within 90 days of enrollment, and must review the care plan periodically based on the enrollee's rating category (CMS 2014c). Massachusetts enrollees must receive assistance and accommodations to prepare for and fully participate in the care planning process, including the development of the individualized care plan (CMS 2013f, CMS 2012a).

Interdisciplinary care teams

Plans also must develop an interdisciplinary care team with specific members identified in each state's MOU. Typically, the team includes a primary care provider, care coordinator, LTSS providers, specialists, the enrollee, and family members. The care coordinator—sometimes referred to as the care manager, or service coordinator—is a key member of the team, and usually helps develop the care plan, coordinates care transitions, educates the enrollee regarding available services and community resources, and coordinates with social service agencies.

States may specify educational and experience requirements for the care coordinator. Some states require that the care coordinator have a clinical background. For example, in Michigan care coordinators must be licensed registered nurses, nurse practitioners, physicians' assistants, or social workers (CMS 2014b). In other states, the education and experience of the care coordinators varies according to the enrollee's needs. In Illinois, care coordinators for those with high health needs must have clinical backgrounds while counselors or peer support counselors can be assigned to enrollees with fewer needs (CMS 2013d). Other states do not require a clinical credential but instead focus on coordinators' knowledge of specific subject matter such as aging and loss, appropriate support services in the community, frequently used medications and their potential negative side effects, depression, challenging behaviors, Alzheimer's disease and other dementias (CMS 2013b).

Continuity of care

To ensure smooth transitions, states require plans to allow enrollees to continue to see their established providers and complete an ongoing course of treatment at the beginning of the demonstration, regardless of whether those providers participate in the demonstration, and whether the plan covers the services. The length of time an enrollee can continue to see a non-participating provider or receive non-covered services varies by state and health need. In Massachusetts, New York, and Texas, plans must allow enrollees to maintain their current providers and service authorizations for a period up to 90 days, or until the assessment and care plans are completed (CMS 2014a, CMS 2013b, CMS 2013g). In Ohio, beneficiaries identified for high-risk care management have a 90-day transition period to maintain current physician services; all other beneficiaries have one year to maintain current physician services. Ohio also allows HCBS waiver enrollees to maintain current waiver service levels for one year, and current providers for either 90 days or one year, depending on the type of service (CMS 2012b).

In May 2016, California announced that it would change the length of time an enrollee can continue to see a non-participating provider or receive non-covered services, from 6 to 12 months (California Department of Health Care Services 2016a).

A study by the Kaiser Family Foundation found issues with continuity of services during early implementation of the program. For example, in Virginia, continuity requirements masked network inadequacies. Providers were

aware of the continuity provisions and that they would be paid for services provided during the transition period. These stakeholders also expressed concerns that some beneficiaries may not have been informed about the transition period, and could be surprised when the transition period ended and could be required to change providers (Summer and Hoadley 2015).

Consumer Protections

The Financial Alignment Initiative contains multiple requirements to ensure transparency and protect consumers, including a single denial notice for both Medicaid and Medicare that notifies beneficiaries of their rights to appeal adverse coverage decisions. CMS also requires that states hold public forums, focus groups, and other meetings to obtain public input as they develop their demonstration proposals. Each state is required to establish an ombudsman program to address concerns or conflicts that may interfere with enrollment or access to health benefits and services once a beneficiary has enrolled. The ombudsman program also provides enrollees with information and assistance filing appeals and grievances.

Appeals

Medicaid and Medicare have different processes to submit an appeal and receive an appeal decision. These differences have created confusion, inefficiencies, and administrative burdens for beneficiaries, providers and states. While the Financial Alignment Initiative gave states the option to align and streamline the appeals process for dually eligible beneficiaries, most continue to have separate processes and timelines for Medicaid and Medicare appeals. Currently, only the New York demonstrations integrate the Medicaid and Medicare appeals process above the health plan level, consolidating Medicare (excluding Part D) and Medicaid appeals processes into one four-level process: (1) the plan's internal appeals process; (2) an integrated administrative hearing; (3) the Medicare Appeals Council; and (4) the federal district court. If a beneficiary receives an adverse decision at the plan level and files an appeal to the integrated administrative hearing within 10 days benefits can continue until the Medicare Appeals Council hands down its decision.

Ombudsman programs

On June 27, 2013, the U.S. Department of Health and Human Services released a Funding Opportunity Announcement to support development of independent ombudsman programs in states implementing the Financial Alignment Initiative. The role of such programs is to monitor beneficiary experience, provide beneficiaries with additional resources, and assist with resolving issues related to the demonstration (CMS 2013j).

As of April 2016, ten states, including eight testing the capitated model, had received funding to support an ombudsman program (CMS 2015j). All 10 states participating in the capitated model have established such programs (CMS 2016m, ACL 2015a, ACL 2015b, CalDuals 2015, Council on Aging of Southwestern Ohio 2015, One Care Ombudsman 2015, New York Health Access 2015a). (Both New York programs are using the same ombudsman.)

The federal Administration for Community Living operates the Office of Dual Demonstration Ombudsman Technical Assistance Program to support the design and implementation of the Financial Alignment Initiative's ombudsman program (ACL 2015c).

Program Evaluation

CMS has contracted with RTI International to evaluate the demonstrations as well as conduct state-specific evaluations. The evaluation will include site visits, analysis of program data, focus groups, key informant interviews, analysis of changes in quality, utilization, and cost measures, and calculation of savings attributable to the demonstrations.

As of April 2016, CMS has released two preliminary examinations of the demonstration. The first evaluation is a general overview of the structure of the demonstration programs and early experiences within seven of the 14 programs. It does not provide information on the demonstration's effect on utilization, spending, or outcomes. The second evaluation is a state-specific evaluation focusing on Washington's FFS model. This evaluation presents preliminary results on the first 18 months of the demonstration. This report found that the demonstration reduced Medicare spending by 6 percent relative to a comparison group during its first 18 months of operation and had saved the program about $22 million. Data on changes in Medicaid spending and service utilization are not yet available, and were not included in this report. Other state-specific annual reports are expected to be published in 2016 and will continue to be published every year of the demonstration, while the final report to CMS regarding the entire demonstration is expected to be due to CMS in 2020 (Barnett, L., CMS 2015, CMS 2015h, Engelhardt 2015).

In late 2014 and early 2015, MACPAC conducted focus groups with individuals enrolled in the Massachusetts, Ohio and California demonstrations in order to understand the early effects of the demonstrations on beneficiaries. The focus groups examined enrollment processes, communication with beneficiaries, and experiences receiving care coordination services and accessing services (MACPAC 2015b, PerryUndem 2015). Although results varied by site, in general, most individuals in the focus groups supported the concept and purpose of the program, valued the expanded services they received through the demonstration, in general were able to keep their primary care provider, and noticed a decrease in costs. However, focus group enrollees did not have a clear understanding of the demonstration program, reported that they received confusing information regarding the demonstration, had not connected with or had not been contacted by a care coordinator, had not received the required health risk assessment, and had not experienced a team approach to care delivery.

Additionally, MedPAC conducted site visits to California, Massachusetts, and Illinois to gain stakeholder perspectives on the effects of the demonstration. Stakeholders identified that beneficiaries were likely to opt-out or disenroll from the demonstration due to satisfaction with existing care, lack of information regarding the demonstration, and resistance from providers. Plans noted that they are often unable to locate enrollees to send enrollment information or conduct health risk assessments. Stakeholders also reported that the effects of the demonstration on service use and quality of care is not yet available (Rollins 2016).

The Kaiser Family Foundation also conducted stakeholder interviews in three states (Virginia, Ohio, and Massachusetts). These interviews were conducted at the start of the demonstrations in order to obtain early experiences within the demonstrations. In general, the interviews found that beneficiaries and providers were confused about the benefits, policies, and intent of the program. Enrollment was often delayed due to provider negotiations, provider and beneficiary outreach, and implementing information technology systems, plans had difficulty locating beneficiaries. Plans were also identifying unmet health needs through the health risk assessments (KFF 2016).

MACPAC intends to continue monitoring the effects and status of the Financial Alignment Initiative, as well as other issues relating to dually eligible beneficiaries.

Endnotes

[1] On July 16, 2015 CMS announced it would offer states participating in the Financial Alignment Initiative the opportunity to extend their demonstrations for an additional two years (CMS 2015i). All states submitted a letter of intent to extend the demonstration. However, the letters are non-binding and since submitting a letter Virginia plans to end the demonstration on December 31, 2017.

[2] Minnesota has implemented an alternative model to test integration of administrative functions without financial alignment.

[3] Some states are conducting their own evaluations of the demonstration. Other entities examining the demonstration include the SCAN Foundation, Integrated Care Resource Center and the Kaiser Family Foundation.

[4] Montefiore initially participated in the demonstration but never enrolled anyone into the program.

[5] On February 27, 2015, the New York Department of Health announced an indefinite delay in implementation in Suffolk County and Westchester (New York Health Access 2015b). CMS has identified that enrollment in Suffolk County and Westchester will not begin until after mid-2016.

[6] In San Mateo, the county had previously been responsible for administering Medicaid benefits and is the only plan participating in the demonstration in that county. Demonstration enrollees living in San Mateo were already members of Health Plan of San Mateo and thus only experienced a change when their Medicare coverage was integrated with Medicaid.

[7] However, Commonwealth Care Alliance opened enrollment for a January 1, 2016 effective date for up to 100 new One Care members in Suffolk County (Massachusetts Executive Office of Health and Human Services 2016).

[8] Savings assumptions are based on literature that suggests that better care coordination can reduce emergency room visits, inpatient hospital utilization, long-term nursing facility services, and post-acute skilled nursing facility services. However, these assumptions do not account for the extent to which care coordination will result in increased health care utilization.

[9] In general, states specify criteria for classifying an enrollee into a specific rating category in the three-way contract between the state, CMS and the health plan. However, health plans have the opportunity to provide additional data to the state if the plans have evidence that an individual needs to be reclassified.

[10] These quality measures are also required for Medicare Advantage plans, but unlike Medicare Advantage plans, Financial Alignment Initiative plans do not participate in the Medicare Advantage quality star rating system.

[11] Specialty mental health services not covered by Medicare include day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, targeted case management, portions of inpatient psychiatric hospital services, and medication support services. Certain Medi-Cal drug benefits include levoalphacetylmethadol (LAAM) and methadone maintenance therapy, day care rehabilitation, outpatient individual and group counseling, perinatal residential services, and naltrexone treatment for narcotic dependence.

[12] Section 1915(b) of the Social Security Act, enacted in 1981 as part of the Omnibus Budget Reconciliation Act (P.L. 97-35), permits states to pursue mandatory managed care for enrollees in a certain geographic area, for certain populations, or otherwise limit individuals' choice of providers under Medicaid.

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