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. These individuals are among the poorest and sickest individuals covered by either program and account for a disproportionate share of Medicaid and Medicare spending (MedPAC and MACPAC 2017).

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 the 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, commonly referred to as the Medicare-Medicaid Coordination Office (MMCO), within the Centers for Medicare & Medicaid Services (CMS). MMCO is charged with improving care and reducing costs for dually eligible beneficiaries, and rationalizing administration between Medicaid and Medicare.

One of the strategies MMCO is pursuing to improve coordination between the two programs is the Financial Alignment Initiative. Under this demonstration project, CMS is offering two models: (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 all 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. In addition, states can design a different approach and seek approval from CMS.

This issue brief describes the design of the Financial Alignment Initiative, and compares key provisions of state approaches in the 11 capitated model demonstrations currently underway. As of December 2017, 13 states were participating in a total of 14 demonstrations, with New York operating two separate capitated model demonstrations (Table 1) (CMS 2016b).[1] Each state model differs in terms of its target population, benefits, care coordination services, and payment framework. The earliest demonstrations began in July

2013 and CMS has offered several opportunities for extensions. Two states–Colorado and Virginia–ended their demonstrations in December 2017.

Although evaluation results are not yet available on the financial viability of these models and their effect on quality of care, early results from the managed FFS models have found some initial savings. Washington's managed FFS model demonstrated $67 million for Medicare from July 2013 to December 2015 due to decreased spending for inpatient hospital services, home health agency costs, and professional services costs. However, costs increased for outpatient hospital and skilled nursing facility services; moreover, data regarding Medicaid costs are not yet available (CMS 2017a). A two-year study of Colorado's managed FFS model demonstrated savings of $120 per member per month, with other funded initiatives accounting for approximately 20 percent of those savings (Colorado HCPF 2017).

However, stakeholders have raised concerns about certain aspects of the Financial Alignment Initiative. Beneficiaries and advocacy groups have voiced concerns regarding enrollment processes and information available to beneficiaries when choosing a plan. Plans have raised concerns about the accuracy of enrollee contact information, adequacy of payment rates, willingness of providers to participate, and their ability to hire and retain care coordinators. Provider concerns include payment rates, burdensome service authorizations, claim submissions, and provider credentialing processes (Summer and Hoadley 2015, Watts 2015). Multiple health plans across participating states have dropped out of the demonstration (Dickson 2015, Virginia DMAS 2017, WNYLC 2016).

CMS contracted with RTI International for a comprehensive evaluation of the initiative including beneficiary experience, budgetary effects, and the effects on access to care, quality of care, and health outcomes; early findings on stakeholder engagement, care coordination, enrollment and beneficiary safeguards have been posted to the CMS website (CMS 2017e). MACPAC, among others, has examined beneficiaries' early experiences (MACPAC 2015a) and will continue to monitor the demonstration.[2]

Participation in the Financial Alignment Initiative

State participation

States needed to take several steps to participate in the Financial Alignment Initiative, including responding to a solicitation from CMS, submitting a letter of intent, submitting a proposal that specified what type of model they would establish, and signing a memorandum of understanding (MOU) with CMS.

Design contract awards. CMS issued a solicitation for design contract grants to support the upfront costs and infrastructure needed to design new delivery and payment models in December 2010. In June 2011, grants were provided for up to $1 million in funding to 15 states (CMS 2011a, FBO 2010).

Letters of intent. In July 2011, CMS requested 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; Table 1).

Proposals. Twenty-six states submitted an initial proposal (CMS 2011c, CMS 2015a). Of these, 16 subsequently withdrew their proposals and 2 partially withdrew their proposals citing concerns about the payment methodology, rate setting mechanisms, carve-out allowances, and limited interest from health plans (Tennessee DFA 2012, New Mexico DHS 2012, Idaho DHW 2014). For example, Tennessee officials noted that participating plans would receive lower capitation rates than under Medicare Advantage even though they would be held to higher standards for quality and care coordination (Tennessee DFA 2012). New Mexico withdrew its proposal after CMS did not approve its carve-out of LTSS (New Mexico DHS 2012). After one of two health plans in Washington withdrew from the capitated demonstration, the state cancelled its capitated model in February 2015 while continuing its managed FFS model demonstration (Community Catalyst 2015). In California, Alameda County dropped out of the demonstration due to the financial difficulties of the county's only participating plan, Alameda Alliance for Health (AIS Health Data 2015). Three states that initially withdrew their original proposals, later signed MOUs on subsequent proposals.

Extensions. CMS has offered states two opportunities to extend their demonstrations. In July 2015, states were offered the opportunity to extend their scheduled end dates by two years. According to CMS, extensions minimize risk of beneficiary disruption and allow states to have clearer decision-making ability for budgeting (CMS 2015b). Since then, 11 states extended their contracts although in some cases with changes in programs or processes. For example, in California the payment method for in-house services and supports will no longer be part of the capitated model but will be covered under Medicaid fee for service beginning January 1, 2018 (California DHCS 2017a and CalDuals 2017).

In January 2017, CMS offered three states—Washington, Massachusetts, and Minnesota—an additional two-year extension (AIS 2017, CMS 2017b).

Terminations. Colorado and Virginia will end their demonstrations in December 2017. Colorado will transition beneficiaries into the state's FFS accountable care collaborative program, without changes in benefits. Virginia will shift beneficiaries into a managed long-term services and supports (MLTSS) waiver program that began statewide in August 2017 (NASUAD 2017). This program is a fully integrated care model including physical health, behavioral health, home- and community-based services (HCBS), and institutional services (Virginia DMAS 2016).

TABLE 1. State Participation in the Financial Alignment Initiative

State	Received design contract award	Submitted letter of intent	Submitted proposal (by type)	Withdrew proposal	Signed MOU	Exiting demonstration
Total	**15**	**38**	**26**	**16**	**13**	**2**
Alabama	–	–	–	–	–	–
Alaska	–	✓	–	–	–	–
Arizona	–	✓	Capitated	✓	–	–
Arkansas	–	–	–	–	–	–
California	✓	✓	Capitated	–	✓	–
Colorado[1]	✓	✓	FFS	–	✓	✓
Connecticut	✓	✓	FFS	✓	–	–
Delaware	–	✓	–	–	–	–
District of Columbia	–	✓	–	–	–	–
Florida	–	✓	–	–	–	–
Georgia	–	–	–	–	–	–
Hawaii	–	✓	Capitated	✓	–	–
Idaho	–	✓	Capitated	✓	–	–
Illinois	–	✓	Capitated	–	✓	–
Indiana	–	✓	–	–	–	–
Iowa	–	✓	FFS	✓	–	–
Kansas	–	✓	–	–	–	–
Kentucky	–	✓	–	–	–	–
Louisiana	–	–	–	–	–	–
Maine	–	✓	–	–	–	–
Maryland	–	✓	–	–	–	–
Massachusetts	✓	✓	Capitated	–	✓	–
Michigan	✓	✓	Capitated	–	✓	–
Minnesota[2]	✓	✓	Capitated	✓	✓	–
Mississippi	–	–	–	–	–	–
Missouri	–	✓	FFS	✓	–	–
Montana	–	✓	–	–	–	–
Nebraska	–	–	–	–	–	–
Nevada	–	✓	–	–	–	–
New Hampshire	–	–	–	–	–	–
New Jersey	–	–	–	–	–	–
New Mexico	–	✓	Capitated	✓	–	–
New York[3]	✓	✓	FFS and capitated	✓	✓	–
North Carolina	✓	✓	FFS	✓	–	–

TABLE 1. (continued)

State	Received design contract award	Submitted letter of intent	Submitted proposal (by type)	Withdrew proposal	Signed MOU	Exiting demonstration
North Dakota	–	–	–	–	–	–
Ohio	–	✓	Capitated	–	✓	–
Oklahoma[4]	✓	✓	Capitated and FFS	✓	–	–
Oregon	✓	✓	Capitated	✓	–	–
Pennsylvania	–	✓	–	–	–	–
Rhode Island	–	✓	Capitated	–	✓	–
South Carolina	✓	✓	Capitated	–	✓	–
South Dakota	–	–	–	–	–	–
Tennessee	✓	✓	Capitated	✓	–	–
Texas	–	✓	Capitated	–	✓	–
Utah	–	–	–	–	–	–
Vermont	✓	✓	Capitated	✓	–	–
Virginia[5]	–	✓	Capitated	–	✓	✓
Washington[6]	✓	✓	Capitated and FFS	✓	✓	–
West Virginia	–	–	–	–	–	–
Wisconsin	✓	✓	Capitated			
Wyoming	–	–	–	–	–	–

Notes: FFS is fee for service. MOU is memorandum of understanding.
[1] Colorado's Financial Alignment Initiative is scheduled to end in December 2017.
[2] Minnesota withdrew its proposal, but signed a separate MOU with CMS that focuses on aligning administrative aspects of Medicaid and Medicare.
[3] New York withdrew its managed FFS proposal and has two capitated demonstrations, fully integrated duals advantage (FIDA) and fully integrated duals advantage for individuals with intellectual and developmental disabilities (FIDA-IDD), the latter of which focuses on individuals with intellectual and developmental disabilities.
[4] 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 Program of All-Inclusive Care for the Elderly (PACE) model.
[5] Virginia's Financial Alignment Initiative is scheduled to end in December 2017.
[6] Washington was approved to participate in both models but withdrew its plan to test the capitated model.
Sources: CMS 2016b. CMS 2015a. CMS 2015c. CMS 2011a. CMS 2011c. KFF 2014. KFF 2012.

Health plan participation

As of December 2017, 58 plans were participating in capitated models in 10 states (Table 2). Such plans are often referred to as Medicare-Medicaid Plans (MMPs). The number of MMPs ranges from one plan in Rhode Island and the New York fully integrated duals advantage for individuals with intellectual and developmental disabilities (FIDA-IDD) program to 14 plans in the New York Fully Integrated Duals Advantage (FIDA) program. Not all plans are offered in every participating county or region of a state. For example, California has 10 participating MMPs but only one plan, the Health Plan of San Mateo, serves San Mateo County.

MMPs are responsible for enrollment, communication with beneficiaries, care coordination and delivery of benefits. Plans selected by the state must meet CMS requirements. Some states used existing Medicaid managed care contracts to select plans 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 (CMS 2016r).

Some plans have dropped out of the demonstration. For example, Fallon Total Care announced in June 2015 that it would exit the Massachusetts demonstration because continued participation was not economically sustainable (Dickson 2015). In 2016, three plans in New York's FIDA demonstration—AlphaCare, WellCare, and CenterLight—announced they would no longer participate, following four plans that had dropped out in 2015. Some of these plans had relatively low enrollment (WNYLC 2016, CMS 2016c).

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

TABLE 2. MMP Experience Serving Dually Eligible Beneficiaries, Prior to the Financial Alignment Initiative, as of December 2017

Participating plans by state	Prior experience in state		No prior experience in state with D-SNP or Medicaid managed care plan
	D-SNP[1]	Medicaid managed care plan[2]	
California (10 plans)			
Anthem Blue Cross Cal MediConnect	✓	✓	–
Care1st Health Plan	✓	✓	–
Community Health Group	✓	✓	–
HealthNet Cal MediConnect Medicare Medicaid	✓	✓	–
Health Plan of San Mateo	✓	✓	–
IEHP Dual Choice	✓	✓	–
LA Care Cal MediConnect Plan	✓	✓	–
Molina Healthcare of California	✓	✓	–
OneCare Connect	✓	✓	–
Santa Clara Family Health Plan Cal	–	✓	–
Illinois (7 plans)			
Aetna Better Health Premier Plan	–	–	✓
Blue Cross Community MMAI	–	–	✓

TABLE 2. (continued)

Participating plans by state	Prior experience in state		No prior experience in state with D-SNP or Medicaid managed care plan
	D-SNP[1]	Medicaid managed care plan[2]	
Cigna-HealthSpring	✓	–	–
Humana Gold Plus Integrated	✓	–	–
IlliniCare Health	–	–	✓
Meridian Complete	✓	–	–
Molina Healthcare of Illinois	✓	–	–
Massachusetts (2 plans)[3]			
Commonwealth Care Alliance, Inc.	✓	✓	–
Tufts Health Plan	✓	✓	–
Michigan (7 plans)			
Aetna Better Health Premier Plan	–	–	✓
AmeriHealth Caritas VIP Care Plus	–	–	✓
Michigan Complete Health, Inc.	✓	✓	–
HAP Midwest MI Health Link	✓	✓	–
Meridian Complete	✓	✓	–
Molina Healthcare of Michigan	✓	✓	–
Upper Peninsula Health Plan (UPHP) MI Health	✓	✓	–
New York FIDA (14 plans)			
Aetna Better Health FIDA Plan[4]	–	–	✓
Agewell New York FIDA Plan	✓	–	–
Centers Plan for FIDA Care Complete[4]	–	–	✓
Elderplan FIDA Total Care	✓	✓	–
Fidelis Care	✓	✓	–
GuildNet Gold Plus FIDA	✓	✓	–
Healthfirst Medicare Plan	✓	–	–
ICS Community Care Plus FIDA MMP	–	✓	–
MetroPlus FIDA	✓	✓	–
North Shore-LIJ Health Plan, Inc.[4]	–	–	✓
RiverSpring FIDA Plan	–	✓	–
SWH Whole Health FIDA Plan	✓	✓	–
VNSNY CHOICE FIDA Complete	✓	✓	–
VillageCareMAX Full Advantage FIDA[5]	–	✓	–
New York FIDA-IDD (1 plan)			
Partners Health Plan	–	–	✓
Ohio (5 plans)			
Aetna Better Health of Ohio, MyCare Ohio	–	–	✓
Buckeye Health Plan—MyCare Ohio[6]	✓	✓	–
CareSource MyCare Ohio[6]	✓	✓	–

TABLE 2. (continued)

Participating plans by state	Prior experience in state		No prior experience in state with D-SNP or Medicaid managed care plan
	D-SNP[1]	Medicaid managed care plan[2]	
Molina Healthcare of Ohio[6]	✓	✓	–
United Healthcare Community Plan[6]	✓	✓	–
Rhode Island (1plan)			
Neighborhood Health Plan of Rhode Island[7]	–	–	✓
South Carolina (3 plans)			
Absolute Total Care[7]	–	–	✓
FIRST CHOICE VIP CARE PLUS	–	–	✓
Molina Healthcare of South Carolina, Inc.	–	–	✓
Texas (5 plans)			
Amerigroup STAR+PLUS MMP	✓	✓	–
Cigna-Healthspring CarePlan	✓	✓	–
Molina Healthcare of Texas	✓	✓	–
Superior HealthPlan	✓	✓	–
UnitedHealthcare	✓	✓	–
Virginia (3 plans)			
Anthem Healthkeepers[7]	–	–	✓
Humana Gold Plus Integrated	✓	–	–
Virginia Premier CompleteCare[7]	–	–	✓

Notes: FIDA is fully integrated duals advantage. MMP is Medicare-Medicaid plan. Health plans are listed by their marketing name in the CMS monthly enrollment data.
[1] Plans serving dually eligible beneficiaries through a D-SNP are from CMS SNP Comprehensive Report, as of December 2014 (CMS 2014a).
[2] Plans serving dually eligible beneficiaries in Medicaid managed care are from the CMS Medicaid managed care enrollment report for 2014. Data for each plan is as of July 2013 (CMS 2015d).
[3] In Massachusetts, both participating plans served dually eligible beneficiaries in the Senior Care Options program which authorizes, delivers, and coordinates all services covered by Medicaid and Medicare for certain individuals 65 and older.
[4] All participating plans must have met the requirements to become a managed long-term care plan and must have received a certificate of authority to operate in the state by May 14, 2013. These plans met this requirement.
[5] This plan served dually eligible beneficiaries in a Medicaid long-term-care only plan.
[6] In 2014, Ohio concurrently implemented mandatory Medicaid managed care and the Financial Alignment Initiative. All Medicaid beneficiaries were transitioned into Medicaid managed care plans. Plans identified as having prior experience serving dually eligible beneficiaries have served them since the launch of MyCare Ohio in 2014.
[7] As of July 2014, Neighborhood Health Plan (RI), Absolute Total Care (SC), and Anthem and VA Premier (VA) served Medicaid-only beneficiaries through their state Medicaid managed care plan, but did not include dually eligible beneficiaries (CMS 2015d).
Sources: CMS 2016p. CMS 2015d. CMS 2014a. Illinois DHFS 2012. KFF 2015c. Massachusetts EOHHS 2015a. Michigan Health Link 2015. NYLAG 2014. Pressey 2015. PR Newswire 2017. Texas HHS 2017. Virginia DMAS 2015.

Enrollment

Over 1.3 million full benefit dually eligible beneficiaries meet eligibility criteria in the 10 states that are participating in the capitated model. Since October 2013, enrollment has grown from fewer than 500 beneficiaries to over 404,000 beneficiaries in December 2017 (CMS 2017b, CMS 2017c).

Target groups

States may target enrollment to specific groups of beneficiaries or 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). Other states limit enrollment to specific regions and focus on populations defined by age or degree of service need.

Enrollment process

Typically, states participating in the capitated model provide an opt-in enrollment period during which beneficiaries can select a health plan (Table 3). Except in New York and California, this opt-in period is followed by a passive enrollment period during which any remaining beneficiaries who have not selected a plan are automatically assigned to one.

Enrollees can opt out of the demonstration at any point and if they do so, they typically enroll in FFS or managed care to receive their benefits. High opt-out rates may reflect beneficiary preferences and pressure from providers. For example, nursing homes in Virginia reportedly discouraged beneficiaries from participating in the demonstration (Dickson 2011). Opt-out rates have been reported for the following states:

- New York FIDA: 49 percent as of May 2016 (NYSDOH 2016);
- California: 50 percent as of October 2017 (California DHCS 2017b);
- Massachusetts: 34.1 percent as of September 2017 (Massachusetts EOHHS 2017b).

Implementation

Massachusetts was the first state to enroll individuals into the demonstration, beginning in October 2013, while Rhode Island was the last, beginning enrollment in July 2016 (Justice in Aging 2017).

In the capitated model, start dates were frequently 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 (AIS 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 (AIS Health Data 2015, Nahmias 2015, Douglas 2014). In South Carolina, passive enrollment was initially delayed due to pending state legislative action on the budget (South Carolina DHHS 2016).

TABLE 3. Financial Alignment Initiative Demonstrations: Capitated Models, as of December 2017

State demonstration	Eligible beneficiaries	Timeline			Enrollment		
		MOU signed	Demo start date[1,2]	Demo end date	Passive enrollment[2]	Number of enrollees[3]	Estimates of number eligible
California: Cal MediConnect	Full-benefit dually eligible beneficiaries age 21 and older; live in a participating county; meet certain continuous eligibility requirements; are not enrolled in certain HCBS waivers or residents of certain institutions	March 2013	April 2014	December 2019	Suspended July 2016	118,130	424,000
Illinois Medicare-Medicaid Alignment Initiative	Full-benefit dually eligible beneficiaries age 21 and older; live in a participating region; are not enrolled in certain HCBS waivers or certain other programs	February 2013	March 2014	December 2019	June 2014	53,085	154,000
Massachusetts One Care	Full-benefit dually eligible beneficiaries age 21 and older; live in a participating county; are not enrolled in HCBS waivers; are not residents of certain institutions	August 2012	October 2013	December 2020[4]	January 2014	18,551	101,000
Michigan MI Health Link	Full-benefit dually eligible beneficiaries age 21 and older; live in a participating county; have not previously disenrolled from Medicaid managed care due to special disenrollment, or elected hospice services, or have CSHCS services.	April 2014	March 2015	December 2020	Between May and July 2015	39,993	105,000
New York Fully Integrated Duals Advantage (FIDA)	Full-benefit dually eligible beneficiaries age 21 and older; live in a participating region; require more than 120 days of community-based LTSS or are eligible for but not receiving facility-based or community-based LTSS; are not receiving inpatient services in an Office of Mental Health facility; are not residing in certain institutions or receiving certain services	August 2013	January 2015	December 2019[4]	Suspended December 2015	4,468	100,000
New York FIDA for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD)	Full-benefit dually eligible beneficiaries age 21 and older; live in a participating region; eligible for OPWDD services or ICF/IDD; receive section 1915(c) waiver services as an alternative to ICF/IDD placement; or are enrolled in the section 1915(c) OPWDD waiver	November 2015	April 2016	December 2020	None	713	20,000

TABLE 3. (continued)

State demonstration	Eligible beneficiaries	Timeline			Enrollment		
		MOU signed	Demo start date[1,2]	Demo end date	Passive enrollment[2]	Number of enrollees[3]	Estimates of number eligible
Ohio MyCare Ohio	Full-benefit dually eligible beneficiaries age 18 and older; live in a participating region; do not have developmental disabilities served through an ICF/IDD or waiver; are not enrolled in PACE or the Independence at Home demonstration	December 2012	May 2014	December 2019	January 2015	75,941	93,000
Rhode Island Integrated Care Initiative	Full-benefit dually eligible beneficiaries age 21 and older; live in Rhode Island; do not reside in certain institutions or receive certain services	July 2015	May 2016	December 2020	July 2016	14,382	30,000
South Carolina Healthy Connections Prime	Full-benefit dually eligible beneficiaries age 65 and older; live in South Carolina; are not enrolled in certain HCBS waivers; do not reside in certain institutions.	October 2013	February 2015	December 2018[4]	April 2016	11,726	50,000
Texas Dual Eligibles Integrated Care Demonstration Project	Full-benefit dually eligible beneficiaries age 21 and older; live in a participating county; qualify for SSI benefits or Medicaid HCBS STAR+PLUS waiver services; are not enrolled in certain HCBS waivers; do not reside in an ICF/IID.	May 2014	March 2015	December 2020	April 2015	44,073	165,000
Virginia Commonwealth Coordinated Care	Full-benefit dually eligible beneficiaries age 21 and older; live in a participating county; are not enrolled in certain waivers; do not live in certain institutions or receive certain services.	May 2013	April 2014	December 2017	July 2014	22,991	67,000
Total						**404,053**	**1,309,000**

Notes: CSHCS is Children's Special Health Care Services. HCBS is home- and community-based services. ICF/IID is intermediate care facility for individuals with intellectual disabilities. ICF/IDD is intermediate care facility for individuals with developmental disabilities. LTSS is long-term services and supports. OPWDD is Office for People with Developmental Disabilities. PACE is Program of All-inclusive Care for the Elderly. SSI is Supplemental Security Income. Estimates of the number of eligible beneficiaries are from the Medicare Payment Advisory Commission's (MedPAC) June 2016 Report to the Congress, Chapter 9, and from CMS press releases.

[1] The date when beneficiaries could first opt-in.

[2] California and Michigan have a range of opt-in start dates that vary by county or region. Michigan's passive enrollment start dates vary by region. The New York FIDA program suspended its passive enrollment in December 2015, and California ended its passive enrollment program in July 2016.

[3] Enrollment is as of December 2017.

[4] Extension pending or under discussion.

Sources: CMS 2017c. CMS 2016a. CMS 2016c–m. CMS 2015d. CMS 2014a. Illinois DHFS 2012. Massachusetts EOHHS 2017a. Massachusetts EOHHS 2015a. MedPAC 2016. Michigan Health Link 2015. Ohio DM 2014. NCLER 2017. NYLAG 2014. Pressey 2015. Texas HHS 2017. Virginia DMAS 2015.

Payment Framework in the Capitated Model

CMS and the states jointly develop capitation rates for 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, another from CMS for Medicare Part D, and a third from the state for Medicaid. Payment rates are established by 1) projecting baseline spending, 2) applying savings percentages, 3) applying risk adjustments, 4) applying additional risk mitigation techniques, and 5) applying withhold percentages (CMS 2012d, Brandel and Cook 2013). Over time, CMS and the states have made changes to these elements in order to keep the program financially sustainable. Elements of payment rates and changes to these elements are described below.

Projecting baseline spending

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

Medicaid baseline spending. 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 is modeled using historical FFS enrollment projected to the time period of the demonstration (CMS 2012d, Brandel and Cook 2013).

Medicare baseline spending. While the Medicaid methodology varies across states, there is only one Medicare methodology (CMS 2012d, 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 2013h, 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 2013h, CMS 2012d, 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 which are deducted up front from Medicaid and

Medicare payments to plans. These percentages 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 2013h).

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 2013h).[3] 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, KFF 2015b). 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 down to 0.5 percent, and in year 3 down 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. Financial Alignment Initiative Demonstrations: Medicare and Medicaid Savings Percentages for Capitated Payments, as of December 2017

State	Demonstration year				
	Year 1	Year 2	Year 3	Year 4	Year 5
California[1]	1%–1.47%	2%–3.5%	4%–5.5%	4%–5.5%	4%–5.5%
Illinois	1%	3%	5%	5%	5%
Massachusetts[2]	0%–1%	0%	0%	.25%	.50%
Michigan	1%	2%	4%	4%	4%
New York FIDA	1%	1.5%	3%	Not yet available	Not yet available
New York FIDA-IDD[3]	.25%	.5%	1%	1%	N/A[7]
Ohio[4]	1%	2%	4%	4%	4%
Rhode Island[3]	1%	1.25%	3%	3%	N/A
South Carolina	1%	2%	4%	Not yet available	Not yet available
Texas[5]	1.25%–2.75%	3.75%	5.5%	5.5%	5.5%
Virginia	1%	1%	2%	N/A	N/A

TABLE 4. (continued)

Notes: FIDA is fully integrated duals advantage. FIDA-IDD is fully integrated duals advantage for individuals with developmental disabilities.
[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 one percent savings percentage to the Medicaid and Medicare capitated rate.
[3] Demonstration is four years long.
[4] Saving percentages for demonstration years 4 and 5 for the Ohio demonstration are 4 percent (CMS 2016n).
[5] 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 2017d. CMS 2016n. CMS 2016o. CMS 2015c. CMS 2015e. KFF 2015b. CMS 2014b. CMS 2014c. CMS 2013a–e. CMS 2012a. CMS 2012b.

Risk adjustment

Risk adjustment modifies payments to 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 2012d, Brandel and Cook 2013, Massachusetts EOHHS 2012).

Each state classifies eligible beneficiaries into subgroups in an attempt to capture differences in risk among beneficiaries. These rating categories are specified by the state in their MOUs and three-way contracts.[4] 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, two different categories for HCBS, and community.

TABLE 5. Financial Alignment Initiative Demonstrations: Medicaid Rating Categories in the Capitated Models, as of December 2017

Rating category	Definition
California	
Institutionalized	Beneficiaries who reside in a long-term care facility for 90 or more days
HCBS high	Beneficiaries who are high users of HCBS, who receive community-based adult services, are part of the Medicare Shared Savings Programs (MSSP), or receive in-home supports and services (IHSS) or classified under the IHSS program as severely impaired
HCBS low	Beneficiaries who are low users of HCBS; they receive IHSS but are not classified as severally 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	
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 well	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
Massachusetts[1]	
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 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 skill need, have two or more ADL limitations, and have three days of skilled nursing need, and individuals with four or more ADL limitations, and who do not have a diagnosis 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 co-occurring diagnoses of substance use and serious mental illness

TABLE 5. (continued)

Rating category	Definition
Community Tier 1—community other	Beneficiaries who do not meet F1, C2, or C3 criteria
Michigan	
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	
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	
Dually eligible adults, age 21 to 49	Beneficiaries who are age 21 or older and less than 50 years of age
Dually eligible adults, age 50 and older	Beneficiaries who are age 50 and older
Ohio	
Nursing facility level of care (NFLOC)	Beneficiaries who meet an NFLOC standard as determined initially through waiver enrollment or 100 or more consecutive days in a nursing facility
Community well	Beneficiaries who do not meet the NFLOC standard
Rhode Island[2]	
Community non-LTSS	Enrollees living in the community and 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)

Rating category	Definition
South Carolina	
NF1: Nursing facility-based care	Beneficiaries identified as having a nursing facility stay of more than 3 months and meeting Medicare skilled nursing criteria or Medicaid NFLOC
H1: HCBS	Beneficiaries who do not meet NF1 criteria, and meet the level of care requirements for nursing facility placement or applicable HCBS waiver
H2: HCBS plus	Beneficiaries moving away 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	
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	
Nursing facility level of care: age 21 to 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 and older	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 to 64	Beneficiaries age 21–64 who do not meet an NFLOC standard or meet an NFLOC standard and are currently in a nursing facility for fewer than 20 days
Community well: age 65 and older	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: FIDA is fully integrated duals advantage. FIDA-IDD is fully integrated duals advantage for individuals with intellectual disabilities. HCBS is home and community based services. LTSS is long term services and supports.
[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–e. CMS 2012a. CMS 2012b.

The rating categories ultimately determine the Medicaid rate the plan receives. 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 EOHHS 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. MLR 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 demonstration states 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 must 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. Massachusetts is the only state with a capitated model that uses a high-cost risk pool to mitigate the risk of adverse selection that is drawing a disproportionate number of high-cost enrollees. These were established in the fourth year of the demonstration (EOHHS 2017c). High cost is 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. These funds are then divided among participating plans based on their share of total costs above the threshold amount associated with the high-cost members (CMS 2012a).

Risk corridors. Risk corridors are used to protect plans against uncertainty in rate setting when they lack data on health spending for potential enrollees (AAA 2011). Michigan applied risk corridors for the first year of its demonstration, Massachusetts applied risk corridors for the first four years, and California applied risk corridors for the first 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). New York's FIDA-IDD demonstration has applied risk corridors to the first three years of the demonstration (CMS 2015e). Rhode Island is also applying risk corridors in its demonstration (CMS 2015c).

Quality measures and withholds

Withholds. CMS and states also withhold a portion of capitation payments from both the Medicare and Medicaid portion that plans can earn back upon meeting certain quality thresholds. Withholds are from 1 to 3 percent. If the plan achieves its measures, the withhold amount is repaid retrospectively (CMS 2016q, Brandel and Cook 2013).

Some quality measures are consistent across all the demonstrations and are drawn from the Healthcare Effectiveness Data and Information Set (HEDIS), Health Outcomes Survey, Consumer Assessment of Healthcare Providers and Systems (CAHPS), and existing Part D measures.[5] State-specific measures include those related to LTSS, utilization, coordination, transitions, and waiver requirements (CMS 2012e). Measures may also vary from year to year.

Star rating system. In November 2015, CMS announced it would develop a star rating system for health plans participating in the Financial Alignment Initiative, and received comments from stakeholders. The

star rating system is built off the Medicare Advantage and Part D star rating system, but also measures quality across the full spectrum of Medicare and Medicaid services, including LTSS and treatment related to behavioral health and substance use. CMS has published some performance data on eight capitated models, but notes the limitations of those data.

Benefits and Care Delivery in the Capitated Model

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 vary both within and across states. Some capitated models require plans to offer additional benefits. For example, 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 palliative care benefits (CMS 2015g, Walsh et al. 2014). New York's FIDA-IDD offers expanded inpatient and outpatient psychiatric services, including inpatient mental health over the 190-day Medicare lifetime limit, intensive psychiatric rehabilitation treatment programs, intensive behavioral health services, and substance use disorder services.

Plans may also contract with community-based entities to 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, the plan, and providers (CMS 2012a). In Ohio, plans must contract with area agencies on aging to coordinate services for enrollees age 60 and older (CMS 2012b).

Some states carve out certain benefits from their capitated models. For example, in California, plans are financially responsible for all Medicare behavioral health services; some Medicaid specialty mental health services and certain Medi-Cal drug benefits are not included in the capitated payment.[6] These services are financed and administered by county agencies under the state's Medicaid managed care waiver and its state plan.[7] California requires plans to contract with county mental health and substance use agencies to ensure that enrollees have access to those services (California DHCS 2013).

TABLE 6. Financial Alignment Initiative Demonstrations: Selected Benefits Offered in the Capitated Models, as of December 2017

State	Expanded state Medicaid plan benefits	Carved out benefits[1]	Required community involvement
California	• Non-emergency medical transportation • Vision	• Behavioral health[2] • Hospice	• Not specified in MOU
Illinois	• None	• ICF/IDD	• Not specified in MOU

TABLE 6. (continued)

State	Expanded state Medicaid plan benefits	Carved out benefits[1]	Required community involvement
Massachusetts	• Dental • Personal care assistance with cueing and monitoring • Durable medical equipment • Diversionary behavioral health • Community support services	• Targeted case management services • Rehabilitation option services • Medicare hospice	• Plans are required to contract with an LTSS coordinator who would work with a community organization for provision of LTSS
Michigan[3]	• HCBS waiver services and items	• Mental health and substance use services	• Not specified in MOU
New York FIDA	• HCBS waiver services and items	• 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 health services • Individual directed goods and services • Transportation • Substance use disorder 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 residence

TABLE 6. (continued)

State	Expanded state Medicaid plan benefits	Carved out benefits[1]	Required community involvement
Ohio	• None	• Hospice	• Plans are required to contract with area agencies on aging to coordinate waiver services for individuals 60 and older
Rhode Island	• None[4]	• Dental • Hospice • Non-emergency medical transportation • Residential services for enrollees with intellectual and developmental disabilities • Opioid use disorder treatment program health homes	• Not specified in MOU
South Carolina	• Palliative care	• Hospice • Non-emergency medical 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: FIDA is fully integrated duals advantage. FIDA-IDD is fully integrated duals advantage for individuals with intellectual and developmental disabilities. HCBS is home- and community-based services. ICF/IDD is intermediate care facility for individuals with development disabilities. LTSS is long term services and supports. MOU is memorandum of understanding. OPWDD is office for people with developmental disabilities.
[1]Although the participating plan does not cover these services, beneficiaries have access to them through Medicare or Medicaid fee for service.
[2]Some Medicaid specialty mental health rehabilitative and targeted case management services and non-Medicare drug services are not included in the capitated payment.
[3]In Michigan, home- and community-based waiver services and items are only available to enrollees who meet a nursing facility level of care 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.

TABLE 6. (continued)

[4]Rhode Island's MOU and three-way contract allow the state and CMS to consider adding certain supplemental benefits (e.g., integrated pain management program, Screening, Brief Intervention and Referral to Treatment, and non-emergency medical transportation) to the required demonstration benefit package in subsequent demonstrations years (CMS 2016o, CMS 2015c).

Sources: CMS 2016o. CMS 2015c. CMS 2014b. CMS 2014c. CMS 2013a–f. CMS 2012a. CMS 2012b.

Care Coordination in the Capitated Model

The capitated model is designed to coordinate services through a single health plan. Each demonstration program specifies different levels of care coordination, which 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 with activities of daily living (ADLs), and cognitive status including dementia. The specific components of the assessment and the timeline are spelled out in the MOU or the three-way contract. For example, in Massachusetts each health plan must complete the comprehensive assessment tool for each new enrollee within 90 days of enrollment and such assessments must 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 and members of the enrollee's care team. The structure and timeline for putting care plans into action are included in the 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 a plan with the enrollee and his or her care team within 90 days of enrollment, and must review the 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 the state's MOU. Typically, the team includes the enrollee, a primary care provider, care coordinator, LTSS providers, specialists, and family members. The care coordinator—sometimes referred to as the care manager or service coordinator—usually helps develop the care plan, coordinates 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, physician 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, at the beginning of the demonstration, states require plans to allow enrollees to continue to see their established providers and complete an ongoing course of treatment, 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. 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 DHCS 2016).

One study found issues with continuity of services during early implementation of the program (Summer and Hoadley 2015). 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 if they were required to change providers when the transition period ended (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 developed their demonstration proposals.

Appeals

While the Financial Alignment Initiative gives 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

States must establish an ombudsman program to address concerns or conflicts that may interfere with enrollment or access to benefits and services. The ombudsman program also provides enrollees with information and assistance in resolving issues related to the demonstration, including filing appeals and grievances (CMS 2013i).

The U.S. Department of Health and Human Services made dedicated funding available to support such programs. Ten states, including eight testing the capitated model, received funding through a special funding opportunity offered in 2013 and have established ombudsman programs (CMS 2015gj). The federal Administration for Community Living (ACL) operates the Duals Demonstration Ombudsman Technical Assistance Program to support the design and implementation of the Financial Alignment Initiative's ombudsman program (ACL 2017).

Program Evaluation

CMS has contracted with RTI International to evaluate the demonstrations as well as conduct state-specific evaluations. This includes site visits; data analysis; focus groups; key informant interviews; and an analysis of changes in quality, utilization, and cost measures associated with the demonstrations.

CMS reports released in 2016 focus on early implementation, care coordination, and beneficiary experience. Major challenges facing capitated models include hiring and retaining care coordinators; reaching enrollees; completing health risk assessments and individualized care plans; involving all members of the interdisciplinary care teams, including physicians and enrollees; and sharing and coordinating information among providers. A March 2017 report noted that the demonstrations were

making progress in recruiting care coordinators, and implementing systems to integrate care across settings. Enrollees noted continuing challenges including access to providers, pharmacy, medical equipment and supplies; adequacy of networks; and understanding of benefits, rights, and protections (CMS 2017e; CMS 2017f).

Preliminary analysis of Washington's FFS plan finds that the demonstration reduced Medicare spending by a total of $67 million for demonstration periods 1 and 2; however, data on changes in Medicaid spending and service utilization are not yet available. Annual reports on the demonstrations in Massachusetts and Minnesota provide insights into the successes and challenges of implementation. Evaluations should be available about one year after the scheduled end date of each demonstration (CMS 2015h).

In late 2014 and early 2015, MACPAC conducted focus groups with enrollees in California, Massachusetts, and Ohio to better understand enrollment processes, communication with beneficiaries, and experiences receiving care coordination and accessing services (MACPAC 2015b, PerryUndem 2015). Although results varied by state, in general, most focus group participants supported the concept and purpose of the demonstration, valued the expanded services they received, were able to keep their primary care provider, and noticed a decrease in costs. However, participants did not have a clear understanding of the demonstration, 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.

In 2016, the Medicare Payment Advisory Commission conducted site visits to California, Illinois, and Massachusetts to learn from stakeholders. Stakeholders noted that beneficiaries were likely to opt out or disenroll from the demonstration if they were satisfied with their existing care, they had insufficient information regarding the demonstration, or there was 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 were not yet available (Rollins 2016).

The Kaiser Family Foundation also conducted stakeholder interviews in Massachusetts, Ohio, and Virginia in 2015. 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 because of negotiations with providers, lack of provider and beneficiary outreach, and implementation of new information technology systems. Plans had difficulty locating beneficiaries. Plans were also identifying unmet health needs through the health risk assessments (KFF 2015a).

Endnotes

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

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

[3] Savings assumptions are based on literature suggesting that 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.

[4] 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.

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

[6] 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.

[7] Section 1915(b) of the Social Security Act 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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