Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare

Medicaid and Medicare together provide health coverage for 10.7 million low-income seniors and people with disabilities who are dually eligible for both programs (MACPAC 2015a). 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 2014).

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 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, they often must navigate multiple sets of requirements, benefits, and plans. In addition, differing coverage and payment policies may create incentives to shift costs back and forth between states and the federal government, leading to underutilization in some cases and overutilization in others. Lack of coordination between the programs may result in fragmented care, leading 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 three-year 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 eligible for a retrospective performance payment if they meet established quality thresholds and Medicare achieves a target level of savings.

As of September 2015, 13 states participate in the demonstration (10 under the capitated model and 3 under the managed FFS or an alternative model), with approximately 400,000 individuals enrolled (CMS 2011a, CMS 2015a).[2] Each state model is unique with different target populations, benefits and 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. 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

receiving incorrect participant contact information from CMS and states. Providers have voiced concerns regarding fees, passive enrollment, service authorizations, claim submissions, and credentialing processes (Summer and Hoadley 2015, Watts 2015).

CMS has contracted with RTI International for a comprehensive evaluation of the beneficiary experience, cost savings, and effects on access to care, quality of care, and health outcomes. Preliminary results will not be available until 2016. MACPAC, among others, has examined beneficiaries' early experiences (MACPAC 2015b) and will continue to monitor the demonstration.[3]

This issue brief describes the overall design of the initiative, and compares key provisions of state approaches in the 10 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 2011b, 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 2011a). 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 March 2015, 26 states followed through with a proposal (CMS 2011c, CMS 2015b). Subsequently, 13 states fully withdrew and 2 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). The director of Tennessee's Medicaid program, TennCare, noted that participating plans would receive lower capitation rates than Medicare Advantage plans even thought they would be held to higher standards of quality and care coordination (State of Tennessee Department of Finance and Administration 2012).

New Mexico withdrew its proposal because it failed to obtain a carve out for 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 FFS model demonstration (Washington State Health Care Authority 2015). In California, Alameda County has dropped out of the demonstration due to financial difficulties of the county' s participating plan, Alameda Alliance for Health (Atlantic Information Services 2015).

As of March 2015, 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 is participating in an alternative form of the demonstration testing the integration of administrative functions without financial alignment (CMS 2015a). Connecticut submitted a FFS model proposal to CMS that has not yet been approved (CMS 2015b).

TABLE 1. State Interest in the Financial Alignment Initiative

State	Received design contract award	Submitted letter of intent	Submitted proposal	Withdrew proposal	Signed MOU
Alaska		X			
Arizona		X	Capitated	X	
California	X	X	Capitated		X
Colorado	X	X	FFS		X
Connecticut	X	X	FFS		
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	
Pennsylvania		X			

TABLE 1. (continued)

State	Received design contract award	Submitted letter of intent	Submitted proposal	Withdrew proposal	Signed MOU
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		X	Capitated		X
Washington[4]	X	X	FFS and capitated	X	X
Wisconsin	X	X	Capitated	X	
Total	**15**	**38**	**26**	**13 fully withdrawn, 2 partially withdrawn**	**10 capitated, 2 FFS, and 1 other**

Notes: MOU is memorandum of understanding. FFS is fee for service. Connecticut submitted a proposal to CMS, which is still active but has not yet been approved. States that did not submit a letter of intent or 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 participation in managed FFS.
[3]Oklahoma's proposal consisted of three demonstration project ideas.
[4]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 2015q, CMS 2011b, CMS 2011c, CMS 2015a, CMS 2015b, Integrated Care Resource Center 2014, KFF 2012.

Health plan participation

As of August 2015, 66 plans were participating in capitated models in the nine states actively enrolling and serving beneficiaries (Table 2). The number of participating plans ranges from 3 plans in Massachusetts to 21 plans in New York. 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). One of these was 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).

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, South Carolina, or Virginia,

had experience serving dually eligible beneficiaries in Medicaid managed care. Some had served dually eligible beneficiaries in other states (CMS 2011d). Most of the plans participating in California, Massachusetts, Michigan, New York, Ohio, and Texas 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 (CMS 2014f).

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

State[1]	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)[2]	Medicaid managed care plan in state prior to demonstration (2011)[3]	
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	8	• 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) • Health Alliance Medical Plans
Massachusetts	3	• Commonwealth Care Alliance • Fallon Total Care[5] • Tufts Health Plan-Network Health	• Commonwealth Care Alliance[6] • Fallon Total Care[5,6] • Tufts Health Plan-Network Health[6]	• None
Michigan	7	• Fidelis SecureCare of Michigan • HAP Midwest Health Plan • Molina • Upper Peninsula Health Plan	• Aetna Better Health of Michigan, Inc. • HAP Midwest Health Plan • Molina • Upper Peninsula Health Plan	• AmeriHealth Michigan, Inc.
New York	21	• Agewell New York, LLC • AlphaCare of New York, Inc. • Amerigroup New York, LLC • CenterLight Healthcare, Inc • Elderplan, Inc. • GuildNet, Inc. • Health Insurance Plan of Greater New York • Managed Health, Inc. • MetroPlus Health Plan, Inc. • New York State Catholic Health Plan, Inc.	• Amerigroup New York, LLC • Catholic Managed Long-term Care, Inc.[7] • CenterLight Healthcare, Inc.[7] • Elderplan, Inc. • Elderserve Health, Inc.[7] • GuildNet, Inc. • Health Insurance Plan of Greater New York • Independence Care System, Inc.[7] • Managed Health, Inc.	• Aetna Better Health of NY, Inc.[8] • Centers for Health Living, LLC[8] • Integra MLTC, Inc.[8] • North Shore-LIJ Health Plan, Inc.[8]

TABLE 2. (continued)

State[1]	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)[2]	Medicaid managed care plan in state prior to demonstration (2011)[3]	
New York (continued)	21	• Senior Whole Health of New York, Inc. • VNS Choice • Wellcare of New York, 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[7] • VNS Choice • WellCare of New York, Inc.	
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.[9] • CareSource[9] • Molina Healthcare of Ohio, Inc.[9] • United Healthcare Community Plan of Ohio, Inc.[9]	• Aetna Better Health, Inc.
South Carolina	4	• Select Health	• None	• Absolute Total Care • Advicare Molina
Texas	5	• Amerigroup • Cigna-HealthSpring • Molina • Superior • United	• Amerigroup • Molina • Superior	• None
Virginia	3	• Humana	• None	• Anthem • VA Premier

Notes:
[1]Rhode Island is not included in this table as it has not yet specified the plans participating in its demonstration. However, the MOU notes that the one health plan participating in the Rhody Health Options program (Neighborhood Health Plan of Rhode Island) is the only current prospective plan for the demonstration (CMS 2015r).
[2]Unless noted otherwise, data on plans serving dually eligible beneficiaries through a D-SNP are from CMS SNP Comprehensive Report (CMS 2014f).
[3]Unless noted otherwise, data on plans serving dually eligible beneficiaries in Medicaid managed care are from CMS, Medicaid managed care enrollment report (CMS 2011d).
[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).
[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]Denotes plans that served dually eligible beneficiaries in a Medicaid long-term-care only plan.
[8]All plans participating in the New York demonstration must have met all requirements to become a managed long-term care (MLTC) plan and have received a certificate of authority to operate a MLTC plan in the state by May 14, 2013. These plans met this requirement.
[9]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.

Sources: California Department of Health Care Services 2015, CMS 2014f, CMS 2011d, Massachusetts Executive Office of Health and Human Services 2015a, MI Health Link 2015, MyCare Ohio 2014, New York Legal Assistance Group 2014, 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 beneficiaries are eligible to enroll in the 10 participating states. Since the launch of the first capitated demonstration in October 2013, enrollment has grown steadily, from approximately 9,800 enrollees in January 2014, to approximately 400,000 enrollees in September 2015 (CMS 2015a, CMS 2015c, CMS 2015n).

Target groups

States may target enrollment to specific groups of beneficiaries and 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. The eight other 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. New York 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 2012a, CMS 2013a, CMS 2013b).[4]

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 (Cal Duals 2014).[5]

Enrollees can opt out of the demonstration at any point and 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). For example, 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).

Currently, opt-out rates are only available for a few states. As of July 1, 2015, approximately 28 percent of all demonstration-eligible beneficiaries living in Massachusetts and approximately 44 percent of all eligible beneficiaries in California opted out of the demonstration (Massachusetts Executive Office of Health and Human Services 2015a, California Department of Health Care Services 2015a). As of March 7, 2015, approximately 19 percent of eligible individuals had opted out of the demonstration in New York (New York Health Access 2015a, CMS 2015n). (At that time New York had not yet begun passive enrollment.) In addition, approximately 40 percent of eligible individuals opted out of the Virginia demonstration.

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 participation (Dickson 2011, Gutman 2014). California reports that approximately 9 percent of enrolled members voluntarily disenrolled from its capitated program as of July 1, 2015 (California Department of Health and Human Services 2015b).

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. Texas is the most recent state to start enrollment, with opt-in enrollment beginning in March 2015 and passive enrollment in April 2015 (CMS 2015d, CMS 2015k).

In the capitated model, enrollment starts 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 2015, Nahmias 2015, Douglas 2014).

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

State	Demonstration	Eligible beneficiaries	MOU signed	Opt-in (O) and passive (P) enrollment start dates[1]	Enrollment as of September 2015[2]	Estimated 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	O: April 1, 2014–July 2015 P: April 1, 2014–August 2015	120,039	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	O: March 1, 2014 P: June 1, 2014	54,411	135,000
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	O: October 1, 2013 P: January 1, 2014	17,503	97,987
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	O: March 1, 2015–May 1, 2015 P: May 1, 2015–July 1, 2015	48,108	100,000
New York	Fully Integrated Duals Advantage	• 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	O: January 1, 2015 P: April 1, 2015	8,303	150,000
Ohio	MyCare Ohio	• Full benefit dually eligible; • Age 18 and older; • Living in participating region; and,	December 11, 2012	O: May 1, 2014	63,426	115,000

TABLE 3. (continued)

State	Demonstration	Eligible beneficiaries	MOU signed	Opt-in (O) and passive (P) enrollment start dates[1]	Enrollment as of September 2015[2]	Estimated number eligible to enroll
Ohio (continued)	MyCare Ohio	• 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		P: January 1, 2015		
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	O: September 1, 2015[3] P: February 1, 2016[2]	N/A[4]	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	O: February 1, 2015 P: August 1, 2015[5]	1,784	53,600
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/IID	May 23, 2014	O: March 1, 2015 P: April 1, 2015	59,231	168,000
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	O: April 1, 2014 P: July 1, 2014	24,360	78,600
Total					**397,165**	**1,352,187**

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

[1]States with ranges of opt-in and passive enrollment start dates had dates that differed by county or region.

[2]Enrollment numbers are derived from the CMS Medicare Advantage Monthly Enrollment by Plan, September 2015 dataset (CMS 2015n).

[3]These dates represent the earliest enrollment could begin in Rhode Island based on its MOU. The MOU states that the passive enrollment can begin no earlier than September 1, 2015, and the tentative effective enrollment date for the first wave of passive enrollment is no earlier than February 1, 2016, or two months after the first opt-in effective enrollment date.

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

[5]As of June 2015 passive enrollment in South Carolina is on hold pending budget language considered by the South Carolina state legislature (Barnett, L., CMS 2015).

Sources: Barnett, L., CMS, CMS 2015c, CMS 2015d, CMS 2015e, CMS 2015f, CMS 2015g, CMS 2015h, CMS 2015i, CMS 2015j, CMS 2015k, CMS 2015l, CMS 2015n, CMS 2015q, CMS 2015r, CMS 2014d, CMS 2014e, CMS 2013i, CMS 2013j, CMS 2013k, CMS 2013l, CMS 2013m, CMS 2012d and CMS 2012e, Massachusetts Executive Office of Health and Human Services 2015b.

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 2012c, Brandel and Cook 2013). These factors 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.

Medicaid baseline. Each state develops a projection of baseline Medicaid costs in 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 2012c, Brandel and Cook 2013).

Medicare baseline. While the Medicaid methodology varies from state to state, the Medicare methodology is consistent across all states (CMS 2012c, Brandel and Cook 2013). To project what baseline Medicare costs would have been in absence of the demonstration, CMS calculates the Medicare Parts 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 2013n, 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 2013n, CMS 2012c, Brandel and Cook 2013).

Savings percentages

The Financial Alignment Initiative is intended to reduce spending over time through better care coordination and 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, savings percentages are deducted upfront from Medicaid and Medicare payments to plans. These percentages, established by CMS and each state, are applied equally to the Medicare Parts A and B and Medicaid baseline projections (CMS 2013c). Savings percentages are not applied to the Medicare Part D component of the rate (CMS 2013n).

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 2012, CMS 2013n).[6] 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 (CMS 2012c, Brandel and Cook 2013). States may also vary savings percentages by region. Most states expect savings percentages to increase each year. However, Massachusetts has amended the savings percentages from the original MOU reflecting an expectation of less savings than originally anticipated (Barry et al. 2015, Barnett, L. CMS 2015).

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

State	Demonstration year 1	Demonstration year 2	Demonstration 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%	0.5%	2%
Michigan	1%	2%	4%
New York	1%	1.5%	3%
Ohio	1%	2%	4%
Rhode Island	1%	1.25%	3%[3]
South Carolina	1%	2%	4%
Texas[4]	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 revised savings percentages for years 2 and 3. Originally, these were 2 percent in year 2 and 4 percent in year 3.
[3]The Rhode Island MOU notes that if plans experience annual losses in demonstration year 1 exceeding 3 percent of revenue in the aggregate of all regions in which the MMP participates, the savings percentage for demonstration year 3 will be reduced to 1.5 percent.
[4]Texas defines demonstration year 1 as Year 1a (March 1, 2015–December 31, 2015) and Year 1b (January 1, 2016–December 31, 2016).

Sources: Barnett, L., CMS 2015, CMS 2015q, CMS 2014a, CMS 2014b, 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 the 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 2012c, 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.[7] 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.
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 4 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 4 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 2—community high behavioral health (C2A)	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 do not have a co-occurring diagnoses of substance abuse and serious mental illness.
Michigan	3	Tier 1	Beneficiaries who meet the nursing facility level of care as determined by the Michigan NFLOCD on the first day of the month, and occupy a nursing facility bed certified for both Medicaid and Medicare.

TABLE 5. (continued)

State	Number of rating categories	Rating categories	Rating category definitions
Michigan (continued)	3	Tier 2	Beneficiaries who meet the nursing facility level of care as determined by the Michigan Nursing Facility Level of Care Determination (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	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.
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	4	Rating category 1	Enrollees eligible to receive community or facility-based LTSS
		Rating category 2	Enrollees residing in the community who are not eligible to receive LTSS
		Rating category 3	Enrollees with severe and persistent mental illness
		Rating category 4	Enrollees with intellectual/developmental disabilities
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.

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

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, 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 or 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).

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 2014b, CMS 2013e, CMS 2012a). Rhode Island will also apply risk corridors in its demonstration (CMS 2015q).

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.[8] 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).

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. 2014b).

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.[9] These services are financed and administered by county agencies under the state's Medicaid managed care waiver and its state plan.[10] 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 • Diversionary behavioral health • Community support services	• Targeted case management services • Rehabilitation option services • Medicare hospice	• Plans are required to contract with a community based organization to provide enrollees with a long-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

TABLE 6. (continued)

State	Expanded state Medicaid plan benefits	Carved out benefits[1]	Required community involvement
New York	• HCBS waiver items and services	• Hospice • Out-of-network family planning services • Directly observed therapy for tuberculosis • Methadone maintenance treatment	• Not specified in MOU
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	• N/A[4]	• Day/employment supports for enrollees with Intellectual/developmental disabilities (I/DD) • Dental • Family supports for enrollees with I/DD • HIV medical and non-medical case management • Hospice • Non-emergency transportation services • Residential services for enrollees with I/DD	• Not specified in MOU
South Carolina	• Palliative care	• Hospice • Non-emergency transportation	• Not specified in MOU
Texas	• None	• 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 a nursing facility level of care (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 states that the three-way contract, which is not yet available, will specify all services that the plans must cover. However, it does note that the state and CMS may consider adding certain supplemental benefits (e.g., integrated pain management program, Screening, Brief Intervention and Referral to Treatment (SBIRT), and non-medical transportation) to the required demonstration benefit package in demonstration years 2 and 3 (CMS 2015q).

Sources: CMS 2015q, CMS 2014a, CMS 2014b, 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 activities of daily living, 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 2013g). 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.

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 2013g, 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 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). Some 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 providers for either 90 days or one year, depending on the type of service (CMS 2012b).

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 New York integrates 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 (HHS) 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 2013f).

As of March 1, 2015, eight states, including six testing the capitated model, had received funding to support an ombudsman program (CMS 2015m). Of the 10 states participating in the capitated model, eight have established such programs (ACL 2015a, ACL 2015b, Cal Duals 2015, Council on Aging of Southwestern Ohio 2015, One Care Ombudsman 2015a, New York Health Access 2015b). South Carolina and Rhode Island have not yet identified its 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. The first state-specific annual report is expected to CMS in the beginning of 2016, while the final report to CMS regarding the entire demonstration is expected to be due to CMS in 2020 (Barnett, L., CMS 2015, CMS 2015o, 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).

Endnotes

[1] On July 16, 2015 CMS announced it will offer states participating in the Financial Alignment Initiative the opportunity to extend their demonstrations for an additional two years (CMS 2015p).

[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] 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 2015a).

[5] 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.

[6] Savings assumptions are based on literature that suggests that better care coordination can reduce emergency rooms 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.

[7] 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.

[8] 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.

[9] 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.

[10] 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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