Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare

Medicaid and Medicare together provide health coverage for approximately 12.2 million low-income seniors and people with disabilities who are eligible for both programs (MACPAC and MedPAC 2022). Dually eligible beneficiaries experience fragmented care and poor health outcomes due to poor coordination of services across both programs.[1] They also account for a disproportionate share of Medicaid and Medicare spending, about one-third of total costs to the federal government and the states in each program, although they represent about 14 percent of Medicaid beneficiaries and about 19 percent of Medicare beneficiaries (MACPAC and MedPAC 2022).

Medicare and Medicaid 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). Having multiple sources of coverage may mean that beneficiaries have to navigate multiple sets of requirements, benefits, and plans. 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 has pursued to improve coordination between the two programs is the Financial Alignment Initiative (FAI) demonstration. Under the FAI, CMS works with states to test models that coordinate financing across the two programs and integrate coverage of primary care, acute care, behavioral health and long-term services and supports (CMS 2021a). CMS offered states three models to choose from: (1) the capitated model in which CMS, a state, and health plans enter into a three-way contract agreeing to a blended capitated payment rate for participating plans for all Medicaid and Medicare benefits for dually eligible beneficiaries; (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, and (3) an alternative model where states have the flexibility to design a different approach and seek approval from CMS.

This issue brief describes the design of the FAI and the three types of models currently operating, with a focus on the capitated model since most states chose that type of model. Of the 11 states participating in the FAI as of January 2022, 9 states are operating a capitated model, 1 state is operating a managed FFS

model, and 1 state is operating an alternative model. We compare key provisions of state approaches in the nine capitated model demonstrations and describe the approaches used in Washington (managed FFS model) and Minnesota (alternative model) (CMS 2021a). The brief also describes the FAI's consumer protection requirements and provides a high-level summary of available evaluations, including some key takeaways.

Participation in the Financial Alignment Initiative

State participation in the FAI is voluntary, and, as noted above, 11 states are currently operating demonstration programs. Each state 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. Three demonstrations—Colorado, Virginia, and New York's Fully Integrated Duals Advantage (FIDA) model—have ended. In January 2022, CMS published a notice of proposed rulemaking suggesting that the nine states operating a capitated model should develop a plan to convert their Medicare-Medicaid plans (MMPs) to Medicare Advantage dual eligible special needs plans (D-SNPs), if the provisions of the proposed rule requiring greater integration in D-SNPs are finalized. The rule does not affect states participating in the managed FFS model or alternative model (CMS 2022a).

TABLE 1. State Participation in the Financial Alignment Initiative Demonstrations, 2022

State	Type of model	Beneficiaries enrolled[1]	Scheduled end date[4]
California	Capitated	114,001	December 31, 2022
Illinois	Capitated	90,122	December 31, 2023
Massachusetts	Capitated	31,568	December 31, 2022
Michigan	Capitated	40,216	December 31, 2023
Minnesota	Alternative	42,381[2]	December 31, 2023
New York, FIDA-IDD	Capitated	1,686	December 31, 2023
Ohio	Capitated	81,358	December 31, 2022
Rhode Island	Capitated	12,932	December 31, 2023
South Carolina	Capitated	15,035	December 31, 2023
Texas	Capitated	37,505	December 31, 2022[5]
Washington	Managed fee for service	11,657[3]	December 31, 2022

Notes: FIDA-IDD is Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities.
1 Enrollment numbers are current as of January 2022.
2 Enrollment numbers for Minnesota are current as of January 2022 (Minnesota DHS 2022). This enrollment figure represents enrollment in the Minnesota Senior Health Options (MSHO) program.
3 Enrollment numbers for Washington are current as of September 2021 (Washington HCA 2022).
4 Demonstration scheduled end dates may be extended at the joint discretion of CMS and the state.
5 This demonstration's end date has an option for renewal in 2023 (CMS 2021f).
Sources: CMS 2022b, CMS 2022c, CMS 2021b, CMS 2021c, CMS 2021d, CMS 2021e, CMS 2021f, CMS 2021j, CMS 2020a, CMS 2020b, CMS 2019a, ICRC 2022, Minnesota DHS 2022, and Washington HCA 2022.

Steps to establish a demonstration

States undertook several steps to participate in the FAI, 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.

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).[2]

Since 2015, CMS has worked with states to provide opportunities to extend demonstrations beyond the three years they were originally scheduled to last. Since then, 11 states requested extensions for their demonstrations and received approval from CMS. Extensions have typically been for two years and have occurred multiple times. CMS has allowed extensions to give states time for budget planning, for the Medicare Advantage bid process to occur, and to accommodate the federal clearance process (CMS 2017). In some cases, states changed their programs or processes as part of their extensions. For example, in California, the payment method for in-house services and supports is no longer part of the capitated model but, effective January 1, 2018, is covered under Medicaid FFS (California DHCS 2017a and CalDuals 2017). Notably, in its recent extension, Illinois expanded the demonstration to all counties in the state (CMS 2021c). As of January 2022, the 11 demonstrations are scheduled by December 31, 2023.

Demonstrations that have ended or are planned to end

Since the FAI began, several demonstrations have ended and beneficiaries were transitioned into new forms of integrated coverage. Colorado and Virginia ended their demonstrations in December 2017 and New York ended one of its two demonstrations in 2019. California is planning to end its demonstration in 2023. Some states ended demonstrations because of limited staff capacity and limited enrollment. Other states built on lessons from the demonstration to launch new statewide plans. These include managed long-term services and supports (MLTSS) programs and D-SNPs, a type of Medicare Advantage plan designed to provide coverage to dually eligible beneficiaries.

Colorado ended its demonstration because of a number of challenges (CMS 2021g). The state had limited staff capacity and funding to manage the demonstration and encountered major information technology (IT) challenges along the way. The state transitioned to a new IT vendor in early 2017, which created problems in many aspects of the demonstration including obtaining accurate eligibility and enrollment data. For example, some enrollees who had Medicare Part D coverage were told, at the point of service, that they did not, because Medicare enrollment data was not transferred accurately into the new system (CMS 2021h). Also, in some cases the new system identified individuals as enrolled in the demonstration even though they were not eligible because they had Medicare Advantage coverage (CMS 2021h). In addition, provider reporting of quality measures was low because the provider and payment requirements were not aligned with the quality measures (CMS 2021g). The demonstration did not result in any savings

to Medicare or Medicaid. At the end of the demonstration, the state transitioned beneficiaries into the state's FFS accountable care collaborative program, without changes in benefits.

Virginia ended its demonstration in 2017 and transitioned to a new MLTSS program, Commonwealth Coordinated Care (CCC) Plus (ADvancing States 2021). This program is a fully integrated care model and covers physical health, behavioral health, home- and community-based services (HCBS), and institutional services (Virginia DMAS 2016). Under CCC Plus, participating health plans are required to operate a D-SNP, allowing care coordination across Medicaid and Medicare services. Virginia's CCC Plus began regionally in 2017 and is now operating statewide (NASUAD 2017, ADvancing States 2021).

New York ended its FIDA demonstration in 2020 and transitioned to an integrated model based on enrolling dually eligible beneficiaries under Medicaid Advantage Plus (MAP) plans and affiliated D-SNPs operated by the same parent company. The FIDA demonstration had experienced declining enrollment leading to concerns from MMPs about continuing to participate. At its inception in 2015, the demonstration had 21 health plans participating and by the time it ended in 2019, 6 health plans were participating. Other concerns raised about FIDA included lower payment rates than other plans operating in the state such as MAP plans and a negative reputation established early on that kept providers and beneficiaries from participating (Greene and Feng 2021). The evaluation found that the extensive provider training requirements in place at the start of the demonstration along with a policy that required real-time meeting participation from providers and beneficiaries on the interdisciplinary care team contributed significantly to their decisions not to participate (Greene and Feng 2021). In consultation with MMPs, providers, and CMS, the state chose to end the demonstration on December 31, 2019, and thereafter the state transitioned the enrollees to MAP plans affiliated D-SNPs under the same parent organization (CMS 2021b). MAP plans allow individuals formerly in the FIDA demonstration to continue receiving integrated care and care coordination for their Medicaid and Medicare benefits (NYSDOH 2019). This transition also included applying the integrated appeals and grievance process in place under FIDA to MAP plans and affiliated D-SNPs (CMS 2021b).

Under the California Advancing and Innovating Medi-Cal Initiative (CalAIM), California is planning to transition its demonstration to a statewide MLTSS and D-SNP structure beginning in 2023, similar to the CCC Plus model in Virginia (California DHCS 2022). Plans participating in the statewide MLTSS program will be required to offer a D-SNP so full-benefit dually eligible beneficiaries can receive care coordination across Medicaid and Medicare. Dually eligible beneficiaries will be mandatorily enrolled in Medi-Cal managed care plans and can voluntarily enroll in D-SNPs that are operated by the same parent company. This initiative is intended to build on the lessons and successes of the demonstration and improve care integration statewide (California DHCS 2020). The state will discontinue MMPs and transition beneficiaries to affiliated MLTSS and D-SNP plans beginning in 2023 in the seven demonstration counties. In counties that do not participate in the demonstration, enrollment will phase in as plans are stood up, no later than contract year 2026 (California DHCS 2022).

Potential transition to D-SNPs

On January 12, 2022, CMS published a notice of proposed rulemaking with implications for the future of the FAI demonstrations. The proposed rule would make changes to D-SNPs, specifically applying features

of MMPs to D-SNPs (CMS 2022a). CMS also suggests that states participating in the capitated model convert their MMPs to D-SNPs if the provisions of the proposed rule related to requiring greater integration in D-SNPs are finalized. The rationale for this change is that there are now opportunities in Medicare Advantage for benefit flexibility and to implement integrated care on a larger scale than previously existed. CMS indicates that the agency would work with the nine states participating in the capitated model demonstration during calendar year 2022 to develop a plan for converting the models. Minnesota and Washington, which participate in the demonstration through the alternative model and managed fee-for-service (MFFS) model, would not be affected by provisions in the rule. CMS does not specify the future of these demonstrations.

Capitated Model

The capitated FAI model involves a three-way contract between CMS, the state, and the health plan to provide coverage to dually eligible beneficiaries through a capitated arrangement. The capitated model is the most popular of the available models, used by 9 of 11 participating states.

Health plan participation

As of January 2022, 38 plans were participating in the 9 states operating a capitated model (Table 2). Such plans are referred to as Medicare-Medicaid plans (MMPs). The number of MMPs varies by state from one plan in Rhode Island and the New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration to 10 plans in California. Not all plans are offered in every participating county or region of a state. For example, of the 10 participating MMPs in California, 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 2020c).

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). 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).

MMPs have various levels of prior experience providing coverage to dually eligible beneficiaries (Table 2). For example, all plans participating in California had prior experience covering dually eligible beneficiaries in Medicaid managed care. None of the plans participating in the Illinois, New York FIDA-IDD, South Carolina, Rhode Island, or Virginia demonstrations had such experience. Some had provided coverage to dually eligible beneficiaries in other states (CMS 2016a). Most of those participating in the demonstrations

in California, Massachusetts, Michigan, Ohio, Texas, and New York's FIDA program had prior experience covering 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.

TABLE 2. MMP Experience Providing Coverage to Dually Eligible Beneficiaries, Prior to the Financial Alignment Initiative, as of January 2022

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	✓	✓	--
Blue Shield of California Promise Health	✓	✓	--
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 (5 plans)			
Aetna Better Health Premier Plan	--	--	✓
Blue Cross Community MMAI	--	--	✓
Humana Gold Plus Integrated	✓	--	--
Meridian Complete	✓	--	--
Molina Healthcare of Illinois	✓	--	--
Massachusetts (2 plans)[3]			
Commonwealth Care Alliance, Inc.	✓	✓	--
Tufts Health Plan	✓	✓	--
Michigan (6 plans)			
Aetna Better Health Premier Plan	--	--	✓
AmeriHealth Caritas VIP Care Plus	--	--	✓
HAP Midwest MI Health Link	✓	✓	--
Meridian Complete	✓	✓	--
Molina Healthcare of Michigan	✓	✓	--
Upper Peninsula Health Plan (UPHP) MI Health	✓	✓	--
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]	✓	✓	--
Molina Healthcare of Ohio[6]	✓	✓	--

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]	
United Healthcare Community Plan[6]	✓	✓	--
Rhode Island (1 plan)			
Neighborhood Health Plan of Rhode Island[7]	--	--	✓
South Carolina (3 plans)			
Absolute Total Care[7]	--	--	✓
First Choice by Select Health of South Carolina, Inc.	--	--	✓
Molina Healthcare of South Carolina, Inc.	--	--	✓
Texas (5 plans)			
Amerigroup STAR+PLUS MMP	✓	✓	--
Molina Healthcare of Texas	✓	✓	--
Superior HealthPlan	✓	✓	--
UnitedHealthcare	✓	✓	--

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 covering dually eligible beneficiaries through a D-SNP are from the CMS SNP Comprehensive Report, as of December 2014 (CMS 2014a).

[2] Plans covering dually eligible beneficiaries in Medicaid managed care are from the CMS Medicaid managed care enrollment report for 2014 (CMS 2016a). Data for each plan is as of July 2014.

[3] In Massachusetts, both participating plans provided coverage to dually eligible beneficiaries in the Senior Care Options program which authorizes, delivers, and coordinates all services covered by Medicaid and Medicare for certain individuals age 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 provided coverage to 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 covering dually eligible beneficiaries have enrolled them since the launch of MyCare Ohio in 2014.

[7] As of July 2014, Neighborhood Health Plan (RI) and Absolute Total Care (SC) covered Medicaid-only beneficiaries through their state Medicaid managed care plan, but did not include dually eligible beneficiaries (CMS 2016a).

Sources: CMS 2016a, ICRC 2022, Illinois DHFS 2012, KFF 2015, Michigan DHHS 2015, Massachusetts EOHHS 2015, Michigan Health Link 2015, NYLAG 2014, PR Newswire 2017, Pressey 2015, and Texas HHS 2017.

Enrollment

Enrollment in the capitated models has grown to over 424,000 beneficiaries, as of January 2022 (ICRC 2022). States may target enrollment to specific groups of beneficiaries or specific geographic areas (Table 3). For example, Massachusetts limits enrollment to individuals between the ages of 21 and 64 (CMS 2020d). Other states limit enrollment to specific regions and focus on populations defined by age or degree of service need. Enrollment in the demonstrations has been lower than initial expectations, in part due to high opt-out rates and disenrollment. For example, over 1.3 million full benefit dually eligible beneficiaries met eligibility criteria in the 9 states with capitated models, yet only 5–62 percent of eligible beneficiaries have enrolled in the demonstration in these states (Grabowski et al. 2017).

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.

Passive enrollment is a key factor associated with higher rates of enrollment (MACPAC 2019). Once beneficiaries are passively enrolled, they are less likely to opt-out, although this varies by state. Other factors associated with higher enrollment include alignment of key FAI and MLTSS design features, such as the populations eligible to enroll and the geographic areas covered, and positive beneficiary relationships with health plan care coordinators (MACPAC 2019). However, some stakeholders have raised concerns that the passive enrollment process may limit the ability of dually eligible individuals to review accessible materials, understand their options, and make an informed choice (Brill et al. 2021).

Enrollees can opt out of a demonstration at any point and if they do so, they typically enroll in FFS or regular managed care to receive their benefits from Medicaid and Medicare, without integration. Some demonstrations have seen beneficiaries opt out at high rates (around 50 percent), which may reflect beneficiary preferences and pressure from providers (MedPAC 2018, California DHCS 2017b, Massachusetts EOHHS 2017, NYSDOH 2016). For example, a survey of beneficiaries in California found that the primary reasons beneficiaries opted out were to continue seeing an existing provider, concerns about coverage of specific services or benefits needed, satisfaction with current coverage, and difficulty understanding the new program (Graham et al. 2016). In another example, nursing homes in Virginia reportedly discouraged beneficiaries from participating in the demonstration (Dickson 2011). From a state's perspective, the ease with which beneficiaries can opt-out can make it difficult to establish a continuum of care for an individual (MACPAC 2019).

Eligible beneficiaries began enrolling in the demonstrations as early as 2013 but the process took time to ramp up, with some states starting much later (Table 3). Massachusetts was the first state to enroll individuals into the demonstration, beginning in October 2013, while Rhode Island was the last, beginning in July 2016. 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 (Benson 2014, Gorn 2014). In Suffolk and Westchester counties in New York, and in Orange County, California, delays occurred because plans did not meet network adequacy standards

(AIS Health Data 2015, Goldberg 2015). 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

State demonstration	Who is eligible?	Timeline			Use of passive enrollment
		MOU signed	Demo start date[1,2]	Scheduled end date	
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 2022	Suspended July 2016
Illinois Medicare-Medicaid Alignment Initiative[3]	Full-benefit dually eligible beneficiaries age 21 and older; are not enrolled in certain HCBS waivers or certain other programs	February 2013	March 2014	December 2023	Began June 2014
Massachusetts One Care	Full-benefit dually eligible beneficiaries age 21 to 64; live in a participating county; are not enrolled in HCBS waivers; are not residents of certain institutions	August 2012	October 2013	December 2022	Began January 2014
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 2023	Began between May and July 2015, depending on the region of the state
New York Fully Integrated Duals Advantage 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 2023	None
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 2022	Began January 2015
Rhode Island Integrated Care	Full-benefit dually eligible beneficiaries age 21 and older; do not reside in certain institutions or receive certain services	July 2015	April 2016	December 2023	Began October 2016

State demonstration	Who is eligible?	Timeline			Use of passive enrollment
		MOU signed	Demo start date[1,2]	Scheduled end date	
Initiative Demonstration					
South Carolina Healthy Connections Prime	Full-benefit dually eligible beneficiaries age 65 and older; are not enrolled in certain HCBS waivers; do not reside in certain institutions.	October 2013	February 2015	December 2023	Began April 2016
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 2022[4]	Began April 2015

Notes: CSHCS is Children's Special Health Care Services. FIDA-IDD is Fully Integrated Dual Advantage for Individuals with Intellectual and Developmental Disabilities. 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. MOU is memorandum of understanding. PACE is Program of All-inclusive Care for the Elderly. SSI is Supplemental Security Income.

[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.

[3] Starting on July 1, 2021, Illinois offers its demonstration statewide.

[4] The amendment to the three-way contract executed in 2020 for the demonstration in Texas includes an option to renew for 2022 and 2023 (CMS 2021f).

Sources: CMS 2022b, CMS 2022c, CMS 2021b, CMS 2021c, CMS 2021e, CMS 2021f, CMS 2020a, CMS 2020b, CMS 2020d, CMS 2020e, CMS 2020f, CMS 2020g, CMS 2020h, CMS 2020i, CMS 2020j, CMS 2020k, CMS 2019a, CMS 2018, and ICRC 2022.

Payment framework

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 2012c, Brandel and Cook 2013). Over time, CMS and the states changed these elements 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. 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 2012c, Brandel and Cook 2013).

While the Medicaid methodology varies across states, there is only one Medicare methodology (CMS 2012c, 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 2013a, 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 2013a, CMS 2012c, Brandel and Cook 2013).

Savings percentages. The FAI is intended to reduce spending over time through better care coordination and by reducing unnecessary use 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 that are deducted upfront 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 2013a). Savings percentages are not applied to the Medicare Part D component of the rate (CMS 2013a).

To inform this process, CMS examines evidence of the effect of care management on health care use and predicts changes in utilization and a range of potential savings in each state (Brandel and Cook 2013, CMS 2013a).[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 based on target population, covered services, managed care penetration, and trends in use of services (Brandel and Cook 2013). States may also vary target savings percentages by region. Most states expect savings percentages to increase each year. Some states have retroactively changed their savings percentages as reflected by updated contract agreements.

TABLE 4. Financial Alignment Initiative Capitated Model Demonstrations: Medicaid and Medicare Savings Percentages for Capitated Payments, as of March 2022

State	Savings percentages by demonstration year								
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
California[1]	1–1.47%	2–3.5%	4–5.5%	4–5.5%	4–5.5%	4–5.5%	4–5.5%	4–5.5%	N/A
Illinois[2]	1	3	5	5	5	6	6	6	6
Massachusetts[3]	0–1	0	0	0.25	0.50	0.50	0.50[6]	0.75[6]	0.75
Michigan	1	2	3	3	3	3	3	3	3
New York FIDA-IDD	0.25	0.5	1	1	N/A	N/A	N/A	N/A	N/A
Ohio	1	2	4	4	4	4	4	4	4
Rhode Island	1	1.25	3	3	3	3	3	N/A	N/A
South Carolina	1	2	3	3	3	3	3	3	3
Texas[5]	1.25–2.75	3.75	5.5	5.5	5.5	5.5	5.5	5.5	5.5

Notes: FIDA-IDD is Fully Integrated Duals Advantage for Individuals with Intellectual and 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 2013b). The rates above show the range across counties. California's demonstration is scheduled to end in 2022.
[2] In Illinois, new counties have savings percentages of 1 percent in year 7 and 3 percent in year 8.
[3]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. Massachusetts added the caveat that these rates may retroactively be revised to percentages not in excess of those currently set if the state is still in a state of emergency related to COVID-19 after May 15, 2020.
[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: CMS 2022b, CMS 2022c, CMS 2022d, CMS 2022e, CMS 2021c, CMS 2021e, CMS 2021f, CMS 2021h, CMS 2020a, CMS 2020b, CMS 2020n, and CMS 2019a.

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.

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.

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, 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. For example, Texas uses three rating categories—HCBS, other community care, and nursing facility—while South Carolina enrollees are classified in four different rating categories—nursing facility, two different categories for HCBS, and community.

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.

MLR refers to the share of premium revenues that a plan spends on patient care and quality improvement activities as opposed to administration and profits. Six demonstration states have a minimum MLR; Illinois, Michigan, Rhode Island and South Carolina set a targeted MLR at 85 percent, and Ohio 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.

Massachusetts is the only state with a capitated model that uses a high-cost risk pool to mitigate the risk of adverse selection drawing in a disproportionate number of high-cost enrollees. These were established in the fourth year of the demonstration (CMS 2019b). 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).

Quality. CMS and states also withhold a portion of capitation payments (from both the Medicaid and Medicare 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 2016b, Brandel and Cook 2013). MMP achievements on these withholds are included in evaluations of each state's model that are required by CMS and published on the CMS website (CMS 2021i).

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) survey, and existing Part D measures.[5] State-specific measures include those related to LTSS, utilization, coordination, transitions, and waiver requirements (CMS 2012d). Measures may also vary from year to year. Under the 2019 CAHPS survey, 88 percent of respondents were usually or always able to receive needed care and 96 percent were able to get needed prescription drugs, however the response rate among MMP enrollees surveyed was only 27.4 percent for those in a capitated FAI demonstration (CMS 2020l).

Benefits and care delivery

MMPs are required to cover all services included in the Medicaid state plan and all medically necessary Medicare Part A and B services (Table 5). They must also meet all Medicare Part D requirements, including benefits and network adequacy. Even so, the benefits offered and delivered through the FAI vary both within and across states. For example, California offers expanded vision coverage and South Carolina allows enrollees who have a serious, chronic, or life-limiting illness but do not qualify for hospice care to receive palliative care benefits (CMS 2013b, 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.

MMPs 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, provides communication and support needs, and acts as an independent facilitator and liaison between the beneficiary, the plan, and providers (CMS 2012b). In Ohio, plans must contract with area agencies on aging to coordinate services for enrollees age 60 and older (CMS 2012c).

Some states carve out certain benefits from their capitated models. For example, in California, MMPs are financially responsible for all Medicare behavioral health services but carves out Medicaid specialty mental health services and certain Medi-Cal drug benefits.[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 MMPs to contract with county mental health and substance use agencies to ensure that enrollees have access to those services (California DHCS 2013).

TABLE 5. Financial Alignment Initiative Demonstrations: Selected Benefits Offered in the Capitated Models, as of March 2022

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	• No copayments for prescription drugs and over-the-counter-products, transportation, and dental	• ICF/IDD	• 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 an LTSS coordinator who would work with a community organization for provision of LTSS
Michigan[3]	• HCBS waiver services and items • Adaptive medical equipment and supplies • Community transition services • Fiscal Intermediary • Personal emergency response system	• Mental health and substance use services	• 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

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

Notes: 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.
[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 2016c, CMS 2015a).
Sources: CMS 2022b, CMS 2022c, CMS 2022d, CMS 2022e, CMS 2021c, CMS 2021e, CMS 2021f, CMS 2020a, CMS 2020b, CMS 2020n, CMS 2019a, CMS 2015a, CMS 2014b, CMS 2014c, CMS 2013b, CMS 2013c, CMS 2013d, CMS 2013e, CMS 2012b, and CMS 2012c.

Care coordination

The capitated model is designed to coordinate Medicaid and Medicare services through a single health plan. Each demonstration specifies different levels of care coordination such as health assessments, individualized care plans, interdisciplinary care teams, and methods for ensuring care continuity.

Health assessments. All MMPs 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, 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 plan must complete the comprehensive assessment tool 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 2012b). In Illinois, plans must administer an initial health risk screening within 60 days. Enrollees designated as moderate or high risk must receive an additional assessment within 90 days of enrollment (CMS 2013c).

Individualized care plans. MMPs also must develop an individualized care plans 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 their 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 care plan must include the 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, MMPs 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). In 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 2020d, CMS 2012b).

Interdisciplinary care teams. MMPs 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 2014c). 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 2013f). Other states do not require a clinical credential but instead focus on coordinators' knowledge of specific subject matter such as aging and loss, frequently used medications and their potential negative side effects, depression, Alzheimer's disease and other dementias (CMS 2013d).

Continuity of care. To ensure smooth transitions, at the beginning of the demonstration, states require MMPs 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, MMPs 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 2014b, CMS 2013e, 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 2012c). In May 2016, California changed 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).

Managed FFS and Alternative Models

The other models being tested under the FAI are the managed FFS model in Washington and an alternative model in Minnesota.

Managed FFS

Washington is now the only state operating a managed FFS model. Under an agreement between the state and CMS, the state is eligible to share in savings resulting from initiatives to improve quality of care and reduce spending (CMS 2012e). Washington's demonstration is statewide and is based on Medicaid health homes. The state's Medicaid health homes program launched the same day that the demonstration began operating on July 1, 2013 (Archibald et al. 2019).

Alternative

Minnesota is operating an alternative model which it designed to focus on administrative alignment. It operates statewide and intends to strengthen the integration of the existing managed care plans that are operating in the state's long-standing Minnesota Senior Health Options (MSHO) program (CMS 2021j). MSHO is a program that provides integrated care to enrollees that has been in operation since 1997. Minnesota's model was not designed to result in any new enrollment and therefore, is not typically an area of focus for policymakers. It has set out to better align Medicaid and Medicare policies and processes for the MSHO program.

Consumer Protections

The FAI has 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 required that states hold public forums, focus groups, and other meetings to obtain public input as they developed their demonstration proposals.

Appeals

The FAI gave states the option to align and streamline the appeals process for dually eligible beneficiaries. All participating states unify Medicaid and Medicare appeals (ATI Advisory 2021). New York developed a fully integrated appeals process, consolidating Medicare (excluding Part D) and Medicaid appeals 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 (CMS 2020o). 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. Some states, such as Ohio, have used an existing long-term care ombudsman for their demonstrations (Archibald et al. 2021). The ombudsman program also provides enrollees with information and assistance in resolving issues related to the demonstration, including filing appeals and grievances (CMS 2013h).

The U.S. Department of Health and Human Services made dedicated funding available to support such programs. Eight states, including seven testing the capitated model, received funding through a special funding opportunity offered in 2013 and have established ombudsman programs (CMS 2020m). The federal Administration for Community Living (ACL) operates the Duals Demonstration Ombudsman Technical Assistance Program to support the design and implementation of the FAI's ombudsman program (ACL 2017).

Evaluations

CMS contracts with RTI International to evaluate the demonstrations at an aggregate level and to conduct state-specific evaluations for each year of each demonstration. The evaluation includes site visits; data analysis; focus groups; key informant interviews; and an analysis of changes in areas such as quality, service utilization, and spending, associated with the demonstrations. At the aggregate level, available evaluations include reviews of how the demonstrations affect issues such as social determinants of health, beneficiary experience, and care coordination (CMS 2022g). Findings on stakeholder engagement, care coordination, enrollment, and beneficiary safeguards have been posted to the CMS website (CMS 2022g).

CMS publishes evaluation reports for active demonstrations on an ongoing basis. Recent reports have found mixed results across demonstrations. For example, in Massachusetts, some MMPs reported financial losses in recent years while others reported gains (CMS 2021k). For beneficiaries in Massachusetts, the evaluation found that the demonstration is associated with increases in the probability of inpatient admission and skilled nursing facility admission and with decreasing the probability of long-stay nursing facility use relative to a comparison group (CMS 2021k). In South Carolina, the opposite was observed, with the demonstration thus far associated with a decrease in the probability

of inpatient admission and an increase in the probability of long-stay nursing facility use (CMS 2022f). Similar to Massachusetts, the majority of beneficiaries rated their plans highly and cited an improvement in quality of life. However, MMPs in South Carolina cited competition from Medicare Advantage plans and difficulties submitting encounter data as ongoing challenges (CMS 2022f).

For additional detail on the evaluations of the FAI and of other integrated care models, MACPAC has compiled an inventory of available evaluations of integrated care models, including the FAI (MACPAC 2020a). An accompanying issue brief summarizes key findings and research gaps (MACPAC 2020b).

Endnotes

[1] See chapter 1 of MACPAC's June 2020 report to Congress for a description of the dually eligible population, including demographic characteristics, eligibility, and use of services and spending (MACPAC 2020c).

[2] In July 2011, CMS requested letters of intent from states interested in participating in the demonstration (CMS 2011a). By October of that year, 37 states and the District of Columbia (including all 15 states that were awarded design contracts) submitted letters of intent (CMS 2011b; Table 1). Of the 26 states that submitted a proposal, 16 subsequently withdrew their proposals and two partially withdrew their proposals citing concerns about the payment methodology, rate setting mechanisms, carve-out allowances, and limited interest from health plans (CMS 2015b, New Mexico DHS 2012).

[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 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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