For many years some health policy experts have argued that integration of financing streams and better coordination of care for the over 9 million people eligible for both Medicare and Medicaid, the “dual eligibles,” could result in improved beneficiary outcomes and lower costs. The Patient Protection and Affordable Care Act of 2010 (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to work with states to seek ways to improve financing streams and delivery systems under Medicare and Medicaid for these beneficiaries. CMS’s Medicare-Medicaid Coordination Office and Center for Medicare and Medicaid Innovation are collaborating on a major demonstration initiative called the Financial Alignment Initiative, which is intended to test ways to better align the programs’ financing and to integrate primary, acute, behavioral health, and long-term services and support (LTSS) for dual eligibles.

Under this initiative, CMS is partnering with states to test ways to identify and validate delivery systems and financial alignment models that are intended to improve patient outcomes and control costs. Two financial alignment models are being tested. The first is a capitated approach to integration whereby CMS, states, and eligible health plans enter into three-way contracts in which health plans would receive prospective blended payments to provide comprehensive, coordinated care. Eligible health plans include Medicare Advantage plans or Medicaid managed care plans and other entities that can meet certain CMS standards. The second is a managed fee-for-service model whereby CMS and the state enter into an agreement in which the state would be eligible to benefit from savings that result from any activities that improve quality and reduce costs. Before states are permitted to enter into a memorandum of understanding (MOU) with CMS to proceed, they must
demonstrate their ability to meet or exceed certain CMS-established standards and conditions, including beneficiary protections, stakeholder engagement, and network adequacy, among others.

Although it is still very early in the process, participating states have planning and implementation strategies well under way. Twenty-six states submitted proposals to participate in the demonstration. Nine states have met the demonstration standards and conditions and have approved MOUs with CMS: California, Illinois, Massachusetts, Minnesota, New York, Ohio, South Carolina, Virginia, and Washington. Enrollment of beneficiaries began in July 2013 in Washington and is scheduled to begin in July 2014 in South Carolina.

SPEAKERS

This Forum session focused on progress to date by CMS and states in their planning and implementation of the financial alignment initiative. Melanie Bella, MBA, director, Federal Coordinated Health Care Office at CMS, provided a national overview of the program and implementation progress. Karen E. Kimsey, MSW, deputy director for complex care services, Virginia Department of Medical Assistance Services, discussed Virginia’s efforts to coordinate care for dual eligibles under its Commonwealth Coordinated Care program. Kevin Prindiville, JD, executive director of the National Senior Citizens Law Center, discussed the demonstration initiative from the beneficiary perspective.

KEY QUESTIONS

• How are CMS, states, and health plans sharing responsibility for the demonstration?

• What standards and conditions must states meet in order to participate in the financial alignment initiative, in areas such as quality of care, consumer protections, and network adequacy?

• What steps are being taken to ensure that states and health plans that participate in the demonstration are managing the full range of care needs of the dual eligible population, including primary, acute, behavioral, and LTSS needs? And that health plans coordinate LTSS with acute and primary care providers?

• What methods will states and health plans use to target services and delivery systems on the dual eligibles who have the greatest needs and account for a large part of Medicare and Medicaid expenditures?
• How do states and CMS determine enrollment procedures, including providing beneficiaries with information about their eligibility for and participation in the demonstration?

• What entity is responsible for ensuring that health plans adhere to standards and conditions set by CMS and the states?

• How will CMS monitor the impact of the demonstration on overall costs? What is being done to track costs and savings? What is the status of federal evaluation efforts?

RELATED MATERIALS
