According to the Centers for Medicare & Medicaid Services (CMS), there were approximately 10.7 million individuals enrolled in both Medicare and Medicaid in 2014; two-thirds were low-income older adults and one-third were younger people with disabilities.¹ These dually eligible beneficiaries—the duals—account for a disproportionate share of spending in both programs. Some health policy experts argue that the differences between Medicare and Medicaid create problems for duals, and that integrating financing streams and coordinating care across the two programs could improve beneficiary outcomes and lower costs.²

Authorized under the Patient Protection and Affordable Care Act of 2010, the Financial Alignment Initiative (FAI) demonstration or “duals demo” allows states to integrate Medicare and Medicaid financing streams and benefits. The CMS Medicare-Medicaid Coordination Office in collaboration with the CMS Center for Medicare and Medicaid Innovation (CMMI) oversees the demonstration. Two models are being tested: capitation and managed fee-for-service. Under the capitation model, CMS, states, and health plans enter into three-way contracts in which the health plan receives prospective payments to provide comprehensive coordinated care to beneficiaries. Under the managed fee-for-service model, states are eligible to “benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicare and Medicaid.”³ Regardless of which model they select, all states participating in the initiative must demonstrate that they can meet or exceed certain standards and conditions established by CMS related to beneficiary protections, stakeholder engagement, and network adequacy, among others.⁴
Nine states—California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia—are implementing the capitated model. CMS approved a memorandum of understanding (MOU) for Rhode Island’s capitated model at the end of July, with enrollment scheduled to begin by December 2015. Colorado and Washington chose the managed fee-for-service approach. In addition to the two models that align financing, Minnesota (which has been granted prior waivers to integrate services) is testing whether the integration of administrative functions also can improve care and reduce costs for older duals.\(^5\)

CMS set a maximum enrollment ceiling of 2 million duals nationwide.\(^6\) CMS reported in July 2015 that over 400,000 duals are enrolled in either the capitated or fee-for-services models.\(^7\) The Kaiser Family Foundation estimated that the nine states currently participating in the capitation model have enrolled nearly 355,000 duals, or about 27 percent of those estimated to be eligible.\(^8\) An additional 30,000 beneficiaries will be eligible in Rhode Island. Although enrollment data for Colorado and Washington have not been reported, about 69,000 beneficiaries in these two states are estimated to be eligible. An additional 36,000 beneficiaries are estimated to be eligible for the Minnesota demonstration.\(^9\)

**PROGRAM DESIGN**

States have adopted different approaches in designing their demonstrations.\(^10\) Key areas of variation include target populations, geographic service areas, rules and procedures for beneficiaries to opt out of the demonstration for some or all of their benefits, continuity of care provisions, appeals procedures, contracting requirements, etc. The Massachusetts demonstration, for example, is the only model focused solely on duals under the age of 65, many of whom have behavioral health and substance abuse problems.\(^11\) Texas’s demonstration will serve adult duals with disabilities who qualify for Supplemental Security Income or Medicaid waiver home- and community-based services.\(^12\) Duals in Virginia\(^13\) can opt out of the demonstration for both their Medicare and Medicaid benefits, whereas opting out in Ohio is permitted only for Medicare benefits. Health plans participating in Ohio’s demonstration must contract with local area agencies on aging (AAAs) and other entities that have experience working with people with disabilities.\(^14\) One area of commonality among the capitated model states is a health risk assessment that participating health plans must complete for
each beneficiary, ideally within 90 days of enrollment, to facilitate care planning and coordination.

Each agreement with states choosing the capitated model includes the terms under which anticipated aggregate program savings are deducted up front from both CMS and state payments to health plans. In anticipation of greater savings over time, the deduction increases over the three-year life of the demonstration, starting at 1 percent and ending between 2 and 5.5 percent. Illinois plans, for example, will incur deductions of 1, 3, and 5 percent over the three years of the demonstration. In addition, all of the states participating in the capitated model withhold a portion of plan payments that are returned if quality metrics are met. Savings in the managed fee-for-service demonstration are determined retrospectively: states can share in savings if quality and savings targets are met; states are not at risk if savings targets are not met.

**Enrollment**

Under the capitation model, states began with an enrollment period during which duals living in service areas covered by the demonstration (typically counties) could choose a managed care plan to provide both their Medicare and Medicaid benefits. Those not choosing a plan were subsequently passively enrolled using “intelligent assignment” algorithms designed to help “preserve continuity of providers and services when assigning beneficiaries to plans.” Duals in all states can proactively opt out of the demonstration for their Medicare benefits, but some states require duals to enroll in a managed care plan to receive their Medicaid benefits.

**A WORK IN PROGRESS**

Some states are in their second year of implementation, yet many consider the duals demo to still be getting under way. Several states delayed the launch of their demonstrations due to the challenges of implementing major financial and delivery system changes simultaneously. Communicating the details of the program to both providers and beneficiaries has been challenging. Overall, enrollment has gone more slowly than anticipated in most states, and opt-out rates have been high in some states, especially California. Some providers have actively discouraged their patients.
from participating in the demonstration because of concerns about payment rates and added paperwork.\textsuperscript{19}

Other common challenges for states have included securing health plan participation, ensuring adequate provider networks, determining capitation rates, overcoming provider opposition, and locating eligible participants. Health plans have also experienced difficulties, including understanding the needs of beneficiaries who require long-term services and supports, bringing providers on board, and completing health risk assessments in a timely fashion. Interviews with 12 program participants in three states highlighted problems related to enrollment, beneficiary/plan communications, assessments, and access to services.\textsuperscript{20} Overall, however, these participants seemed relatively pleased with the care they received. Consumer advocacy groups are actively involved in monitoring the implementation of the duals demonstrations, with several providing a steady stream of educational materials for advocates and families.\textsuperscript{21} In response to early concerns about beneficiary rights, CMS has made funds available to states with approved MOUs to plan and provide ombudsman services for beneficiaries in the demonstration.

It’s too early to say whether the duals demos are achieving their goal of improving care coordination and lowering costs. Evaluation results are not expected until about a year before the end date of each state’s demonstration. Recognizing that this timing does not give states sufficient lead time to decide whether to continue participating in the demonstration, CMS offered to extend the scheduled end date for each demonstration by two years, bringing the total length of each state’s demonstration to five years.\textsuperscript{22}

\textbf{SESSION}

This Forum session will provide an update on the status of the FAI demonstration, review the experience of one state in implementing its demonstration, discuss beneficiary concerns, and describe efforts to incorporate geriatrics best practices into the demos. \textbf{Tim Engelhardt}, director of CMS’s Medicare-Medicaid Coordination Office will begin the discussion with an overview of the initiative and implementation progress nationwide. \textbf{Karen E. Kimsey, MSW}, deputy director for complex care services, Virginia Department of Medical Assistance Services, will discuss Commonwealth Coordinated Care, Virginia’s capitated duals demonstration, focusing on challenges and successes since the
program launched in April 2014. Renée Markus Hodin, JD, director of the Voices for Better Health program at Community Catalyst, will bring a consumer perspective to the discussion, focusing on the concerns and experiences of beneficiaries. Gregg Warshaw, MD, clinical professor in the department of family medicine, University of North Carolina, will talk about his experiences working with providers participating in the duals demonstrations.

KEY QUESTIONS

- What have been the main implementation challenges faced by CMS and the Medicare-Medicaid Coordination Office in getting the duals demos started? What is the outlook for the future?

- What challenges have the states faced? How do these vary by the type of model (capitation or managed fee-for-service) chosen? What other factors at the state level have made it easier or harder for states to implement their demonstrations?

- What steps are being taken to ensure that states and health plans are managing the full range of care needs of the duals, including primary, acute, behavioral, and long-term services and supports?

- How are states and health plans targeting services to those duals who have the greatest needs and who account for a large part of Medicare and Medicaid expenditures?

- What problems have beneficiaries encountered in enrolling in the demos and accessing care?

- How prepared were health plans and individual providers to care for duals, especially the most vulnerable?

ENDNOTES


10. For more information about the design of each state’s demonstration, please see the signed memoranda of understanding available on the CMS website at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html.


22. Engelhardt, memo.