



# Update on Demonstrations for Dual-Eligible Medicare-Medicaid Beneficiaries

*August 2017*



BIPARTISAN POLICY CENTER

## **HEALTH PROJECT**

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, BPC's Health Project seeks to develop bipartisan policy recommendations that will improve health care quality, lower costs, and enhance health care coverage and delivery. The Health Project focuses on coverage and access to care, delivery system reform and cost containment, and long-term care.

## **ACKNOWLEDGEMENTS**

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the author(s) and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

BPC staff would like to thank the numerous individuals—including current and former federal executive and legislative branch agency officials, state officials, consumer organizations, provider organizations, insurers, program evaluators, and other subject-matter experts—who provided guidance.

## **DISCLAIMER**

The findings and policy options expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders or its board of directors.

# *Staff*

## **G. William Hoagland**

Senior Vice President

## **Katherine Hayes**

Director, Health Policy

## **Matthew McKearn**

Associate Director, Health Policy

## **Peter Fise**

Senior Policy Analyst, Health Project

## **Marisa Salemme**

Senior Policy Analyst, Health Project

## **Erin White**

Administrative Assistant, Health Project

## **Will Bayliss**

Intern, Health Project

# Table of Contents

4	<b>Executive Summary</b> Characteristics of Individuals Dually Eligible for Medicare and Medicaid Financial Alignment Initiative Demonstrations State Participation Conclusion
6	<b>Integrated Care for Dual-Eligible Beneficiaries</b> I. Characteristics of Dual-Eligible Beneficiaries II. Challenges Associated With Caring for Dual-Eligible Beneficiaries III. The Financial Alignment Initiative IV. Profiles of Three States V. Conclusion
19	<b>Appendix</b>
22	<b>Endnotes</b>

# *Executive Summary and Recommendations*

## *Characteristics of Individuals Dually Eligible for Medicare and Medicaid*

Policymakers have long sought ways to improve quality of care and reduce costs for Medicare beneficiaries with complex *medical* conditions. Among the most expensive individuals are low-income Medicare beneficiaries who also qualify for Medicaid, or “dual-eligible” beneficiaries.

- *Dual-eligible beneficiaries have significantly greater need for acute medical care, long-term care, and other non-clinical supports and services.*
- *Full-benefit dual-eligible beneficiaries have average Medicare spending that is twice as high as average per-beneficiary spending for all other Medicare beneficiaries.*
- *Most dual-eligible beneficiaries currently receive medical care in an unmanaged, fee-for-service (FFS) delivery model, which does not provide incentives for care coordination across programs, providers, or care settings.*
- *Since Medicare-covered services are financed through the federal government, while Medicaid-covered services are paid for with state government dollars (with significant financial support to the states from the federal government), it can be difficult for each program to focus investments on care delivery changes that will accrue savings overall across programs.*

## *Financial Alignment Initiative Demonstrations*

The Financial Alignment Initiative, a series of demonstrations launched in 2011 by the Medicare-Medicaid Coordination Office (MMCO) and the Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS), was designed to test new approaches that address the siloed contracting and reimbursement issues that result in fragmentation of care delivery of Medicare and Medicaid benefits.<sup>1</sup> The Financial Alignment Initiative established a Capitated Model and a Managed FFS Model. States could elect to participate in either model, or both.

## *State Participation*

As of 2016, 13 states had agreed to participate in the Financial Alignment Initiative, ten states had chosen to participate in the Capitated Model exclusively, and two states had elected to participate in the Managed FFS Model. Minnesota participates in a novel alternative arrangement, rather than in either the Capitated Model or the Managed FFS Model.<sup>2</sup> Approximately 458,000 dual-eligible beneficiaries received care through the Financial Alignment Initiative,<sup>3</sup> including more than 373,000 beneficiaries enrolled in the Capitated Model.<sup>4</sup> About one-third of all Capitated Model enrollees resides in California, while Illinois, Ohio, and Texas together account for another 29 percent of the population enrolled in the Capitated Model.<sup>5</sup>

## Conclusion

### Early Challenges with Potential for Improved Quality and Savings Over Time

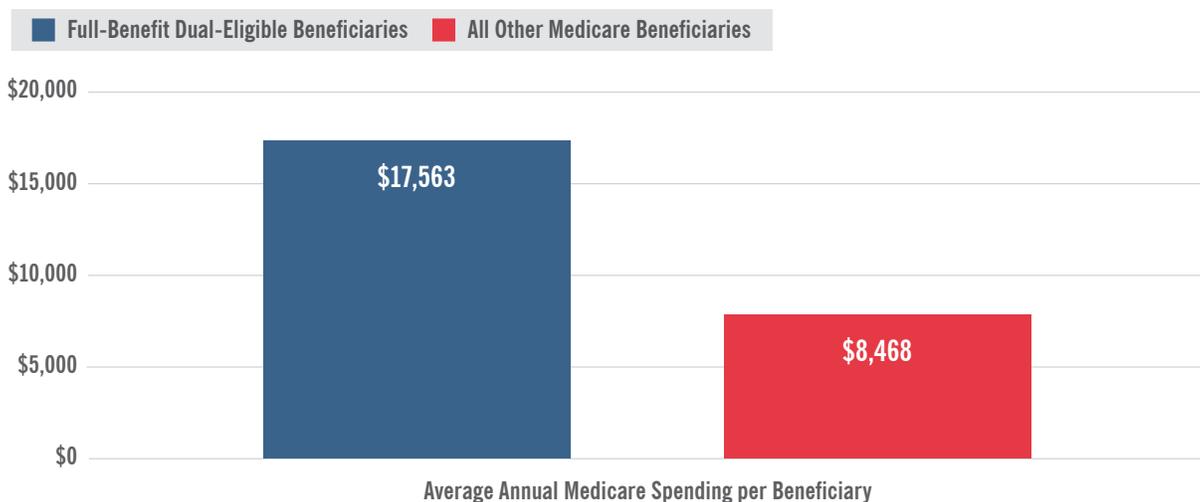
While results of the early evaluations are inconclusive, and may cause policymakers to question the success of the demonstrations, experience from states such as Minnesota and Massachusetts—which had a fifteen-year history of integrating Medicare and Medicaid services for dual-eligible beneficiaries aged 65 and over—indicates that care integration may lead to improved outcomes. Positive outcomes include: a reduction in emergency department visits and hospital admissions. Further, structural changes in the demonstrations, such as better alignment of program administration and permitting up-front infrastructure investments in the early years, can result in long-term savings, improved quality of care, and greater availability of services in the home, rather than costlier institutional care.

Early challenges can be remedied with revisions in law and program guidelines, including:

- Better alignment of coverage standards for Medicare and Medicaid overlapping benefits and the grievance and appeals processes;
- A longer phase-in of required savings to allow states to become more experienced with the new integrated financing model;
- If appropriate, adjustments in capitation rates to reflect unanticipated costs, provided there is no added federal cost over the life of the demonstration; and
- Quality-based payment adjustments for high-performing states.

Whether full integration of Medicare and Medicaid services will improve quality and lower the total cost of care for dual-eligible beneficiaries will vary based on numerous factors, including the care delivery model and state implementation. The demonstrations present an opportunity to better integrate Medicare and Medicaid services, to improve value, quality of care, and access to services, and should be continued and expanded over time.

### Medicare Per Beneficiary Spending (CY 2011)



Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center

# *Integrated Care for Dual-Eligible Beneficiaries*

## *Characteristics of Dual-Eligible Beneficiaries*

### **Eligibility**

In 2015, 11.4 million individuals were dually enrolled in Medicare and Medicaid.<sup>6</sup> Of those individuals, roughly 8.2 million were “full-benefit” dual-eligible beneficiaries, who qualify for the full range of Medicaid-covered benefits, including long-term care.<sup>7</sup> The remaining 3.2 million individuals were “partial-benefit” dual-eligible beneficiaries, whose Medicaid coverage is limited to financial assistance from Medicaid to help pay for Medicare premiums and cost-sharing amounts for Medicare-covered services. While Medicaid eligibility for partial-benefit dual-eligible beneficiaries is principally based on meeting low-income thresholds, full-benefit dual-eligible beneficiaries qualify for coverage based upon similar income thresholds and net asset limits, as well as the presence of additional factors—predominantly through meeting certain disability status requirements or having certified needs,<sup>8</sup> such as need for long-term services and supports (LTSS).

### **Poor Health Status**

Compared to the average Medicare beneficiary<sup>9</sup> or individuals who are eligible only for Medicaid, dual-eligible beneficiaries have significantly greater need for acute care and medical services, long-term care, and other non-clinical supports and services.<sup>10</sup> Full-benefit dual-eligible individuals have roughly six chronic conditions on average, as compared to all other Medicare patients, who have roughly four chronic conditions on average.<sup>11</sup>

In part as a result of these elevated clinical needs, full-benefit dual-eligible beneficiaries have average Medicare spending that is twice as high as average per-beneficiary spending for all other Medicare beneficiaries.<sup>12</sup> Full-benefit dual-eligible individuals require the use of home health care or skilled nursing facility services at nearly twice the rate of Medicare beneficiaries who are not dually eligible for Medicaid.<sup>13</sup> Dual-eligible beneficiaries also have an outsized impact on Medicaid spending. In 2012, dual-eligible beneficiaries made up only 15 percent of the Medicaid population, but accounted for 34 percent of Medicaid spending.<sup>14</sup>

Full-benefit dual-eligible individuals also tend to have worse health outcomes compared to all other Medicare beneficiaries, including significantly higher re-hospitalization rates for several ambulatory care sensitive conditions, such as congestive heart failure.<sup>15</sup> Dual-eligible beneficiaries also have higher rates of hospital associated infections relative to that of all other Medicare beneficiaries.<sup>16</sup> Research conducted by the Department of Health and Human Services Assistant Secretary for Planning and Evaluation found that among beneficiaries with social risk factors, dual enrollment was the most powerful predictor of poor outcomes. This was generally true even after risk adjustment and across care settings, measurement types, and programs.<sup>17</sup>

# *Challenges Associated with Caring for Dual-Eligible Beneficiaries*

## **Lack of Incentives for Care Coordination across Providers and Programs**

Most dual-eligible beneficiaries currently receive medical care in an unmanaged, pure fee-for-service (FFS) delivery model, which does not provide needed incentives for care coordination across provider types and care settings. Only about 20 percent of dual-eligible individuals are enrolled in organized systems of care that attempt to coordinate a beneficiary's Medicare and Medicaid service needs.<sup>18</sup>

Medicare managed care plans—such as Medicare Advantage (MA) Dual-Eligible Special Needs Plans (D-SNPs)—often establish incentives for acute care providers to monitor a beneficiary's condition and medical services across a continuum of care. However, unless that Medicare managed care plan also has a contract with the state to provide a beneficiary's Medicaid services, that monitoring and care coordination is unlikely to span across the Medicare-Medicaid divide, to allow for assessment of the impact of LTSS decisions and utilization on acute care outcomes.

Although certain care models, such as Fully-Integrated D-SNPs (FIDE-SNPs) and the Programs for All-Inclusive Care for the Elderly (PACE) model, can integrate coverage of a dual-eligible individual's Medicare and Medicaid benefits under a unified financial arrangement, penetration of these models has not been widespread in the dual-eligible population.<sup>19</sup> Only about two percent of the full benefit dual-eligible beneficiary population receive care through these financially integrated models.<sup>20</sup>

**“ Even for beneficiaries who are in managed care, the fragmentation of Medicare and Medicaid payment and regulatory structures can inhibit the ability of the health care delivery system to provide integrated, person-centered care to meet the needs of dual-eligible individuals. ”**

## **State and Federal Roles for Dual-Eligible Beneficiaries**

While the Centers for Medicare and Medicaid Services (CMS) establish federal rules governing Medicare coverage for dual-eligible individuals, each state Medicaid agency (with oversight from CMS) develops the regulations applicable to dual-eligible beneficiaries' Medicaid coverage. This patchwork structure often results in a mismatch of benefit design and benefit administration protocols between the dual-eligible beneficiary's Medicare benefit and his or her Medicaid benefit. For instance, the grievance and appeals processes for Medicare benefits are often completely incongruent with the Medicaid grievance and appeals processes established by the state Medicaid agency.

Similarly, CMS and state Medicaid agency rules can establish different enrollment processes, cost-sharing arrangements, and claims submission processes for Medicare coverage versus Medicaid coverage—which often increases the burden placed on the dual-eligible beneficiary in navigating an already complex health care system.<sup>21</sup>

## Services paid for by Medicare and Medicaid for dual eligible beneficiaries

Medicare	Medicaid
<ul style="list-style-type: none"> <li>• Acute care (hospital) services</li> <li>• Outpatient, physician, and other supplier services</li> <li>• Skilled nursing facility services</li> <li>• Home health care</li> <li>• Dialysis</li> <li>• Prescriptions drugs</li> <li>• Durable Medical equipment</li> <li>• Hospice</li> </ul>	<p><i>Mandatory services:</i></p> <ul style="list-style-type: none"> <li>• Medicare cost sharing (Part A and Part B deductibles, Part B premiums and coinsurance)</li> <li>• Coverage for hospital and skilled nursing facility services if Part A benefits are exhausted</li> <li>• A portion of the cost of prescription drugs</li> <li>• Nursing home care</li> <li>• Home health care not covered by Medicare</li> <li>• Transportation to medical appointments</li> <li>• Durable medical equipment not covered by Medicare</li> </ul> <p><i>Optional services:</i></p> <ul style="list-style-type: none"> <li>• Dental</li> <li>• Vision</li> <li>• Hearing</li> <li>• Home- and community-based services</li> <li>• Personal Care</li> </ul>

Source: Medicare Payment Advisory Commission 2010

## *The Financial Alignment Initiative*

First launched in 2011, the Financial Alignment Initiative is a series of demonstrations developed by the Medicare-Medicaid Coordination Office (MMCO) and the Center for Medicare and Medicaid Innovation (CMMI) within CMS to test new approaches that address the siloed contracting and reimbursement issues that result in fragmentation of care delivery of Medicare and Medicaid benefits.<sup>22</sup> The Financial Alignment Initiative established both a Capitated and a Managed FFS Model. States could elect to participate in either model, or both. As of 2016, 13 states had agreed to participate in the Financial Alignment Initiative. Ten states chose to participate in the Capitated Model, while two states implemented the Managed FFS Model. Minnesota participates in a novel alternative arrangement, rather than in either the Capitated Model or the Managed FFS Model.<sup>23</sup>

Under Minnesota's demonstration, the state aligned administrative contracting requirements for participating managed care plans in the Minnesota Senior Health Options (MSHO) program that contract both with CMS as D-SNPs and with the state as Medicaid managed care organizations. The MSHO program predates the Financial Alignment Initiative, having provided integrated Medicare-Medicaid coverage through managed care plans to dual-eligible individuals in Minnesota since 1997. The demonstration aligns requirements for beneficiary communication materials, network adequacy, grievance/appeals processes, quality measures, and models of care.

In 2015, CMS allowed states to extend the duration of their participation in the demonstrations by two years, through 2018, or later for some states.<sup>24</sup> While all 13 states submitted non-binding letters of intent in 2015 to extend participation for an additional two years, some states have signaled changes since then. For instance, California will need to adjust its demonstration to meet state budgeting requirements, while Virginia submitted a Medicaid waiver request in 2016, which would transition its Capitated Model demonstration into a specialized Managed LTSS (MLTSS) program that would fully integrate physical health, behavioral health, and LTSS for dual-eligible beneficiaries in the state.<sup>25</sup>

## Eligibility and Enrollment

States were allowed to design their Financial Alignment Initiative demonstrations to limit and target enrollment to specific subgroups of dual-eligible beneficiaries. For example, South Carolina targeted enrollment for its Capitated Model demonstration to dual-eligible beneficiaries aged 65 or older, while Massachusetts targeted its Capitated Model demonstration enrollment to dual-eligible beneficiaries under the age of 65, many of whom have disabling conditions.<sup>26</sup> All states limited demonstration enrollment to full-benefit dual-eligible beneficiaries, and excluded partial-benefit dual-eligible individuals from the demonstrations.<sup>27</sup>

“*With states, CMS establishes an aggregate savings percentage for each year of the demonstration and then applies this percentage discount to the blended Medicare and Medicaid capitation rates, ranging from as low as 1 percent in Year One to as much as 5.5 percent by Year Three.*”

States also had the prerogative to limit eligibility for their demonstrations to specific geographic regions within the state. For example, California elected to limit enrollment in its Capitated Model demonstration to dual-eligible beneficiaries in seven large metropolitan counties, mostly in southern California.<sup>28</sup> By contrast, states like South Carolina and Rhode Island chose to make their demonstrations applicable statewide.<sup>29</sup>

As of July 2016, roughly 458,000 dual-eligible beneficiaries, or roughly six percent of all full benefit dual-eligible individuals, received care through the Financial Alignment Initiative demonstration,<sup>30</sup> including more than 373,000 beneficiaries enrolled in the Capitated Model.<sup>31</sup> Approximately one-third of all Capitated Model enrollees reside in California, while Illinois, Ohio, and Texas together account for another 27 percent of the population enrolled in the Capitated Model.<sup>32</sup> Approximately 50,000 dual-eligible beneficiaries were enrolled in the Managed FFS Model demonstrations in 2015,<sup>33</sup> while Minnesota’s demonstration model had enrolled 36,000 dual-eligible individuals as of 2016.<sup>34</sup>

Individuals are given a choice about whether to participate in the demonstration. The Capitated Model uses an initial voluntary opt-in period for dual-eligible beneficiaries to enroll, followed by a passive enrollment period during which beneficiaries are assigned to a participating managed care plan.<sup>35</sup> However, beneficiaries retain the option of dis-enrolling from the program at any time.<sup>36</sup>

## Care Delivery and Payment Models

### *Single Contract between States, CMS, and Health Plans*

At the center of the Capitated Model is a three-way contract between CMS, the state Medicaid agency, and a managed care plan. Under the three-way contract, a managed care organization agrees to contract with a state Medicaid agency to provide Medicaid-covered benefits, and agrees to contract with CMS to cover Medicare-covered benefits. In return, the three-way

contract provides a blended capitation rate. The managed care plan's capitation rate (to which the savings discounts are applied) was designed as a blend consisting of: (1) historical county-level per-beneficiary spending on Medicare Part A and Part B services for counties in the demonstration regions; (2) the national average monthly bid amount for Medicare Part D coverage; and (3) state actuary-developed and CMS-approved Medicaid rates based upon per-beneficiary Medicaid FFS spending in each demonstration region.<sup>37</sup> These rates are then risk adjusted to account for each specific enrollee's medical conditions, age, and certified levels of LTSS need.<sup>38</sup>

CMS assumes that the demonstrations can achieve overall savings through improved care management and administrative efficiencies. In consultation with each state, CMS establishes a specific aggregate savings percentage for each year of the demonstration and then applies this percentage discount to the blended capitation rates,<sup>39</sup> ranging from as low as 1 percent in Year One to as much as 5.5 percent by Year Three.<sup>40</sup> These savings are then shared by the state and CMS.<sup>41</sup>

“ *The Capitated Model uses an initial voluntary opt-in period for dual-eligible beneficiaries to enroll, followed by a passive enrollment period during which beneficiaries are assigned to a participating managed care plan. However, beneficiaries retain the option of dis-enrolling from the program at any time.* ”

Capitated Model payments are risk adjusted to reflect the health needs of participants; higher service costs are associated with serving beneficiaries with more complex medical needs. Risk adjustment is applied separately to Medicare Parts A, B, and D and the Medicaid components of capitated payments. In 2015, CMS determined that risk-adjusted payment rates for full-benefit dually eligible beneficiaries understate the costs of providing service. As a result, CMS further adjusted rates for dual-eligibles participating in the Financial Alignment Initiative.<sup>42, 43</sup>

## *Managed FFS Model*

Under the Managed FFS Model, states agree to work with providers of Medicaid-covered services to seamlessly integrate and coordinate service delivery of dual-eligible beneficiaries' Medicare and Medicaid benefits. States are entitled to share with CMS in the Medicare savings that result from the integration of care.<sup>44</sup> In order to receive those shared savings payments, the state must meet or exceed certain quality thresholds and the Medicare savings must exceed a target savings amount, net of any increased Medicaid spending above set baseline amounts.<sup>a,45</sup>

The Financial Alignment Initiative focuses on coordinating medical care, behavioral health, and LTSS through a single source. Coordination requirements vary among states but include health assessments, individualized care plans, interdisciplinary care teams, and methods for ensuring care continuity. Plans assess enrollee medical and behavioral health needs, chronic conditions, disabilities, functional impairments, need for assistance in activities of daily living, and cognitive status.

<sup>a</sup> Because of the limited to-date evaluation results from the two managed fee-for-service demonstrations, this report focuses on the Capitated Model demonstrations.

Individualized care plans include health goals and timetables to meet medical, behavioral health, and LTSS needs. Plans also establish an interdisciplinary care team that typically includes a primary care provider, care coordinator, LTSS providers, specialists, the enrollee, and family members. The care coordinator is responsible for facilitating care transitions, educating the enrollee regarding available services and community resources, and coordinating with social service agencies.<sup>46</sup>

## Demonstration Evaluations

CMS contracted with RTI International to monitor and evaluate the implementation and impact of the demonstrations on beneficiary experience, quality, utilization, and cost. In January 2016, CMS released its *Report on Early Implementation of the Demonstrations under the Financial Alignment Initiative*.<sup>47</sup> The report describes the early experiences in seven demonstration states during the first six months of implementation, including information about specific successes and challenges states faced in aligning Medicare and Medicaid systems and policies. The report does not provide information on the demonstration's effect on service use, spending, or outcomes, which will be provided in subsequent reports. CMS is collecting information on beneficiary experience and satisfaction with the Financial Alignment Initiative using the Consumer Assessment of Healthcare Providers and Systems survey.

**“ CMS, members of Congress, and other organizations have suggested changes in the program to help better integrate services, improve patient experience, increase potential for savings, and increase state participation in the demonstrations. ”**

RTI is also conducting state-specific evaluations and will produce annual evaluation reports, and a final report in 2020. RTI will collect qualitative and quantitative data from participating states quarterly; analyze Medicare and Medicaid enrollment, claims, and encounter data, as well as data from the Nursing Home Minimum Data Set (MDS); conduct site visits and interviews with staff involved in the demonstration, beneficiary focus groups, and key stakeholder interviews; and incorporate relevant findings from beneficiary surveys.

State-specific reports have been released for the Minnesota Demonstration to Align Administrative Functions, the Massachusetts Capitated Model, and the Washington Managed FFS demonstration.<sup>48, 49, 50</sup> Massachusetts' experience is outlined in more detail below. In Washington, evaluators found that more than half of the participants reported they had experienced a significant improvement in their health or quality of life as a result of health home services. They viewed care coordinators as helpful with setting goals and developing plans to achieve them and in facilitating access to services, health information, and other resources.<sup>51</sup> In Minnesota, which had considerable experience in managing care for dual-eligible beneficiaries over age 65, evaluators found that demonstration enrollees had lower hospital and emergency department use, greater use of primary care, were more likely to use home- and community-based long-term care services, and rarely opted out of the program once enrolled.<sup>52</sup>

In March 2017, RTI released three issue briefs on beneficiary experience, care coordination, and special populations under the Financial Alignment Initiative.<sup>53, 54, 55</sup> The issue brief on beneficiary experience describes results from beneficiary focus groups

conducted in six states, including Massachusetts, California, and Virginia, which are profiled in Section IV of this report. The issue brief on care coordination reports on information from site visits, enrollee focus groups, and state reports and data, gathered from nine states including the three profiled in this report. Finally, the issue brief on special populations (i.e., individuals with LTSS and behavioral health needs and linguistic, ethnic, and racial minorities) draws from quantitative and qualitative analyses of the Washington Managed FFS and Massachusetts Capitated demonstrations.

## Recommendations for Changes to the Financial Alignment Initiative

CMS, members of Congress, and other organizations have suggested changes in the program to help better integrate services, improve patient experience, increase potential for savings, and increase state participation in the demonstrations. CMS has proposed legislative changes that would integrate the appeals system for the broader Medicare-Medicaid population enrolled in health plans that integrate Medicare and Medicaid benefits.<sup>56</sup> In its bipartisan proposal to improve care for patients with chronic conditions, the Senate Finance Committee's Chronic Care Working Group also included recommendations to align the Medicare and Medicaid grievance and appeals processes.<sup>57</sup>

Finally, in September 2016, the Bipartisan Policy Center issued a report that included a series of recommendations to improve the Financial Alignment Initiative, including recommendations for both ongoing demonstrations, and new demonstrations. For ongoing demonstrations, CMS should:

- Revise contracts to ensure that, where appropriate, rates reflect unanticipated costs of infrastructure investment or significant differences in costs associated with serving certain special-needs populations, such as those with previously untreated mental illnesses or homeless individuals. Note: CMS has made these adjustments in some states;
- Ensure that adjustments do not result in increased cost to the federal government over the five-year demonstration period;
- Work with states to develop unique state-specific quality and access measures, and to the extent there are savings, permit states to share in a greater percentage of those savings or, where appropriate for high-performing states, permit added flexibility in the scope of covered benefits, while assuring that beneficiaries continue to receive optimal access to care; and
- Align coverage standards for Medicare and Medicaid benefits that overlap, including durable medical equipment and home health services.

CMS should establish additional demonstrations to integrate Medicare and Medicaid for dual-eligible beneficiaries based on findings from the evaluations of the first-round demonstrations. New demonstrations will allow additional states to gain experience providing managed LTSS to dual-eligible populations and coordinating these services with Medicare acute care.<sup>58</sup>

“ In an initial evaluation, RTI noted the need to allow adequate time for the program interventions to have an effect on the utilization of services. ”

## *Profiles of Three States*

We selected Massachusetts because the state had considerable experience integrating care for dual-eligible beneficiaries over age 65, and it chose to expand integration of services to the under-65 population. Lessons learned are outlined below.

California's demonstration was ambitious in scope, both in terms of the number of participants and the variation in service arrangements across the seven participating counties.

Finally, Virginia was chosen as a state without prior experience in integrating care for dual-eligible individuals. A table summarizing key components of each state is included in the appendix.

### **Massachusetts**

Massachusetts was the first state to launch a Capitated Model (One Care) under the Financial Alignment Initiative, in October 2013. As a state with longstanding experience with Medicaid managed care for the over-65 population, One Care was designed to provide coordinated care for dual-eligible individuals ages 21-65. Enrollees have access to new and expanded benefits as part of the demonstration, including access to dental and vision services, behavioral health services, and care coordination.

Today, One Care offers two available plans for consumers: Commonwealth Care Alliance (CCA), which covers about 80 percent of enrollees, and Tufts Health Unify, which covers the remaining 20 percent. As of June 2017, about 16,800 individuals – 16.2 percent of total eligible duals – are enrolled in One Care.<sup>59</sup> To enroll, dually-eligible individuals can either opt in or be passively enrolled into the demonstration, with the option to dis-enroll and/or opt out of the demonstration at any time. Of the 104,007 individuals who have been determined to be eligible for One Care, 32.2 percent have chosen to opt out as of June 2017.

According to an initial analysis by of the Massachusetts demonstration, there were numerous administrative and operational challenges in the integration of care for under-65 dual-eligible enrollees.<sup>60</sup> Some of these challenges were directly associated with reconciling discrepancies across MassHealth (the Massachusetts Medicaid agency), CMS, and One Care plans. Plans also noted difficulty in locating One Care enrollees due to the prevalence of homelessness and behavioral health needs among the demonstration population.

**“ Massachusetts has been viewed as very successful in actively engaging stakeholders throughout the demonstration process, especially through the Implementation Council comprised of 21 members (of which 11 members must be consumer members) to solicit feedback. ”**

Over time, plans reported improved ability to conduct timely assessments of enrollees, noting the importance of addressing the behavioral health needs of the dual-eligible population early in the care planning process. Overall, One Care enrollees were in poorer health than non-enrollees in Massachusetts—over one-third of enrollees were categorized as having “high community

need”<sup>b</sup> according to a One Care enrollment report for June 2017.<sup>61</sup> Stakeholder interviews and focus groups conducted by RTI revealed that beneficiaries were generally satisfied with One Care, and frequently attributed their satisfaction to the new or expanded benefits offered under One Care.<sup>62</sup> However, some focus group participants in Massachusetts reported confusion about the roles of their care team, and also expressed concern that their care coordinators were overloaded and had high rates of turnover.<sup>63</sup> A few participants also reported having more limited provider choices compared to what they experienced before enrolling in the demonstration.<sup>64</sup>

A Commonwealth Fund study of 4,500 enrollees in CCA’s One Care plan found that the study population experienced 7.5 percent fewer hospital admissions and 6.4 percent fewer emergency department visits compared to the 12 months prior to enrollment.<sup>65</sup> Preliminary analysis suggested that CCA’s crisis stabilization units, which provide short-term acute psychiatric care, may be particularly responsible for the reduction in admissions.

One Care is structured so that plans receive two monthly capitation payments from CMS (Medicare Parts A and B services and a separate payment for Part D), and one capitation payment from MassHealth.<sup>66</sup> Prior to implementation, plans, state officials, and stakeholders voiced concerns about the adequacy of the capitation rates, specifically citing high initial implementation costs and the lack of allocation of financial support for start-up costs.<sup>67</sup> To mitigate the lack of financial support for startup costs, plans sought large cohorts of enrollees during open-enrollment periods to leverage the volume of enrollees against the inadequate start-up financing and rates.

Several factors contributed to the financial challenges in the initial implementation of the demonstration, including unmet need, difficulty in locating enrollees for assessments (which resulted in longer care periods), incorrect assessments of hierarchical rating categories of enrollees that did not reflect an enrollee’s true care needs, and the impact of Part D reimbursement methodology. During the first year of the demonstration, participating plans experienced financial losses, and one of these plans withdrew from the demonstration in October 2015. CCA, which covers the majority of enrollees, reported losses of \$34.9 million on revenue of \$256.9 million during the first 15 months of the demonstration.<sup>68</sup> Overall, both plans and stakeholders summarized the financial challenges by asserting the rates were not aligned with the care model or the under-65 population. Since then, adjustments to the rates have been made to ease the financial losses incurred in the first two years of the demonstration, and interviews with stakeholders have indicated these steps have improved the financial status of the plans.

Although plans experienced financial losses in the first two years of the demonstration due to the challenges discussed above, adjustments to the capitation rates are thought to address these issues as the demonstration continues to mature and serve the under-65 dually-eligible population. In 2015, CCA reported smaller losses of \$416,000 on revenue of \$385.7 million, and expects to achieve savings in 2017.<sup>69</sup>

---

<sup>b</sup> As part of the rating methodology to determine the Medicaid capitated payment, enrollees are assigned to one of four categories based on historical claims data. These categories are based on activities of daily living, facility versus community care, and diagnoses.

## California

In 2014, California launched Cal MediConnect (CMC), a Capitated Model demonstration aligning the financing and administration of Medi-Cal (California's Medicaid program) and Medicare services in the following seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. CMC integrates Medicaid and Medicare benefits, including medical care, behavioral health care, and LTSS for all full-benefit dual eligible beneficiaries age 21 and older. It also provides new benefits such as care coordination, transportation, and expanded vision and dental services. As of June 2017, approximately 116,000 individuals were enrolled in CMC – 28 percent of the eligible population.<sup>70</sup> Los Angeles County, which accounts for almost one-third of CMC enrollees, has a significantly lower enrollment rate compared to other counties, with only 19 percent of eligible individuals enrolled in CMC.

“*California's demonstration offered the broadest test of the Financial Alignment Initiative in terms of geographic scope, variations in service delivery among counties, and the number of individuals participating.*”

The goals of CMC are to:

- Coordinate state and federal benefits and access to care across care settings, improve continuity of care, and use a person-centered approach.
- Maximize the ability of dual-eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care.
- Increase the availability and access to home- and community-based alternatives.
- Preserve and enhance the ability for consumers to self-direct their care and receive high quality care.
- Optimize the use of Medicare, Medi-Cal, and other state/county resources.

After an initial opt-in period, California employed a passive enrollment process that automatically enrolled all eligible individuals into a CMC health plan unless the individual chose not to join and notified the state. Beneficiaries opting out of CMC are still required to receive their Medicaid benefits through a Medi-Cal health plan. As of June 2017, 50 percent of all eligible beneficiaries in California opted out of the demonstration.<sup>71</sup> Passive enrollment in the California demonstration ended as scheduled in July 2016.<sup>72</sup> Across several states, plans reported having difficulty getting in contact with demonstration enrollees, but this challenge was especially pronounced in California where plans were unable to locate 35.6 percent of beneficiaries within 90 days of their enrollment.<sup>73</sup> To address this problem, plans in California reported hiring lower-level staff with local experience or language capabilities to search for enrollees in the community.

The Community Living Policy Center at the University of California, San Francisco and the UC Berkeley Health Research for Action Center are conducting a multi-year evaluation of CMC, examining the impact of the program on individuals' experiences with care, and the response of the service delivery system to the initiative. Surveys and focus groups of participants found that overall satisfaction with care in CMC was high. Reasons cited included simplified health insurance with one card and one phone number to call; lower out-of-pocket expenses and easier access to medications, medical equipment and hospital visits; more support and access to services through care coordination; and better access to care for behavioral health.<sup>74,75</sup> The proportion of beneficiaries opting out was higher than expected, however. Interviews with providers and individuals identified several contributing factors, including concerns about continuity of care and beneficiary notification materials that did not clearly explain the potential benefits of the program.<sup>76</sup>

Health systems reported concerns about the competing pressures of investing in services to improve care coordination while simultaneously producing savings from baseline levels.<sup>77</sup> California's memorandum of understanding with CMS set minimum savings percentages for the state that were based on target savings established for each county. These targets ranged from 1.0 to 1.5 percent in year one; 2.0 to 3.5 percent in year two; and 4.0 to 5.5 percent in year three.<sup>78</sup> Providers reported that the savings targets in CMC were ambitious and that additional time would be needed to realize cost savings. The new systems of care required an expanded workforce, including enhanced specialty provider networks; recruiting and training of adequate and qualified care coordinators; and expanded contractual, legal, and administrative staff. Implementation of CMC was affected by significant differences across regions and plans in terms of experience with managed care, provider capacity, volume and geographic spread of beneficiaries, and integration of health and social services.<sup>79</sup> These differences led to variations in how CMC plans established their networks, how services were delegated, the structure of contracts and payments, and stakeholder collaborations.

Providers reported that the required health risk assessments (HRAs) were valuable, and a key first step in developing person-centered care, but difficult to complete because of outdated contact information on beneficiaries and some reluctance by beneficiaries to participate in assessments. There were also concerns that the HRAs did not adequately assess non-medical or social needs. Interviews of key stakeholders found that CMC encouraged collaboration across the health system, and that care coordination held promise and could improve access to LTSS.

The California Department of Health Care Services (DHCS) has worked closely with program evaluators and is implementing strategies targeted to areas of potential improvement identified in the evaluations. DHCS has committed to continue to use data-driven quality improvement strategies as program implementation continues.

The CMC demonstration is part of a broader California Coordinated Care Initiative. While the 2017-18 Governor's Budget does not continue the Coordinated Care Initiative, it does extend the CMC program and continues the integration of long-term services and supports, with the exception of the county-administered in-home services and supports (IHSS) program. IHSS will no longer be included as a health plan benefit, but would continue to be available to eligible beneficiaries as a fee-for-service benefit, just as it was before implementation of the CCI.<sup>80</sup>

## Virginia

In April 2014, Virginia launched its Capitated Model demonstration, which sought to enroll full-benefit dual-eligible individuals<sup>c</sup> over the age of 21 who resided in one of the following five regions: Central Virginia, Northern Virginia, Tidewater, Western/Charlottesville, or Roanoke.<sup>81</sup> As of June 2017, Virginia’s Capitated Model had enrolled about 25,800 dual-eligible beneficiaries, or 40 percent of the total eligible population.<sup>82</sup> Roughly half of beneficiaries who were eligible for the demonstration have chosen to opt out.

“*Health plan efforts to avoid unnecessary utilization of medical services include: care coordination for at-risk members, increased support for members and caregivers, improved transitions across sites of care, and attempts to mitigate financial incentives that encourage LTC facilities to re-hospitalize residents.*”

Under the terms of the memorandum of understanding between CMS and Virginia, managed care plans were expected to produce savings on per-beneficiary spending on Medicare Part A, Medicare Part B, and Medicaid-covered services<sup>d</sup> equivalent to one percent savings in Year One, two percent savings in Year Two, and four percent savings in Year Three.<sup>83</sup>

Virginia elected to “carve out” targeted case management (TCM) services<sup>e</sup>, dental services, and certain other case management services from the benefit package.<sup>84</sup> These services were excluded from the benefits and capitation rates under the Capitated Model, and instead paid for separately under Virginia’s Medicaid FFS payment systems, to the extent applicable. Among other things, participating managed care plans were required to establish integrated grievance and appeals processes for enrollees and ensure that Medicare and Medicaid-covered services are furnished under a coordinated, person-centered approach.<sup>85</sup> Plans in Virginia reported steep learning curves in providing LTSS, in part because most care coordinators did not have experience providing these services.<sup>86</sup>

In a preliminary analysis of the Financial Alignment Initiative demonstration conducted by RTI International on behalf of CMS, researchers found that the use of care managers by managed care plans in Virginia’s Capitated Model helped identify service gaps and address non-clinical needs of dual-eligible enrollees.<sup>87</sup> Such non-clinical needs included transportation to medical appointments (to prevent avoidable emergency department visits), in-home meal delivery for diabetic enrollees, and increasing

<sup>c</sup> The model excluded dual-eligible beneficiaries who are required to “spend down” to meet Medicaid eligibility requirements, as well as dual-eligible individuals in State mental hospitals, end-stage renal disease (ESRD) patients, individuals in hospice care, and dual-eligible beneficiaries who were enrolled in PACE or a variety of other existing Medicaid demonstrations.

<sup>d</sup> Note: Although prescription drug benefits under Medicare Part D were included in the combined benefit package under the Capitated Model managed care plan, annual savings requirements were not applied to the portion of the capitation rate associated with Part D drug spending.

<sup>e</sup> Note: TCM services are defined in the Virginia’s Memorandum of Understanding with CMS as case management services provided to individuals with substance abuse disorders, developmental disabilities, behavioral health disorders, and intellectual disabilities. Such services include “referral/transition management and clinical services such as monitoring, self-management support, medication review and adjustment.”

personal care services staffing for homebound enrollees.<sup>88</sup> In a survey of Capitated Model enrollees commissioned by Virginia, on average dual-eligible enrollees reported a plan satisfaction rate of 8.6 out of 10 (with 10 being the highest possible score) for 2015.<sup>89</sup> The survey elicited 291 enrollee comments, which were overwhelmingly positive and indicated that enrollees were particularly satisfied with their care coordinators. Beneficiaries who participated in RTI focus groups indicated satisfaction with the accessibility and lower costs of services in the demonstration.<sup>90</sup> Similar to beneficiaries in other states, Virginia focus group

**“ In January 2016, Virginia submitted a Medicaid waiver application that would seek to transition its Capitated Model-enrolled dual-eligible beneficiaries into new MLTSS plans that are also CMS-approved D-SNPs under the MA program. ”**

participants reported having more limited access to providers compared to their experiences before enrolling in the demonstration.<sup>91</sup> In January 2016, Virginia submitted a Section 1115 Medicaid waiver application that would transition its Capitated Model-enrolled dual-eligible beneficiaries into new MLTSS plans that are also CMS-approved D-SNPs under the MA program.<sup>92</sup> To participate in the waiver demonstration, MLTSS plans would be required to offer D-SNP coverage in the geographic areas that the MLTSS plan serves. To the extent possible, Virginia would seek to enroll dual-eligible beneficiaries in the same plan for both Medicare and Medicaid services.<sup>93</sup> To help replicate the integrated care approach from the Capitated Model, the contracts between Virginia and the MLTSS plans also require extensive care coordination with the applicable D-SNP.<sup>94</sup> The waiver demonstration would also incorporate Virginia Integrated Provider Partnerships, which would allow for certain providers to better coordinate care for medically complex and high-risk dual-eligible beneficiaries, in consultation with the MLTSS plan.<sup>95</sup> According to the waiver application, the waiver demonstration is intended to “build off of the successes” of the Financial Alignment Initiative demonstration in Virginia, while transitioning Financial Alignment Initiative demonstration enrollees into an “even greater level of coordinated services.”<sup>96</sup> Under the waiver demonstration, Virginia expects to initially enroll roughly 50,000 dual-eligible individuals in 2017, followed in 2018 by an enrollment of an additional 67,000 dual-eligible beneficiaries who are currently eligible for the Financial Alignment Initiative demonstration.<sup>97</sup> To date, CMS is still in the process of reviewing the waiver application.<sup>98</sup>

## *Conclusion*

While the ability of the Financial Alignment Initiative demonstrations to both improve quality and lower costs continues to be in question in some states, experience from other states such as Minnesota and Massachusetts—which had a history of integrating services for dual-eligible beneficiaries aged 65 and over—indicates that care integration may lead to improved outcomes. The positive outcomes include a reduction in emergency department visits and hospital admissions. Further, structural changes in the demonstration, such as better alignment of program administration and permitting up-front infrastructure investments in the early years, may result in longer-term savings, improved quality of care, and greater availability of services in the home, rather than costlier institutional care.

- The Financial Alignment Initiative has experienced both success and challenges, most of which can be remedied with revisions in law and program guidelines.
- Whether full integration of Medicare and Medicaid services will improve quality and lower the total cost of care for dual-eligible beneficiaries will vary based on numerous factors, including the care delivery model and state implementation.
- There is potential for improved quality and greater value, and the Financial Alignment Initiative should be continued and expanded over time.
- The demonstration presents the opportunity to better integrate Medicare and Medicaid services in a way that improves quality and access to services.

# Appendix

State	Model Type	Eligible Population <sup>f</sup>	Limited Areas within State?	Start Date	Total Enrollment <sup>g</sup>
California	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 21 and older; and,</li> <li>• Not enrolled in certain HCBS waivers, not residing in certain institutions, and meet certain continuous eligibility requirements.</li> </ul>	Counties	April 1, 2014	118,386
Colorado	FFS	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Currently receive Medicaid benefits under a Medicaid FFS arrangement;</li> <li>• Are not residing in an Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID);</li> <li>• Are not enrolled in an MA plan, PACE, Denver Health Medicaid Choice Plan, or Rocky Mountain Health Plan.</li> <li>• Are not already participating in Colorado's ACC Program Payment Reform Pilot.</li> </ul>	Statewide	September 1, 2014	25,147
Illinois	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 21 and older; and,</li> <li>• Not enrolled in certain HCBS waivers or certain programs</li> </ul>	Regions	March 1, 2014	51,063
Massachusetts	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 21 through 64; and,</li> <li>• Not enrolled in HCBS waivers, not residing in certain institutions.</li> </ul>	Counties	October 1, 2013	16,950
Michigan	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 21 and older; and</li> <li>• Had not previously dis-enrolled from Medicaid managed care due to special dis-enrollment, election of hospice services, or CSHCS services.</li> </ul>	Regions	March 1, 2015	39,681

<sup>f</sup> Sources: Medicaid and CHIP Payment and Access Commission, “Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare,” MACPAC Issue Brief, July 2016; CMS, Memoranda of Understanding with Financial Alignment Initiative Participant States, 2017.

<sup>g</sup> Sources: Integrated Care Resource Center, Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, June 2016 to June 2017, January 2017; Colorado Dept. of Health Care Policy & Financing, ACC Program Data for PIAC – February 2017; Minnesota Health Care Programs Managed Care Enrollment Totals July 2017; Washington State Health Care Authority, Washington State’s Fee-For-Service Dual Eligible Demonstration Summary Report, January 1, 2017.

State	Model Type	Eligible Population <sup>f</sup>	Limited Areas within State?	Start Date	Total Enrollment <sup>g</sup>
Minnesota	Alternative <sup>h</sup>	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible; and</li> <li>• Age 65 and older.</li> </ul>	Statewide	September 13, 2013 (Financial Alignment Demo) February 1997 (Original MSHO)	37,653
New York (Non-IDD)	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 21 and older; and</li> <li>• 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.</li> </ul>	Regions	January 1, 2015	4,708
New York (IDD)	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 21 and older; and</li> <li>• Eligible for Office for Persons with Developmental Disabilities (OPWDD) services, eligible for intermediate care facilities for individuals with IDD level of care, receiving Section 1915(c) waiver services as an alternative to ICF-IDD placement, or enrolled in the Section 1915(c) OPWDD waiver.</li> </ul>	Regions	April 1, 2016	575
Ohio	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 18 and older; and</li> <li>• 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.</li> </ul>	Regions	May 1, 2014	75,603
Rhode Island	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 21 and older; and</li> <li>• Not residing in certain institutions or receiving certain services.</li> </ul>	Statewide	May 1, 2016	14,002

<sup>h</sup> The Minnesota Senior Health Options (MSHO) program predates the Financial Alignment Initiative, having provided integrated Medicare-Medicaid coverage, through managed care plans, to dual-eligible individuals in Minnesota since 1997. Therefore, rather than participating in the Capitated Model or the Managed FFS Model, CMS and Minnesota agreed to an alternative Financial Alignment Initiative demonstration, under which CMS and Minnesota aligned administrative contracting requirements for MSHO-participating managed care plans that contract with CMS as D-SNPs and with Minnesota as Medicaid managed care organizations. Administrative alignments included synthesizing requirements for beneficiary communication materials, network adequacy, grievance/appeals processes, quality measures, and models of care.

State	Model Type	Eligible Population <sup>f</sup>	Limited Areas within State?	Start Date	Total Enrollment <sup>g</sup>
South Carolina	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 65 and older; and</li> <li>• Not enrolled in certain HCBS waivers, and not residing in certain institutions.</li> </ul>	Statewide	February 1, 2015	8,033
Texas	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 21 and older; and</li> <li>• Qualify for SSI benefits or Medicaid HCBS STAR+PLUS waiver services, and not enrolled in certain HCBS waivers, and not residing in an ICF/ID.</li> </ul>	Counties	March 1, 2015	40,738
Virginia	Capitated	<ul style="list-style-type: none"> <li>• Full-benefit dually eligible;</li> <li>• Age 21 and older; and</li> <li>• Not enrolled in certain waivers, and not residing in certain institutions or receiving certain services.</li> </ul>	Regions	April 1, 2014	27,958
Washington	FFS	<ul style="list-style-type: none"> <li>• Be enrolled in Medicare Parts A and B and eligible for Part D and Medicaid, regardless of age, and have no other comprehensive private or public health insurance; and</li> <li>• Be eligible for Medicaid State Plan health home services under section 1945(h)(2) of the Social Security Act, and any approved health home SPA(s) in the state, due to the presence of at least two chronic conditions, one chronic condition and risk for another, or one serious and persistent mental health condition.</li> </ul>	Counties	July 1, 2013	21,031

# Endnotes

- 1 Centers for Medicare & Medicaid Services, *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*, CMS Letter to State Medicaid Directors, July 2011. Available at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial\\_Models\\_Supporting\\_Integrated\\_Care\\_SMD.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf).
- 2 CMS Center for Medicare and Medicaid Innovation, *CMS Innovation Center: Report to Congress*, 61-64, December 2016. Available at: <https://innovation.cms.gov/Files/reports/rtc-2016.pdf>.
- 3 CMS Center for Medicare and Medicaid Innovation, *CMS Innovation Center: Report to Congress*, 61-64, December 2016. Available at: <https://innovation.cms.gov/Files/reports/rtc-2016.pdf>.
- 4 Integrated Care Resource Center, *Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State*, January 2016 to January 2017, January 2017. Available at: [http://www.integratedcareresourcecenter.com/PDFs/MMP\\_Enroll\\_by\\_State\\_January\\_2017.pdf](http://www.integratedcareresourcecenter.com/PDFs/MMP_Enroll_by_State_January_2017.pdf).
- 5 Ibid.
- 6 Centers for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office. *Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2015*. December 2016. Available at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEnrollment\\_2006-2015.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEnrollment_2006-2015.pdf).
- 7 Ibid.
- 8 Medicaid and CHIP Payment and Access Commission and Medicare Payment Advisory Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, 42, January 2017. Available at: [https://www.macpac.gov/wp-content/uploads/2017/01/Jan17\\_MedPAC\\_MACPAC\\_DualsDataBook.pdf](https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf).
- 9 Bipartisan Policy Center, *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*, 19-21, September 2016. Available at: <http://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/>.
- 10 Medicaid and CHIP Payment and Access Commission and Medicare Payment Advisory Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, 30, January 2017. Available at: [https://www.macpac.gov/wp-content/uploads/2017/01/Jan17\\_MedPAC\\_MACPAC\\_DualsDataBook.pdf](https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf).
- 11 Bipartisan Policy Center, *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*, 36-37, September 2016. Available at: <http://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/>.
- 12 Ibid at 5.
- 13 Medicaid and CHIP Payment and Access Commission and Medicare Payment Advisory Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, 49, January 2017. Available at: [https://www.macpac.gov/wp-content/uploads/2017/01/Jan17\\_MedPAC\\_MACPAC\\_DualsDataBook.pdf](https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf).
- 14 Ibid at 30.
- 15 Bipartisan Policy Center, *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*, 20, September 2016. Available at: <http://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/>.
- 16 Andrew Dick, Hangsheng Liu, Jack Zwanziger, et al. "Long-term survival and healthcare utilization outcomes attributable to sepsis and pneumonia," *BMC Health Services Research* 2012; 12:432. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3534544/pdf/1472-6963-12-432.pdf>.
- 17 Department of Health & Human Services Assistant Secretary for Planning and Evaluation. *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*. December 2016. Available at: <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>.
- 18 Bipartisan Policy Center, *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*, 18, September 2016. Available at: <http://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/>.
- 19 James Verdier, *SNP and MMP Development: A National Profile and Key Issues for the Future*, Presentation at SNP Alliance Forum, Mathematic Policy Research, November 2015. Available at: <https://www.mathematica-mpr.com/our-publications-and-findings/publications/snp-and-mmp-development-a-national-profile-and-key-issues-for-the-future>;  
See also Integrated Care Resource Center, *Program of All-Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization*, January 2017. Available at: [http://www.integratedcareresourcecenter.com/PDFs/PACE\\_Enroll\\_by\\_State\\_January\\_2017.pdf](http://www.integratedcareresourcecenter.com/PDFs/PACE_Enroll_by_State_January_2017.pdf).

- 20 Verdier, James, “SNP and MMP Development: A National Profile and Key Issues for the Future,” Presentation at SNP Alliance Forum, Mathematic Policy Research, November 2015. Available at: <https://www.mathematica-mpr.com/our-publications-and-findings/publications/snp-and-mmp-development-a-national-profile-and-key-issues-for-the-future>;  
See also Integrated Care Resource Center, “Program of All-Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization,” January 2017. Available at: [http://www.integratedcareresourcecenter.com/PDFs/PACE\\_Enroll\\_by\\_State\\_January\\_2017.pdf](http://www.integratedcareresourcecenter.com/PDFs/PACE_Enroll_by_State_January_2017.pdf)
- 21 Ibid at 25-26.
- 22 Centers for Medicare & Medicaid Services, *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*, CMS Letter to State Medicaid Directors, July 2011. Available at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial\\_Models\\_Supporting\\_Integrated\\_Care\\_SMD.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf).
- 23 CMS Center for Medicare and Medicaid Innovation, *CMS Innovation Center: Report to Congress*, 61-64, December 2016. Available at: <https://innovation.cms.gov/Files/reports/rtc-2016.pdf>.
- 24 Centers for Medicare & Medicaid Services, *CMS Financial Alignment Initiative Extension Memo*, July 16, 2015. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAExtensionMemo071615.pdf>
- 25 Virginia Dept. of Medical Assistance Services, *Innovative, Focused, and Scalable Delivery System Transformation: Section 1115 Waiver Application*, 8-9, January 2016. Available at: [http://www.dmas.virginia.gov/Content\\_atchs/mltss/Virginia\\_percent20Section\\_percent201115\\_percent20Demonstration\\_percent20Waiver\\_percent20Application\\_percent20Jan\\_percent2019\\_percent202016.pdf](http://www.dmas.virginia.gov/Content_atchs/mltss/Virginia_percent20Section_percent201115_percent20Demonstration_percent20Waiver_percent20Application_percent20Jan_percent2019_percent202016.pdf).
- 26 Medicaid and CHIP Payment and Access Commission, *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare*, MACPAC Issue Brief, July 2016. Available at: <https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare.pdf>.
- 27 Ibid.
- 28 Centers for Medicare & Medicaid Services, *California Financial Alignment Demonstration (Cal MediConnect)*, CMS Information Page on California’s Financial Alignment Initiative Demonstration, Updated September 30, 2015. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-office/FinancialAlignmentInitiative/California.html>.
- 29 Medicaid and CHIP Payment and Access Commission, *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare*, MACPAC Issue Brief, July 2016. Available at: <https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare.pdf>.
- 30 CMS Center for Medicare and Medicaid Innovation, *CMS Innovation Center: Report to Congress*, 61-64, December 2016. Available at: <https://innovation.cms.gov/Files/reports/rtc-2016.pdf>.
- 31 Integrated Care Resource Center, *Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State*, January 2016 to January 2017, January 2017. Available at: [http://www.integratedcareresourcecenter.com/PDFs/MMP\\_Enroll\\_by\\_State\\_January\\_2017.pdf](http://www.integratedcareresourcecenter.com/PDFs/MMP_Enroll_by_State_January_2017.pdf).
- 32 Ibid.
- 33 Colorado Dept. of Health Care Policy and Financing, “Intent to extend Colorado’s Medicare-Medicaid Demonstration,” Letter to CMS Medicare-Medicaid Coordination Office, August 31, 2015. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/COLetterofIntent.pdf>;  
See also RTI International, “Financial Alignment Initiative Annual Report: Washington Health Homes MFFS Demonstration,” RTI International Report prepared for CMS, 4, July 2016. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAFirstAnnualEvalResults.pdf>
- 34 Centers for Medicare & Medicaid Services, “Extension of Memorandum of Understanding (MOU) Between The Centers for Medicare & Medicaid Services and the State of Minnesota Regarding a Federal-State Partnership to Align Administrative Functions for Improvements in Medicare-Medicaid Beneficiary Experience,” 1, October 2016. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOUExtension10262016.pdf>
- 35 Medicaid and CHIP Payment and Access Commission, “Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare,” MACPAC Issue Brief, July 2016. Available at: <https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare.pdf>

- 36 RTI International, "Report on Early Implementation of Demonstrations under the Financial Alignment Initiative, RTI Report for CMS, 20, October 2015. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf>
- 37 Ibid at 43.
- 38 Centers for Medicare & Medicaid Services, *Joint Rate-Setting Process for the Capitated Financial Alignment Model*, Frequently Asked Questions Guidance, Updated August 9, 2013. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/JointRateSettingProcess.pdf>.
- 39 Ibid.
- 40 Medicaid and CHIP Payment and Access Commission, "Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare," MACPAC Issue Brief, July 2016. Available at: <https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare.pdf>
- 41 Centers for Medicare & Medicaid Services, "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees," CMS Letter to State Medicaid Directors, July 2011. Available at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial\\_Models\\_Supporting\\_Integrated\\_Care\\_SMD.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf)
- 42 Centers for Medicare & Medicaid Services. *Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017*. October 25, 2015. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/HCCRiskAdjustmentModel102815.pdf>.
- 43 Centers for Medicare & Medicaid Services. *Medicare A/B Payment to Medicare-Medicaid Plans Participating in the Financial Alignment Initiative for Contract Year 2016*. November 12, 2015. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/PartABPaymenttoMMPs111215.pdf>.
- 44 Ibid.
- 45 Ibid.
- 46 Medicaid and CHIP Payment and Access Commission, *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare*, MACPAC Issue Brief, July 2016. Available at: <https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare.pdf>.
- 47 Centers for Medicare & Medicaid Services (CMS), *Report on Early Implementation of Demonstrations under the Financial Alignment Initiative*, 2016. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf>.
- 48 See RTI International, *Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience: Annual Report*, September 2, 2016. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MINNFirstAnnualEvalReport.pdf>.
- 49 See also RTI International, *Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare*, September 1, 2016. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASSFirstAnnualEvalReport.pdf>.
- 50 See also RTI International, *Financial Alignment Initiative Annual Report: Washington Health Homes MFFS Demonstration*, July 2016. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAFirstAnnualEvalResults.pdf>.
- 51 Ibid.
- 52 Department of Health & Human Services Assistant Secretary for Planning and Evaluation, *Minnesota Managed Care Longitudinal Data Analysis*, March 2016. Available at: <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>.
- 53 See RTI International, *Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative*, March 2017. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf>.

- 54 See RTI International, *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative*, March 2017. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf>.
- 55 See RTI International, *Issue Brief: Special Populations Enrolled in Demonstrations under the Financial Alignment Initiative*, March 2017. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SpecialPopulationsIB508032017.pdf>.
- 56 Centers for Medicare & Medicaid Services, *Medicare-Medicaid Coordination Office Report to Congress FY 2015*. 7. 2015. Available at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO\\_2015\\_RTC.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2015_RTC.pdf).
- 57 United States Senate Committee on Finance, S. \_\_\_, the “Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2016,” Committee Discussion Draft Legislation, October 2016. Available at: [https://www.finance.senate.gov/imo/media/doc/The percent20CHRONIC percent20Act percent20of percent202016 percent20- percent20Discussion percent20Draft.pdf](https://www.finance.senate.gov/imo/media/doc/The%20percent20CHRONIC%20percent20Act%20of%20percent202016%20-%20percent20Discussion%20Draft.pdf).
- 58 Bipartisan Policy Center, *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*, 25-26, September 2016. Available at: <http://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/>.
- 59 Massachusetts Executive Office of Health & Human Services, *One Care: June 2017 Enrollment Report*. Available at: <http://www.mass.gov/eohhs/docs/masshealth/onecare/enrollment-reports/enrollment-report-june2017.pdf>.
- 60 RTI International, *Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare*, RTI Report for CMS, September 1, 2016. Available at: <http://www.mass.gov/eohhs/docs/masshealth/onecare/one-care-annual-evaluation-report-demonstration-year-1.pdf>.
- 61 Massachusetts Executive Office of Health & Human Services, *One Care: June 2017 Enrollment Report*. Available at: <http://www.mass.gov/eohhs/docs/masshealth/onecare/enrollment-reports/enrollment-report-june2017.pdf>.
- 62 See also RTI International, *Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare*, September 1, 2016. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASSFirstAnnualEvalReport.pdf>.
- 63 See RTI International, *Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative*, March 2017. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf>.
- 64 Ibid.
- 65 Sarah Klein, Martha Hostetter, and Douglas McCarthy, *The “One Care” Program at Commonwealth Care Alliance: Partnering with Medicare and Medicaid to Improve Care for Nonelderly Dual Eligibles*, The Commonwealth Fund, December 2016. Available at: [http://www.commonwealthfund.org/publications/case-studies/2016/dec/~media/files/publications/case-study/2016/dec/1917\\_klein\\_commonwealth\\_care\\_alliance\\_case\\_study.pdf](http://www.commonwealthfund.org/publications/case-studies/2016/dec/~media/files/publications/case-study/2016/dec/1917_klein_commonwealth_care_alliance_case_study.pdf).
- 66 Centers for Medicare & Medicaid Services, *Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services and the Commonwealth of Massachusetts Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees*, August 2012. Available at: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/120822-duals-demo-mou.pdf>.
- 67 RTI International, *Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare*, RTI Report for CMS, September 1, 2016. Available at: <http://www.mass.gov/eohhs/docs/masshealth/onecare/one-care-annual-evaluation-report-demonstration-year-1.pdf>.
- 68 Sarah Klein, Martha Hostetter, and Douglas McCarthy, *The “One Care” Program at Commonwealth Care Alliance: Partnering with Medicare and Medicaid to Improve Care for Nonelderly Dual Eligibles*, The Commonwealth Fund, December 2016. Available at: [http://www.commonwealthfund.org/publications/case-studies/2016/dec/~media/files/publications/case-study/2016/dec/1917\\_klein\\_commonwealth\\_care\\_alliance\\_case\\_study.pdf](http://www.commonwealthfund.org/publications/case-studies/2016/dec/~media/files/publications/case-study/2016/dec/1917_klein_commonwealth_care_alliance_case_study.pdf).
- 69 Sarah Klein, Martha Hostetter, and Douglas McCarthy, *The “One Care” Program at Commonwealth Care Alliance: Partnering with Medicare and Medicaid to Improve Care for Nonelderly Dual Eligibles*, The Commonwealth Fund, December 2016. Available at: [http://www.commonwealthfund.org/publications/case-studies/2016/dec/~media/files/publications/case-study/2016/dec/1917\\_klein\\_commonwealth\\_care\\_alliance\\_case\\_study.pdf](http://www.commonwealthfund.org/publications/case-studies/2016/dec/~media/files/publications/case-study/2016/dec/1917_klein_commonwealth_care_alliance_case_study.pdf).
- 70 California MediConnect Monthly Enrollment Dashboard, June 2017. Available at: <http://calduals.org/wp-content/uploads/2017/07/June-2017-CMC-Enrollment-Dashboard.pdf>.
- 71 Ibid.

- 72 California Department of Health Care Services, State of California. May CCI stakeholder call and materials for stakeholder comment. Sacramento, CA: California Department of Health Care Services. Available at: <http://www.calduals.org/news-and-updates/>.
- 73 See RTI International, *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative*, March 2017. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf>.
- 74 Carrie Graham, Pi-Ju Liu, and Steve Kaye, Evaluation of Cal MediConnect, *Key Findings from a Survey with Beneficiaries*, Long Beach, CA: The SCAN Foundation (2016). Available at: [http://www.thescanfoundation.org/sites/default/files/uc\\_duals\\_phonesurvey\\_2016.pdf](http://www.thescanfoundation.org/sites/default/files/uc_duals_phonesurvey_2016.pdf).
- 75 Carrie Graham, Elaine Kurtovich, Holly Stewart, et. al. *Evaluation of Cal MediConnect: Results of focus groups with beneficiaries*. Long Beach, CA: The SCAN Foundation (2016). Available at: [http://www.thescanfoundation.org/sites/default/files/cal\\_mediconnect\\_focus\\_group\\_report\\_march\\_2016.pdf](http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_focus_group_report_march_2016.pdf).
- 76 Carrie Graham, Pi-Ju Liu, and Steve Kaye, Evaluation of Cal MediConnect, *Key Findings from a Survey with Beneficiaries*, Long Beach, CA: The SCAN Foundation (2016). Available at: [http://www.thescanfoundation.org/sites/default/files/uc\\_duals\\_phonesurvey\\_2016.pdf](http://www.thescanfoundation.org/sites/default/files/uc_duals_phonesurvey_2016.pdf).
- 77 Brooke Hollister, Carrie Graham, Charlene Harrington, et. al. Cal MediConnect, *How Have Health System Responded?* Long Beach, CA: The SCAN Foundation (2016). Available at: [http://www.thescanfoundation.org/sites/default/files/cal\\_mediconnect\\_health\\_system\\_full\\_report.pdf](http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_health_system_full_report.pdf).
- 78 Centers for Medicare & Medicaid Services (CMS), *Memorandum of understanding (MOU) between the Centers for Medicare & Medicaid Services (CMS) and the State of California regarding a federal-state partnership to test a capitated financial alignment model for Medicare-Medicaid enrollees*: California demonstration to integrate care for dual eligible beneficiaries. 2013, Baltimore, MD: CMS. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAMOU.pdf>.
- 79 Ibid.
- 80 California Department of Health Care Services, *Coordinated Care Initiative 2017 Budget Update*, 2017. Available at: <http://www.calduals.org/2017/01/13/coordinated-care-initiative-2017-budget-update/>.
- 81 Centers for Medicare & Medicaid Services, *Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services and the Commonwealth of Virginia Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees*, 35-37, May 2013. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/VAMOU.pdf>.
- 82 Virginia Dept. of Medical Assistance Services, *Commonwealth Coordinated Care Monthly Enrollment Dashboard, Enrollment Report*, June 2017. Available at: [http://www.dmas.virginia.gov/content\\_atchs/altc/Monthly%20Dashboard%20-%20062017.pdf](http://www.dmas.virginia.gov/content_atchs/altc/Monthly%20Dashboard%20-%20062017.pdf).
- 83 Centers for Medicare & Medicaid Services, *Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services and the Commonwealth of Virginia Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees*, 42, May 2013. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/VAMOU.pdf>.
- 84 Ibid at 73.
- 85 Ibid at 13-15.
- 86 See also RTI International, *Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare*, September 1, 2016. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASSFirstAnnualEvalReport.pdf>.
- 87 RTI International, *Report on Early Implementation of Demonstrations under the Financial Alignment Initiative*, RTI Report for CMS, 20, October 2015. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf>.
- 88 Ibid.
- 89 Alison Cuellar, Gilbert Gimm, and Carole Gresenz, *A Survey of EDCD Waiver Participants Who Were Enrolled in the Commonwealth Coordinated Care (CCC) Program for Dual-Eligibles: Findings from Telephone and Mail Surveys*, George Mason University Department of Health Administration & Policy, 11, September 2016. Available at: [http://www.dmas.virginia.gov/Content\\_atchs/altc/CCC\\_Tel\\_Mail\\_Survey\\_percent20Findings\\_Enrollees\\_16-9-2.pdf](http://www.dmas.virginia.gov/Content_atchs/altc/CCC_Tel_Mail_Survey_percent20Findings_Enrollees_16-9-2.pdf).

- <sup>90</sup> See RTI International, *Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative*, March 2017. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf>.
- <sup>91</sup> *Ibid.*
- <sup>92</sup> Virginia Dept. of Medical Assistance Services, *Innovative, Focused, and Scalable Delivery System Transformation: Section 1115 Waiver Application*, 8-9, January 2016. Available at: [http://www.dmas.virginia.gov/Content\\_atchs/mltss/Virginia%20Section%201115%20Demonstration%20Waiver%20Application%20Jan%202019%202016.pdf](http://www.dmas.virginia.gov/Content_atchs/mltss/Virginia%20Section%201115%20Demonstration%20Waiver%20Application%20Jan%202019%202016.pdf).
- <sup>93</sup> *Ibid.*
- <sup>94</sup> Virginia Dept. of Medical Assistance Services, *Commonwealth Coordinated Care Plus MCO Contract for Managed Long-Term Services and Supports*, February 2017. Available at: [http://www.dmas.virginia.gov/Content\\_atchs/mltss/CCC%20Plus%20Final%20February%202017.pdf](http://www.dmas.virginia.gov/Content_atchs/mltss/CCC%20Plus%20Final%20February%202017.pdf).
- <sup>95</sup> *Ibid* at 12.
- <sup>96</sup> *Ibid* at 6-9.
- <sup>97</sup> *Ibid* at 9.
- <sup>98</sup> Centers for Medicare & Medicaid Services, "State Waivers List," CMS Medicaid Waivers Website, Accessed February 15, 2017. Available at: [https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers\\_faceted.html](https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html).

# *Notes*



## BIPARTISAN POLICY CENTER

2017 marks the Bipartisan Policy Center's 10th anniversary. For a decade, BPC has worked to find actionable solutions to America's major policy challenges.

### ***Celebrating ten years of productive partisanship.***

The Bipartisan Policy Center is a non-profit organization that combines the best ideas from both parties to promote health, security, and opportunity for all Americans. BPC drives principled and politically viable policy solutions through the power of rigorous analysis, painstaking negotiation, and aggressive advocacy.

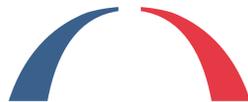
[bipartisanpolicy.org](http://bipartisanpolicy.org) | 202-204-2400

1225 Eye Street NW, Suite 1000 | Washington, D.C. 20005

-  [@BPC\\_Bipartisan](https://twitter.com/BPC_Bipartisan)
-  [facebook.com/BipartisanPolicyCenter](https://facebook.com/BipartisanPolicyCenter)
-  [instagram.com/BPC\\_Bipartisan](https://instagram.com/BPC_Bipartisan)
-  [flickr.com/BPC\\_Bipartisan](https://flickr.com/BPC_Bipartisan)

## BPC Policy Areas

- Economy
- Energy
- Finance
- Governance
- Health
- Housing
- Immigration
- Infrastructure
- National Security



**BIPARTISAN POLICY CENTER**

**1225 Eye Street NW, Suite 1000 | Washington, D.C. 20005**

202-204-2400 | [bipartisanpolicy.org](http://bipartisanpolicy.org)