Last Updated 6/28/2016

FINANCIAL ALIGNMENT INITIATIVE

The Centers for Medicare & Medicaid Services (CMS) launched the Financial Alignment Initiative in 2011 to begin addressing the financial misalignment between Medicare and Medicaid that often presents a barrier to coordinated care for enrollees. The Financial Alignment Initiative aims to better align the financing of these two programs and integrate primary, acute, behavioral health and long-term services and supports in a more easily navigable, simplified system for enrollees. The Initiative has two models, the capitated model and managed fee-for-service model, both of which are serving beneficiaries in states throughout the country. This document provides a snapshot of enrollment, age, and health risk assessment (HRA) experience to date for the capitated financial alignment model.

ENROLLMENT: In the capitated financial alignment model, states and CMS contract with health plans known as Medicare-Medicaid Plans (MMPs) to provide comprehensive, coordinated care for enrollees. Enrollment into MMPs varies according to each state's demonstration design. In most states enrollment is phased in over time. Many factors may influence demonstration enrollment such as the demonstration service area within each state, the number of plans participating in each demonstration, and state Medicaid managed care enrollment policies. Since the launch of the first capitated demonstration in October 2013, enrollment in MMPs nationally has grown from approximately 9,800 enrollees in January 2014 in a single state to over 370,000 across nine states in June 2016. The table on the following page provides a snapshot of June 2016 enrollment data for each of the nine capitated demonstrations that were operational during 2015.

HEALTH RISK ASSESSMENTS: CMS and states require that MMPs provide a more person-centered experience and that the care model promotes coordination of services for enrollees. In all capitated model demonstrations, CMS and the participating states require that MMPs provide an HRA to foster the development of a person-centered care plan.[1] Typically, the HRA is the first step in a more comprehensive care coordination process, requirements for which are included in each demonstration three-way contract. CMS collects HRA completion data from the MMPs in each state to monitor plans' progress initiating the care coordination process for new enrollees. The HRA completion rate is also one of several core quality measures that constitute the MMPs' quality withhold requirements.[2]

CMS collects data on the rate of HRA completion within 90 days of enrollment, although each demonstration's three-way contract has different requirements for the timing of the assessments. Each contract also has its own requirements for a continuity-of-care period that allows enrollees to access their pre-demonstration services and providers for a period of time (often 90 to 180 days after enrollment). In some demonstrations, the continuity period applies until the assessment is completed. MMP timeframes for assessment completion may be based in part on the particular demonstration's continuity of care requirements.

[1] The HRA requirements vary across state demonstrations, and are outlined in the three-way contracts between CMS, the state, and the participating MMPs. Each three-way contract can be found on the MMCO website: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

[2] More information about quality withhold measures can be found in each demonstration's three-way contract.

The HRA completion data shown in the table below are cumulative based on all enrolled individuals who reached their 90th day of enrollment through March 31, 2016 in each of the nine capitated model demonstrations that were operational during 2015. Data reported for quarters in 2013, 2014, and 2015 were subject to performance measure validation and are considered final. Data reported for quarters in 2016 are preliminary and therefore subject to revision.

Enrollment, Age, and Preliminary 90-day Assessment Completion in Capitated Financial Alignment Model

State	Demonstration name	Demonstration start date	Number of participating MMPs as of June 2016	Total enrollment as of June 2016*	Percentage of enrollees under age 65	Percentage of enrollees age 65+	Preliminary % of members with an assessment completed within 90 days (through March 2016)**
California	Cal MediConnect	April 2014	10	122,905	29%	71%	84%
Illinois	Medicare-Medicaid Alignment Initiative	March 2014	7	48,468	44%	56%	71%
Massachusetts	One Care	October 2013	2	13,106	98%***	2%***	65%
Michigan	MI Health Link	March 2015	7	40,884	57%	43%	58%
New York	Fully Integrated Duals Advantage (FIDA)	January 2015	17	5,516	9%***	91%***	95%
Ohio	MyCare Ohio	May 2014	5	62,981	49%	51%	73%
South Carolina	Healthy Connections Prime	February 2015	4	5,614	0%***	100%***	83%
Texas	Texas Dual Eligible Integrated Care Project	March 2015	5	42,924	32%	68%	85%
Virginia	Commonwealth Coordinated Care	April 2014	3	27,768	51%	49%	88%
	Sum across nine capitated model demonstrations		**60**	**370,372**	**41%**	**59%**	**77%**

* Enrollment data are from the CMS Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations Monthly Report by Contract unless otherwise noted (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract.html)

**As collected by the Core 2.1 measure required by each demonstration's three-way contract. Rates are cumulative based on quarterly data submissions from MMPs. Includes only members whose 90th day of enrollment occurred through March 31, 2016. Excludes members who were unwilling to participate or who did not respond to at least three outreach attempts. Excludes assessments completed after the 90th day of enrollment. Complete specifications are available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2016CoreReportingRequirements010816.pdf

*** While the majority of demonstrations include individuals age 21 and over, the Massachusetts, New York and South Carolina demonstrations differ in their target populations. The Massachusetts demonstration serves individuals ages 21-64 at the time of enrollment, and allows people to remain in their MMP when they turn 65 as long as they maintain eligibility under the Medicaid State plan. New York FIDA serves individuals age 21 and over requiring a nursing facility level of care or 120 days of community-based long-term care. The South Carolina demonstration serves individuals 65 and older who are living in the community at the time of enrollment.