The Financial Alignment Initiative (FAI) Demonstration: How Four States Are Navigating the New Policy Landscape for Integrated Care Programs

State Medicaid Leaders and Disability Advocates from California, Rhode Island, South Carolina, and Washington Share Policy Priorities and Strategies

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caretakers. Leena received a bachelor's degree in political science from Rutgers University and a Master in Public Policy (MPP) from Monmouth University. Leena has made many contributions to this field. In celebration of Women's History month in 2022, Arnold Ventures recognized Leena for her role in empowering dually eligible individuals to improve their care experiences. Leena's recommendation for a person-centered enrollment infrastructure, as states move to D-SNPs and FIDE-SNPs, demonstrates her commitment to empowerment.

The Financial Alignment Initiative (FAI) Demonstration: How Four States Are Navigating the New Policy Landscape for Integrated Care Programs

This brief summarizes information for policymakers on how four Financial Alignment Initiative (FAI) demonstration states are designing, developing, and implementing new integrated care programs for individuals who are dually eligible covered under Medicare and Medicaid. In 2023, the authors interviewed FAI state Medicaid leaders in California, Rhode Island, South Carolina, and Washington. We also interviewed disability leaders and advocates dedicated to people's rights to live meaningful lives in the community in the three FAI states participating in the capitated model and operating Medicare-Medicaid Plans (MMPs). Of note, this brief presents information for four FAI states "as of a point in time," with a significant emphasis on FAI states operating under a capitated model.

To learn more about dually eligible individuals and the four FAI demonstration states including three FAI states with capitated models, see Figures 1-5, located at the end of this brief. To learn more about state Medicaid agency contracts (SMACs), see January 2024 resource prepared by the Integrated Care Resource Center (ICRC). The ICRC is a national initiative of Center for Medicare & Medicaid Services' (CMS) Medicare-Medicaid Coordination Office (MMCO), established to help states develop integrated care programs for individuals who are dually eligible. CMS requires plans that are Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) serving dually eligible individuals to hold a contract with the state Medicaid agency. The contract is referred to as a SMAC. To learn more about the flexibility that states have to leverage SMACs beyond the minimum requirements, readers may also review the January 2024 presentation prepared by the Medicaid and CHIP Payment Advisory Committee (MACPAC). MACPAC is a non-partisan legislative branch agency.

KEY TAKEAWAYS

#1. State Medicaid leaders are at varying stages of navigating the new policy environment. States are deadline-focused and process-driven. They are prioritizing a smooth transition for individuals who are dually eligible for Medicare and Medicaid. The states are taking an iterative approach to developing state Medicaid agency contracts (SMACs). States plan to make future policy changes in a process of continuous improvement. Some states are feeling the loss of Medicare expertise they had from the Centers for Medicare & Medicaid Services (CMS) under the FAI with three-way contracts. All states shared their commitment to funding the FAI ombudsman programs.

#2. State Medicaid programs are leveraging the SMACs to achieve alignment and integration. California cross-walked the features of its FAI demonstration program to its SMAC with the goal of creating alignment between the Medicare model of care (MOC) and Medicaid MOC. California's SMAC reflects all FAI-enhanced features allowed under the final rule and is accompanied by state-created D-SNP policy guide. Rhode Island and South Carolina suggested that they will follow California's approach. They wish to preserve the FAI features, while also

adding state-specific FAI provisions. Washington's SMAC aligns the Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) MOC with Medicaid's health homes model.

#3. State-based disability leaders require more information to effectively engage in the FAI transitions. State disability leaders in three MMP states – California, Rhode Island, and South Carolina – described varying levels of engagement with their state Medicaid programs. Advocates in two states conveyed a comprehensive understanding of their state's integrated care program and advocacy agenda for creating strong SMACs. However, several leaders in one state struggled to understand the fundamental aspects of the FAI transition and reported limited engagement opportunities. Disability leaders in that state want more knowledge-sharing opportunities to strengthen their advocacy skills for person-centered care.

The Opportunity for State Medicaid Programs to Create a New Era of Programs

A decade after launching the Medicare-Medicaid Financial Alignment Initiative (FAI) demonstration, the Centers for Medicare & Medicaid Services (CMS) ended the FAI demonstration in the calendar year (CY) 2023 Medicare Advantage and Part D Final Rule, citing mixed FAI results. Several states operating under the demonstration's capitated model are transitioning from Medicare-Medicaid Plans (MMPs) to Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs).

As CMS acknowledges, the final rule does not resolve the "financial misalignment between Medicare and Medicaid. The rule also does not protect federal funding for initiatives such as the Ombudsman programs. The final rules requires states to develop a state Medicaid agency contract (SMAC) with D-SNPs. States can leverage SMACs to align the Medicaid and Medicare programs, drive quality improvement, and advance equity.

STATE MEDICAID AND DISABILITY LEADERS IN FOUR STATES SHARE PLANS

Three MMP states—California, Rhode Island, South Carolina—and Washington are the focus of this brief. Washington is not an MMP state but operates a managed fee-for-service (MFFS) program through a contract with CMS. Four diverse states were chosen to represent the many dimensions and FAI results. Many states had significant concerns about the FAI results, at odds with the methodology the CMS FAI evaluator uses to measure the FAI's impact on Medicaid's total cost of care.

Disability leaders in the three MMP states were interviewed:

- California: Justice in Aging (JIA).
- Rhode Island: Rhode Island Parent Information Network (RIPIN).
- South Carolina: Able-SC and Disability Rights South Carolina.

We contacted other disability leaders in Washington, but they were not available to engage in the project due to capacity constraints.

State leaders were asked to comment on several topics, including: (1) state transition plans, (2) capacity and expertise, (3) priorities for the transition, (4) stakeholder engagement and ombudsman programs, and (5) SMACs. Disability organizations were asked to offer their perspective on priorities for the transition and engagement in the transition process.

Transition Plans: Four State Medicaid Leaders with Four Different Plans

By 2026, the three MMP states, California, Rhode Island, and South Carolina, will administer different programs than they do today. Each state will offer a varying level of integration, based on its D-SNP selection. D-SNP types include fully integrated D-SNPs (FIDE SNPs); highly integrated D-SNPs (HIDE SNPs); and coordination-only (CO) D-SNPs. As required by CMS, regardless of type, all D-SNPs must hold a SMAC with the state Medicaid program. For more information, see CMS's tip sheet.

See **Exhibit 1** for definitions of Medicare Advantage D-SNP types , as described by the Integrated Care Resource Center (ICRC).

Exhibit 1. D-SNP Types Defined by CMS Integrated Care Resource Center (ICRC)

D-SNP Types	Definitions Used by ICRC (as of January 1, 2023)
D-SNP	"Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage (MA) plan that only enroll dually eligible individuals."
CO-D-SNP	"CO D-SNPs are D-SNPs that meet minimum CMS requirements but do not qualify as a HIDE SNP or FIDE SNP. CO D-SNPs must: (1) hold a contract with the state Medicaid agency in each state of operation that meets the requirements described at 42 CFR 422.107; (2) coordinate the delivery of Medicare and Medicaid services for its enrollees; and (3) meet the information-sharing requirements described at 42 CFR 422.107(d)."
HIDE SNP	"HIDE SNPs are D-SNPs that provide coverage of Medicaid benefits (through the DSNP or an affiliated Medicaid managed care plan), including coverage of LTSS, behavioral health benefits, or both, under a capitated contract with the state Medicaid agency in the applicable state. The capitated contract with the state Medicaid agency may be executed directly with the D-SNP, with the D-SNP's parent organization, or with another entity that is owned and controlled by the D-SNP's parent organization."
FIDE SNP	"FIDE SNPs are D-SNPs that provide coverage of Medicare and Medicaid benefits under a single legal entity that holds both: (1) an MA contract with CMS; and (2) a contract with the state Medicaid agency that meets the requirements of a managed care organization as defined in section 1903(m) of the Social Security Act. FIDE SNPs must cover at least Medicaid primary and acute care services and long-term services and supports (LTSS), including at least 180 days of nursing facility coverage during the plan year.6 FIDE SNPs must also coordinate Medicare and Medicaid benefits "using aligned care management and specialty care network methods for high-risk beneficiaries" and employ "policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievances and appeals, and quality improvement" (42 CFR 422.2)"
Source	Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025 (integratedcareresourcecenter.com)

California is the first state to transition away from the FAI demonstration. The state launched its demonstration in 2014, developed its transition plan in 2022, and converted from MMP status to its new program on January 1, 2023. The state has two SMACs accompanied by a policy guide. More specifically, the state converted from Cal MediConnect plans to Medicare Medi-Cal plans (MMPs or Medi-Medi plans). Enrollees in a Medi-Medi Plan now receive Medicare benefits through a D-SNP and Medi-Cal benefits through a managed care organization. The new program is an exclusively aligned enrollment (EAE) D-SNP; however, certain counties will have non-EAE D-SNPs.[1] By 2026, the state will require all Medi-Cal plans to have EAE D-SNPs. The rollout is occurring incrementally. The state expects EAE D-SNPs will be available in five more counties in 2024. In the meantime, legacy non-EAE D-SNPs will continue but with limited enrollment. California has one FIDE-SNP and a number of Program of All-Inclusive Care for the Elderly (PACE) Plans. California also has continued funding for its ombudsman program for dually eligible individuals statewide. The state contracts with a non-profit organization, called the Health Consumer Alliance.[2]

Rhode Island and South Carolina are in the design stages. The two states plan to convert their MMPs to new programs on January 1, 2026. Rhode Island plans to convert from an MMP to a FIDE SNP, although its transition plan notes that this move is dependent on CMS approval. South Carolina intends to convert from an MMP to an enhanced HIDE-SNP. The state may eventually switch to a FIDE SNP when it brings long-term services and supports (LTSS) into managed care.

Washington 's MFFS, less impacted by the final rule, plans to continue its MFFS program. The state has D-SNPs including HIDE SNPs and one CO SNP. Post-FAI, Washington will have a combination of HIDE SNPs and CO SNPs. D-SNP type will be determined county by county based on network availability.

State Medicaid Leaders Submerged in the Practical Details of the Transition Process

State Medicaid leaders are focused on designing, developing, and implementing new programs to preserve FAI enhanced features. It does not appear that they have the capacity to resolve financial and quality misalignments between Medicare and Medicaid, however. The lack of capacity could delay states in prioritizing health equity. This makes it critically important for states to make dually eligible individuals a key part of the governance structures and implementation councils from the start and ask plans to help fund these efforts.

State capacity is essential to advancing health equity and engaging the disability community.

[1] See Integrated Care Resource Center. ""Exclusively aligned enrollment" (EAE) occurs when a state limits D-SNP enrollment to full-benefit dually eligible individuals who receive their Medicaid benefits from the D-SNP, or an affiliated Medicaid managed care plan offered by the same parent organization as the D-SNP. This requirement ensures that anyone who enrolls in the D-SNP is ultimately entitled to the same, unified package of benefits and facilitates several important benefits for plan enrollees, providers, and states."

[2] See ICRC for information about state approaches to developing and operating Ombuds programs under the FAI.

Conversely, several disability organizations in one state needs support to understand these complex programs and decipher their implications for the more than 8.8 million individuals with full Medicaid coverage. These full-benefit dual eligibles (FBDEs) are eligible for Medicare-Medicaid integrated care programs.

State Capacity and Expertise. Medicaid leaders in all four states are mission driven. They are intentional about their policy and operational work. They also are working double time to establish equal expertise in both Medicaid and Medicare. In California, the Medicaid program has a dedicated Medicare staff person to help the Medicaid team understand and address the misalignment between Medicaid policy and Medicare policy. Two of the four state leaders stated their need for more resources such as dedicated staff to work on integrated care programs. That said, all four state leaders complimented CMS on providing technical assistance to the states.

One leader underscored the effort involved in launching programs that are so complex. This individual said, "It took us nearly three years to get up and running in a capacity where people knew what we were doing."

Medicaid and Disability Leaders' Priorities. All state Medicaid leaders made clear that their first priority was to create a smooth and seamless transition for individuals. Other priorities included being prescriptive about SMAC requirements for D-SNPs, identifying a solution to financial misalignment, and aligning the Medicare and Medicaid models of care (MOCs).

One state Medicaid leader said, "The Medicare model of care does not uphold the same goals as the Medicaid MOC. The Medicare model is medical, while the Medicaid MOC is not," emphasizing the SMAC's importance. Integrated care programs must have one model of care.

Each state's specific priorities are as follows: California's shared several priorities: (1) being methodical to ensure members make a seamless transition, (2) engaging stakeholders in many ways, from creating a "kitchen cabinet" to holding open stakeholder forums, (3) gaining Medicare expertise, (4) maximizing Medicaid and Medicare alignment in the SMAC to create an integrated member experience, and (5) taking a long view. California's leader offered: "We will iterate and keep working on it. We can continue to improve each year." California's "kitchen cabinet," a name for its unofficial and informal group of advisors whose opinions are highly regarded, is considered to be a successful way to engage stakeholders.

Rhode Island priorities include: (1) being able to model a new program after its MMP, (2) requesting funds from the legislature for the state's ombudsman program, and (3) developing a roadmap to close disparities in hospitalization rates across populations.

South Carolina's priorities include: (1) taking the unprecedented step of extending integrated care to persons enrolled in home and-community-based services (HCBS) waivers, (2) achieving

buy in from LTSS providers, and (3) building a data lake for collecting Medicare and Medicaid data.

As South Carolina's representative shared, "It continues to look at lessons learned during the financial alignment demonstration as well as continues to evaluate ways to enhance the member experience in Healthy Connections Medicaid. Key to this enhancement, SCDHHS [South Carolina Department of Health and Human Services] continues to explore ways to eliminate barriers to care with considerations of waiver and nursing homes and the current managed care landscape. South Carolina also is reviewing opportunities to leverage the recent D-SNP final rule as a potential vehicle and path forward to integrated care as SCDHHS continues to work through the extension period of the FAI. CMS notes and offers guidance for exclusively aligned enrollment, and SCDHHS continues to evaluate what implementation may look like for our membership in this capacity." To learn more about South Carolina's key lessons, see the state's FAI demonstration evaluation reports: here.

Finally, Washington's priorities include: (1) leveraging the SMAC and, specifically, the MOC, "to improve care coordination holistically and for the most at-risk populations by leveraging proven care coordination models, like Health Homes," and (2) protecting member continuity of care and connection to providers.

Across the states, disability leaders shared four major priorities: (1) getting consistent actionable information, (2) needing a "seat at the table," 3) securing continued funding for the ombudsman program, and 4) advancing community-based living and investing in non-medical services.

Stakeholder Engagement and the Ombudsman Program. Stakeholder engagement, in this context, refers to all disability advocates and individuals who rely on Medicaid and Medicare services. All states indicated a commitment to engagement, but state plans to engage stakeholders varied considerably. Stakeholder awareness and expertise tracked favorably with state Medicaid programs with robust engagement strategies, and unfavorably with states lacking vigorous strategies. In California, disability advocates are highly engaged and well informed about the transition to a D-SNP platform.

Rhode Island shared its plan for a robust process, with many established forums to communicate with stakeholders. Rhode Island also expressed its commitment to addressing the loss of federal funding for state ombudsman programs.

South Carolina indicated that its communications office handles engagement efforts. South Carolina's state Medicaid leader considers stakeholder engagement one of the "keys to success." This leader is "focusing on what change means for members, providers, and our partnered health plans. We intend to ensure that all groups are at the table as we look to build a better pathway for healthcare."

Of note, our conversations with Rhode Island and South Carolina did not focus on how states and disability advocates could leverage ombudsman program experience and demographic data to track inequities in service access, to advance equity.

Washington's approach includes leveraging several avenues including its service experience team (SET), statewide health insurance benefits advisors (SHIBA) and client advocates, and its extensive stakeholder work for the FAI. Washington also shared its intent to expand its stakeholder engagement with disability organizations. Disability advocates in Washington could not be engaged.

State Medicaid Agency Contracts (SMACs). To understand how states are leveraging SMACs, SMACs in California and Washington were reviewed. It was premature to focus on Rhode Island and South Carolina.

California has two SMACs—one for its EAE D-SNPs, and the other for non-EAE D-SNPs. California has augmented its SMAC by writing policy guidance for D-SNPs to create extensive alignment between Medicaid and Medicare. Although California's SMAC is comprehensive, the state's current SMAC does not achieve financing and quality alignment between Medicare and Medicaid. This is an opportunity for all states to pursue in their SMACs.

Washington's SMAC is uniquely designed to support its health home model. The state's 2023 SMAC requires D-SNPs to align its D-SNP MOC with the state Medicaid health homes program "for at least those individuals engaged in Medicaid health homes program at the time of enrollment in the MA Health Plan" and "pay at least the Medicaid rates for HH services according to the definition of said services." For 2024, Washington will continue to focus on care coordination. Overall, Washington considers its approach to be very prescriptive, extending to requiring that D-SNPs use data collection templates. The state also will require D-SNPs to coordinate with the Behavioral Health Services only MCO, contract with all Health Home (HH) lead entities in the service areas their D-SNP covers. Like California, Washington also shared that it lacks a solution to the problem of Medicare-Medicaid financial misalignment to prevent cost shifting and capture potential Medicare savings.

Looking Forward: State Opportunities to Advance Strong Policy Goals

Following CMS's Medicare final rule, California, Rhode Island, Washington, and South Carolina Medicaid program leaders and disability advocates shared that they are in a new policy environment for integrated care programs for dually eligible individuals.

State Challenges and Opportunities

States face both challenges and opportunities in the future.

Key Challenges Related to the FAI. States, for example, will no longer be able to use an enrollment method called passive enrollment, a key tool that states used to increase plan enrollment. This means that D-SNPs must compete for enrollees and revenue, preferably on the

basis of measures that matter to dually eligible individuals. Individuals who are dually eligible, or consumers, require transparency on all levels to make a sound decision. They will need to know more about access, care experiences, and quality. Integrated care plans will no longer operate under a three-way contract, operating under a unified financing approach. CMS and the states will pay the plans separately. CMS and the states will reconcile expenditures against revenue separately. The state has no mechanism to recoup savings. Due to the financial split, this means that plans may have less incentive to invest upstream in community services.

Key Challenges Related to Market Incentives. State Medicaid leaders must also contend with market challenges. As D-SNPs increase their market role, states may see an increase in practices that challenge consumer rights. The role of private equity in health care is currently a major concern to states and disability advocates. As reported in a comprehensive study, "trends in PE ownership rapidly increased across almost all healthcare settings studied. Such ownership is often associated with harmful impacts on costs to patients or payers and mixed to harmful impacts on quality." The National Bureau of Economic Research found that, in nursing home purchases, "private equity firms are associated with higher patient mortality rates, fewer caregivers, higher management fees, and a decline in patient mobility." As KFF Health News reported, COVID-19 also underscored concerns about the increase in private equity ownership of nursing homes and the call for stronger regulations and need for transparency. Policymakers are concerned about protecting consumer rights, preventing fraud, and controlling private equity's influence.

To date, many state and federal officials including the Medicare Payment Advisory Commission (MedPAC) have also expressed major concerns about the Medicare industry's practices across marketing and materials, fraudulent billing, and the use of authorizations and denials. State Medicaid leaders have an imperative to advance transparency and ensure that private equity transactions are in the interest of the public, and more specifically, dually eligible individuals. States have an obligation to monitor and control the information between plans and dually eligible individuals. States must provide mechanisms for consumers to report and resolve care access problems through neutral entities such as ombudsman programs, fraud detection programs, and other conflict-free groups. States must protect consumers from the interests of private equity. As cited in Forbes.com, private equity tends to be focused on cost-cutting strategies, associated with harmful effects. The shifts in ownership from healthcare providers to venture capitalists creates" a new operating reality where the previous central tenet of healthcare delivery—doing what is best for the patient—now has a competing imperative: doing what is best for shareholders and investors."

Some states such as California have moved to limit the influence of private capital in healthcare, by creating an ethical framework within which a venture-capital-driven healthcare system must work. In 2023, California Governor Gavin Newsom signed a law mandating that venture capitalist firms release annual reports regarding the number of diverse founders they're

investing in – this law is the first of its kind in the country mandating that venture capitalists report on the diversity of founding members.

State Opportunities to Leverage the State Medicaid Agency Contract

State Medicaid leaders have an opportunity to create SMACs that preserve and build upon the FAI to better meet dually eligible individuals' needs. Creating strong SMACs will require states to design robust stakeholder engagement and deployment strategies to engage individuals, communities, and disability and recovery community-based organizations (CBOs).

States also have many opportunities to ensure that dually eligible individuals are protected from the negative impacts of private equity observed in the nursing home industry. Advocates have an opportunity to take best practices from the FAI and advocate for state SMACs that reflect key priorities, such as upstream spending, rebalancing care to the community, and advancing equity to reduce disparities and advance independent living and recovery goals.

States have significant authority to leverage their SMACs around state goals. According to a January 2024 Medicaid and CHIP Payment Advisory Commission (MACPAC) presentation on SMACs, MACPAC reported: "CMS officials said states are free to include any requirements as long as they do not conflict with federal law." In fact, the Integrated Care Resource Center (ICRC), a national initiative of the CMS Medicare-Medicaid Coordination Office (MMCO), provides very helpful SMAC resources for states. Many states may need more clarity from CMS and additional state capacity to pursue their state goals, however. MACPAC's report also indicated that "state officials [were] mixed on their perceptions of the level of flexibility" they have, and "states also said certain factors imposed operational limits on what they could feasibly require in their SMAC," such as "staff capacity" and "lack of Medicare knowledge."

See **Exhibit 2** for examples of the opportunities that states have to leverage SMAC and advance consumer protections.

Exhibit 2. State Opportunities to Leverage the SMAC

#	State Opportunity	Benefit to Dually Eligible Individuals
1	Review the composition of each Medicaid and D-SNP plan's Board of Directors.	To ensure that potential influences over D-SNP policies and practices are aligned with state priorities and the model of care.
2	Require D-SNPs to adhere to regulations and policies.	To ensure that D-SNP plans operate in accordance with state priorities and mitigate the use of harmful revenue-maximizing practices.
3	Require D-SNPs to partner with disability organizations and social service organizations.	This opportunity creates many opportunities. Two examples are as follows. Example #1: To ensure that D-SNPs produce reading materials for dually eligible individuals that are: (1) clear, (2) expressed in plain language in the translations of materials from English, and (3) culturally and linguistically accurate, responsive to individuals' needs, practices, and beliefs. Example #2: To ensure that D-SNPs provide benefits that consider the social determinants of health infused with the principles of independent living and recovery models of care.
4	Educate disability communities about Medicare fraud entities and health insurance counseling centers.	To ensure that dually eligible individuals are protected from fraud and have access to a counselor to help them select the right program.
5	Require D-SNPs to create pathways for feedback with disability organizations and other trusted community-based organizations.	To ensure that dually eligible individuals can report and address access to care issues with support from experts.
6	Connect with the national Medicare coverage protection groups.	To ensure that dually eligible individuals have access to resources from a trusted group.

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Figure 1.

Background on Dually Eligible Individuals

In health care circles, individuals enrolled in both the Medicare and the Medicaid programs are referred to as dually eligible individuals. According to MACPAC's 2024 data book, in Calendar Year 2021, there were 12.8 million dually eligible individuals, representing only 4 percent of the U.S. population. Dually eligible individuals represent 14 percent of the total Medicare population and 19 percent of the total Medicaid population. Among those who are dually eligible, 36 percent of dually eligible individuals were under the age of 65 and 64 percent were 65 and older. The majority of all dually eligible individuals were female (59 percent).

As described in a prior report: "Dually eligible individuals are diverse in race, ethnicity, age, gender, health, and disability type, and other characteristics. All dually eligible individuals are very low-income and the majority experience some combination of multiple chronic conditions, behavioral health needs, cognitive and physical disabilities, and social needs including unstable housing, lack of access to transportation, food insecurity, employment instability, exposure to community and interpersonal violence, and social isolation and loneliness. Accordingly, dually eligible individuals are more likely to report that they are in poor health than Medicare-only individuals. Most dually eligible individuals must navigate two programs that are almost entirely siloed, operating under different policies and processes. Health disparities inherent in the current health care system compound these barriers. Black, Indigenous, and people of color (BIPOC) and Latinx people comprise a greater share of the dually eligible population than among Medicare-only individuals magnifying the need to ground new programs in health equity, designed around an intersectional understanding of health disparities. During the COVID-19 pandemic, dually eligible individuals have been disproportionately affected with poorer health outcomes such as higher mortality rates and hospitalization rates approximately 2.6 times higher than Medicare-only individuals."

Full benefit dually eligible (FBDE) individuals, or those eligible for full Medicaid benefits, are of particular interest to federal and state policymakers, and health plans. The FBDE population was eligible to enroll in the Financial Alignment Initiative (FAI) demonstration. In CY 2021, FBDEs accounted for 73 percent or 9.3 million of all dually eligible individuals and 85 percent combined Medicare and Medicaid spending, or $417.70 billion. (Total combined Medicare and Medicaid spending $493.4 billion.) Disability advocates see a great opportunity to de-medicalize the care delivery system for dually eligible individuals by shifting medical spending to the community to advance independent living and recovery.

Dually eligible individuals need a better system. They need programs offering a strong disability model of care to address the whole person needs of dually eligible individuals. In 2011, the Centers for Medicare and Medicaid Services (CMS) announced the Financial Alignment Initiative (FAI) demonstration to improve coordination and align the financing between the Medicare and Medicaid programs. Under the FAI, CMS worked with states "to test models that coordinate

financing across the two programs and integrate coverage of primary care, acute care, behavioral health and long-term services and supports (CMS 2021a).” As states end their FAI demonstrations, we note that most dually eligible individuals are not enrolled in any integrated care program. The majority of dually eligible individuals must navigate separate Medicare and Medicaid programs that are almost entirely siloed, operating under different policies and processes.

For more information about the key challenges that dually eligible individuals face, see the following materials: (1) toolkit; (2) presentation; and, (3) brief.

Figure 2.

National Data on Dually Eligible Individuals and Medicare and Medicaid Expenditures (Calendar Years 2020 & 2021)

CY 2020 Data Points February 2023 MedPAC MACPAC Dually Eligible Data Book	**All Dually Eligible**	**Full-Benefit Dually Eligible (FBDEs) Only**
Dually Eligible Individuals	12.2	8.8
Percent of the Medicare population	19%	
Percent of the Medicaid population	14%	
Combined spending (in billions)		
Medicare	$287.20	$219.50
Medicaid	$169.00	$166.10
Combined	$456.20	$385.70
Per person per year spending		
Medicare	$23,552	
Medicaid	$13,854	
Combined	$37,406	
Share of spending		
Medicare	63%	57%
Medicaid	37%	43%
Combined	100%	100%

CY 2021 Data Points: January 2024 MedPAC MACPAC Dually Eligible Data Book	**All Dually Eligible**	**Full-Benefit Dually Eligible (FBDEs) Only**
Dually Eligible Individuals	12.8	9.3
Percent of the Medicare population	19%	
Percent of the Medicaid population	13%	
Combined spending (in billions)		
Medicare	$312.00	$239.00
Medicaid	$181.50	$178.60
Combined	$493.40	$417.70
Per person per year spending		
Medicare	$24,370	
Medicaid	$14,175	
Combined	$38,545	
Share of per person per year spending		
Medicare	63%	57%
Medicaid	37%	43%
Combined	100%	100%

Notes: Authors' table, based on data books jointly produced by the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission.

Figure 3.

National Data on Medicare and Medicaid Spending for Full Benefit Dual Eligible Individuals (FBDEs) (Calendar Year 2020)

<table>
<tr><th colspan="2">MEDICARE AND MEDICAID</th></tr>
<tr><th>MEDICARE SPENDING</th><th>MEDICAID SPENDING</th></tr>
<tr><td>Medicare's Share of Total Spending for All FBDEs:

Medicare spending accounts for 57 percent of combined Medicare and Medicaid spending, based on the U.S. average. Medicare's share of total spending would vary by age group, risk group, and state.

Note: See Exhibit 3 of the MACPAC "Duals Databook."</td><td>Medicaid's Share of Total Spending for All FBDEs:

Medicaid spending accounts for 43 percent of combined Medicare and Medicaid spending, based on the U.S. average. Medicaid's share of total spending would vary by age group, risk group, and state.

Note: See Exhibit 3 of the MACPAC "Duals Databook."</td></tr>
<tr><td>Medicare Covers These Services:

• Inpatient
• Skilled Nursing Facility
• Home Health
• Other Outpatient
• Prescription Drugs</td><td>Medicaid Covers These Services:

• Inpatient
• Outpatient
• Institutional
• HCBS State Plan
• HCBS Waiver
• Prescription Drugs
• Managed Care Capitation</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Medicare Spending Highlights for FBDEs (under age 65 and ages 65 and older), Fee-For-Service (FFS) Spending Only:

• Spending on inpatient accounts for 36 percent of Medicare spending.
• Spending on Skilled Nursing Facilities (SNFs) accounts for 16 percent of Medicare spending.
• Taken together, these two spending areas account for 52 percent of Medicare spending.
• Medicare spends $1 out of every $2 dollars on inpatient services and SNFs.

Note: See Exhibit 15 of the MACPAC "Duals Databook."</td><td>Medicaid Spending Highlights for FBDEs (under age 65 and ages 65 and older), Fee-For-Service (FFS) Spending Only:

• Spending on inpatient accounts for 1 percent of Medicaid spending.
• Spending on long-term services and supports (LTSS) accounts for 77 percent of Medicaid spending. That includes: (1) spending on HCBS state plan and HCBS waiver services account for 41 percent of Medicaid spending; and (2) spending on institutional services accounts for 36 percent of Medicaid spending.
• Medicaid spends about $4 out of every $5 dollars on LTSS.

Note: See Exhibit 15 of the MACPAC "Duals Databook."</td></tr>
</table>

Notes: Authors' table, based on the data book jointly produced by the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. Full-Benefit Dual Eligible (FBDEs); Fee-for-Service (FFS); Home and community-based services (HCBS).

Figure 4

A Comparison of Four States Across Key Dimensions

#	Dimension	CA	RI	SC	WA	US
1	Geography	West	Northeast	South	West	n/a
2	State health system performance (2023)	14	4	37	7	n/a
3	% adults 18+ with a disability (2021)	25%	25%	29%	25%	26%
4	% Black population (2021)	5.1%	4.3%	24.7%	3.7%	11.6%
5	% Hispanic population (2021)	43.0%	17.4%	6.3%	17.6%	19.0%
6	Median annual household income (2021)	$84,907	$74,008	$59,318	$84,287	$69,717
7	FAI demonstration model	MMP	MMP	MMP	MFFS	n/a
8	CY 2020 FBDEs (in thousands)	1,638	41	150	155	8,829
9	HCBS % of LTSS (2012)	61%	57%	41%	64%	50%
10	HCBS % of LTSS (2019)	79%	50%	49%	73%	59%
11	HCBS % of LTSS (2020)	70.1%	55.7%	45.8%	75.1%	62.5%

Notes: Authors' table; Financial Alignment Initiative (FAI); full-benefit dual eligibles (FBDEs); home and community-based services (HCBS); long-term services and supports (LTSS). California (CA); Rhode Island (RI); South Carolina (SC); Washington (WA). The HCBS % of LTSS in 2020 was based on *Medicaid LTSS Annual Expenditures (2023).*

Figure 5.

A Comparison of Four States Across FAI Evaluation Results

State	CA	RI	SC	WA
Evaluation Report Results	Third: DY 1-DY 5	Third: DY 1-DY 4	Third: DY 1-DY 5	Fifth: DY 4-DY 6
	2014-2019	2016-2020	2015-2020	2017-2019
Service Utilization Measures (4)				
Monthly probability of any inpatient admission	No summary	No effect	Decreased (F)	No effect
Monthly probability of any emergency department visits	No summary	No effect	No effect	No effect
Monthly number of physician evaluation and management visits	No summary	Increased (F)	No effect	Decreased (U)
Monthly probability of any skilled nursing facility admission	No summary	No effect	Decreased (F)	Decreased (F)
Quality of Care Measures (5)				
Monthly number of any preventable emergency department visits	No summary	No effect	No effect	No effect
Monthly probability of an ambulatory care sensitive admissions (overall and chronic)	No summary	No effect	Decreased (F)	No effect
Monthly (or annual) probability of long-stay nursing facility use	No summary	No effect	Decreased (F)	Decreased (F)
Probability of 30-day follow up after mental health discharge	No summary	No effect	No effect	Decreased (U)
Number of all-cause 30-day readmissions	No summary	No effect	Decreased (F)	No effect
Total Results: Favorable (F)	No data.	1 out of 9	5 out of 9	2 out of 9
Total Results: No Effect		8 out of 9	4 out of 9	5 out of 9
Total Results: Unfavorable (U)				2 out of 9
Demonstration Impact on Costs				
Cumulative Impact on Costs	Increase	Increase	Increase	Decrease
(1) Medicare & Medicaid Expenditures				
Average Demonstration Effect on Medicare Expenditures, PMPM	$62.82			
Average Demonstration Effect on Medicaid Total Cost of Care, PMPM	$325.46			
(2) Medicare Expenditures				
Average Demonstration Effect on Medicare Expenditures, PMPM		$83.99	$46.14	
(3) Medicare Expenditures				
Total Gross Savings (in millions)				($384.68)
Total Net Savings (in millions)				($297.38)

Notes:
Authors' table, based on CMS evaluation reports. CMS evaluated the FAI demonstrations for their ability to improve quality and reduce costs. These results are categorized in the table as having: no effect, increased, or decreased. (F) indicates a favorable result. (U) indicates an unfavorable result. Financial Alignment Initiative (FAI), demonstration year (DY); per member per month (PMPM). California (CA); Rhode Island (RI); South Carolina (SC); Washington (WA). The table excludes the following findings: (1) Rhode Island also had a “no effect” for the “annual probability of any long-stay nursing facility use.” (2) South Carolina also had a favorable finding for the “annual probability of any long-stay nursing facility use.”

CMS Evaluation reports:

1. California: California Cal MediConnect: Preliminary Third Evaluation Report (cms.gov)
2. Rhode Island: Rhode Island Integrated Care Initiative: Third Evaluation Report (cms.gov)
3. South Carolina: South Carolina Healthy Connections Prime: Third Evaluation Report (cms.gov)
4. Washington: Washington Health Home MFFS Demonstration: Fifth Evaluation Report (cms.gov)