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THE HENRY J. KAISER FAMILY FOUNDATION

State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS

October 2012

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kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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Table of Contents

List of Tables

Executive Summary

Over 9.1 million seniors and younger people with disabilities are dually eligible for both the Medicare and Medicaid programs. Dual eligible beneficiaries are among the poorest and sickest people covered by either program. The cost of caring for dual eligible beneficiaries and the lack of coordination between the separate Medicare and Medicaid programs have led to an increased focus on improving care quality and decreasing costs for this population.

To that end, the Centers for Medicare and Medicaid Services (CMS) has proposed two models to align Medicare and Medicaid benefits and financing for dual eligible beneficiaries, one capitated model and one managed fee-for-service model. In the spring of 2012, 26 states submitted proposals to CMS seeking to test one or both of these models. CMS is presently reviewing the states' proposals to determine which will be implemented.

This background paper examines the contents of the 26 states' proposals in the areas of target population, implementation date, enrollment, financing, benefits, beneficiary protections, stakeholder engagement, and demonstration evaluation as set out in the states' initial submissions to CMS. Negotiations between CMS and the states are ongoing and are likely to result in some changes from the states' initial proposals. An appendix explains the Center for Medicare and Medicaid Innovation's § 1115A authority, which underlies the demonstrations. A companion brief provides a basic overview of the demonstrations. The following executive summary table provides an overview of the states' proposals as submitted to CMS.

Target Population: Twenty-one of the 26 states submitting demonstration proposals plan to include all full dual eligible beneficiaries within the geographic areas proposed in their demonstrations. The remaining states propose restricting their target population by age or by diagnosis and/or service use. Major populations excluded from the proposed target groups include Program of All-Inclusive Care for the Elderly (PACE) participants and beneficiaries with developmental disabilities.

Geographic Area: Twenty-one of the 26 states propose implementing all or a portion of their demonstrations statewide. The remaining states propose restricting their demonstrations to a certain geographic area.

Implementation Date: Two states seek to implement at least part of their demonstrations in late 2012, 13 states seek to implement in 2013, and 11 states seek to implement in 2014.

Enrollment Process: Twenty-three of the 26 states submitting proposals plan to passively enroll dual eligible beneficiaries into their demonstration plans unless beneficiaries take action to opt out. Despite CMS guidance to the contrary, a few states propose enrollment lock-in periods. Seven states commit to using neutral enrollment brokers to assist beneficiaries.

Financing: Eighteen states seek to test the capitated model, five states seek to test the managed fee-for-service model, and three states seek to test both models. Over half of the states

propose sharing savings with health plans and/or providers. Just under half of the states include risk-sharing mechanisms.

Benefits: State proposals are most likely to exclude long-term care services from their proposed integrated benefits packages, with nine states excluding services for people with developmental disabilities. Three-quarters of the states require or permit plans to offer additional benefits beyond the existing Medicare and Medicaid benefits packages. Eleven states cite their demonstrations as part of their ongoing efforts to rebalance their long-term care systems.

Beneficiary Protections: Half of the states' proposals include requirements for plans and/or providers to comply with the Americans with Disabilities Act. Nine states are considering providing beneficiaries with access to an independent ombudsman. Most states' proposals lack detail about how the demonstrations will handle beneficiary appeals.

Stakeholder Engagement: Eighteen of the 26 states include proposals for continued stakeholder engagement with the state during the demonstration. Nine of the 26 states mention provisions for stakeholder engagement with demonstration health plans.

Demonstration Evaluation and Oversight: Three states include plans to evaluate their demonstrations. Nearly all the states' proposals indicate that specific quality measures for the demonstration are still to be determined.

While the states' initial proposals to CMS provide more information than was previously available about the demonstrations, additional detail is still needed in many key areas including:

- How will beneficiaries be notified about the demonstrations and enroll and disenroll?
- How will Medicare and Medicaid contributions be calculated, risk-adjusted, and adjusted over time?
- What will the source(s) of savings be, and how will savings be shared among CMS, the state, and plans and/or providers?
- How will the demonstrations affect beneficiary access to home and community-based services?
- How will medical necessity determinations be made, and how will beneficiaries appeal decisions with which they disagree?
- Will beneficiaries be able to retain their current providers and services and how will access to an adequate provider network be ensured?
- How will plans and providers meet the needs of and provide reasonable accommodations to beneficiaries with a range of physical, mental health, and cognitive disabilities?
- How will quality be measured, and how will the demonstrations be monitored and evaluated?
- To what extent will the specific standards that health plans must meet to participate in the demonstrations vary from existing Medicare Advantage and Medicaid managed care requirements?
- How will stakeholders continue to be engaged throughout the design and implementation process?

Executive Summary Table: State Demonstration Proposals to Integrate Care and Align Financing for Dual Eligible Beneficiaries, June, 2012

State	Total Estimated Enrollees	Targets All Full Duals in Proposed Geographic Area?	Statewide?	Passive Enrollment Proposed?	Financial Model to Test			Implementation Date		
					Capitated	Managed FFS	Both Models	2012	2013	2014
AZ	115,065	X	X	X	X					X
CA	685,000	X		X	X				X	
CO	62,982	X	X	X		X			X	
CT	57,569	X	X	X		X			X	
HI	24,189	X	X	X	X					X
ID	17,735	X	X	X	X					X
IL	156,000	X		X	X				X	
IA	62,714	X	X			X			X	
MA	115,000		X	X	X				X	
MI	198,644	X	X	X	X				X	
MN	93,165	X	X		X			X		
MO	5,093		X	X		X		X		
NM*	40,000	X	X	X	X					X
NY	260,462	X	X	X			X		X	
NC	176,050	X	X			X			X	
OH	114,972	X		X	X				X	
OK	~105,423	X	X	X			X		X	
OR	68,000	X	X	X	X					X
RI	22,737		X	X	X					X
SC	68,000		X	X	X					X
TN	~136,000	X	X	X	X					X
TX	214,402	X		X	X					X
VT	22,000	X	X	X	X					X
VA	65,415	X		X	X					X
WA	115,000	X	X	X			X		X	
WI	15,000-16,000		X	X	X				X	
TOTAL: 26	**Not to exceed 2 million per CMS**	**21**	**21**	**23**	**18**	**5**	**3**	**2**	**13**	**11**

*NM's proposal is no longer active with CMS.

Introduction

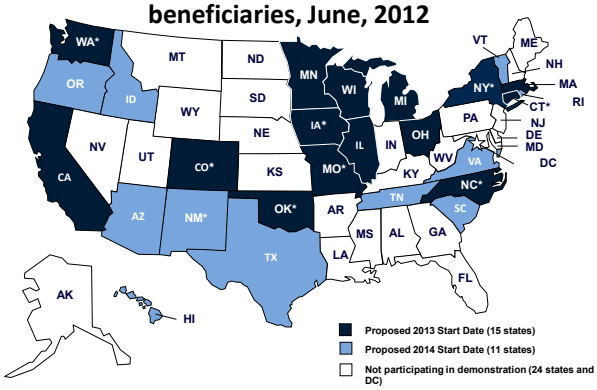
Over 9.1 million seniors and younger people with disabilities are dually eligible for both the Medicare and Medicaid programs.[1] Just over seven million members of this group are "full duals" who receive their state's complete Medicaid benefits package as well as Medicaid assistance with paying for Medicare premiums and cost-sharing. The remaining two million people are "partial duals" who receive Medicaid assistance with paying for their Medicare premiums and cost-sharing only.

Dual eligible beneficiaries are among the poorest and sickest people covered by either Medicare or Medicaid and consequently account for a disproportionate share of spending in both programs. In addition, the predominant existing service delivery models for dual eligible beneficiaries typically involve little to no integration of or coordination among physical health, behavioral health, pharmacy, and long-term care services. The cost of caring for dual eligible beneficiaries and the lack of coordination between the separate Medicare and Medicaid programs have led to an increased focus on improving care quality and decreasing costs for this population.

To that end, CMS has proposed two models to align Medicare and Medicaid benefits and financing for dual eligible beneficiaries, one capitated model and one managed fee-for-service (FFS) model. In the spring of 2012, 26 states submitted proposals to CMS seeking to test one or both of these models (Figure 1). CMS is presently reviewing the states' proposals to determine which will be implemented. In late August, 2012, CMS finalized a memorandum of understanding (MOU) with Massachusetts to implement its demonstration,[2] and MOUs with other states are expected to follow.

Figure 1

26 states have submitted demonstration proposals to integrate care and align financing for dual eligible beneficiaries, June, 2012



* CO, CT, IA, MO, and NC are proposing managed FFS models. NY, OK, and WA are proposing both capitated and managed FFS models. All others have proposed capitated models.
NOTES: MO and MN have proposed a 2012 start date. NM's proposal is no longer active with CMS.
SOURCE: CMS Financial Alignment Initiative, State Financial Alignment Proposals, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

This background paper examines the contents of the 26 states' proposals in the areas of target population, implementation date, enrollment, financing, benefits, beneficiary protections, stakeholder engagement, and demonstration evaluation as set out in the states' initial submissions to CMS. MOU negotiations between CMS and the states are ongoing and are likely to result in some changes from the states' initial proposals. In addition, not all states are likely to implement their proposals. For example, New Mexico's proposal is no longer active with CMS.[3] An appendix explains the Center for Medicare and Medicaid Innovation's (CMMI) § 1115A authority, which underlies the demonstrations. A companion brief provides a basic overview of the demonstrations.[4]

State Interest in Testing CMS's Medicare-Medicaid Financial Alignment Models

The current initiative to test financial alignment models for dual eligible beneficiaries began in April, 2011, when CMS awarded design contracts to 15 states (CA, CO, CT, MA, MI, MN, NY, NC, OK, OR,

SC, TN, VT, WA, WI) (Table 1).[5] The initiative expanded in July, 2011, when CMS released a State Medicaid Director letter[6] outlining its proposed capitated[7] and managed fee-for-service models and inviting any interested state to submit a non-binding letter of intent to test either or both models; 37 states, including the 15 that received design contracts, and the District of Columbia responded (Table 1).[8] Twenty-six of those states ultimately submitted demonstration proposals to CMS (Table 1, Figure 1). Table 1 summarizes state interest in testing CMS's financial alignment models from April, 2011 through August, 2012.

Proposed Target Population and Implementation Date

Table 2 summarizes the 26 states' proposed target population, geographic area, implementation date, and phase-in plans for their demonstrations.

CMS Guidance: CMS's July, 2011 State Medicaid Director letter indicates that the financial alignment demonstrations will target full dual eligible beneficiaries. In its request for proposals for states seeking design contracts, CMS directed states to describe their plans to expand their integrated care models to include additional populations and/or service areas if their demonstrations initially would be piloted on a less than statewide basis for less than all dual eligible beneficiaries.[9] CMS recently confirmed its plans to limit total participation in the demonstrations to no more than 2 million dual eligible beneficiaries nationally.[10] CMS's guidance initially targeted January, 2013 as the effective date for beneficiary enrollment in the demonstrations, but implementation reportedly will be delayed by several months to a year, depending upon the state. According to its recently released MOU with CMS, the earliest effective enrollment date for beneficiaries in Massachusetts' demonstration is April 1, 2013.[11]

State Proposals:

<u>Target Population</u>

Twenty-one of the 26 states submitting demonstration proposals plan to include all full dual eligible beneficiaries within the geographic areas proposed in their demonstrations (AZ, CA, CO, CT, HI, IA, ID, IL, MI, MN,[12] NC, NM,[13] OH, OK,[14] OR, RI, TN, TX, VA, VT, WA) (Table 2).

Two states propose restricting their target population by age. MA focuses on non-elderly dual eligible beneficiaries ages 21 to 64. SC focuses on elderly dual eligible beneficiaries ages 65 and older who are not receiving nursing facility services at the time of enrollment.

The remaining three states restrict their target population by diagnosis and/or service use. WI targets adult full dual eligible beneficiaries residing in nursing homes with long-term (100 or more days in a calendar year) FFS Medicaid-funded stays. MO proposes limiting its demonstration to dual eligible beneficiaries who are eligible to participate in a health home (diagnosed with serious mental illness, or mental illness/substance use and another chronic condition, or a specific somatic chronic condition). Part of NY's proposal focuses on full dual eligible beneficiaries with two or more chronic conditions, HIV/AIDS, and/or a mental health diagnosis (who do not receive developmental disability (DD) or state mental health facility services and do not require 120 or more days of long-term services and supports

(LTSS)). The other parts of NY's proposal are aimed at adult dual eligible beneficiaries who require 120 or more days of LTSS outside of a state mental health facility with separate portions of the demonstration for those among this group with and without developmental disabilities.

Two states that target all full dual eligible beneficiaries in other parts of their proposals also include additional elements that focus on a subset of beneficiaries based on diagnosis. Part of AZ's proposal targets dual eligible beneficiaries with serious mental illness living in one county, and part of OK's proposal focuses on full dual eligible beneficiaries age 45 and older with two or more complex chronic conditions and functional limitations that at minimum meet eligibility criteria for personal care services.

Major populations excluded from enrollment in the demonstrations include PACE participants and beneficiaries with developmental disabilities. Ten states propose excluding PACE participants (CO, MI, MO, NC, OH, OK, OR, SC, TN, VT). Eight states propose excluding people with developmental disabilities (including those receiving state developmental disability services, residing in ICF/IDs, and/or receiving home and community-based waiver services) (AZ, CO, HI, IL, OH, RI, TX VA).

Some states propose excluding other groups of beneficiaries from the demonstrations. These include dual eligible beneficiaries residing in certain institutions in three states[15] (MO, TX, VA); dual eligible beneficiaries enrolled in certain non-DD home and community based services (HCBS) waivers in three states (CA, TX, VA); dual eligible beneficiaries who are eligible for Medicaid via a spend down in three states (IL, MI, OH); dual eligible beneficiaries with other sources of insurance coverage in four states (CA, IL,[16] OH, VA); Medicare Advantage participants in two states (CT, NC); and SNP participants in one state[17] (MO).

Geographic Area

Twenty-one of the 26 states propose implementing all or a portion of their demonstrations statewide (AZ, CO, CT, HI, ID, IA, MA, MI, MN, MO, NM,[18] NY, NC, OK, OR, RI, SC, TN, VT, WA, WI) (Table 2). Among these states, five propose implementing at least one part of their demonstration less than statewide (AZ - one county for duals with SMI, CT – health neighborhoods in three to five regions, NY – non-DD capitated model in eight counties, OK – part of demonstration targeted in Tulsa area and another part in OK City or Lawton metro area and a rural area, WA – fully capitated model in certain counties, partially capitated model in other counties).

The remaining five states propose restricting their demonstrations to a certain geographic area (CA – eight counties, IL – five regions, OH – seven regions of three to five counties each, TX – in managed long-term care service area, VA – four regions).

Implementation Dates and Phase-in Plans

Two states (MN,[19] MO) seek to implement at least part of their demonstrations in late 2012, 13 states seek to implement at least part of their demonstrations in 2013 (CA, CO, CT,[20] IL, IA, MA, MI,

NY,[21] NC, OH, OK, WA,[22] WI), and 11 states seek to implement in 2014 (AZ, HI, ID, NM,[23] OR, RI, SC, TN, TX, VT, VA) (Figure 1 and Table 2).

Among the states that propose initially implementing all or a part of their demonstrations less than statewide, 6 plan to eventually expand them statewide (AZ, CA) or to additional regions (NY, TX, VA) or populations (SC).[24]

Nine states include plans to phase-in enrollment in their demonstrations among their initial target populations over time and/or by geographic area (CA- over 12 months, CO –over six months, IL – 5,000 beneficiaries per plan per month, MA –by geographic region, MI – quarterly by geographic region and by population within each region, OH – by region over six months, SC – by geographic area, TX – in four groups beginning with most populous counties, WI – by region over three years). WA notes that its fully capitated model will be implemented based upon whether state legislative criteria are met and plan readiness.

Proposed Enrollment Mechanisms

Table 3 summarizes the 26 states' proposed enrollment mechanisms, exemptions from passive enrollment, lock-in periods, and plans to use neutral enrollment brokers.

CMS Guidance: CMS's guidance on the demonstrations indicates that it will allow states to passively enroll dual eligible beneficiaries so long as beneficiaries have the opportunity to opt out of the demonstration on a month-to-month basis.[25] Under current law, Medicare beneficiaries are not required to enroll in managed care plans for their Medicare-covered benefits. Requiring dual eligible beneficiaries to enroll in the demonstrations would be a significant change, as most dual eligible beneficiaries currently receive Medicare benefits on a fee-for-service basis with the option to participate in managed care (Table 4). While Medicaid benefits traditionally have been delivered on a fee-for-service basis, some states offer Medicaid managed care arrangements on a voluntary or mandatory basis. States may require dual eligible beneficiaries to participate in Medicaid managed care if states obtain CMS approval to do so through a waiver.

State Proposals:

<u>Enrollment Process</u>

Twenty-three of the 26 states submitting proposals plan to passively enroll dual eligible beneficiaries into their demonstration plans, unless beneficiaries take action to opt out (AZ, CA, CO, CT, HI, ID, IL, MA, MI, MO, NM,[26] NY, OH, OK, OR, RI, SC, TN, TX, VT, VA, WA, WI) (Table 3). Five of these states propose exempting Medicare Advantage participants from passive enrollment (CA, CT, MA, OR, WI). Other states propose exempting PACE participants (CA, NY, WA), ACO enrollees (CT, NY), and Native Americans (AZ) from passive enrollment into the demonstrations.

Two states (IA, MN) propose voluntary enrollment mechanisms, in which dual eligible beneficiaries would actively opt in to the demonstration to participate. One state (NC) does not detail

an enrollment mechanism in its proposal. Enrollment in NC's current Medicaid PCCM program is passive with an opt out.[27]

Enrollment Lock-in Periods

Seven states propose allowing dual eligible beneficiaries to opt out of the entire demonstration (for both Medicare and Medicaid benefits) at any time or on a month-to-month basis (IL, IA, MA, MN, OR, RI, VT) (Table 3). Four other states (CT, MO, OK, VA) indicate that an opt out will be available, but the timeframe is unspecified.

Four states propose allowing dual eligible beneficiaries to opt out of their demonstrations at any time for their Medicare benefits only (AZ, ID, NY,[28] TX). In these states, Medicaid managed care enrollment would be mandatory for dual eligible beneficiaries.

Despite the CMS guidance described above indicating that the opportunity to opt out of the demonstration must be available on a month-to-month basis, a few states propose offering the opportunity to opt out of the demonstration within an initial defined time period. One state proposes offering an opt out only during the first 60 days of enrollment (HI – Medicare only), and four states propose offering an opt out only during the first 90 days of enrollment (CO, MI, OH – Medicare only, SC). After these initial periods, participants would be locked into their demonstration plans until the next annual open enrollment period, unless they had good cause.

Some other states propose locking beneficiaries into their demonstrations for a certain period of time before providing the opportunity to opt out. WA proposes offering an opt out after 90 days of enrollment. Three states propose six month enrollment lock-in periods before beneficiaries would have the opportunity to opt out of the demonstration (CA, NM[29] (for beneficiaries who actively opt into the demonstration by selecting a managed care organization (MCO), with an initial 90 days to switch MCOs), TN). WI initially proposed a six month enrollment lock-in but subsequently withdrew that element of its proposal.[30] TX did not propose a lock-in period but states that it would like to revisit the possibility of a 90 day lock-in period in the second year of its demonstration.

Some states' demonstrations would newly require dual eligible beneficiaries to enroll in Medicaid managed care plans. For example, two states (ID, OH) that presently have no dual eligible beneficiaries enrolled in capitated Medicaid managed care plans propose requiring beneficiaries to enroll in Medicaid managed care plans as part of their demonstrations (Tables 3, 4). Three of the states that states propose an initial 90-day opt out period and would thereafter require beneficiaries to remain enrolled in their demonstrations until the next open enrollment period presently do not require dual eligible beneficiaries to enroll in comprehensive Medicaid managed care (CO, MI, SC).[31] One state that proposes a 90 day lock-in period for its demonstration (WA) presently does not require dual eligible beneficiaries to enroll in Medicaid managed care.[32]

Use of Neutral Enrollment Broker and Independent Consumer Assistance Counseling

Seven state proposals commit to using a neutral enrollment broker to handle health plan enrollment for the demonstration (CA, CT,[33] ID, IL, MA, NY, SC) (Table 3). Another four states may do so (MI, VA, WA,[34] WI).

One state (OR) indicates that beneficiary choice counseling, to assist beneficiaries with the decision about whether to opt out of the demonstration and/or which plan to select, will be available in its demonstration, and four other states indicate that choice counseling may be available (CA,[35] NM,[36] RI, WI). In late August, 2012, CMS and the Administration for Community Living announced a new funding opportunity for State Health Insurance Assistance Programs (SHIPs) and/or Aging and Disability Resource Centers (ADRCs) to provide options counseling to dual eligible beneficiaries in states that have finalized MOUs to implement financial alignment demonstrations.[37]

Proposed Financing Mechanisms

Table 5 summarizes the 26 states' proposals regarding how to share demonstration savings with CMS, plans and providers, as well as their proposed risk-sharing mechanisms and savings estimates.

CMS Guidance: CMS guidance requires that health plans in states pursing the capitated model receive a prospective blended rate from CMS for the Medicare portion of covered services and from the state for the Medicaid portion of covered services. For CMS to approve a demonstration, the capitated rate must provide upfront savings to both CMS and the state.[38] CMS and state will share savings, as compared to lower of the expected fee-for-service or managed care spending for Medicare and Medicaid, respectively, for each service area. CMS's guidance indicates that plans will be subject an increasing quality withhold (of one percent in year one, two percent in year two, and three percent in year three of the demonstration).[39] Plans will be able to earn back the withheld capitation revenue if they meet quality objectives.

State Proposals:

Financing Models

Eighteen states seek to test the capitated model (AZ, CA, HI, ID, IL, MA, MI, MN, NM,[40] OH, OR, RI, SC, TN, TX, VT, VA, WI), 5 states seek to test the managed fee-for-service model (CO, CT, IA, MO, NC), and 3 states seek to test both models (NY, OK, WA) (Table 2). The move to managed care, and to capitated managed care in particular, will be a change in the way that care is financed for many dual eligible beneficiaries, as most of this population presently receives care on a FFS basis, with a minority of states already serving over half of dual eligible beneficiaries in Medicaid managed care organizations (AZ, HI, NM,[41] TN) (Table 4).

Shared Savings Between CMS and State

A minority of states propose how to apportion program savings between CMS and the state (Table 5). Two states (ID, OH) propose sharing savings with CMS proportionate to the contributions

made by the federal and state governments. One state (CO) proposes sharing savings proportionate to the investments in program operations made by CMS and the state. One state (CA) proposes sharing savings equally between CMS and the state. HI indicates that it will share savings with CMS but also states that some savings are needed to fund the state's increased administrative costs associated with the demonstration. MN and NM[42] indicate that they will share savings with CMS but do not specify how they propose to apportion those savings. MA[43] and WI state that how savings will be shared is still to be determined. TN wants savings realized from long-term care rebalancing to continue to be used by the state to expand access to home and community-based services rather than sharing those savings with the federal government.

A few states propose how they would use program savings. AZ plans to use its savings to expand the benefits package, reduce drug copays, and provide care managers. CO proposes reinvesting its savings to provide additional benefits and/or provider incentives. TX will reinvest a portion of the savings attributable to the state to fund improvements and reforms to its overall LTSS system. VT notes that its state law requires at least 50 percent of its savings to be used to enhance the demonstration, unless otherwise appropriated by the state legislature.

Shared Savings with Health Plans

Over half of the state proposals include provisions to share savings with health plans (Table 5). Three states (CA, MN, NM[44]) indicate that they would include the quality withhold from the capitation rate (of one percent in year one, two percent in year two, and three percent in year three of the demonstration) for plans to earn back as outlined in CMS's guidance. IL proposes withholds of one percent in year one, one and one-half percent in year two, and two percent in year three, which plans could earn back in year one based on administrative process and access to services measures and in years two and three based on quality measures. Two states propose performance incentives or quality withholds for plans after the first year of the demonstration (NY, WI). These states would use the first year of the demonstration to develop the applicable quality measures.

Three states (HI, RI, TX) indicated that they would use or modify their existing Medicaid managed care performance incentives. Another six states indicated that they would use unspecified plan quality withhold or performance incentive payments (ID, MA,[45] MI, OK, OR, WA). Three more states indicated that they may do so (OH, SC, VA). SC also proposes a one-time financial incentive for plans that transition enrollees to home or community-based settings after a 90 day nursing facility stay if enrollees remain in the community with needed support services for a specified period of time.

Shared Savings with Providers

Over half the states' proposals include provisions to share savings with providers (Table 5). Thirteen states plan to include performance based incentive payments or risk sharing arrangements with providers (CA, CO, CT, HI, ID, IA, MI, MO, NC, OH, OK, VT, WI). Four states indicate that they would permit or encourage demonstration health plans to establish shared savings arrangements with providers (OR, SC, TN, VA).

Risk Sharing Mechanisms

Just under half the states' proposals include provisions for risk sharing mechanisms (Table 5). Six states will require provisions such as risk corridors or stop loss provisions (HI,[46] MA, MI,[47] MN, TN,[48] WI[49]). Another six states may use risk corridors or other risk sharing arrangements (CA,[50] NY, OH, RI,[51] SC, VT). By contrast, one state (ID) indicates that its plans will assume full risk.

Savings Estimates

A minority of states estimate expected savings from the demonstrations (Table 5). Among the states proposing capitated models, MI, OK, and WI estimate specific amounts of savings. ID notes that its exact savings are uncertain, but the potential is "significant," citing several studies. By contrast, AZ projects that savings estimates must be "nominal" in early years due to its existing high prevalence of managed care. TX expects "significant" reductions in Medicare costs with "modest to no" increases in state Medicaid costs as a result of its demonstration.

Among the states proposing managed FFS models, MO includes specific savings estimates. IA has not projected savings from its duals demonstration but includes specific savings estimates from its overall health homes program.

Proposed Benefits Packages

Table 6 summarizes the 26 states' proposed benefits package carve-outs, supplemental benefits, provisions for mental health benefits, continuity of care provisions, and proposed use of community health workers. Table 7 summarizes the states' proposals in the areas of LTSS access, intent to use the demonstration to help with long-term care (LTC) rebalancing efforts, and provisions for beneficiary self-direction of personal care services.

CMS Guidance: CMS has stated that demonstration plan benefits packages should include all primary, acute, behavioral health and long-term services and supports presently covered by Medicare and Medicaid. Medicaid necessity determinations will be based on Medicare standards for acute services and prescription drugs and on Medicaid standards for long-term services and supports. Where coverage overlaps, the contract language will specify how medical necessity will be determined. CMS guidance also indicates that CMS, the state and health plans will ensure beneficiary access to an adequate network of medical and supportive services providers. Medicare network adequacy standards will apply for medical services and prescription drugs, and Medicaid network adequacy standards will apply for long-term services and supports. For areas of coverage overlap between Medicare and Medicaid, such as home health services, the MOU and contract will determine the appropriate network adequacy standard so long as the network is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.[52]

State Proposals:

Benefits Package Exclusions

State proposals are most likely to exclude long-term care services from their proposed integrated benefits packages, with nine states excluding services for people with developmental disabilities (HI, ID – may phase-in coverage, MN – excluded for ages 18 to 64, NM,[53] OR, RI – excluded in phase one, TN, VA – targeted case management excluded, WA – excluded in fully capitated model) (Table 6). Other states exclude home and community-based services more generally (MA, SC) or for seniors and people with physical disabilities (OR). TX excludes nursing facility stays beyond four months.

Some states also propose excluding behavioral health services from their integrated benefits packages (CA, CO – majority excluded, HI, RI – excluded in phase one, VA – targeted case management excluded).

Regarding prescription drugs, one state (VT) proposes using its Medicaid prescription drug benefit and preferred drug list, along with a new medication therapy management program, instead of Medicare Part D. By contrast, CT explicitly notes that it expects that its demonstration participants will remain in their existing Part D plans.

Supplemental Benefits

Over three-fourths of the state proposals envision requiring or permitting demonstration health plans to offer additional benefits beyond those covered in the regular Medicare and Medicaid benefits packages (AZ, CA, CT, HI, ID, IL, MA, MI, NM,[54] NY, OH, OR, RI, SC, TN – after six months' enrollment and if rates sufficient to cover costs, TX, VA, VT, WA, WI) (Table 6).

Mental Health Benefits

Half the states' proposals require the integration or co-location of mental health services (IA, IL, MN – for ages 18-64, NM,[55] OH, OR, RI, SC, TX, WA) or require demonstration plans to coordinate with existing Medicaid behavioral health carve-outs (AZ, CA, CO) (Table 6).

Continuity of Care Provisions

A minority of states include provisions to ensure continuity of care as beneficiaries transition from their existing care arrangements to the demonstrations (Table 6). CA proposes providing beneficiaries with access to out-of-network providers for 12 months for Medicaid benefits and six months for Medicare benefits. Four states propose continuing beneficiary access to out-of-network providers for six months (IL, RI, TN, VA – also proposing that nursing facility residents may remain in their current placements indefinitely). SC proposes to allow beneficiaries undergoing active treatment to retain access to their current providers as well as 60 days access to current prescription drugs (90 days for behavioral health medications). VT proposes allowing beneficiaries to retain their current primary care providers. NY state law guarantees 60 days of continued access to current providers,

which the state is considering increasing to 90 days. AZ and MN will rely upon their existing Medicaid managed care transition processes.

Community Health Workers

Five states will require plans to include community health workers in their integrated care teams, such as peer navigators or other non-traditional health workers to assist beneficiaries with preventative care and health promotion efforts (MA, NM,[56] OR, RI, SC) (Table 6). OK is considering doing so in one of its models.

Long-Term Services and Supports Access

Three states' proposals provide for independent long-term services and supports coordinators or assessments (MA – plans required to have independent LTSS coordinator, NC – to develop independent LTSS assessment, OH – beneficiaries have right to choose the entity that coordinates HCBS and their individual service coordinator) (Table 7).

In four states, the state or county will continue to assess beneficiary eligibility for long-term care services (CA – plans may authorize additional services paid through capitated rate, SC, VA – state handles initial assessments and plans handle reassessments, WA). By contrast, one state (MO) will have its demonstration health homes coordinate and determine the need for HCBS waiver services. Five states' proposals require demonstration plans to coordinate services with HCBS providers (CA, OH – plans must have contracts with state certified HCBS providers, OK, RI, SC).

HCBS Rebalancing

Eleven states' proposals cite their demonstrations as part of their ongoing efforts to rebalance their long-term care systems and transition beneficiaries from institutions to home and community-based settings (CO, CT, HI, ID, IA, NM,[57] SC, TN, TX, VA, WI) (Table 7).[58] In *Olmstead v. L.C.*, the U.S. Supreme Court held that people with disabilities have the right to live at home or in the community if they are able and do not oppose doing so, rather than be institutionalized.[59] As noted above, several states propose using demonstration savings or plan financial incentives to achieve these goals. TN wants savings realized from long-term care rebalancing to continue to be used by the state to expand access to home and community-based services rather than sharing those savings with the federal government. TX will reinvest a portion of the savings attributable to the state to fund improvements and reforms to its overall LTSS system. SC proposes a one-time financial incentive for plans that transition enrollees to home or community-based settings after a 90 day nursing facility stay if enrollees remain in the community with needed support services for a specified period of time. RI is considering a transitional capitated rate to achieve HCBS rebalancing.

Beneficiary Self-Direction of Personal Care Services

Half of the states' proposals require plans or providers to offer beneficiaries the option to self-direct their personal care services (CA, HI, MA, NM,[60] NY, OH, RI, SC, TN, TX, VT, VA, WA) (Table 7).

Proposed Beneficiary Protections

Table 8 summarizes the 26 states' proposals for Americans with Disabilities Act (ADA) compliance, the provision of demonstration ombudsman, and appeals.

CMS Guidance: CMS and the state will develop a unified set of requirements for plan complaints and internal appeal processes that incorporate Medicare Advantage, Part D and Medicaid managed care requirements and a single external appeals process using both Medicare and Medicaid requirements. There will be a single notice that explains the integrated appeals process. The timeframe for filing appeals will be the Medicare standard of 60 days. Initial appeals will "ideally" go through the internal plan process first and then external appeals will go through the Medicare qualified independent contractor. There will be a hybrid standard for continuation of benefits while appeals are pending: benefits will continue during the internal plan review according to the Medicaid standard, but once appeals reach the external review, benefits would not continue according to the Medicare standard, except for Medicaid-only benefits which would continue according to the Medicaid standard. The current Medicare appeal resolution timeframes of 30 days for standard appeals and 72 hours for expedited appeals would apply.[61]

State Proposals:

ADA Compliance

Half of the states' proposals include requirements for demonstration plans and/or providers to comply with the Americans with Disabilities Act (CA, CT, ID, IL, MA, MO, NM,[62] NY, RI, SC, TX, VT, VA) (Table 8). The ADA prohibits disability-based discrimination by state and local governmental entities and places of public accommodation. Some of the specific requirements included in the state proposals are providing enrollee materials in alternative formats, providing sign language interpreters or otherwise ensuring effective communication with beneficiaries, and ensuring beneficiaries' physical access to provider offices.

Ombudsman

Nine states are considering providing beneficiaries with access to an independent ombudsman for the demonstration (CO, CT, HI, MA,[63] MI, NY – if funded by CMS, SC, VA, WI) (Table 8). Three states will provide demonstration participants with access to their existing managed care or long-term care ombudsman outside the demonstrations (MN, VT – required by state law for demonstration participants, WI).

Appeals

Most states' proposals lack detail about how the demonstrations will handle appeals, including the content of notices, the timeframes for filing and resolving appeals, access to external hearings outside of demonstration health plans, and the continuation of benefits while appeals are pending (Table 8).[64] ID proposes allowing beneficiaries 20 to 28 days (compared with CMS's guidance of 60 days) to file appeals. By contrast, MI proposes retaining its current Medicaid standard of 90 days to

file appeals. MO proposes retaining separate Medicare and Medicaid appeals processes (compared with CMS guidance for developing a unified appeals system). CA proposes developing a unified Medicare-Medicaid appeals process by the second year of its demonstration.

Proposed Stakeholder Engagement

Table 9 summarizes the 26 states' proposals for stakeholder engagement with the state and with plans during the demonstrations.

CMS Guidance: Plans must establish "meaningful" beneficiary input processes, such as participation on plan governing boards or beneficiary advisory boards.[65]

State Proposals:

Stakeholder Engagement with State

Eighteen of the 26 states include proposals for continued stakeholder engagement with the state during the demonstrations (AZ, CA, CO, CT, HI, ID, MA, MN, MO, NM,[66] NY, OK, RI, SC, TN, TX VA, WI) (Table 9). The most frequently cited form of stakeholder engagement is advisory committees or workgroups, either specific to the demonstration or as part of a pre-existing stakeholder engagement entity in the state.

Stakeholder Engagement with Plans

Nine of the 26 states mention provisions for stakeholder engagement with demonstration health plans (CA, HI, ID, IL, MN, NY, OH, TN, TX) (Table 9). The most frequently cited form of stakeholder engagement with plans was advisory committees.

Proposed Demonstration Evaluation and Oversight

Table 9 also summarizes the states' proposals for demonstration evaluation.

CMS Guidance: CMS will require states participating in the demonstration to report individual-level quality, cost, enrollment and utilization data. Demonstration health plans will report encounter data and data for certain quality indicators. CMS and the state will jointly select and monitor participating health plans, which will be required to meet established quality thresholds. Plan oversight will be governed by the MOU or contract.[67]

State Proposals:

Demonstration Evaluation

Three states include plans to evaluate their demonstrations (Table 9). IL plans to contract with an outside entity to evaluate its demonstration. IA is working with a university to evaluate its overall health homes program, and a component of that study will focus on dual eligible beneficiaries. MO will assess annual cost savings from its demonstration by using a control group of primary care practices that are not health homes but which serve clinically similar populations.

Quality Measures and Demonstration Oversight

Nearly all the states' proposals indicate that specific quality measures for the demonstrations were still to be determined (Table 9). The 26 states' proposals otherwise contain insufficient detail on quality measures, oversight and monitoring to summarize.

Looking Ahead

While the states' initial proposals to CMS provide more information than was previously available about the parameters of their demonstrations, additional detail still is needed in many areas to understand more completely how the demonstrations will work and how beneficiaries will be affected. Some additional information about how Massachusetts' demonstration will work is contained in the MOU that it recently finalized with CMS.[68] As CMS continues to review the 26 states' proposals and finalizes MOUs to implement demonstrations in selected states over the coming months, attention should be given to several key questions, such as:

- How will beneficiaries be notified about the demonstrations and enroll and disenroll?
- How will Medicare and Medicaid contributions be calculated, risk-adjusted, and adjusted over time?
- What will the source(s) of savings be, and how will savings be shared among CMS, the state, plans and/or providers?
- How will the demonstrations affect access to home and community-based services?
- How will medical necessity determinations be made, and how will beneficiaries appeal decisions with which they disagree?
- Will beneficiaries be able to retain their current providers and services and access an adequate provider network?
- How will plans and providers meet the needs of and provide reasonable accommodations to beneficiaries with a range of physical, mental health, and cognitive disabilities?
- How will quality be measured, and how will the demonstrations be monitored and evaluated?
- To what extent will the specific standards that health plans must meet to participate in the demonstrations vary from existing Medicare Advantage and Medicaid managed care requirements?
- How will stakeholders continue to be engaged throughout the design and implementation process?

This background paper was prepared by MaryBeth Musumeci of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

Appendix: CMMI's § 1115A Demonstration Authority

CMS's financial alignment models for dual eligible beneficiaries are based on the Center for Medicare and Medicaid Innovation's (CMMI) new § 1115A demonstration authority created in the ACA. The following questions and answers explain the scope of the Secretary's authority and the process for testing new payment and service delivery models under § 1115A.

1. What types of models that could affect dual eligible beneficiaries may CMMI test?

CMMI was established to "test innovative payment and service delivery models to reduce program expenditures under" Medicare and Medicaid "while preserving or enhancing the quality of care furnished" to beneficiaries.[69] The law lists 20 different types of models that CMMI may test and also allows CMMI to test other models beyond those named in the statute.[70] Among the models specified in the law are those that allow states to "test and evaluate fully integrating care for dual eligible individuals. . ., including the management and oversight of all funds under" Medicare and Medicaid.[71] These models are the subject of the proposals submitted to CMS by 26 states in spring 2012.

Dual eligible beneficiaries also could be encompassed in several other models specified in the law, such as those that related to:

-patient-centered medical homes for high need individuals;

-care coordination for individuals with multiple chronic conditions;

-chronic care management through health homes; and

-all-payer payment reform.[72]

2. How will the Secretary determine which models should be tested?

When selecting models for testing, the Secretary must determine that "there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures."[73] The law directs the Secretary to "focus on models expected to reduce program costs under" Medicare, Medicaid, or both programs "while preserving or enhancing the quality of care received by" beneficiaries.[74] The law also directs the Secretary to "give preference to models that also improve the coordination, quality, and efficiency of health care services furnished" to Medicare, Medicaid, and dual eligible beneficiaries.[75]

The law lists a number of additional factors that CMMI may consider when selecting models to test, including:

-"[w]hether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of" beneficiaries;

-"[w]hether the model places [beneficiaries], including family members and other informal caregivers. . ., at the center of the care team";

-"[w]hether the model provides for in-person contact with" beneficiaries;

-"[w]hether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings";

-"[w]hether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers";

-"[w]hether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching";

-"[w]hether, under the model, providers of services and suppliers are able to share information with patients, caregivers and other providers of services and suppliers on a real time basis"; and

-"[w]hether the model demonstrates effective linkage with other public sector or private sector payers."[76]

3. What are the requirements for evaluating models that are tested?

The law directs the Secretary to evaluate each model that is tested. The evaluation must include an "analysis of the quality of care furnished under the model, including the measurement of patient level outcomes and patient-centeredness criteria determined appropriate by the Secretary, and the changes in spending under" Medicare and Medicaid "by reason of the model."[77] Evaluation results shall be made "available to the public in a timely fashion."[78] The Secretary "may establish requirements for States and other entities participating in the testing of models. . . to collect and report information that the Secretary determines is necessary to monitor and evaluate" the models.[79] The Secretary also shall, "to the extent feasible. . . select measures that reflect national priorities for quality improvement and patient-centered care" based on input from multi-stakeholder groups.[80]

4. What is the scope of the Secretary's § 1115A waiver authority?

In order to test new payment and service delivery models, the ACA authorizes the Secretary to waive any Medicare requirements in the Social Security Act and the Medicaid requirements in sections 1902(a)(1) (regarding statewideness), 1902(a)(13) (regarding payment rates), and 1903(m)(2)(A)(iii) (regarding actuarial soundness of managed care payment rates) of the Social Security Act.[81] The Secretary also has authority to limit the testing of models to certain geographic areas.[82] States that want to change their Medicaid programs in ways that are outside the scope of the Secretary's § 1115A waiver authority must pursue separate waivers (e.g., combination §§ 1915(b)/(c) waivers or § 1115(a) waivers for states that seek to implement managed long-term care programs).

The law prohibits administrative or judicial review of the Secretary's selection of models, organizations, sites, or participants; the elements, parameters, scope, and duration of models; determinations regarding budget neutrality, termination or modification of a design and implementation; and determinations about the expansion and scope of models.[83]

5. What is the process that CMMI must use to test models?

CMMI's testing of new models must proceed in two phases. In Phase I, models will be tested to determine their effect "on [Medicare or Medicaid] program expenditures. . . and the quality of care received by" beneficiaries.[84] The Secretary may not require that model design ensure budget neutrality initially as a condition for testing in Phase I.[85]

Models may be expanded in Phase II. "Taking into account the evaluation [results], the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and scope of a model. . . if the Secretary determines that expansion is expected to reduce spending [under Medicare or Medicaid] without reducing the quality of care or improve the quality of patient care without increasing spending; the Chief Actuary of [CMS] certifies that such expansion would reduce (or would not result in any increase in) net program spending [under Medicare or Medicaid]; and the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under [Medicare or Medicaid."[86] In determining which models to expand, the Secretary "shall focus on models. . . that improve the quality of patient care and reduce spending."[87]

6. What are the criteria that the Secretary must use to decide whether to terminate or modify a model that is being tested?

The law directs the Secretary to "terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of [CMS certifies regarding program spending], after testing has begun, that the model is expected to" achieve one of the following outcomes:

-"improve the quality of care (as determined by the Administrator of [CMS]) without increasing spending" under Medicare or Medicaid;

-"reduce spending under [Medicare or Medicaid] without reducing the quality of care"; or

- "improve the quality of care and reduce spending."[88]

Termination may occur at any time after testing has begun and before testing has been completed.[89]

7. What information about the model testing must the Secretary report to Congress?

The Secretary must submit an annual report to Congress, beginning in 2012, describing the models being tested, including the number of Medicare and Medicaid beneficiaries participating and payments made for Medicare and Medicaid services; any models chosen for expansion; and the results from evaluations. The Secretary's report also shall provide any recommendations for "legislative action to facilitate the development and expansion of successful payment models."[90]

Table 1: State Interest in Financial Alignment Models for Dual Eligible Beneficiaries as of August, 2012

State	Awarded Design Contract	Submitted Letter of Intent	Submitted Proposal to CMS to Test Capitated Model	Submitted Proposal to CMS to Test Managed Fee-for-Service Model	Submitted Proposal to CMS to Test Both Models	MOU Finalized with CMS
Alabama						
Alaska		X				
Arizona		X	X			
Arkansas						
California	X	X	X			
Colorado	X	X		X		
Connecticut	X	X		X		
Delaware		X				
District of Columbia		X				
Florida		X				
Georgia						
Hawaii		X	X			
Idaho		X	X			
Illinois		X	X			
Indiana		X				
Iowa		X		X		
Kansas		X				
Kentucky		X				
Louisiana						
Maine		X				
Maryland		X				
Massachusetts	X	X	X			X
Michigan	X	X	X			
Minnesota	X	X	X			
Mississippi						
Missouri		X		X		
Montana		X				
Nebraska						
Nevada		X				
New Hampshire						
New Jersey						
New Mexico*		X	X			
New York	X	X			X	
North Carolina	X	X		X		
North Dakota						
Ohio		X	X			
Oklahoma	X	X			X	
Oregon	X	X	X			
Pennsylvania		X				
Rhode Island		X	X			
South Carolina	X	X	X			
South Dakota						
Tennessee	X	X	X			
Texas		X	X			
Utah						
Vermont	X	X	X			
Virginia		X	X			
Washington	X	X			X	
West Virginia						
Wisconsin	X	X	X			
Wyoming						
TOTAL:	**15**	**38**	**18**	**5**	**3**	**1**

*NM's proposal is no longer active with CMS. SOURCE: CMS Medicare-Medicaid Coordination Office Financial Alignment Initiative, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Table 2: State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries By Target Population and Implementation Date

State and Financial Model	Target Population and Geographic area	Estimated Enrollees	Groups Excluded from Target Population	Implementation Date	Implementation Phase-In Plan
AZ Capitated	(1) Full duals statewide with Medicare Parts A and/or B who are eligible for AZ's Medicaid MLTC program for elders and people with physical disabilities; (2) Full duals statewide who do not receive Medicaid MLTC; (3) Full duals with SMI in Maricopa County who do not receive Medicaid MLTC	115,065	Duals receiving state agency DD services	January, 2014	Maricopa County pilot eventually to expand statewide
CA Capitated	Full duals ages 21 and over in 8 counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara)	685,000	Duals with other insurance coverage or ESRD; receiving DD services from a state regional center or developmental center; enrolled in NF, HIV/AIDS, Assisted Living, or In-Home Operations HCBS waiver; or living in rural areas not covered by managed care	Beginning no earlier than March, 2013 and no later than June, 2013	Phased in over 12 months in 8 counties in 2013; expanding to the remaining 22 counties that currently have Medi-Cal managed care in 2014; expanding statewide (28 more counties) in 2015.
CO Managed FFS	Full duals statewide	62,982	Participants in CO Alliance for Health & Independence, Denver Health Medicaid Choice plan, ICF/DD, PACE or Rocky Mountain Health Plan. Still exploring whether SNP enrollees will be excluded from demonstration.	2013	To enroll percentage of duals each month over approximately 6 months
CT Managed FFS – 2 versions	Full duals age 18 and older in 2 models: (1) ASOs statewide; (2) Health Neighborhoods in 3 to 5 geographic areas	57,569	To include LTC participants contingent upon state gaining better understanding of CMS methodology for shared savings. To exclude Medicare Advantage participants.	(1) ASOs – January, 2013; (2) Health Neighborhoods – April, 2013, but may seek implementation as late as January, 2014	Health neighborhoods may be expanded in future if desired outcomes achieved.
HI Capitated	Full duals statewide including children and adults	24,189	HCBS DD waiver enrollees	January, 2014	Not specified
ID Capitated	Full duals ages 18 and older statewide	17,735	None	January, 2014	Not specified
IL Capitated	Full duals ages 21 and over in 5 regions of state	156,000	People with DD receiving institutional or HCBS waiver services; spend down; high third party liability	January, 2013 for Greater Chicago and Central IL regions; 2014 for Rockford, East St. Louis and Quad Cities regions	5,000 beneficiaries per plan per month
IA Managed FFS	Full duals statewide	62,714	None	January, 2013	Not specified
MA* Capitated	Full duals ages 21-64 statewide	115,000	None	January, 2013	Phase-in by geographic region
MI Capitated	Full duals statewide	198,644	PACE and spend down enrollees	January, 2013	Phase in quarterly by geographic region and by population within each region with full implementation by June 30, 2014

Table 2 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries By Target Population and Implementation Date

MN Capitated	Full duals statewide who qualify for Medicaid managed care enrollment (pending state discussions with CMS about financing for younger duals with disabilities)	93,165	None	December, 2012 for seniors; July, 2013 for younger duals with disabilities	Not specified
MO Managed FFS – 2 versions	Duals statewide eligible to participate in a health home: (1) Diagnosis of SMI or MI/SU and another chronic condition; (2) Diagnosis of specific somatic chronic conditions.	5,093	Beneficiaries in institutions; beneficiaries who do not meet health home enrollment criteria; beneficiaries in SNPs or PACE.	Immediately upon CMS approval of demonstration and no later than October, 2012	Not specified
NM* Capitated	All full duals statewide	40,000		January, 2014	Not specified
NY Both – 1 version managed FFS and 2 versions capitated	Managed FFS: Full duals statewide with 2 or more chronic conditions, HIV/AIDS and/or one mental health diagnosis, who are not receiving DD or state mental health facility services, and who do not require 120 or more days of LTSS Capitated: (a) Full duals ages 21 and older in 8 counties who require 120 or more days of LTSS and are not receiving state mental health facility services and do not have DD (b) Full duals statewide age 21 and older who require 120 or more days of HCBS LTSS DD services and are not in a state mental health facility	Managed FFS: 126,582 Capitated: (a) 123,880 (b) 10,000	None	Managed FFS: January, 2013 Capitated: January, 2014	Anticipate expanding capitated model to other service areas beyond the initial 8 counties by 2017.
NC Managed FFS	Full duals over age 21 statewide	176,050	Medicare Advantage and PACE enrollees; incarcerated; receiving specialty behavioral health plan services	January, 2013	Not specified
OH Capitated	Full duals in 7 regions of 3 to 5 counties each	114,972	People with DD served in ICF/DD or HCBS waiver; PACE; other third party coverage; children; spend down	January, 2013	By region over first two quarters of 2013
OK Both – 1 version managed FFS and 2 versions capitated	(1) SoonerCare Silver - all full duals statewide who are not receiving care coordination from another demonstration program or PACE (2) Tulsa Health Innovation Zone – duals in Tulsa and surrounding region who receive primary care services through participating Health Access Network practices (3) All full duals age 45 and older with 2 or more complex chronic conditions and some functional limitations at minimum meeting personal care services LOC and living in geographic region of proposed Integrated Care site in OK City or Lawton metro area and in a rural area of the state	(1) 79,891 (2) ~3,200 (3) 22,332	None	July, 2013	Not specified
OR Capitated	Full duals statewide (although demonstration participation is voluntary for CCOs)	68,000	PACE enrollees	January, 2014	Not specified

Table 2 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries By Target Population and Implementation Date

RI Capitated	Full duals statewide ages 21 and over residing in the community who are not currently receiving LTSS; duals in need of LTSS; duals who receive Medicare Advantage enrollees (also open to Medicaid only LTSS users)	22,737	Adults with DD or SPMI, also to consider exempting duals presently in hospice	January, 2014	Not specified
SC Capitated	Full duals statewide ages 65 and older who are not receiving nursing facility services at time of enrollment	68,000	PACE enrollees	January, 2014	Phase-in by geographic area – January, 2014 for region 1 (Coastal) and July 2014 for region 2 (Upstate and Midlands/Central). Anticipate expansion to other populations by 2017.
TN Capitated	Full duals statewide	~136,000	PACE enrollees	January, 2014	Not specified
TX Capitated	Full duals ages 21 and over residing in service area and required to enroll in STAR+PLUS Medicaid MLTC program	214,402	Voluntary child STAR+PLUS enrollees; individuals residing in NFs beyond 4 months or state supported living centers and § 1915(c) waiver participants are excluded from STAR+PLUS.	January, 2014	Phase-in in 4 groups beginning with most populous counties. Over time may seek to develop rural initiative to integrate care for duals. If STAR-PLUS expands to rural service area, demonstration also will include expansion areas.
VT Capitated	Full duals statewide	22,000	PACE enrollees	January, 2014	Not specified
VA Capitated	Full duals ages 21 and over in 4 regions (Central VA, Northern VA, Tidewater, Western/Charlottesville)	65,415	Enrollees in DD, Technology Assisted, Day Support and Alzheimer's Assisted Living waivers; MFP participants; individuals in state mental hospitals, ICF/DDs, residential treatment facilities or long stay hospitals; individuals enrolled in hospice or family planning; individuals with other comprehensive insurance	January, 2014	To expand to Roanoke region in 2015
WA Both – 1 version managed FFS, 2 versions capitated	Full duals (1) Managed FFS health homes statewide; (2) Full capitation in certain counties; (3) Partial capitation in other counties	115,000	None	January, 2013 for managed FFS health homes; January, 2014 for capitated and partial capitated models	Full capitation to be implemented based upon state legislative criteria being met and plan readiness
WI Capitated	Full duals statewide over age 18 residing in nursing homes with long-term (100 days or more in calendar year) FFS Medicaid-funded stays	15,000-16,000	None	January, 2013	Southeastern region year 1; southern and northeastern regions year 2; western and northern regions (statewide) year 3

*Further detail about MA's proposal is available in its MOU with CMS. NM's proposal is no longer active with CMS.

SOURCE: CMS Medicare-Medicaid Coordination Office Financial Alignment Initiative State Financial Alignment Proposals, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Table 3: State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Proposed Enrollment Processes

State and Financial Model	Proposed Enrollment Mechanism	Exemptions from Passive Enrollment	Proposed Enrollment Lock-In Period	Use of Neutral Enrollment Broker and Independent Consumer Assistance Counseling
AZ Capitated	Passive enrollment into current Medicaid MCO which will provide all Medicare and Medicaid benefits unless opt out for Medicare benefits only.	Native Americans unless they already have opted to enroll in a Medicaid MCO.	Opt out at any time for Medicare only. Opt out is to Medicare FFS, not another Medicare Advantage plan.	Not mentioned.
CA Capitated	Passive unless opt out.	PACE and AIDS Health Care Foundation enrollees and beneficiaries enrolled in a Medicare Advantage plan or D-SNP that is not administered or contracted with a demonstration plan.	Initial 6 month "stable enrollment period" required. After 6 months, another opportunity to opt out (for Medicare only). Native Americans may opt out at any time.	To use Medi-Cal enrollment broker. Contingent upon available funds other than general fund dollars, to contract with community-based non-profit consumer or health insurance assistance organizations with expertise in assisting duals with understanding health coverage options.
CO Managed FFS	Passive unless opt out.		Opt out available during first 90 days of enrollment, annual open enrollment period, and any time for cause.	Not mentioned.
CT Managed FFS	Passive with opt out. Subset of duals will be passively enrolled in health neighborhood if receiving care from participating provider. Remaining duals will be attributed to ASO.	Medicare Advantage or ACO participants.		Yes, for health neighborhoods model
HI Capitated	Passive unless opt out in initial 60 days (opt out for Medicare only).		After initial 60 days, locked in until next open enrollment period unless for cause.	Not mentioned.
ID Capitated	Passive with opt out (for Medicare only).			State to use third party independent enrollment broker.
IL Capitated	Passive unless opt out		Opt out at any time (month to month)	Yes
IA Managed FFS	State to identify beneficiaries through predictive modeling tool. Those determined to be at greatest risk and who live in health home service area will be encouraged to voluntarily connect with health home provider. Beneficiaries with high health risks who do not reside in health home service area will be encouraged to voluntarily participate in disease management program.		Opt out at any time.	
MA* Capitated	Passive unless opt out.	Medicare Advantage members	Opt out at any time	Yes
MI Capitated	Passive unless opt out		Opt out available in first 90 days of initial enrollment, then locked in until next open enrollment period.	Anticipated.
MN Capitated	Voluntary		Opt out at any time (month to month)	No. State to handle enrollment. Consumer choice counseling provided by counties and SHIP.
MO Managed FFS	Passive (already complete for Medicaid), opt out available			

Table 3 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Proposed Enrollment Processes

NM* Capitated	Mandatory for Medicaid. Passive unless opt out for Medicare.		Opt out on monthly basis for Medicare only. Proposed 6 month lock for Medicare enrollees who actively opt in to demonstration by selecting an MCO with initial 90 days to switch MCOs.	Beneficiary outreach strategies may include working with outside agencies to act as navigators to assist individuals with health plan selection.
NY Both	Managed FFS model: passive enrollment in health homes. Main capitated model: duals in the 8 counties receiving LTSS and enrolled in NY's mandatory MLTC program will be passively enrolled in a demonstration plan. DD capitated model: beneficiaries will have option to enroll in specialized MLTC plan in 2013, which will transition to a demonstration plan in 2014 – enrollment will be passive with opt out.	PACE and ACO participants will not be passively enrolled but can voluntarily enroll. State will work with CMS to identify duals with employer sponsored Medicare coverage to determine how to avoid passive enrollment.	Managed FFS: opt out available. Capitated: opt out at end of any month after enrollment (but Medicaid MLTC mandatory). Can re-enroll only in January and July of each year.	Yes for both managed FFS and capitated models.
NC Managed FFS	Not addressed. (NC's existing Medicaid PCCM program is passive with opt out.)	Not addressed.	Not addressed.	Not addressed.
OH Capitated	Passive	Opt out for Medicare after 90 days. Medicaid mandatory.		Not addressed.
OK Both	Passive with opt out available for model 1.			Not mentioned.
OR Capitated	Passive unless opt out	Medicare Advantage enrollees	Opt out at any time. Can opt out from Medicare portion only or entire demonstration.	Choice counseling will be available.
RI Capitated	Voluntary, phased opt out model.		Opt out at any time for Medicare benefits	To consider ADRCs as consumer information and referral source and offer non-biased enrollment counseling.
SC Capitated	Passive unless opt out before end of 90 day trial period.		After opportunity to opt out in 90 day trial period, opportunity to disenroll annually.	Will use independent enrollment broker.
TN Capitated	Passive		Opt out at any time after 6 month transition period.	Not mentioned.
TX Capitated	Medicaid MLTC is mandatory; passive enrollment into corresponding SNP with monthly opt out. Proposes revisiting whether to establish 90 day lock-in period in year 2.		Opt out month to month.	Not mentioned.
VT Capitated	Passive unless opt out		Opt out available on monthly basis	Not mentioned.
VA Capitated	Passive unless opt out.	PACE enrollees can opt in to demonstration if disenroll from PACE.		Anticipated.
WA Both	Passive unless opt out.	PACE and tribal members.	Opt out after 90 days enrollment.	Requesting CMS funding for neutral enrollment broker.
WI Capitated	Passive	Medicare Advantage participants and those with employer-sponsored insurance or Part D subsidies	Original proposal: opt out after 6 month mandatory trial period. Subsequent letter to CMS withdrew 6 month lock-in.	Options counseling may be provided after 6 month mandatory enrollment period to assist with opt out decision, possibly from ADRCs or other enrollment and counseling providers.

*Further detail about MA's proposal is available in its MOU with CMS. NM's proposal is no longer active with CMS. SOURCE: CMS Medicare-Medicaid Coordination Office Financial Alignment Initiative State Financial Alignment Proposals, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Table 4: Dual Eligible Beneficiary Enrollment in States Submitting Integrated Care and Financial Alignment Demonstration Proposals to CMS, 2010

State	Number of Dual Eligibles, 2010	Percentage of Dual Eligible Enrollees in Medicaid Managed Care, 2010[1]					Special Needs Plans (SNP), 2010		Percentage of Dual Eligibles Enrolled in PACE, 2010
		Health Insuring Organizations	Managed Care Organizations[2]	Primary Care Management Providers	Prepaid Inpatient Health Plans	Prepaid Ambulatory Health Plans	Number of Dual SNPs	Percentage of Dual Eligibles Enrolled in Dual SNPs[3]	
Total, US	8,887,087	1.6%	10.3%	1.5%	7.0%	10.6%	337	10.9%	0.20%
AZ	147,772	-	68.2%	-	-	-	14	39.7%	-
CA	1,135,406	12.2%	7.9%	-	-	2.4%	38	11.3%	0.19%
CO	78,556	-	4.1%	7.0%	85.0%	-	5	10.2%	1.93%
CT	106,443	-	-	-	-	-	2	3.4%	-
HI	29,723	-	88.9%	-	-	-	3	24.9%	0.05%
ID	22,993	-	-	68.8%	-	4.2%	2	5.5%	-
IL	649,200	-	-	-	-	-	4	0.9%	-
IA	74,980	-	-	-	80.9%	-	1	0.3%	0.08%
MA	242,000	-	5.8%	-	-	-	4	5.3%	0.96%
MI	239,262	-	-	-	-	-	5	2.2%	0.19%
MN	121,394	-	41.3%	-	-	-	14	31.3%	-
MO	168,084	-	-	-	-	-	5	2.0%	0.09%
NM	62,442	-	50.7%	-	50.7%	-	5	5.1%	0.60%
NY	676,143	-	0.9%	0.1%	3.7%	-	41	12.8%	0.43%
NC	286,798	-	-	32.7%	4.7%	-	2	2.8%	0.04%
OH	284,818	-	-	-	-	-	6	2.8%	0.21%
OK	101,359	-	-	-	-	100.0%	2	0.6%	0.05%
OR	88,039	-	36.5%	1.2%	53.0%	61.3%	8	19.4%	0.93%
RI	35,752	-	-	-	-	-	-	-	0.50%
SC	131,649	-	-	8.8%	-	100.0%	5	1.4%	0.32%
TN	233,094	-	57.4%	-	0.7%	0.3%	10	14.8%	0.13%
TX	578,134	-	15.4%	-	4.6%	-	29	10.1%	0.15%
VT	30,347	-	49.8%	-	-	-	-	-	0.34%
VA	161,847	-	-	-	-	67.5%	1	0.4%	0.33%
WA	149,182	-	0.6%	-	N/A[4]	-	4	2.7%	0.20%
WI	169,543	-	6.1%	-	14.3%	-	13	5.2%	0.44%

NOTES: [1] Dual eligible beneficiaries may be enrolled in more than one type of Medicaid managed care. [2] Medicaid Managed Care Organizations include Commercial Managed Care Organizations and Medicaid-only Managed Care Organizations. [3] The percentage of dual eligibles in dual SNPs does not account for the large share of dual eligibles in other types of SNPs. [4] The percentage of dual eligible enrollees in prepaid inpatient health plans for Washington was found to be inconsistent, and was withheld from this table. Washington prepaid inpatient health plans were not included when calculating national percentages.

SOURCE: Number of dual eligibles, and enrollment figures used to generate percentages enrolled in Medicaid managed care and PACE, as of July 1, 2010, from CMS at http://www.cms.gov/MedicaidDataSourcesGenInfo/05_MdManCrPenRateandExpEnrll.asp

Number of dual SNPs from CMS SNP Landscape Source file. D-SNP enrollment figures used to generate percentages are from CMS May 2010 Monthly Enrollment by Contract/Plan/State/County files. For more information, see Kaiser Family Foundation, Medicare Health Plan Tracker, available at http://healthplantracker.kff.org/topicresults.jsp?i=66&rt=2

Table 5: State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Financing/Delivery System

State	Shared Savings Between CMS and State	Shared Savings with Plans	Shared Savings with Providers	Risk Sharing Mechanisms	Savings Estimates
AZ	Consider using upfront savings to expand benefits package, reduce Rx drug copays and provide care managers.				Expect upfront savings to be nominal in early years due to existing high managed care enrollment.
CA	Share savings equally between CMS and state.	Performance based quality withhold of 1%, 2%, 3% in years 1, 2, 3	Plans have performance based reimbursement or risk sharing for providers	Considering risk sharing and risk corridors to provide sufficient incentives for plans to maximize ability of enrollees to remain in community	
CO	Share savings commensurate with the investments that CMS and state have made in program operations. Anticipates flexibility in reinvestment of savings to provide additional benefits or provider incentives		Can earn incentive payments up to one dollar PMPM for meeting or exceeding utilization and outcome measures.		
CT	To use savings to make advanced payments to support enhanced PCCM		Retrospective performance payments for quality and outcome targets to be made from projected savings.		
HI	Savings are expected and need to be shared but some will be needed to fund state's increased administrative costs.	Existing 1115 managed care program recently implemented financial incentives for performance.	Existing 1115 managed care program recently required increasing percentage of provider networks on value-based contracts.	Will have mandatory minimum MLR and risk corridors.	
ID	Share savings in proportion to contributions made by Medicare and Medicaid.	Payments will be adjusted based on plan performance with respect to quality measures.	Capitated rate does not include physician incentive payments on which plans must report quarterly.	Plans assume full risk.	Exact savings uncertain but potential is significant. One report found that optimal coordinated care program could save average of 3.7% on duals' costs over 10 years with estimated 2.7% savings in year 1.
IL		Pay for performance withhold from monthly capitation rate of 1% in year 1, 1.5% in year 2, 2% in year 3. Year 1 focus on administrative process and access to services, years 2 and 3 focus on quality measures.			
IA			Annual bonus if quality thresholds met – could be as much as 20% of PMPM payments received by health home in reporting year.		Duals demonstration savings not modeled but state expects health home program will result in $7 to 15 million Medicaid savings and $17 to 25 million Medicare savings over 3 years.

Table 5 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Financing/Delivery System

MA*	Yes, TBD	Quality withhold or performance incentive payments		Risk corridors or stop loss provisions	
MI		Incentive pool of supplemental payments based on achieving or progressing toward desired outcomes	Plans are expected to offer incentive payments to providers	Risk corridors initially, converting to full risk eventually	Savings of $30 million built into FY2013 budget, subject to change based on negotiations with CMS.
MN	Yes	Performance based quality withhold of 1%, 2%, 3% in years 1, 2, 3, to be aligned and combined with existing substantial Medicaid withhold			
MO	State seeks separate shared savings methodology for each model and inclusion of Part D costs and only short-term SNF stays		Performance incentive payments if cost savings result across entire program (already in effect for Medicaid, will create similar arrangement for Medicare).		Demonstration savings for PCHH Medicaid estimated $18.4 million from inpatient hospital and $2.05 million from ED. Expected PCHH savings 1.89% in year 1, 3.78% in year 2, 5.67% in year 3. Expected CMCH HHs savings 3% in year 1, 6% in year 2, 10% in year 3.
NM*	Yes	Performance based quality withhold of 1%, 2%, 3% in years 1, 2, 3			
NY		Financial performance incentives in capitated model to reward quality improvements, implemented after a year of collecting data, establishing benchmarks and developing measures.		May use risk corridors in capitated model	
NC			Negotiated portion of retrospective performance payments will be used to provide incentives for providers to enhance capacity, improve outcomes, achieve shared savings and further reduce avoidable hospital use.		
OH	Savings to be shared proportionately between CMS and state	May include pay for performance	At least 50% of quality withhold must be passed on to providers whose performance led to improvements	May include risk sharing	
OK		In model 1, vendor payment based on meeting required milestones, savings and quality measures	In model 2, starting in year 3, providers may receive up to 50% of savings achieved		Model 1: anticipated savings (per year for 3 years) of $21.4 million for inpatient services, $4.3 million for outpatient services, $15.5 million for LTC, $16.2 million for Rx drugs for first 2 years and $32.5 million for year 3, $7.9 million for physician services.

Table 5 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Financing/Delivery System

OR		Once performance metrics are phased in, quality incentives will be incorporated into global budget methodology. Quality payments, including withhold that plans earn back by meeting standards and performance targets beginning in year 1. Quality incentive payments or shared savings with LTC system.	Plans encouraged to use alternative payment methodologies such as bundled payments, quality bonuses and gain sharing.		
RI		Expect to modify and tailor current Medicaid pay for performance program.		Considering transitional capitated rate to rebalance LTC (community based providers get higher institutional rate for 90 days upon discharge and institutional providers get lower community based rate upon admission for 60 days); potentially delaying full financial risk on plans. To agree with CMS on appropriate MLR and determine risk corridors. State and CMS would share in large losses and in MCO financial gains. Considering stop loss and reinsurance.	
SC		Will consider pay for performance based on meeting or exceeding quality metrics as withhold from capitation rate or performance incentive. Proposed one time financial incentive if enrollees who are deinstitutionalized after 90 day NF stay remain in community with needed supports for certain time.	Plans are encouraged to include value-based purchasing strategies, including deinstitutionalization strategies, with provider shared savings and bundled payments.	State to explore with CMS risk corridors and stop loss provisions.	
TN	State cannot afford to have savings from LTC rebalancing diverted to shared savings under demonstration – must continue to be used by state to expand HCBS.		Plans and providers may enter into agreements that involve shared risk or savings arrangements or quality incentive payments.	State requests risk corridors for Medicare portion of capitated rate for at least year 1.	
TX	State plans to reinvest portion of savings in overall LTSS system reforms.	State withholds 5% Medicaid MLTC capitated rate, which plans earn back by meeting quality and access benchmarks – will work with CMS to adopt similar practice for demonstration.			Expects significant reductions in Medicare costs and modest or no increase in state Medicaid costs.

Table 5 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Financing/Delivery System

VT	CMS and state will determine quality thresholds for each year. State law requires at least 50% of state savings to be reinvested in demonstration unless otherwise appropriated by general assembly.		Any quality withhold received by public managed care entity will be shared with providers based on relative performance on quality measures, including enrollee access, outcomes and satisfaction. Managed care entity also will identify additional projected savings targets for specific areas and shared a percent of year end actual savings with providers. Providers can retain certain percent of savings if quality measures met and if state approves plan to reinvest savings to improve access, cost or quality for enrollees.	To explore potential risk sharing with CMS. Providers will assume risk for some bundled services in exchange for more financial and/or service flexibility. In year 1, providers not at financial risk for losses if performance standards met and incurred expenses are reasonable and appropriate. In subsequent years, providers required to absorb losses up to "A" percent, state managed care entity will share equally in losses between "B" and "C" percent, and state managed care entity will absorb all losses above "C" percent subject to aggregate payment ceiling.	
VA		Financial incentive program may be appropriate. Notes CMS requires quality withhold.	State to encourage plans to use pay for performance. To explore option of passing portion of earned withholds to providers whose services led to improvements.		
WA		Capitated model will include quality incentive pool created by withhold from capitated rate.			
WI	Yes, TBD	Quality bonuses and/or withholds in years 2 and 3, based on quality measurement methodology established in year 1. Savings should first accrue to CMS and state.	State expects some plan savings to be shared with members through additional care coordination benefits.	Risk corridors, to be phased out by end of year 2.	Lower end of savings estimates are approximately $1.6 million in year 1, growing to $7.5 million in year 3. Also projects savings of $3 million over 16 months.

*Further detail about MA's proposal is available in its MOU with CMS. NM's proposal is no longer active with CMS.

SOURCE: CMS Medicare-Medicaid Coordination Office Financial Alignment Initiative State Financial Alignment Proposals, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Table 6: State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Proposed Benefits Packages

State	Benefits Package Exclusions	Supplemental Benefits	Mental Health Benefits	Continuity of Care Provisions	Use of Community Health Workers
AZ		State exploring most effective way to include supplemental benefits in plans – one option is to pay plans fixed dollar amount PMPM with plan flexibility to determine types of supplemental benefits.	Behavioral health managed care carve out entity will provide integrated physical and mental health demonstration benefits for duals with SMI in Maricopa County. This model will eventually expand statewide. Until then, behavioral health carve outs will partner with demonstration plans.	To use existing Medicaid managed care and Part D transition processes.	
CA	County-administered mental health and substance use treatment services.	Additional benefits in lieu of institutionalization. Plans are eager to offer other supplemental benefits – extent of plan's ability to do so will be better understood during rate development process.	Plans must develop coordination and integration strategies with county mental health agencies, which could include full financial integration in later years, based on performance measures and incentive payments or shared savings.	Access to out-of-network Medi-Cal providers for up to 12 months for new enrollees with ongoing provider relationship if provider accepts the higher of plan or FFS rate, plan determines provider meets professional standards, and no disqualifying quality of care issues. Access to out-of-network Medicare providers during 6 month lock-in if pre-existing relationship, provider accepts Medicare payment and provider would not be excluded due to quality of care issues. Plans must have continuity of care team.	
CO	Majority of behavioral health services will continue to be delivered through managed care community mental health services program.		Plans required to implement written protocols with carved out behavioral health MCOs. State to explore models with greater integration over longer term.		
CT	Enrollees remain with their existing Part D plans.	Health neighborhoods may include peer support services and recovery assistant services and will include chronic disease self-management education, fall prevention intervention, nutrition counseling, and medication management.			
HI	Specialized behavioral health services for adults with SMI and DD HCBS waiver services.	Plans encouraged to offer additional benefits. State hopes to eliminate or decrease need for Part D cost sharing.			
ID	State may consider phased-in approach to including DD services	Plans encouraged to include additional benefits to improve quality and increase enrollment	Plans may contract with mental health managed care program for non-duals or provide mental health services through other means.		

Table 6 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Proposed Benefits Packages

IL		Plans asked to propose additional benefits within blended capitation rate to help enrollees stay in or move to the community	Co-location of physical and behavioral health services required.	Access to providers for current course of treatment and existing PCPs for 180 days. All current providers will be offered single case of out-of- network agreements. Plans may choose to transition enrollees to network provider before 180 days if certain conditions met and prior authorizations continue for 90 days.	
IA			Health home must consider both physical and mental health needs in care plan.		
MA*	Certain LTSS for HCBS waiver participants.	Additional behavioral health diversionary services and community support services.			Yes
MI		Plans strongly encouraged to offer expanded dental, vision, hearing aids and enhanced community-based supports and services.			
MN	ICF/DD and HCBS waiver services for people with disabilities ages 18 to 64		Proposed model 3 integrates physical, chemical and mental health services for duals ages 18 to 64 with mental health diagnoses	To use existing Medicaid managed care contract provisions for continuity of care and transitions.	
MO		Health home will coordinate medication management therapy with Part D plan.			
NM*	DD waiver LTC services	Dietary/nutritional care. Additional community support services. Plans expected to provide health promotion services such as smoking cessation, weight management, diabetes education and additional value-added services and benefits that are available to their other Medicaid enrollees.	To establish health homes, targeted first at enrollees with behavioral health conditions plus a chronic physical condition. Behavioral health services will be in plan's benefit package.		Plans will incorporate non-traditional health care workers to support Native American communities, health educators and advocates for Spanish-speakers and other similar peer wellness specialists.
NY	Capitated models exclude hospice, out-of-network family planning, directly observed therapy for TB and methadone maintenance services.	Capitated models will offer additional LTSS and health and wellness services.		In managed FFS model, will make effort to assign beneficiaries to health home that includes existing providers, and members can choose providers outside their health home. In capitated models, state is exploring whether to expand current state law from 60 days to see current providers to 90 days.	

Table 6 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Proposed Benefits Packages

NC					
OH		Yes.	To incorporate health homes for beneficiaries with SMI.		
OK			Model 1: contract will specify exactly how care coordinator will work with community mental health services. Model 2: Care team will include behavioral health specialists.		Model 2: practices may augment care teams with community health workers.
OR	Medicaid-funded LTC services (institutional and HCBS) for elderly and people with physical disabilities (plans must have MOU with AAA or APD to coordinate services). HCBS DD waiver services (plans must maintain relationship with local DD service system).	Plans have option to cover specialized services or other services uniquely beneficial to individual health (equipment or supplies to maintain functionality, educational services, culturally specific traditional health practices, paraprofessional/ alternative care providers, home or site visits in coordination with mental health, community and other public health services.	Plans will provide full range of Medicaid mental health services, including supported employment, and by 2014 including adult residential treatment. Existing specialty behavioral health organizations will become part of plans or subcontract.		Will use non-traditional health workers to expand preventative care and health promotion
RI	Phase 1 will exclude LTC services for adults with DD and behavioral health services for individuals with SMI.	Plans have flexibility to substitute lower cost alternatives to avoid institutionalization or use of higher cost services and to offer value-added services including alternative medicine, wellness and disease management. Will include certain non-emergency transportation and non-medical transportation.	PCP required to integrate behavioral health care for all enrollees by co-location or alternative arrangement. Plans required to develop continuum of behavioral health benefits.	Guaranteed access to established FFS providers and services for transition period. State will advocate for newly enrolled members to have out-of-network coverage for minimum of 6 months. Plans required to honor all service authorizations in place when client enrolls for minimum of 6 months. No changes or reductions in care until comprehensive assessment by plan.	Plans required to include community health workers/peer navigators as part of care teams either employed directly by plan or by contract with community-based organization.
SC	HCBS waiver services	Plans encouraged to include additional benefits. State to explore with CMS ability to provide enhanced services (home delivered meals, homemaker, adult day) based on risk level prior to meeting NF level of care.	Plans must facilitate integrate of behavioral health and primary care practices.	Plans must pay existing providers even if out of network for enrollees undergoing active treatment for a specific condition until provider releases enrollee from continued treatment and follow up. Enrollees guaranteed 60 days Rx coverage (90 days for behavioral health Rx) after enrollment.	Plans must include community health workers.

Table 6 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Proposed Benefits Packages

TN	LTSS for people with DD (institutional and waiver services)	Supplemental benefits available to enrollees who remain in demonstration after the 6 month transition period, contingent upon establishment of payment rates sufficient to cover costs – preventative dental, comprehensive dental up to $250/quarter, dentures, routine vision, vision hardware, routine hearing, hearing aids.		Services from current providers continue during 6 month transition period.	
TX	NF services beyond 4 months.	Plans may propose additional services, pending CMS approval.	Behavioral health services to be actively coordinated.		
VT		Proposes using state Medicaid Rx drug benefit and PDL, with new medication therapy management program instead of Part D. Supplemental benefits to be added through savings and/or provider reimbursement mechanisms – state will work with advisory group to prioritize. Providers have flexibility to provide services based on individual needs to improve outcomes.		Beneficiaries will be able to retain current PCP.	
VA	Private duty nursing, targeted case management for DD and SMI, abortions.	Plans may offer supplemental or enhanced benefits to encourage and retain enrollment, promote health and provide services in most appropriate and efficient settings.	Plans will provide all behavioral health and substance abuse services. Plans may work with community service board behavioral health homes.	Automatic transfer of pre-authorizations for traditional Medicare services that conform to Medicare Advantage and Part D timeframes and for 6 months for traditional Medicaid services. Plans must allow NF residents to remain in their NF indefinitely unless individual and/or family agrees to transition.	
WA	Fully capitated model carves out HCBS DD waiver services.	State to explore whether to require plans to offer supplemental benefits.			
WI		Plans encouraged and incentivized to provide services instead of those explicitly included in benefits package that are effective in meeting defined outcomes and are cost-effective.			

*Further detail about MA's proposal is available in its MOU with CMS. NM's proposal is no longer active with CMS.

SOURCE: CMS Medicare-Medicaid Coordination Office Financial Alignment Initiative State Financial Alignment Proposals, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Table 7: State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by LTSS Provisions

State and Financial Model	LTSS Access	Intent to Use Demonstration to Help with LTC Rebalancing	Beneficiary Self-Direction of Personal Care Services
AZ Capitated	State notes that existing Medicaid MLTC program provides full array of HCBS with no enrollment caps or waiting periods.		
CA Capitated	Eligibility for IHSS and assessment and authorization of hours will be done by counties. Plans may authorize additional IHSS paid through capitated rate. Plans will develop and expand care coordination with NF and HCBS providers and must coordinate services that are not necessarily plan benefits but can help enrollees remain in community.		Yes, existing IHSS consumer rights to hire, fire and supervise providers.
CO Managed FFS		Demonstration to build on MFP infrastructure.	
CT Managed FFS		MFP and associated NF diversion activities support demonstration goals.	
HI Capitated		Expect demonstration to continue existing 1115 waiver program's progress in enabling deinstitutionalization.	To integrate existing 1115 waiver consumer direction program for select personal care services.
ID Capitated	All enrollees who qualify for HCBS waiver services will receive them through demonstration plans because state has no waiting list.	State intends to use demonstration as additional way to identify individuals who would be appropriate for MFP – within 1 year of enrollment, plan will evaluate enrollee's suitability for MFP and make referral to state.	Plans must offer self-direction option.
IL Capitated			
IA Managed FFS		State is applying for BIPP to provide health homes with infrastructure to coordinate LTSS care transitions.	
MA* Capitated	Independent LTSS coordinator		Yes
MI Capitated		Proposal notes current significant HCBS waiver waiting list.	
MN Capitated			
MO Managed FFS	Health home will coordinated any HCBS waiver services; training available about range of HCBS available, how to refer for LTSS assessments and options counselors. Health home team will work to identify any gaps in LTSS and proactively determine need for HCBS waiver services.		
NM* Capitated		Capitated rate will be designed to maximize incentives to support people in HCBS settings and to begin to address waiting list.	Current HCBS waiver self-directed programs to be continued but modified. Plans will take responsibility for assisting enrollees with developing budgets and assisting in staff selection.
NY Both			Yes in capitated models.
NC Managed FFS	To develop independent integrated assessment and functional need-based resource allocation process for LTSS.		

Table 7 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by LTSS Provisions

OH Capitated	Plans must contract with HCBS providers certified by state. Beneficiary right to choose entity that provides HCBS waiver service coordination and individual HCBS service coordinator. Plans must contract with outside entity (including AAAs) to provide HCBS waiver service coordination. Expedited process to review changes in care plans with goal of independent community living.		Yes.
OK Both	Model 2: care coordination services will bridge gap between acute care and HCBS/LTC. Care coordinators will facilitate NF resident transitions. Eligible members will be linked with state HCBS LTC team.		
OR Capitated			
RI Capitated	PCP will leverage expertise of LTSS case manager at the plan through rounds, co-location on periodic basis or other innovation TBD.	Considering a transitional capitated rate to achieve HCBS rebalancing.	Yes.
SC Capitated	Care coordinator must ensure LTC assessment and service needs integrated into care plan with waiver case managers. State will continue to complete level of care assessment and determine LTSS eligibility. To develop process for arbitration/review when plan and waiver case manager disagree on amount of LTSS.	State commits to providing HCBS for everyone in demonstration who meets service criteria without a waiting list. State expects demonstration to increase HCBS and decrease institutional services. Proposes one-time financial incentive for plans that transition enrollees to home or community-based settings after a 90 day nursing facility stay if enrollees remain in the community with needed support services for a specified period of time.	Exists in most HCBS waivers.
TN Capitated		Anticipate increased spending and access to HCBS. Wants savings realized from LTC rebalancing to continue to be used by the state to expand access to HCBS rather than sharing those savings with the federal government.	Yes, according to terms of 1115 MLTSS waiver.
TX Capitated		State plans to reinvest portion of savings attributable to state to overall LTSS reforms. MLTSS contracts contain specific incentive to discourage inappropriate NF admissions.	Yes.
VT Capitated			Providers required to support individuals who want to self-manage some or all services (not limited to personal care).
VA Capitated	State will continue to conduct assessment to determine initial LTSS eligibility. Plans responsible for re-assessments.	Plans responsible for coordinating referrals for non-covered services such as affordable housing and other social services to maximize independence.	Yes.
WA Both	State continues to determine functional eligibility for Medicaid and LTSS.		Yes.
WI Capitated		Alternative services provided by plans can support community living instead of institutional care.	

*Further detail about MA's proposal is available in its MOU with CMS. NM's proposal is no longer active with CMS. SOURCE: CMS Medicare-Medicaid Coordination Office Financial Alignment Initiative State Financial Alignment Proposals, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Table 8: State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Beneficiary Protections

State and Financial Model	ADA Compliance	Ombudsman	Appeals
AZ Capitated			Plans will follow state Medicaid managed care guide on language for notices (more detailed than Medicare requirements).
CA Capitated	All sites must comply with state and federal disability access laws including communication in alternative formats. Plans must use facility site review tool to inform beneficiaries about providers' physical accessibility and have contingency plans to provide disability accommodations.		All current appeals processes remain in place initially. To develop unified system by year 2.
CO Managed FFS		State with stakeholders will assess need for ombudsman.	
CT Managed FFS	PCMH learning collaborative training will include disability topics. Beneficiary protections to include right to accommodations, not limited to ADA.	May identify independent statewide ombudsman through which grievances would be submitted.	
HI Capitated		To provide stakeholder advisory board or ombudsman. Existing 1115 waiver has ombudsman.	60 days (Medicare standard) to file appeal. Exhaustion of internal plan appeals required. Medicare standard on aid pending. Appeals to be resolved in 72 hours expedited, 30 days standard pre-service, and 60 days standard post-service.
ID Capitated	Plan handbooks must be accessible to people with disabilities. Plans must comply with ADA and Section 504.		Plans would permit beneficiaries 20 to 28 days to file appeals or grievances. Aid pending available if original authorization period not expired.
IL Capitated	MCOs must have ADA compliance plans.		
IA Managed FFS			
MA* Capitated	Mentions ADA compliance.	Role of ombudsman still undefined.	
MI Capitated		To determine feasibility of establishing ombudsman.	Anticipate retaining current Medicaid standard of 90 days to file appeal. Aid pending available.
MN Capitated		Existing state managed care ombudsman, state LTC ombudsman and state ombudsman for mental health and DD.	
MO Managed FFS	Enrollee materials will be accessible to people with disabilities and meet ADA effective communication obligation.		Will not change existing Medicare and Medicaid appeals processes. Health homes will support beneficiaries in filing and help determine which process meets needs. Right to fair hearing if state denies, terminates or reduces health home services.
NM* Capitated	Enrollee materials will be accessible to people with disabilities.		
NY Both	Notices and outreach materials will be available in alternative formats. Plans must have written policies and procedures on participant rights, including provision of interpreters, access without physical barriers, reasonable accommodations, and interactions with plans and providers.	Capitated model will have independent conflict-free participant ombudsman if funded by CMS.	Anticipate offering aid pending and deadlines for filing and resolving appeals that are most favorable to beneficiaries out of Medicare and Medicaid rules.

Table 8 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Beneficiary Protections

NC Managed FFS			
OH Capitated			Aid pending required for plan appeals.
OK Both			Same appeals process as for all state Medicaid managed care members.
OR Capitated			
RI Capitated	All network providers must meet ADA physical accessibility standards and accommodate communication needs. Enrollment materials will be accessible.		Stricter Medicare timeframes and aid pending provisions will be aligned with state Medicaid standards.
SC Capitated	Plans must comply with ADA.	May include participant ombudsman.	
TN Capitated			
TX Capitated	MCO provider network must be responsive to needs of people with disabilities, including provision of sign language interpreters. MCOs must have written cultural competency plans describing how services will be effectively provided to people with disabilities.		
VT Capitated	State law requires enrollee materials and notices to be accessible to people with disabilities.	State law requires independent advocacy system for all demonstration participants and applicants, including at minimum access to AAA advocacy, legal services and the LTC and health care ombudsman.	
VA Capitated	MCOs must offer materials and methods of communication to ensure effective communication, provide ASL interpreters free of charge, make written materials available in alternative formats, and provide reasonable accommodations to ensure effective communication. State will ensure access to providers for people with mobility impairments.	State will continue discussions with stakeholders and CMS to determine how to best provide beneficiary access to support and assistance external to MCOs, Medicare and Medicaid to facilitate access to services, answer questions and navigate grievances and appeals.	
WA Both			Aid pending available.
WI Capitated		Additional ombudsman and advocacy entities may be contracted in addition to existing LTC ombudsman.	

*Further detail about MA's proposal is available in its MOU with CMS. NM's proposal is no longer active with CMS.

SOURCE: CMS Medicare-Medicaid Coordination Office Financial Alignment Initiative State Financial Alignment Proposals, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Table 9: State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Stakeholder Engagement and Demonstration Evaluation

State and Financial Model	Stakeholder Engagement with State	Stakeholder Engagement with Plans	Demonstration Evaluation
AZ Capitated	Dedicated webpage, flyers at community and senior centers, in-person meetings, dedicated phone number and email address, newsletter. SHIPs will be informed and assist beneficiaries.		
CA Capitated	Stakeholder workgroups and advisory committee.	Plans must ensure beneficiary and advocate participation in local advisory committees to oversee care coordination partnerships.	
CO Managed FFS	Advisory committee, focused interviews, focus groups, stakeholder meetings, statewide and regional conferences, dedicated website and toll-free number.		
CT Managed FFS	Monthly medical assistance advisory council meetings, town hall meetings, focus groups, provider association meetings, workgroups.		
HI Capitated	Stakeholder advisory board or ombudsman.	Plan stakeholder/member advisory boards.	
ID Capitated	Demonstration will be standing agenda item on quarterly personal assistance oversight committee and medical care advisory committee meetings.	Plans must operate advisory committee that meets in-person at least twice a year and includes providers, participants and participants' representatives.	
IL Capitated		Plans must have quarterly consumer advisory board meetings.	State to contract with outside entity for independent evaluation.
IA Managed FFS			State is working with Univ. of IA Public Policy Center to conduct annual evaluations of health home program through compare study with control and non-control groups. A component of the study focuses on duals.
MA* Capitated	Bi-monthly stakeholder meetings during implementation, website, email box.	Plans will be required to have meaningful consumer input processes, including but not limited to governing or advisory boards with sufficient numbers of enrollees and representatives.	
MI Capitated			
MN Capitated	Seniors and disabilities stakeholder group meetings.	Plans must maintain local stakeholders groups.	
MO Managed FFS	Quarterly public meetings by oversight committee. Beneficiary (at least 1), provider, consumer advocate and private payer representatives on steering committee to meet every 6 months.		Proposal has list of measures used for health homes generally – to consider other measures specific to duals. For PCHHs, to assess annual cost savings using control group of primary care practices serving clinically similar populations but not participating as health homes.
NM* Capitated	Demonstration subcommittee of Medicaid advisory committee – meetings open to public. Website.		

Table 9 (continued): State Proposals to Test Financial Alignment Models for Dual Eligible Beneficiaries by Stakeholder Engagement and Demonstration Evaluation

NY Both	For managed FFS model, statewide webinars for stakeholders, dedicated mailbox, call center, regional provider meetings. For capitated models, regular stakeholder meetings during implementation, annual participant satisfaction surveys for all enrollees.	Plans must conduct at least 2 participant feedback sessions in their service areas each year – plans must assist participants with costs, transportation and other challenges of attending and must make meeting summaries publicly available. Plans must have participant advisory committee that meets quarterly.	
NC Managed FFS			
OH Capitated		20% of plan's local governance body must be plan members. Plans must have semi-annual member meetings.	
OK Both	Model 1: steering committee to replace monthly stakeholder meetings. Website.		
OR Capitated			
RI Capitated	May include beneficiary participation in development and oversight of model. Duals advisory board with specific oversight responsibilities. Focus groups. Satisfaction surveys.		
SC Capitated	RFI/RFS process, focus groups, existing stakeholder groups, consumer satisfaction surveys.		
TN Capitated	State will host meetings to present information and answer questions once MOU signed. To expand existing stakeholder processes as needed for ongoing input.	MCOs will use and expand as necessary existing MLTSS advisory groups as forum for ongoing information sharing and input.	
TX Capitated	Existing advisory committees, quarterly meetings with tribes, additional public meetings as needed, webpage.	MCO advisory committee meetings.	
VT Capitated			
VA Capitated	To schedule series of workgroup meetings on operational aspects of demonstration, continue to hold public stakeholder meetings, dedicated website and email box.		
WA Both			
WI Capitated	Stakeholder advisory committee and workgroups, public forums and information sharing, surveys and research.		

*Further detail about MA's proposal is available in its MOU with CMS. NM's proposal is no longer active with CMS.

SOURCE: CMS Medicare-Medicaid Coordination Office Financial Alignment Initiative State Financial Alignment Proposals, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Endnotes

[1] Kaiser Commission on Medicaid & the Uninsured, *Medicaid's Role for Dual Eligible Beneficiaries* (April 2012), available at http://www.kff.org/medicaid/7846.cfm.

[2] For a summary of the MOU between CMS and Massachusetts, *see* Kaiser Commission on Medicaid and the Uninsured, *Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries* (Oct. 2012), available at http://www.kff.org/Medicaid/8291.cfm.

[3] *See* CMS, Medicare-Medicaid Coordination Office, Financial Alignment Initiative, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html (noting that only active proposals are listed).

[4] Kaiser Commission on Medicaid and the Uninsured, *Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries* (Oct. 2012), available at http://www.kff.org/Medicaid/8368.cfm.

[5] For background on the 15 states' initial design contract proposals, *see* Kaiser Commission on Medicaid and the Uninsured, *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS* (Aug. 2011), available at http://www.kff.org/Medicaid/8215.cfm.

[6] Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees (July 8, 2011), available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

[7] For a summary of CMS's subsequent guidance about the capitated financial alignment model, *see* Kaiser Commission on Medicaid and the Uninsured, *An Update on CMS's Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees* (April 2012), available at http://www.kff.org/medicaid/8290.cfm.

[8] For background on the states' letters of intent, *see* Kaiser Commission on Medicaid and the Uninsured, *Financial Alignment Models for Dual Eligibles: An Update,* (Nov. 2011), available at http://www.kff.org/medicaid/8260.cfm.

[9] CMS Request for Proposals, State Demonstrations to Integrate Care for Dual Eligibles, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html.

[10] Testimony of Melanie Bella, Director, Medicare-Medicaid Coordination Office, at U.S. Senate Special Committee on Aging hearing "Examining Medicare and Medicaid Coordination for Dual Eligibles" (July 18, 2012), available at http://aging.senate.gov/hearing_detail.cfm?id=337279&.

[11] MOU between CMS and the Commonwealth of Massachusetts Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees, Demonstration to Integrate Care for Dual Eligible Beneficiaries (Aug. 22, 2012), available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf.

[12] MN's proposal targets all full dual eligible beneficiaries who qualify for Medicaid managed care enrollment and clarifies that the inclusion of younger dual eligible beneficiaries with disabilities is pending discussions with CMS about financing.

[13] NM's proposal is no longer active with CMS.

[14] The portion of OK's proposal that includes full dual eligible beneficiaries omits those who receive care coordination from another demonstration program or PACE.

[15] CT notes that its inclusion of long-term care participants is contingent on the state "gaining a better understanding of" CMS's shared savings methodology.

[16] IL excludes dual eligible beneficiaries with high third party liability.

[17] CO is exploring whether to exclude SNP participants.

[18] NM's proposal is no longer active with CMS.

[19] MN seeks to implement by December, 2012 for seniors and by July, 2013 for younger dual eligible beneficiaries with disabilities.

[20] CT may seek implementation as late as January, 2014.

[21] NY seeks to implement its managed FFS model in 2013 and its capitated models in 2014.

[22] WA seeks to implement its managed FFS model in 2013 and its capitated and partially capitated models in 2014.

[23] NM's proposal is no longer active with CMS.

[24] CT indicates that it may expand its health neighborhoods in the future if desired outcomes are achieved.

[25] Draft Template Memorandum of Understanding for Capitated Model, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

[26] NM's proposal is no longer active with CMS.

[27] Kaiser Commission on Medicaid and the Uninsured, *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey* at 45 (Sept. 2011), available at http://www.kff.org/medicaid/8220.cfm.

[28] For capitated models.

[29] NM's proposal is no longer active with CMS.

[30] Letter from Dennis G. Smith, Secretary, Wisconsin Dep't of Health Services to Marilyn Tavenner, Acting Administrator, CMS (June 19, 2012), available at http://www.dhs.wisconsin.gov/wipartnership/pace/pdf/tavennerltr061912.pdf.

[31] Compare Table 3 with Kaiser Commission on Medicaid and the Uninsured, *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey* at 44-45 (Sept. 2011), available at http://www.kff.org/medicaid/8220.cfm.

[32] *Id.*

[33] For health neighborhoods model.

[34] WA is requesting CMS funding for this purpose.

[35] CA states that contingent upon available funds other than general fund dollars, the state will contract with community-based non-profit consumer or health insurance assistance organizations.

[36] NM's proposal is no longer active with CMS.

[37] CMS, *Funding Opportunity Under the Affordable Care Act to Support SHIP and ADRC Options Counseling* (Aug. 23, 2012), available at http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4437&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

[38] CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans (Jan. 25, 2012), available at https://www.cms.gov/medicare-medicaidcoordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

[39] *Id.*

[40] NM's proposal is no longer active with CMS.

[41] *Id.*

[42] *Id.*

[43] As stated in MA's proposal to CMS. Additional detail is provided in the MOU between CMS and MA. For a summary of the MOU between CMS and Massachusetts, *see* Kaiser Commission on Medicaid and the Uninsured, *Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries* (Oct. 2012), available at http://www.kff.org/Medicaid/8291.cfm.

[44] NM's proposal is no longer active with CMS.

[45] As stated in MA's proposal to CMS. Additional detail is provided in the MOU between CMS and MA. For a summary of the MOU between CMS and Massachusetts, *see* Kaiser Commission on Medicaid and the Uninsured, *Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries* (Oct. 2012), available at http://www.kff.org/Medicaid/8291.cfm.

[46] HI also will require a medical loss ratio for its demonstration health plans.

[47] MI proposes using risk corridors initially and converting to full risk eventually.

[48] TN is requesting that CMS use risk corridors for the Medicare portion of the capitated rate for at least the first year.

[49] WI will phase out risk corridors by the end of year two.

[50] CA is considering risk sharing and risk corridors to maximize the ability of plan enrollees to remain in the community.

[51] RI also is considering a transitional capitated rate to achieve HCBS rebalancing.

[52] *See generally* CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans (Jan. 25, 2012), available at https://www.cms.gov/medicare-medicaidcoordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

[53] NM's proposal is no longer active with CMS.

[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] For information about state enrollment and expenditures for Medicaid HCBS, *see* Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home and Community-Based Services Programs: Data Update* (Dec. 2011), available at http://www.kff.org/medicaid/7720.cfm.

[59] *Olmstead v. L.C.*, 527 U.S. 581 (1999), available at http://www.law.cornell.edu/supct/html/98-536.ZS.html.

[60] NM's proposal is no longer active with CMS.

[61] *See generally* CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans (Jan. 25, 2012), available at https://www.cms.gov/medicare-medicaidcoordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

[62] NM's proposal is no longer active with CMS.

[63] Mentioned in MA's proposal but not in the MOU between CMS and MA.

[64] For information about the Medicaid appeals system, including notices, administrative fair hearings, and requirements for Medicaid managed care appeals, *see* Kaiser Commission on Medicaid and the Uninsured, *A Guide to the Medicaid Appeals Process* (March, 2012), available at http://www.kff.org/medicaid/8287.cfm.

[65] *See generally* CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans (Jan. 25, 2012), available at https://www.cms.gov/medicare-medicaidcoordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

[66] NM's proposal is no longer active with CMS.

[67] *See generally* CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans (Jan. 25, 2012), available at https://www.cms.gov/medicare-medicaidcoordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

[68] For a summary of the MOU between CMS and Massachusetts, *see* Kaiser Commission on Medicaid and the Uninsured, *Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries* (Oct. 2012), available at http://www.kff.org/Medicaid/8291.cfm.

[69] ACA § 3021(a), adding 42 U.S.C. § 1315a(a)(1).

[70] *Id.,* adding 42 U.S.C. § 1315a(b)(2).

[71] *Id.*, adding 42 U.S.C. § 1315a(b)(2)(B)(x).

[72] *Id.,* adding 42 U.S.C. § 1315a(b)(2)(B).

[73] *Id.*, adding 42 U.S.C. § 1315a(b)(2)(A).

[74] *Id.*

[75] *Id.*, adding 42 U.S.C. § 1315a(a)(1).

[76] *Id.*, adding 42 U.S.C. § 1315a(b)(2)(C).

[77] *Id.,* adding 42 U.S.C. § 1315a(b)(4)(A).

[78] *Id.*, adding 42 U.S.C. § 1315a(b)(4)(B).

[79] *Id.*

[80] *Id.*, adding 42 U.S.C. § 1315a(b)(4)(C).

[81] *Id.,* adding 42 U.S.C. § 1315a(d)(1).

[82] *Id.*, adding 42 U.S.C. § 1315a(a)(5).

[83] *Id.,* adding 42 U.S.C. § 1315a(d)(2).

[84] *Id.*, adding 42 U.S.C. § 1315a(b)(1).

[85] *Id.*, adding 42 U.S.C. § 1315a(b)(3)(A).

[86] *Id.,* adding 42 U.S.C. § 1315a(c).

[87] *Id.*

[88] *Id.,* adding 42 U.S.C. § 1315a(b)(3)B).

[89] *Id.*

[90] *Id.,* adding 42 U.S.C. § 1315a(g).

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