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Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS

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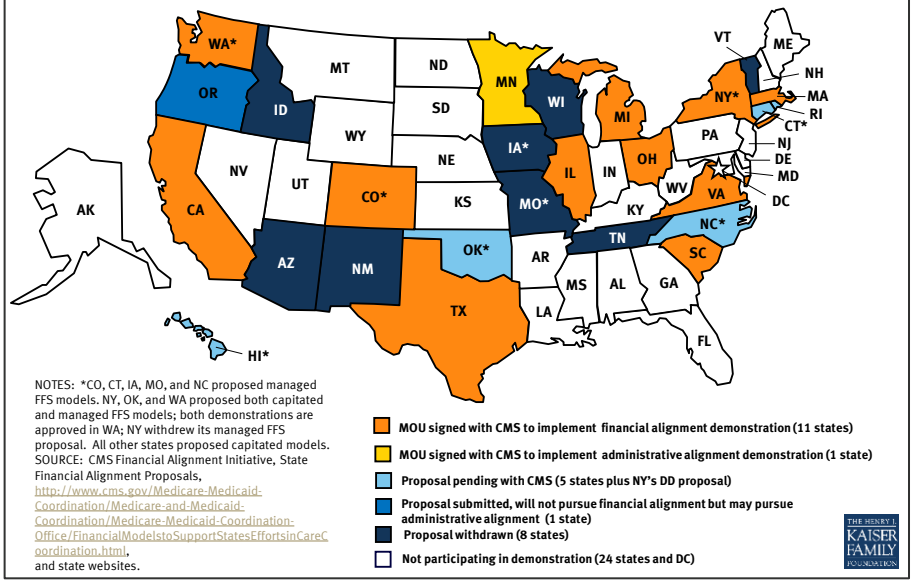
Using new authority in the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) is launching demonstrations that seek to improve care and control costs for people who are dually eligible for Medicare and Medicaid. These three year demonstrations, implemented beginning in July 2013, are introducing changes in the care delivery systems through which beneficiaries receive medical and long-term care services. The demonstrations also are changing the financing arrangements among CMS, the states, and providers. As of July 2014, CMS has finalized memoranda of understanding (MOUs) with 12 states to implement 13 demonstrations:[1]

- California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia are testing a capitated financial alignment model;
- Colorado is testing a managed fee-for-service (FFS) financial alignment model;
- Washington is testing both a capitated financial alignment model and a managed FFS financial alignment model; and
- Minnesota is testing the integration of administrative functions without financial alignment.

Figure 1

State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiaries, July 2014



NOTES: *CO, CT, IA, MO, and NC proposed managed FFS models. NY, OK, and WA proposed both capitated and managed FFS models; both demonstrations are approved in WA; NY withdrew its managed FFS proposal. All other states proposed capitated models.
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, and state websites.

New York's proposal to test a capitated model for beneficiaries with developmental disabilities (DD) who require long-term services and supports (LTSS) and proposals from five other states are pending with CMS (Figure 1).

This issue brief compares key provisions of the approved demonstrations (summarized in Table 1 on the next page with additional details by state in the Appendix).

Table 1:
State Dual Eligible Financial/Administrative Alignment Demonstrations Approved by CMS, July 2014

State	Estimated Number of Eligible Beneficiaries	Target Population[a] and Geographic Area	Financial Model	Earliest Effective Enrollment Date	Savings Percentage Applied to Medicare and Medicaid Contributions to Baseline Capitated Rate[b]
CA	456,000	Adult dual eligible beneficiaries in 8 counties	Capitated	April 2014	1% minimum, 1.5% maximum in year 1; 2% minimum, 3.5% maximum in year 2; 4% minimum, 5.5% maximum in year 3[c]
CO	48,000	Adult dual eligible beneficiaries statewide	Managed FFS	August or September 2014	N/A (state shares savings with CMS retrospectively if savings and quality criteria met)
IL	135,825	Adult dual eligible beneficiaries in 21 counties grouped into 2 regions	Capitated	March 2014	1% in year 1; 3% in year 2; 5% in year 3;
MA	90,240	Non-elderly adult dual eligible beneficiaries in 1 partial and 8 full counties	Capitated	October 2013	0 in 2013, 1% in 2014 (remainder of year 1)[d]; 2% in year 2; >4% in year 3[e]
MI	100,000	Adult dual eligible beneficiaries in 25 counties grouped into 4 regions	Capitated	January 2015	1% in year 1; 2% in year 2; 4% in year 3, except that year 3 savings will be 3% if at least 1/3 of plans have losses exceeding 3% of revenues in year 1
MN	36,000	Dual eligible beneficiaries age 65 and over enrolled in the Minnesota Senior Health Options program statewide	N/A[f]	September 2013	N/A (Minnesota's demonstration will test the integration of administrative functions without financial alignment)
NY	170,000	Adult dual eligible beneficiaries in 8 counties who require nursing facility or nursing facility diversion and transition home and community-based waiver services or more than 120 days of community-based LTSS[g]	Capitated	January 2015	1% in year 1; 1.5% in year 2; 3% in year 3, except that year 3 savings will be 2.5% if at least 1/3 of plans have losses exceeding 3% of revenue in year 1[h]
OH	115,000	Adult dual eligible beneficiaries in 29 counties grouped into 7 regions	Capitated	May 2014	1% in year 1; 2% in year 2; 4% in year 3;
SC	53,600	Dual eligible beneficiaries age 65 and over statewide who live in the community at the time of enrollment	Capitated	July 2014	Same as Ohio
TX	168,000	Adult dual eligible beneficiaries with disabilities who qualify for SSI or Medicaid waiver HCBS in 6 counties	Capitated	March 2015	1.25% in year 1.a;[i] 2.75% in year 1.b;[j] 3.75% in year 2; 5.5% in year 3
VA	78,600	Adult dual eligible beneficiaries in 104 localities grouped into 5 regions	Capitated	April 2014	Same as Michigan[k]
WA	21,000	High cost/high risk adult dual eligible beneficiaries statewide except in 2 urban counties	Managed FFS	July 2013	Same as Colorado
	27,000	Adult dual eligible beneficiaries in 2 urban counties	Capitated	February 2015	1% in year 1; 2% in year 2; 3% in year 3

(See next page for Table Notes and Sources)

Table 1 Notes and Sources:

Notes: [a] See the Appendix for subpopulations excluded from each state's demonstration. [b] Demonstration savings in the capitated models will be derived upfront by reducing CMS's and the state's respective baseline contributions to the plans by a savings percentage for each year. [c] California's maximum demonstration-wide savings percentages, along with county-specific interim savings percentages, will be used to determine the demonstration's risk corridors. [d] Massachusetts reduced its 2013 savings from 1% to zero. Demonstration year 1 in Massachusetts begins in 2013 and runs through December 2014. [e] Massachusetts anticipates savings of greater than 4% (approximately 4.2%) in year 3 to make up for forgone savings in year 1. [f] Minnesota's administrative alignment demonstration will take place in its existing capitated delivery system in which Medicaid MCOs also qualify as Medicare Advantage D-SNPs. [g] New York's capitated proposal for beneficiaries who have DD and need LTSS remains pending with CMS. [h] This determination will be based on at least 15 months of data (demonstration year 1 in New York encompasses July 2014 through December 2015). [i] Demonstration year 1.a in Texas is March to Dec. 2015. [j] Demonstration year 1.b in Texas is 2016. [k] This determination will be based on at least 20 months of data and in all regions in which plans participate (demonstration year 1 in Virginia encompasses February 2014 through December 2015).

Sources: CMS Financial Alignment Initiative, State Financial Alignment Demonstration Memoranda of Understanding, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html; *see also* endnotes 13, 24, 33, 38, 39, 40, 58, 72, and 81.

Background

Dual eligible beneficiaries include seniors and non-elderly people with significant disabilities, some of whom are among the poorest and sickest beneficiaries covered by either Medicare or Medicaid. The predominant existing service delivery models for these beneficiaries typically involve little to no coordination between the two programs. Dual eligible beneficiaries account for a disproportionate share of spending in the Medicare and Medicaid programs.[2] In the case of Medicare, this is mainly due to their relatively poorer health status, which requires higher use of medical services compared to other program beneficiaries. In the case of Medicaid, dual eligible beneficiaries' relatively high spending is generally attributable to their greater need for LTSS.

Key Demonstration Provisions

Geographic Area and Target Population

Three states' (Colorado, Minnesota, and South Carolina) demonstrations are statewide, while the others are limited to certain regions.

The states' target populations for their demonstrations vary, with eight states (California, Colorado, Illinois, Michigan, Ohio, Texas, Virginia, and Washington's capitated model) including both elderly and non-elderly beneficiaries. Among the states targeting sub-populations:

- Massachusetts targets non-elderly people with disabilities;
- Minnesota's administrative alignment demonstration targets elderly beneficiaries;
- South Carolina targets elderly beneficiaries who live in community-based settings at enrollment;

- New York focuses on elderly and non-elderly beneficiaries who receive nursing facility services or nursing facility diversion and transition home and community-based waiver services or who require more than 120 days of community-based LTSS;
- Texas targets elderly and non-elderly beneficiaries with disabilities who qualify for Supplemental Security Income (SSI) benefits or certain Medicaid home and community-based waiver services for seniors and adults with physical disabilities; and
- Washington's managed FFS model targets high cost/high risk beneficiaries with chronic conditions.

Michigan is the only capitated demonstration state to include beneficiaries with DD.

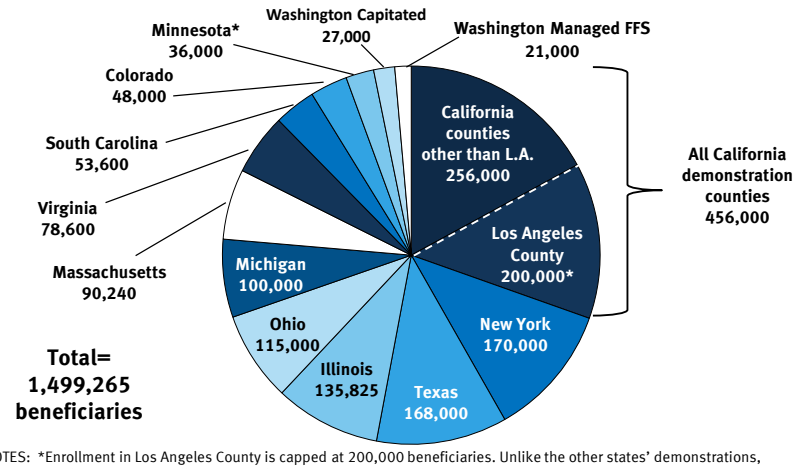
Enrollment

Estimated Number of Eligible Beneficiaries

CMS has stated that it plans to limit enrollment in the demonstrations to no more than two million dual eligible beneficiaries nationally. As of July 2014, CMS has approved 13 demonstrations in 12 states in which an estimated nearly 1.5 million beneficiaries are eligible to enroll. (Not all beneficiaries who are eligible to participate in the demonstrations are expected to enroll.) The estimated number of beneficiaries eligible for California's demonstration is over 30 percent of the total number of beneficiaries eligible for all demonstrations approved to date and exceeds the number of eligible beneficiaries in each of the other states with approved demonstrations. Enrollment in Los Angeles County, capped at 200,000 beneficiaries, will be greater than the number of beneficiaries eligible to participate in any of the other demonstration states (Figure 2).

Figure 2

CMS Has Approved 13 Financial and/or Administrative Alignment Demonstrations in 12 States, in which Nearly 1.5 Million Dual Eligible Beneficiaries Will Be Eligible to Enroll, as of July 2014



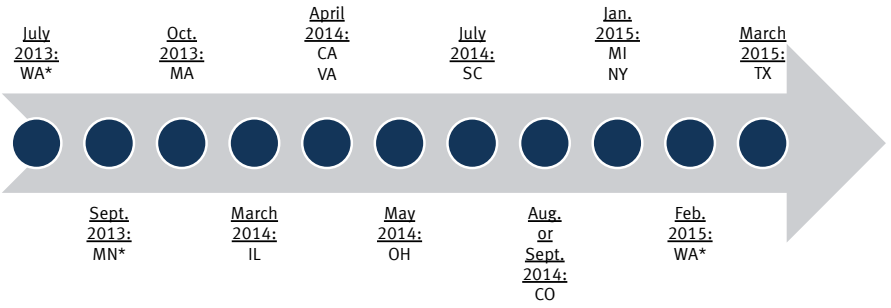
NOTES: *Enrollment in Los Angeles County is capped at 200,000 beneficiaries. Unlike the other states' demonstrations, Minnesota's demonstration will integrate administrative processes but will not align financing.
SOURCE: CMS/State Memoranda of Understanding, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Enrollment Timeline

Enrollment already has begun in Washington's managed FFS demonstration (July 2013), Massachusetts (October 2013), Illinois (March 2014), California and Virginia (April 2014), and Ohio (May 2014). The earliest effective enrollment dates in the other demonstrations are scheduled as follows: South Carolina (July 2014); Colorado (August or September 2014); Michigan and New York (January 2015); Washington's capitated demonstration (February 2015); and Texas (March 2015) (Figure 3). (Minnesota's administrative alignment demonstration affects beneficiaries who are already enrolled in the state's Senior Health Options program and began in September 2013.)

Figure 3

Earliest Effective Enrollment Dates in Financial/Administrative Alignment Demonstrations for Dual Eligible Beneficiaries, as of July 2014



NOTES: *July 2013 = WA's managed FFS demonstration; Feb. 2015 = WA's capitated demonstration. MN's demonstration is administrative only, without financial alignment.
SOURCE: CMS/State Memoranda of Understanding, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Enrollment Process and Beneficiary Choices

Nearly all of the capitated demonstrations (some counties in California, plus Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, Virginia and Washington) begin with a voluntary enrollment period in which beneficiaries can "opt in" to the demonstration and select a managed care plan. The voluntary enrollment period is followed by passive enrollment periods in which the remaining beneficiaries will be automatically assigned to a managed care plan. In other California demonstration counties, beneficiaries will be automatically enrolled in the demonstration without an initial voluntary enrollment period. To effectuate passive enrollment, states are to develop "intelligent assignment" algorithms to preserve continuity of providers and services when assigning beneficiaries to plans.

Beneficiaries retain the right to opt out of the demonstration at any time but must take affirmative action to do so. In all states, beneficiaries can opt out of the demonstration and choose another delivery system (i.e., FFS, Medicare Advantage, Program of All-Inclusive Care for the Elderly (PACE)) for their Medicare benefits. However, states may seek CMS approval to require beneficiaries to enroll in Medicaid managed care even if they opt out of the financial alignment demonstration for their Medicare benefits, and five states with capitated demonstrations (California, Illinois, New York, Ohio, and Texas) have indicated that they are doing so. By

contrast, five states with capitated demonstrations (Massachusetts, Michigan, South Carolina, Virginia, and Washington) allow beneficiaries who opt out of the demonstration to remain in the FFS delivery system for both their Medicare and Medicaid benefits (Table 2).

Table 2:
Beneficiary Enrollment Choices in the Capitated Financial Alignment Demonstrations

State	Managed Care Enrollment Required for: Medicare	Medicaid[a]
California	No	Yes[b]
Illinois	No	Yes[c]
Massachusetts	No	No
Michigan	No	No
New York	No	Yes[d]
Ohio	No	Yes[e]
South Carolina	No	No
Texas	No	Yes[f]
Virginia	No	No
Washington	No	No

NOTES: [a] CMS approval is necessary for states to require beneficiaries to enroll in Medicaid managed care, even if beneficiaries opt out of the financial alignment demonstration for their Medicare benefits. [b] California's § 1115 waiver was amended to require beneficiaries to enroll in managed care plans for their Medicaid benefits, including LTSS. [c] Illinois has a draft § 1115 waiver application seeking to require Medicaid managed care enrollment. [d] New York's § 1115 waiver requires beneficiaries in the financial alignment demonstration geographic area who receive more than 120 days of LTSS to enroll in a Medicaid MLTSS plan. [e] Ohio's MOU indicates that the state may seek additional § 1915(b)/(c) waiver authority to require beneficiaries to enroll in Medicaid managed care. [f] Texas's existing § 1115 waiver requires adult dual eligible beneficiaries to enroll in Medicaid managed LTSS.

SOURCE: KCMU analysis of states' financial alignment demonstration memoranda of understanding with CMS, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Given the complexities of the enrollment decision, beneficiaries are likely to need individual in-person options counseling to make their choice.[3] Five states (California, Illinois, Massachusetts, Virginia, and Washington) have received CMS funding to date to support beneficiary outreach, education, and options counseling in their demonstrations through their State Health Insurance Program and Aging and Disability Resource Centers.[4]

In Washington's managed FFS demonstration, beneficiaries are automatically enrolled in a health home network but retain the choice about whether to receive Medicaid health home services; other Medicare and Medicaid services will continue to be provided on a FFS basis. Similarly, in Colorado's managed FFS demonstration, beneficiaries will be automatically assigned to the Regional Care Collaborative Organization in their geographic area to access care coordination services but may disenroll from the demonstration at any time.

Minnesota's administrative alignment demonstration does not involve passive enrollment; instead enrollment in Senior Health Options plans remains voluntary, although the demonstration will test an integrated enrollment system.

Care Delivery Model

The ten states with capitated demonstrations are using managed care plans to coordinate services for beneficiaries through a person-centered planning process. Person-centered planning focuses on the strengths, needs, and preferences of the individual beneficiary instead of being driven by the care delivery system.[5]

Some states require or allow their managed care plans to contract with other entities to provide services in their demonstrations (Table 3). Massachusetts requires its plans to contract with community-based organizations to provide Long-Term Supports coordinators as independent members of the beneficiary's care team, Michigan requires its plans to contact with existing Prepaid Inpatient Health Plans (PIHPs) to provide behavioral health services, and Ohio requires its plans to contract with Area Agencies on Aging to coordinate home and community-based waiver services for enrollees over age 60. (Illinois, New York, South Carolina, Texas, Virginia, and Washington's capitated MOUs do not include any similar requirements). California requires its plans to establish MOUs with county behavioral health agencies to provide specialty mental health services and with county social services agencies to coordinate In Home Supportive Services (IHSS). Demonstration managed care plans in Los Angeles County are subcontracting with other Medicare Advantage plans to offer a variety of benefits packages to enrollees in California's demonstration.

Washington's managed FFS demonstration is using Medicaid health home care coordination organizations to manage services among existing Medicare and Medicaid providers, and Colorado will use its existing Medicaid Accountable Care Collaborative program to coordinate Medicare and Medicaid services for beneficiaries in its demonstration.

Minnesota's administrative alignment demonstration maintains the existing Senior Health Options program delivery system in which Medicaid managed care plans contract with the state and also are qualified as Medicare Advantage Special Needs Plans focused on dual eligible beneficiaries (D-SNPs) under contract with CMS.

Financing

Ten states (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, Virginia, and Washington) are testing CMS's capitated financial alignment model, in which managed care plans will receive capitated payments from CMS for Medicare services and the state for Medicaid services.

Anticipated program savings in the capitated financial alignment demonstrations are deducted up-front from CMS's and the state's respective baseline contributions to health plans by a savings percentage for each year (Table 1). CMS will contribute the Medicare portion of the capitated rate. The Medicaid portion of the capitated rate includes both the federal and state funding.[6] None of the MOUs explicitly states the basis for the savings percentages, although Illinois' MOU notes that it currently has one of the highest rates of potentially

avoidable hospital admissions among dual eligible beneficiaries nationally and one of the highest proportions of spending on institutional services compared to HCBS. While California's MOU specifies minimum savings percentages of 1% in year one, 2% in year two, and 4% in year three, it also includes maximum savings percentages of 1.5% in year one, 3.5% in year two, and 5.5% in year three, making the maximum savings percentages in California among highest of the approved demonstrations to date. Texas's MOU specifies savings percentages of 1.25% in year 1.a (March to December 2015), 2.75% in year 1.b (2016), 3.75% in year 2, and 5.5% in year 3.

All 10 capitated financial alignment demonstrations include provisions to withhold a portion of the capitated rate that plans can earn back if specified quality measures are met. California also requires its plans to provide incentive payments from the quality withhold funds to county behavioral health agencies based on achievement of service coordination measures, and Michigan requires its plans to reward the PIHPs that will provide behavioral health services when the plan earns the withheld payment. South Carolina plans must provide financial incentives to providers that achieve NCQA patient-centered medical home certification.

Two states (Colorado and Washington) are testing CMS's managed FFS model in which providers will continue to receive FFS reimbursement for both Medicare and Medicaid-covered services. Any savings in these demonstrations will be determined retrospectively, with the state eligible to share in savings with CMS if savings targets and quality standards are met.

Minnesota's administrative alignment demonstration will not test one of CMS's financial alignment models. Instead, Minnesota's Senior Health Options program will maintain its existing capitated integrated payment and delivery system arrangements involving Medicaid MCOs that also qualify as Medicare Advantage D-SNPs. Plans will be allowed to integrate Medicare and Medicaid primary care payments to promote care coordination through health care homes and improved coordination among primary, acute, and LTSS and among physical and behavioral health services.

Benefits

The 10 capitated financial alignment demonstrations include nearly all Medicare and Medicaid services in the plans' benefits package and capitated payment. All states include nursing facility services in the plans' capitated payment and benefits package. Eight of the 10 states testing the capitated model (Illinois, Michigan, New York, Ohio, South Carolina, Texas, Virginia, and Washington) include beneficiaries who receive services through certain Medicaid HCBS waivers, while two states (California and Massachusetts) exclude all HCBS waiver enrollees from their demonstrations. Plans are allowed to offer additional benefits, outside the traditional Medicare and Medicaid benefits packages, as appropriate to beneficiary needs. All states require their health plans to offer beneficiaries the option to self-direct their LTSS (Table 3).

Five of the capitated states require plans to offer additional benefits as part of the demonstration. Massachusetts plans must offer certain diversionary behavioral health and community support services that are not otherwise covered as well as expanded Medicaid state plan benefits. Ohio's MOU indicates that its

anticipated § 1915(b)/(c) waiver application is expected to include expanded Medicaid state plan benefits and additional HCBS. California's demonstration includes dental, vision, and non-emergency medical transportation benefits, and its plans may offer additional HCBS. South Carolina's demonstration includes a palliative care benefit for enrollees with a serious, chronic or life-threatening illness who may not meet hospice criteria. Michigan's plans must offer adaptive medical equipment and supplies, community transition services, fiscal intermediary services (to support self-direction), personal emergency response systems, and respite services (Table 3).

Washington's managed FFS demonstration adds Medicaid health home services but does not otherwise change the existing Medicare and Medicaid benefits packages. Similarly, Colorado offers care coordination services but otherwise does not change the existing Medicare and Medicaid benefits packages.

Minnesota's administrative alignment demonstration will continue to provide Medicare benefits at least equivalent to the basic benefit levels included in Medicare Parts A, B, and D and Medicaid benefits based on existing Medicaid MCO contracts.

Demonstration Ombudsman

CMS has announced a funding opportunity for states with approved MOUs to support the planning, development, and provision of independent ombudsman services in the demonstrations, with six states (California, Illinois, Massachusetts, Ohio, Virginia, and Washington) awarded funding to date.[7] Four states (California, Ohio, Texas, and Washington's capitated model) indicate that existing state ombuds offices will offer individual advocacy and independent systemic oversight in their demonstrations, and five states' (Illinois, Michigan, New York, South Carolina, and Virginia) MOUs indicate that they intend to support an independent ombuds program for their demonstrations. Massachusetts and California have selected their demonstration ombudsman.[8]

Washington's managed FFS MOU does not mention an ombuds program, while Colorado has created an alliance of existing organizations to provide education and advocacy for demonstration enrollees.

Minnesota's MOU provides that the state's managed care ombudsman will provide input on plan and system-wide performance but does not provide further details.

Table 3: LTSS in the Capitated Financial Alignment Demonstrations							
State	Nursing facility services included	Home and community-based waiver services included	DD population/ services included	Traditional Medicaid benefits package expanded	Plans can offer supplemental benefits	Self-direction option required	Required contracting/service coordination
CA	Yes	No	No	Yes – plans must provide dental, vision and non-emergency medical transportation services	Yes	Yes	Yes – plans must have MOUs with county mental health and substance use agency for behavioral health services and county social service agency for IHSS
IL	Yes	Yes (except DD)	No	Not mentioned in MOU	Yes	Yes	Not mentioned in MOU
MA	Yes	No (may seek to include in future)	No	Yes – plans must provide diversionary behavioral health and community support services and (unspecified) expanded Medicaid state plan benefits	Yes	Yes	Yes – plans must provide Long-Term Supports coordinator form independent community-based organization as a member of the care team
MI	Yes	Yes	Yes	Yes – plans must provide adaptive medical equipment and supplies, community transition services, fiscal intermediary for self-direction, personal emergency response system, respite	Yes	Yes	Yes – plans must contract with PIHP for behavioral health services
NY	Yes	Yes (NF diversion and transition waiver only)	No*	Not mentioned in MOU	Yes	Yes	Not mentioned in MOU
OH	Yes	Yes (except DD)	No	Yes – expects to require plans to provide (unspecified) expanded Medicaid state plan benefits and additional HCBS	Yes	Yes	Yes – plans must contract with AAA to coordinate HCBS for beneficiaries over age 60
SC	Yes	Yes (elderly/ disabled, HIV/AIDS, and mechanical ventilation waivers only)	No	Yes – plans must provide palliative care benefit	Yes	Yes	Not mentioned in MOU
TX	Yes	Yes (seniors and people with physical disabilities who meet NF level of care only)	No	Not mentioned in MOU	Yes	Yes	Not mentioned in MOU
VA	Yes	Yes (elderly/ disabled with consumer direction waiver only)	No	Not mentioned in MOU	Yes	Yes	Not mentioned in MOU
WA	Yes	Yes (except DD)	No	Not mentioned in MOU	Yes	Yes	Not mentioned in MOU

NOTES: *NY's capitated proposal for beneficiaries who have DD and need LTSS is pending with CMS.
SOURCE: KCMU analysis of states' financial alignment demonstration memoranda of understanding with CMS, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Appeals

All of the capitated demonstration states will provide beneficiaries with a single integrated notice of appeal rights, and the existing Part D appeals process will continue to apply in all demonstrations. Minnesota's administrative alignment demonstration is building on the integrated appeals system already established in its Senior Health Options program by adding a single integrated notice of appeal rights and standardizing the timeframes to request Medicare and Medicaid appeals. By contrast, Colorado and Washington's managed FFS demonstrations do not make any changes to the existing Medicare and Medicaid appeals systems.

One of the capitated financial alignment demonstrations (New York) includes a fully integrated four level appeals process for all services traditionally covered by Medicare Parts A and B and Medicaid. New York requires its demonstration health plans to continue providing benefits while appeals are pending for both prior-approved Medicare and Medicaid services if the beneficiary so requests within 10 days of the date of the notice. (Continued benefits pending appeal is currently available under federal law for Medicaid services but not for Medicare services.)

Five of the capitated demonstration states (Illinois, Massachusetts, South Carolina, Virginia, and Washington) require beneficiaries to first exhaust an internal health plan appeal before proceeding to external appeals, while four of the capitated demonstration states (California, Michigan, Ohio, and Texas) allow beneficiaries to choose whether to first file an internal health plan appeal or instead to proceed directly to a fair hearing for Medicaid-covered services.

Eight of the capitated demonstrations states (Illinois, Massachusetts, Michigan, Ohio, South Carolina, Texas, Virginia, and Washington, in addition to New York, described above) require health plans to continue Medicare and Medicaid benefits while internal health plan appeals are pending; beneficiaries may request that Medicaid benefits continue while fair hearings are pending, but Medicare benefits will not continue during external appeals. California's demonstration does not currently provide for continued Medicare benefits pending appeal. California's MOU provides that the existing Medicare and Medicaid appeals processes will continue at least through demonstration year one, and the state will work to create a more integrated appeals process in future years.

Looking Ahead

As the demonstrations are implemented, additional details about several features are emerging, including how beneficiaries are being notified, counseled, and enrolled; how the demonstrations are being monitored and overseen; how beneficiary ombuds programs are being implemented; and how the demonstrations are being evaluated. CMS has contracted with RTI International to conduct an overall evaluation of the demonstrations as well as state-specific evaluations. The MOUs provide that the evaluations will include site visits, analysis of program data, focus groups, key informant interviews, analysis of changes in quality, utilization, and cost measures, and calculation of savings attributable to the demonstrations. The evaluation findings are to be reported quarterly, although there is likely to be a lag in data availability.

The approved MOUs provide additional information about how CMS and the states envision the demonstrations working and insight into the framework and policy decisions that CMS may apply when

developing MOUs with other states that submitted proposals. Additional details are specified in the three-way contracts between CMS, the state, and demonstration plans in the capitated model,[9] in the states' final demonstration agreement with CMS in the managed FFS model,[10] and in policy guidance. Key areas to consider as the demonstrations are implemented include:

- how beneficiaries are making their enrollment choices;
- what the actual sources of program savings will be;
- how beneficiaries' access to medically necessary services and supports is being ensured;
- how the demonstrations are affecting beneficiary access to HCBS;
- how beneficiaries are navigating the demonstrations' grievance and appeals processes;
- whether continuity of care and intelligent assignment provisions are sufficient to prevent care disruptions and the extent to which beneficiaries' current providers are participating in demonstration health plan networks;
- how plans and providers are accommodating the needs of beneficiaries with disabilities; and
- what impact the demonstrations are having on care quality and health outcomes.

While the demonstrations offer the potential opportunity to improve care coordination, lower program costs, and achieve outcomes such as better health and the increased use of HCBS instead of institutional care, at the same time the high care needs of many dual eligible beneficiaries increases their vulnerability when care delivery systems are changed.

Appendix:
Key Provisions of CMS Approved Financial Alignment Demonstrations for Dual Eligible Beneficiaries by State, July 2014[11]

The following tables summarize the major elements of the financial alignment demonstrations for dual eligible beneficiaries for the states with memoranda of understanding approved by CMS. As of July 2014, the 13 demonstrations in 12 states include:

- California
- Colorado
- Illinois
- Massachusetts
- Michigan
- Minnesota
- New York
- Ohio
- South Carolina
- Texas
- Virginia
- Washington (managed FFS model)
- Washington (capitated model)

CALIFORNIA:	
MOU Signed:	March 27, 2013 3-way contract issued[12]
Demonstration Duration:	3 years April 1, 2014[13] to Dec. 31, 2016
Target Group:	*Includes:* an estimated 456,000 full benefit dual eligible beneficiaries age 21 and older in 8 counties are eligible to enroll; enrollment is capped at 200,000 in Los Angeles county; PACE, AIDS Healthcare Foundation, and enrollees in certain § 1915(c) HCBS waivers may participate if they disenroll from their existing program *Excludes:* dual eligible beneficiaries with other comprehensive coverage, those who receive services from a regional center, state developmental center or ICF/DD, certain long-term care beneficiaries with a Medicaid share of cost, veterans' home residents, residents in certain rural zip codes, and beneficiaries with end stage renal disease in certain counties unless already enrolled in a separate plan operated by a demonstration prime contractor
Geographic Area:	8 counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara
Enrollment:	California's revised enrollment timeline is as follows:[14] April 2014: all beneficiaries currently in Medicare FFS and Medicaid managed care in San Mateo county and those in MSSP in San Mateo county will be passively enrolled in one month; voluntary enrollment period begins for beneficiaries currently in Medicare FFS in Los Angeles, Riverside, San Bernardino, and San Diego counties May 2014: all beneficiaries currently in Medicare FFS and Medicaid managed care in Riverside, San Bernardino and San Diego counties are passively enrolled in one month; passive enrollment begins by birth month for beneficiaries currently in Medicare FFS and Medicaid FFS in Riverside, San Bernardino, and San Diego counties (except that April birthdays enroll in May 2014) July 2014: all beneficiaries currently in Medicare FFS and Medicaid managed care in Los Angeles county are passively enrolled in one month (passive enrollment will be in CareMore, Care First, Molina, and Health Net plans only; L.A. Care will be eligible for passive enrollment once it improves its Medicare quality rating);[15] 12 month passive enrollment period by birth month begins for beneficiaries currently in Medicare FFS and Medicaid FFS in Los Angeles county August 2014: all beneficiaries currently in MSSP in Los Angeles, Riverside, San Bernardino, and San Diego counties are passively enrolled in one month Jan. 2015: all beneficiaries in Medicare FFS and Medicaid managed care in Alameda and Santa Clara counties, MSSP beneficiaries in Alameda, Orange, and Santa Clara counties, and beneficiaries in Medicare Advantage plans in all 8 demonstration counties are passively enrolled in one month; start of 12 month passive enrollment period by birth month for beneficiaries in Medicare FFS and Medicaid managed care in Orange county and for beneficiaries in Medicare FFS and Medicaid FFS in Alameda and Santa Clara counties L.A. County enrollment is capped at 200,000, and a waiting list will be maintained. Notices will be sent 90, 60, and 30 days prior to passive enrollment. Beneficiaries in certain rural zip codes where only one demonstration plan operates and those in certain non-profit prepaid health plans are exempt from passive enrollment

CALIFORNIA:	
	Beneficiaries may opt out of the demonstration prior to passive enrollment and thereafter on a monthly basis CMS approved the amendment to California's existing § 1115 waiver,[16] which requires beneficiaries to enroll in a Medicaid managed care plan if they opt out of the financial alignment demonstration Passive enrollment intelligent assignment process based on 12 months of Medicare and Medicaid claims history data to identify most frequently used providers and to ensure that beneficiaries in long-term care facilities will not need to change facilities
Financing:	Capitated with minimum savings percentage (1% in year one, 2% in year two, and 4% in year three) applied upfront to baseline Medicare and Medicaid contributions; for purposes of California's risk corridors (see endnote 20), the MOU also specifies county-specific interim savings percentages and demonstration-wise maximum savings percentages of 1.5% in year one, 3.5% in year two, and 5.5% in year three; capitation rate withhold (1% in year one, 2% in year two, 3% in year three) which plans earn back by meeting specified quality measures Plans must provide incentive payments from quality withhold funds to county behavioral health agencies based on achievement of service coordination measures
Medicare baseline for capitated payments:	Parts A and B = blend of Medicare Advantage benchmarks (including quality bonus payments) and Medicare FFS standardized county rates weighted by whether beneficiaries who are expected to transition to the demonstration are enrolled in Medicare Advantage or Medicare FFS in the prior year; Medicare Advantage risk score coding intensity adjustment factor will apply after calendar year 2013;[17] Part D = national average monthly bid amount plus average projected low income cost sharing subsidy and average projected federal reinsurance amounts
Medicare risk adjustment:	CMS Hierarchical Condition Categories model used for Medicare Advantage plans
Medicaid baseline for capitated payments:	Medicaid capitation rates under § 1115 waiver that would apply to beneficiaries who are in target population but not enrolled in the demonstration (excluding specialty behavioral health services financed and managed by county behavioral health agencies and costs for county administration of In Home Supportive Services)
Medicaid risk adjustment:	Rating categories with financial incentives for HCBS over institutional care[18] to be implemented in each county in 3 phases[19]
Risk sharing:	Limited risk corridors in all years[20]
Care Delivery Model:	Cal MediConnect plans will provide person-centered medical homes, care coordination and integrated medical, behavioral health, and LTSS Requires behavioral health MOU with county mental health and substance use agency and MOU with county social services agency to coordinate In Home Supportive Services Prime contractor plans may subcontract with other Medicare Advantage plans to offer multiple plan benefit packages
Participating Health Plans:	-Alameda County (2 plan model county): Alameda Alliance Complete Care and Anthem Blue Cross -Los Angeles County (2 plan model county): Health Net and L.A. Care (L.A. Care partner plans include CareMore, Care First Health Plan, and Kaiser Permanente) -Orange County (county organized health system): CalOptima OneCare

CALIFORNIA:	
	-Riverside County (2 plan model county): Inland Empire Health Plan and Molina Dual Options -San Bernardino County (2 plan model county): Inland Empire Health Plan and Molina Dual Options -San Diego County (geographic managed care): Care First Health Plan, Community Health Group Communicare Advantage, Health Net, and Molina Dual Options -San Mateo County (county organized health system): Health Plan of San Mateo Care Advantage -Santa Clara County (2 plan model county): Anthem Blue Cross and Santa Clara Family Health Plan
Benefits:	Includes all Medicare and Medicaid services except Medicare hospice and certain § 1915(b) specialty mental health and substance use services that will continue to be financed and administered by county behavioral health agencies; includes In Home Supportive Services although counties will continue to assess and authorize the need for these services and enroll providers; plans may provide additional HCBS and behavioral health services to prevent institutionalization as appropriate to beneficiary needs; adds dental, vision, and non-emergency medical transportation services
Continuity of Care:	Beneficiaries must maintain current providers and service authorizations for up to 6 months for Medicare services and up to 12 months for Medicaid services except for IHSS providers, DME, medical supplies, transportation, and other ancillary services
Ombuds Program:	California's state Medicaid managed care ombuds office will support individual advocacy and independent systemic oversight for the demonstration with an emphasis on community integration, independent living and person-centered care. California has been awarded CMS funding to support its ombuds program[21] and has selected Legal Aid Society of San Diego as the primary contractor for the ombuds program.[22]
Stakeholder Engagement:	Plans must establish at least one consumer advisory committee that provides input to the governing board and include beneficiaries with disabilities in the plan governance structure
Appeals:	*Notice:* single integrated notice *Timeframe to request initial appeal:* 60 days for Medicare-covered service; 90 days for Medicaid-covered service *Internal health plan appeal:* appeals for services traditionally covered by Medicare and by Medicaid are to be integrated over time; for demonstration year 1 and until a new system is established, current Medicare and Medicaid managed care appeals processes continue: initial Medicare appeal is filed with health plan; initial Medicaid appeal is filed with health plan or beneficiary may directly request fair hearing; California will work with CMS and stakeholders to create a more integrated appeals process in future years, with 90 days to request an appeal and a requirement that beneficiaries exhaust health plan and external reviews before requesting a fair hearing *External Medicare appeals:* health plan automatically sends appeal to Medicare Independent Review Entity (IRE) if initial denial upheld; beneficiary may then request Office of Medicare Hearing and Appeals review *External Medicaid appeals:* beneficiary may request fair hearing directly or after internal health plan appeal; beneficiaries may request Independent Medical Review for certain Medicaid appeals if a fair hearing has not already been requested *Appeals where Medicare and Medicaid services overlap:* to be determined in 3-way contract; beneficiaries will retain right to Medicaid fair hearing

CALIFORNIA:

Continued benefits pending appeal: current rules continue to apply (available for Medicaid services but not for Medicare services)

Medicare Part D appeals: existing Medicare Part D appeals process continues

Existing appeals process for county-authorized IHSS and behavioral health services also remains unchanged.

COLORADO:	
MOU Signed:	Feb. 28, 2014 Final demonstration agreement not yet available
Demonstration Duration:	3 years Aug. or Sept., 2014 to Dec. 31, 2017
Target Group:	*Includes:* an estimated 48,000 full benefit dual eligible beneficiaries without other public or private health insurance are eligible to enroll *Excludes:* beneficiaries residing in an ICF/DD; beneficiaries enrolled in Medicare Advantage, PACE, Denver Health Medicaid Choice Plan or Rocky Mountain Health Plan and those participating in the CO House Bill 12-1281 ACC Program Payment Reform pilot may participate if they disenroll from their existing program
Geographic Area:	Statewide, divided into 7 regions: Region 1: Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, and Summit counties Region 2: Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, and Yuma counties Region 3: Adams, Arapahoe, and Douglas counties Region 4: Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, and Saguache counties Region 5: Denver Region 6: Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties Region 7: El Paso, Elbert, Park, and Teller counties
Enrollment:	Beneficiaries will be passively enrolled in the Regional Care Collaborative Organization (RCCO) serving their geographic area and to a primary care medical provider (PCMP) based on existing beneficiary-provider relationships. Enrollment will be phased-in over 6 months with no more than 7,500 beneficiaries enrolled per month. Beneficiaries will be categorized by RCCO, county, delivery system (community relatively well, waiver, high waiver, skilled nursing facility), and provider type (based on Medicare and Medicaid claims history: existing PCMP in Accountable Care Collaborative (ACC) program, Medicare-Medicaid primary care providers not yet in ACC program, Medicare primary care providers without Medicaid billing id number). Enrollment is as follows: Month 1: community relatively well with ACC PCMPs Month 2: remainder of community relatively well with ACC PCMPs; community relatively well with Medicare-Medicaid providers not yet in ACC Month 3: remainder of community relatively well with Medicare-Medicaid providers not yet in ACC; those receiving waiver services with ACC PCMPs Month 4: remainder of community relatively well and those receiving waiver services with Medicare-Medicaid providers not yet in ACC

COLORADO:	
	Month 5: remainder of those receiving waiver services and those receiving high waiver services with Medicare-Medicaid providers not yet in ACC or with Medicare primary care provider with no Medicaid billing id number Month 6: those in skilled nursing facilities Month 7: remainder of skilled nursing facilities Newly eligible beneficiaries will be assigned on a monthly basis For purposes of calculating shared savings, beneficiaries must be assigned to the demonstration within 9 months of implementation (except for newly eligible beneficiaries) Beneficiaries can opt out of the demonstration at any time. CMS must approve Colorado's § 1932 Medicaid state plan amendment to expand the ACC program to dual eligible beneficiaries
Financing:	Managed FFS; providers continue to receive FFS reimbursement; state eligible for retrospective performance payment if savings targets and quality standards met
Medicare baseline for capitated payments:	N/A
Medicare risk adjustment:	N/A
Medicaid baseline for capitated payments:	N/A
Medicaid risk adjustment:	N/A
Risk sharing:	N/A
Care Delivery Model:	Colorado will expand its existing ACC Medicaid managed FFS program to include dual eligible beneficiaries. In the ACC, RCCOs offer care coordination through RCCO staff or arrangements with local providers; develop a network of participating PCMPs; and will establish informal arrangements with ancillary providers. PCMPs receive per member per month payments and must offer increased access to beneficiaries, such as extended office hours or same-day appointments. RCCOs and PCMPs will work together with the state to integrate and coordinate primary, acute, prescription drug, behavioral health, and LTSS. For beneficiaries attributed to a PCMP, RCCO will perform in-person screening and develop care plan to coordinate services. For beneficiaries whose primary care provider is not currently participating in the ACC program, the RCCO will conduct outreach to involve the provider. If outreach efforts are unsuccessful, and the beneficiary would like greater benefit from the ACC Program, the state and RCCO will assist the beneficiary with finding a participating PCMP.

COLORADO:	
Participating Health Plans:	Region 1: Rocky Mountain Health Plan Regions 2, 3, and 5: Colorado Access Region 4: Integrated Community Health Partners Region 6: Colorado Community Health Alliance Region 7: Community Care of Central Colorado
Benefits:	No changes to existing Medicare and Medicaid benefits
Continuity of Care:	Beneficiaries are not required to change providers and retain access to their current choice of Medicare and Medicaid providers
Ombuds Program:	A beneficiary rights and protections alliance will provide beneficiary education, assistance, and advocacy. Alliance members include the state Medicaid agency, the 7 RCCOs, LTC ombudsman, Medicaid managed care ombudsman, SHIP, CO Center on Law and Policy, and CO Cross-Disability Coalition. Permanently invited alliance participants and guests include CMS regional office, CO Legal Services, Demonstration Advisory Subcommittee beneficiaries, and Medicare Quality Improvement Organization.
Stakeholder Engagement:	State will provide opportunities for beneficiaries to provide input and participate in the CO Medicare-Medicaid Enrollees Advisory Subcommittee, the ACC Program Improvement Advisory Committee, the Community Living Advisory Group, and the Nursing Facility Culture Change Accountability Board.
Appeals:	No changes from existing Medicare and Medicaid appeals systems. Demonstration enrollees also can access the ACC complaint process, which includes addressing service complaints with a primary care provider or RCCO, contacting the Medicaid Managed Care Ombudsman about unresolved complaints, and requesting a state fair hearing if beneficiary believes that services are wrongfully denied. The state, RCCOs and other beneficiary rights and protections alliance members will provide beneficiary education about enrollee rights and assist enrollees in exercising grievance and appeal rights.

ILLINOIS:	
MOU Signed:	Feb. 22, 2013 3-way contract signed Nov. 5, 2013[23]
Demonstration Duration:	3 years March 1, 2014[24] to Dec. 31, 2016
Target Group:	*Includes*: an estimated 135,825 full benefit dual eligible beneficiaries age 21 and older in 21 counties grouped into 2 regions are eligible to enroll; Medicare Advantage enrollees in a plan whose parent organization is not offering a demonstration plan may participate if they disenroll from their existing plan *Excludes:* dual eligible beneficiaries with other comprehensive coverage, those with developmental disabilities who are served through an ICF/DD or § 1915(c) HCBS waiver, those on a Medicaid spend down, and those in the Medicaid breast and cervical cancer program
Geographic Area:	21 counties grouped into 2 regions: Greater Chicago region: Cook, Lake, Kane, DuPage, Will, and Kankakee counties Central Illinois region: Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford, Menard, and Stark counties
Enrollment:	Initial enrollment period is voluntary, followed by a six month passive enrollment period in which the remaining beneficiaries in the target population will be automatically enrolled;[25] passive enrollment not to exceed 5,000 beneficiaries per plan per month in Greater Chicago and 3,000 in Central Illinois The MOU provides that beneficiaries may begin to elect voluntary enrollment 60 days prior to an effective date of March 2014 (as revised), followed by six groups of passive enrollment over six months: initial notice will be sent to one group per month, with passive enrollment effective for one group per month 60 days after notice (with the enrollment for the first passive group effective, as revised, in June 2014)[26] Beneficiaries may opt out of the demonstration prior to passive enrollment and thereafter on a monthly basis The MOU provides that Illinois must submit a Medicaid state plan amendment to implement managed care and concurrent authority for its § 1915(c) waiver – while the MOU does not mention mandatory Medicaid managed care, questions and answers released by the state indicate that beneficiaries receiving LTSS will be required to enroll in a Medicaid managed care plan;[27] in addition, Illinois has a draft § 1115 waiver application seeking to require Medicaid managed care enrollment[28] Intelligent assignment for passive enrollment will consider previous managed care enrollment, historic provider utilization, and in year one will equalize enrollment in all MCOs
Financing:	Capitated with savings percentage (1% in year one, 3% in year two, and 5% in year three) applied upfront to baseline Medicare and Medicaid contributions; capitation rate quality withhold same as in California (1% in year 1, 2% in year 2, 3% in year 3)
Medicare baseline for capitated payments:	Same as California, except that Medicare Advantage risk score coding intensity adjustment factor will apply after calendar year 2014
Medicare risk	Same as California

ILLINOIS:	
adjustment:	
Medicaid baseline for capitated payments:	Historical state spending for state plan and HCBS waiver services trended forward
Medicaid risk adjustment:	Rating categories with financial incentives for HCBS over nursing facility care[29]
Risk sharing:	Required minimum medical loss ratio of 85%
Care Delivery Model:	Medicare-Medicaid Alignment Initiative plans will provide medical homes, integrated primary and behavioral health care services, and care management; the intensity of care management services will depend on the beneficiary's risk level
Participating Health Plans:	-Greater Chicago region: Aetna (not participating in Lake County; participation approval on hold in Kankakee County), HealthSpring (not participating in Kankakee County), Healthcare Service Company/Blue Cross Blue Shield, Humana, IlliniCare/Centene, and Meridian (not participating in Kankakee County; participation approval on hold in DuPage and Lake Counties) -Central Illinois region: Health Alliance Medical Plan and Molina (participation approval on hold in McLean, Sangamon, and Macon counties)[30]
Benefits:	Includes all Medicare and Medicaid services except Medicare hospice; includes Medicaid home and community-based waiver services except for beneficiaries with developmental disabilities; plans have discretion to offer flexible benefits as appropriate to beneficiary needs
Continuity of Care:	Beneficiaries have a 180 day transition period for continuing a current course of treatment with out-of-network providers including behavioral health and LTSS
Ombuds Program:	Illinois's MOU indicates that it intends to support an independent ombuds program for the demonstration. Illinois has been awarded CMS funding to support its ombuds program.[31]
Stakeholder Engagement:	Plans must establish an independent beneficiary advisory committee that meets quarterly
Appeals:	*Notice:* same as California (single integrated notice) *Timeframe to request initial appeal:* 60 days *Internal health plan appeal:* all initial appeals must be filed with health plan; appeals to be resolved within 15 business days (standard) or 24 hours (expedited) *External Medicare appeals:* same as California (health plan automatically sends appeal to Medicare IRE if initial denial upheld; beneficiary may then request Office of Medicare Hearing and Appeals review) *External Medicaid appeals:* beneficiary may request fair hearing within 30 days of plan appeal decision for Medicaid services and within 30 days of IRE decision for overlapping Medicare-Medicaid services; to be resolved within 90 days *Appeals where Medicare and Medicaid services overlap:* to be defined in 3-way contract; will automatically be sent to IRE, and if IRE decision not wholly favorable to beneficiary, may request fair hearing or ALJ hearing *Continued benefits pending appeal:* health plans must provide continuing benefits for

ILLINOIS:	
	Medicare Parts A and B and Medicaid services while internal health plan appeals are pending; beneficiaries may request continuing benefits (within 10 days) for Medicaid and overlapping Medicare-Medicaid services while fair hearings are pending *Medicare Part D:* same as California (existing Medicare Part D appeals process continues)

MASSACHUSETTS:	
MOU Signed:	Aug. 22, 2012; 3-way contract signed July 16, 2013[32] (initial term through Dec. 31, 2014)
Demonstration Duration:	3 years Oct. 1, 2013[33] to Dec. 31, 2016
Target Group:	*Includes:* an estimated 90,240 full benefit dual eligible beneficiaries ages 21 to 64 in 8 full counties and 1 partial county[34] are eligible to enroll; Medicare Advantage, PACE, and Independence at Home enrollees may participate if they disenroll from their existing plan *Excludes:* dual eligible beneficiaries with other comprehensive coverage, ICF/DD facility residents, and § 1915(c) HCBS waiver participants
Geographic Area:	9 counties: Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth (partial), Suffolk, Worcester
Enrollment:	Initial enrollment period is voluntary, followed by passive enrollment periods in which the remaining beneficiaries in the target population will be automatically enrolled except that no passive enrollment will take place in counties served by only one demonstration health plan (Essex, Franklin, Middlesex, Norfolk, Plymouth) Beneficiary outreach began in September 2013, with October 2013 as the earliest effective date for voluntary enrollment, followed by passive enrollment in Hampden, Hampshire, Suffolk, and Worcester counties (total 45,019 beneficiaries subject to auto-assignment):[35] initial notice sent in Oct. 2013 for first passive group (an estimated 8,600 beneficiaries in community-other rating category) with enrollment effective January 2014.[36] As of Feb. 1, 2014, 9,541 beneficiaries were enrolled, and 16,642 beneficiaries had opted out of the demonstration.[37] The effective enrollment date for the second passive enrollment group is April 2014 (an estimated 6,400 beneficiaries in the high community need, high community behavioral health, and community-other rating categories) and July 2014 for the third passive group.[38] Beneficiaries receive notices 60 and 30 days prior to passive enrollment. Beneficiaries may opt out of the demonstration prior to passive enrollment and thereafter on a monthly basis Massachusetts is using § 1915(a) authority to enroll dual eligible beneficiaries in Medicaid managed care. Intelligent assignment for passive enrollment will prioritize continuity of providers and/or services
Financing:	Capitated with savings percentage (0 in 2013, 1% in 2014 (remainder of year one),[39] 2% in year two, and >4% in year three[40]) applied upfront to baseline Medicare and Medicaid contributions; capitation rate quality withhold same as in California (1% in year 1, 2% in year 2, 3% in year 3)
Medicare baseline for capitated payments:	Same as California
Medicare risk adjustment:	Same as California
Medicaid baseline for capitated	Historical state spending data trended forward

MASSACHUSETTS:	
payments:	
Medicaid risk adjustment:	Rating categories[41] and high cost risk pools for certain Medicaid LTSS[42]
Risk sharing:	Risk corridors in first year only[43]
Care Delivery Model:	One Care plans will provide patient-centered medical homes that integrate primary care and behavioral health services, care coordination, and clinical care management Requires Long-Term Supports Coordinators from community-based organizations independent of health plans as members of the care team
Participating Health Plans:	-Essex. Franklin, Middlesex, Norfolk, and Plymouth (partial) counties: Commonwealth Care Alliance -Hampden and Hampshire counties: Commonwealth Care Alliance and Fallon Total Care/Fallon Community Health Plan -Suffolk County: Commonwealth Care Alliance and Network Health/Tufts Health Plan -Worcester County: Commonwealth Care Alliance, Fallon Total Care/Fallon Community Health Plan, and Network Health/Tufts Health Plan
Benefits:	Includes all Medicare and Medicaid state plan services except Medicare hospice and Medicaid mental health and DD targeted case management services and mental health rehabilitation option services; plans have discretion to offer flexible benefits as appropriate to beneficiary needs; adds supplemental diversionary behavioral health and community support services and expanded Medicaid state plan benefits (including additional dental services)[44]
Continuity of Care:	Beneficiaries must be allowed to maintain their current providers and service authorizations for 90 days or until the plan completes an initial assessment, whichever is longer
Ombuds Program:	Massachusetts selected Disability Policy Consortium (to be supported by Health Care for All and Consumer Quality Initiatives) as its demonstration ombudsman;[45] not addressed in MOU
Stakeholder Engagement:	Same as California
Appeals:	*Notice:* same as California (single integrated notice) *Timeframe to request initial appeal:* same as Illinois (60 days) *Internal health plan appeal:* same as Illinois (all initial appeals must be filed with health plan) except that appeals are to be resolved in 30 days (standard) or 72 hours (expedited) *External Medicare appeals:* same as California (health plan automatically sends appeal to Medicare IRE if initial denial upheld; beneficiary may then request Office of Medicare Hearing and Appeals review *External Medicaid appeals:* beneficiary may request fair hearing after adverse health plan appeal *Appeals where Medicare and Medicaid services overlap:* to be addressed in 3-way contract; health plan bound by decision most favorable to beneficiary *Continued benefits pending appeal:* health plans must provide continuing benefits for all prior approved Medicare Parts A and B and Medicaid services while health plan appeals

MASSACHUSETTS:	
	are pending; beneficiaries may request continuation of previously authorized services for Medicaid appeals while fair hearings are pending *Medicare Part D:* same as California (existing Medicare Part D appeals process continues)

MICHIGAN:	
MOU Signed:	April 3, 2014 3-way contract not yet available
Demonstration Duration:	3 years Jan. 1, 2015 to Dec. 31, 2017
Target Group:	*Includes:* an estimated 100,000 full benefit dual eligible beneficiaries age 21 and older are eligible to enroll; those enrolled in the MI Choice § 1915(c) HCBS wavier, Money Follows the Person, PACE, or an employer-sponsored Medicare Advantage plan may participate if they disenroll from their existing program *Excludes:* dual eligible beneficiaries previously disenrolled from Medicaid managed care due to uncooperative or disruptive behavior, those who are eligible as Additional Low Income Medicare Beneficiaries/Qualified Individuals or through a Medicaid spend down, state psychiatric hospital residents, those with commercial HMO coverage, and those who elect hospice services
Geographic Area:	25 counties, grouped into 4 regions: Region 1 (Upper Peninsula): Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft counties Region 4 (Southwest): Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren counties Region 7: Wayne county Region 9: Macomb county
Enrollment:	Initial enrollment period is voluntary, followed by passive enrollment periods in which the remaining beneficiaries in the target population will be automatically enrolled Phase 1 voluntary enrollment: beneficiaries in regions 1 and 4 can opt into the demonstration no earlier than Oct. 1, 2014, with enrollment effective Jan. 1, 2015. Phase 2 voluntary enrollment: beneficiaries in regions 7 and 9 can opt into the demonstration no earlier than March 1, 2015 with enrollment effective May 1, 2015. Phase 1 passive enrollment effective date April 1, 2015 for regions 1 and 4. Phase 2 passive enrollment effective date July 1, 2015 for regions 7 and 9. Beneficiaries will receive notices no later than 60 and 30 days prior to passive enrollment. Beneficiaries subject to Medicare reassignment effective Jan. 1, 2015 will not be passively enrolled in the demonstration in 2015, but will be eligible for passive enrollment no earlier than Jan. 1, 2016. Plans designated by CMS as a past performance outlier or identified as consistently low performing based on parent/sibling organization performance will not receive passive enrollment. Beneficiaries may opt out of the demonstration prior to passive enrollment and thereafter on a monthly basis Michigan's demonstration is contingent upon CMS approval of a § 1915(b) Medicaid managed care waiver and concurrent § 1915(c) authority Intelligent assignment for passive enrollment will consider previous managed care enrollment and historic provider utilization

MICHIGAN:	
	SHIP in partnership with AAAs and working with senior centers and CILs will provide options counseling to beneficiaries.
Financing:	Capitated with savings percentage (1% in year one, 2% in year two, 4% in year three, except that if at least 1/3 of ICOs have year one losses exceeding 3% of revenue, the year three savings percentage will be 3%) applied upfront to baseline Medicare and Medicaid contributions; capitation rate quality withhold same as in California (1% in year 1, 2% in year 2, 3% in year 3); all ICO subcontracts with PIHPs must reward the PIHP when ICO achieves withheld amounts; state will phase-in separate quality withhold process specific to PIHP performance after year one
Medicare baseline for capitated payments:	Same as California except that Medicare Advantage risk score coding intensity adjustment factor will apply beginning in 2015[46]
Medicare risk adjustment:	Same as California
Medicaid baseline for capitated payments:	Blend of Medicaid FFS claims for services covered in demonstration and capitation payments for demonstration eligible beneficiaries in Medicaid managed care today
Medicaid risk adjustment:	Rating categories based on level of care[47] with financial incentives for HCBS over institutional care
Risk sharing:	Risk corridors in year 1;[48] MLR of 85% in years 2 and 3; risk sharing does not apply to services separately funded by direct payment from state to PIHPs
Care Delivery Model:	Integrated care organizations (ICOs) provide care coordination and integrated medical, behavioral health, and LTSS directly or through subcontracts or partnership with local Prepaid Inpatient Health Plans (PIHPs). State will continue to contract directly with PIHPs for delivery of Medicaid behavioral health services. ICOs must contract with regional PIHP for Medicare-funded behavioral health services and to jointly coordinate care for enrollees with behavioral health, substance use disorder and I/DD needs. Enrollees have choice of ICO care coordinator. PIHP supports coordinators will be offered to enrollees with behavioral health, substance use, or I/DD needs. ICOs must provide LTSS supports coordination services. LTSS Supports Coordinators will be offered to all enrollees who meet the NF LOC.
Participating Health Plans:	Region 1: Upper Peninsula Health Plan Region 4: CoventryCares of MI and Meridian Health Plan Regions 7 and 9: AmeriHealth, CoventryCares of MI, Fidelis SecureCare, Midwest Health Plan, Molina Healthcare, and United Healthcare[49] Participation is subject to plans meeting readiness review requirements.

MICHIGAN:	
Benefits:	Includes all Medicare and Medicaid state plan services except Medicare hospice. Includes § 1915(c) home and community-based waiver services for enrollees who meet NF LOC; also includes supplemental benefits not currently available under Medicaid state plan: adaptive medical equipment and supplies, community transition services, fiscal intermediary (to support self-direction), personal emergency response system, respite; ICOs can offer flexible benefits as appropriate to enrollee needs; enrollees must be offered option to choose own LTSS providers with an established individualized budget maintained by enrollee with support from fiscal intermediary
Continuity of Care:	For enrollees in habilitation supports waiver and those receiving PIHP services: maintain current provider for 180 days or continue with single case agreement; existing care plans and prior authorizations continue until authorization ends or 180 days from enrollment, whichever is sooner except that home health and state plan PCS level of services and providers continue for 180 days; current waiver service providers and service level continue unless changed through person-centered planning process. For other enrollees: maintain current provider for 90 days or continue with single case agreement; existing care plans and prior authorizations continue until authorization ends or 180 days, whichever is sooner, except that home health and state plan PCS continue for 90 days; enrollees in NFs may remain in that facility through ICO contract or single case agreement or on out-of-network basis for duration of demonstration or until enrollee chooses to relocate; MI Choices HCBS waiver services and providers continue for 90 days unless changed during person-centered planning.
Ombuds Program:	State will establish ombuds program to provide individual advocacy and systemic oversight
Stakeholder Engagement:	Each ICO must establish at least one advisory board that meets at least quarterly and a process for that board to provide input to the HMO governing board. The advisory board should include a mix of enrollees, caregivers and key community stakeholders, with 1/3 of the board composed of enrollees. ICOs must accommodate and support the advisory board members by arranging necessary transportation, appropriate communications, and other measures to ensure and encourage their full participation. Advisory board members will be elected.
Appeals:	*Notice:* same as California (single integrated notice) *Timeframe to request initial appeal:* 90 days *Internal health plan appeal:* initial Medicare appeals to ICO; initial Medicaid appeals to ICO or state; ICOs must resolve standard appeals within 30 days and expedited appeals within 72 hours *External Medicare appeals:* appeals automatically forwarded to IRE, then enrollee can request ALJ hearing *External Medicaid appeals:* enrollee may request state fair hearing after ICO appeal or enrollee may bypass ICO appeal and immediately request state fair hearing *Appeals where Medicare and Medicaid services overlap:* enrollees may file appeal through Medicare or Medicaid appeals process or both *Continued benefits pending appeal:* Medicare and Medicaid benefits continue pending internal ICO appeal *Medicare Part D appeals:* remain unchanged

MINNESOTA:	
MOU Signed:	Sept. 12, 2013
Demonstration Duration:	3 years Sept. 13, 2013 to Dec. 31, 2016
Target Group:	*Includes:* an estimated 36,000 full benefit dual eligible beneficiaries age 65 and older who are enrolled in Minnesota's Senior Health Options Program
Geographic Area:	Statewide
Enrollment:	Voluntary; the demonstration does not involve passive enrollment. The demonstration will use an integrated enrollment system in which beneficiaries enroll and disenroll from Medicare and Medicaid managed care simultaneously using an integrated form, notice, and process.
Financing:	Minnesota's demonstration will not test one of CMS's financial alignment models. Instead, the state will maintain its existing integrated capitated payment and delivery system involving Medicaid MCOs that also qualify as Medicare Advantage D-SNPs
Medicare baseline for capitated payments:	The demonstration maintains the state's existing capitated financing arrangements through separate plan contracts with CMS and with the state. Plans will continue to comply with Medicare Advantage and Medicare Part D bid rules.
Medicare risk adjustment:	Same as above.
Medicaid baseline for capitated payments:	Same as above. Plan contracts with the state as Medicaid MCOs continue to apply.
Medicaid risk adjustment:	Same as above.
Risk sharing:	Same as above.
Care Delivery Model:	Benefits provided through Medicaid MCOs that contract with the state and that also qualify as Medicare Advantage D-SNPs that contract with CMS. Plans may process an integrated set of claims instead of differentiating between Medicare and Medicaid covered services. Plans will be allowed to integrate Medicare and Medicaid primary care payments to facilitate Health Care Homes (HCHs) through Integrated Care System Partnerships (ICSPs) between plans and providers to improve Medicare and Medicaid service coordination, improve health outcomes, and help beneficiaries to remain in home or community-based settings. HCHs will receive an additional payment for care coordination. ICSPs will allow plans to use alternative payment approaches to integrate the HCH model with primary and specialty care coordination arrangements for beneficiaries. There are 3 ICSP models: (1) HCH-Based Virtual ICSPs, which provide payments to primary care providers to incentivize better care coordination; (2) HCH or HCH alternative-based primary, acute, and/or LTC ICSPs, which build on the health care home approach to further integrate primary and LTC coordination and

MINNESOTA:	
	delivery; and (3) Integration of Physical and Behavioral Health ICSPs, which allows further integration of Medicaid mental health targeted case management services with the care coordination required under Medicare and Medicaid HCHs and/or newly developing Medicaid behavioral health homes to focus on reducing emergency room visits.
Participating Health Plans:	Blue Plus, HealthPartners, Itasca Medical Care, Medica Health Plans, Metropolitan Health Plan, PrimeWest Health, South Country Health Alliance, and UCare Minnesota
Benefits:	Medicare benefits will continue to be at least equivalent to those provided under Medicare Parts A, B, and D. CMS and the state will explore options to reduce Part D co-pays for all enrollees to test whether this will improve health outcomes and reduce overall health care expenditures through improved medication adherence. Plans may provide additional benefits to enrollees; the state will be involved in coordinating additional benefits to ensure that these benefits are not included in the Medicaid capitation payment. Medicaid benefits will continue to be provided per the Medicaid MCO contracts with plans.
Continuity of Care:	N/A – demonstration will not change existing plan provider network arrangements.
Ombuds Program:	The Minnesota Ombudsman for Managed Care will provide input on plan and system-wide performance. No further detail specified.
Stakeholder Engagement:	The CMS-state contract management team will review stakeholder input. No further detail specified.
Appeals:	CMS and the state already have integrated elements of the appeals process in the Senior Health Options program. The demonstration will add an integrated notice and appeal timeframes. *Notice:* same as California (single integrated notice) *Timeframe to request initial appeal:* same as Michigan (90 days) *Internal health plan appeal:* not specified in MOU *Integrated external appeals process:* not specified in MOU *Appeals where Medicare and Medicaid services overlap:* not specified in MOU *Continued benefits pending appeal:* not specified in MOU *Medicare Part D:* same as California (existing Medicare Part D appeals process continues)

NEW YORK:	
MOU Signed:	Aug. 26, 2013 3-way contract not yet available
Demonstration Duration:	3 years Jan. 1, 2015 to Dec. 31, 2017[50]
Target Group:	*Includes:* an estimated 170,000 full benefit dual eligible beneficiaries age 21 and older in 8 counties who are eligible for a nursing home level of care and receiving facility-based LTSS or who are eligible for the nursing home transition and diversion § 1915(c) waiver or who require community-based LTSS for more than 120 days are eligible to enroll in the demonstration *Excludes:* dual eligible beneficiaries who reside in a state Office of Mental Health, psychiatric, ICF/IDD, or alcohol/substance abuse long-term residential treatment facility or an assisted living program, those receiving services from the state DD system, those eligible to reside in an ICF/IDD but who choose not to, participants in the § 1915(c) DD and TBI HCBS waivers, those expected to be eligible for Medicaid for less than 6 months, those eligible only for TB-related, breast and cervical cancer or family planning expansion Medicaid services, those receiving hospice services at the time of enrollment, non-elderly individuals who are screened and require breast and cervical cancer treatment in the CDC early detection program who do not have other creditable coverage, those eligible for emergency Medicaid, and participants in the Foster Family Care demonstration
Geographic Area:	8 counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, Westchester
Enrollment:	Initial enrollment period is voluntary, followed by passive enrollment periods in which the remaining beneficiaries in the target population will be automatically enrolled. Beneficiaries receiving community-based LTSS and those in nursing facilities can voluntarily enroll in the demonstration with enrollment effective no earlier than October 2014.[51] Those that do not voluntarily enroll will be passively enrolled no earlier than Jan. 1, 2015.[52] The MOU's dates for notices in advance of voluntary and passive enrollment have not yet been updated. Passive enrollment for each group will be phased in over a minimum 4 month period. Populations who will not be passively enrolled include Native Americans, people who are eligible for the Medicaid buy-in for working people with disabilities and who are nursing home eligible, Aliessa court ordered individuals, and enrollees in PACE, a Medicare Advantage SNP for institutionalized beneficiaries, health homes, ACOs, the Independence at Home demonstration and employer or union-sponsored coverage Beneficiaries can opt out of the demonstration until the last day of the month prior to their effective enrollment date and at any time after enrollment. The MOU indicates that NY will submit conforming amendments to its § 1115 Partnership Plan (MLTC) waiver and § 1915(c) nursing facility transition and diversion waiver. NY's § 1115 waiver requires beneficiaries in the demonstration geographic area who need 120 days of LTSS to enroll in Medicaid managed care.[53] Intelligent assignment for passive enrollment will consider previous managed care enrollment and historic provider utilization
Financing:	Capitated with savings percentage (1% in year one, 1.5% in year two, 3% in year three) applied upfront to baseline Medicare and Medicaid contributions, except that savings in year three will be reduced to 2.5% if at least 1/3 of plans experience losses exceeding 3% of revenue in year 1, based on at least 15 months of data; capitation rate quality withhold same as in California (1% in year 1, 2% in year 2, 3% in year 3)

NEW YORK:		
Medicare baseline for capitated payments:	Same as California except that Medicare Advantage risk score coding intensity adjustment factor will apply beginning in CY 2014[54]	
Medicare risk adjustment:	Same as California	
Medicaid baseline for capitated payments:	Blend of Medicaid MLTC capitated rates that would apply to enrollees in the demonstration area and estimate of FFS costs for services excluded from MLTC rate	
Medicaid risk adjustment:	Rating categories[55] risk adjusted similar to the model used for MLTC capitated rates	
Risk sharing:	Required medical loss ratio of 85%; may require plans to maintain a minimum level of reinsurance	
Care Delivery Model:	Fully Integrated Duals Advantage (FIDA) plans will perform assessments using the state-approved assessment tool and provide person-centered care management and integrated medical, behavioral health, substance use, and community and facility-based LTSS through Interdisciplinary Teams. The Team makes coverage determinations and authorizes services, which may not be modified by the plan outside the Team. Beneficiaries have the right to choose and change their care managers.	
Participating Health Plans:	Aetna Agewell AlphaCare Amerigroup Amida Catholic Managed Long Term Care, Inc. (Archcare) Centerlight Centers Plan for Healthy Living Elderplan (Homefirst) Elderserve Fidelis Care of NY (NYS Catholic Health Plan) GuildNet Healthfirst (Managed Health, Inc.) HHH Choices HIP	Independence Care Systems Integra MetroPlus Montefiore North Shore LIJ HealthPlan, Inc. Senior Whole Health United Healthcare Village Care MAX VNYSNY Choice Wellcare Participation is subject to plans meeting readiness review requirements, and the final plan announcement is expected in the second quarter of CY 2014.[56]
Benefits:	Includes all Medicare and Medicaid services except hospice, out-of-network family planning, directly observed therapy for TB and methadone maintenance; includes § 1115 Medicaid MLTC services and § 1915(c) nursing facility diversion and transition HCBS; plans have flexibility to enhance covered services with additional non-covered services to address beneficiary needs and to cover items or services not traditionally covered by Medicare or Medicaid that are necessary and appropriate for the beneficiary	
Continuity of Care:	Beneficiaries must maintain current providers and service levels for at least 90 days after enrollment or until a care assessment has been completed by the FIDA plan, whichever is later, except that beneficiaries must maintain current nursing facility providers for the duration of the demonstration	
Ombuds Program:	NY is creating a new independent FIDA participant ombudsman to help beneficiaries access care through the demonstration, provide individual advocacy and systemic oversight, and	

NEW YORK:	
	gather and report data
Stakeholder Engagement:	FIDA plans must establish at least one participant advisory committee that meets quarterly and is open to all participants and a process for the committee to provide input to the plan. Plans must demonstrate that beneficiaries with disabilities participate in the plan governance structure. Plans also are encouraged to include beneficiaries on their boards of directors.
Appeals:	*Notice:* same as California (single integrated notice) *Timeframe to request initial appeal:* same as Illinois (60 days) *Internal health plan appeal:* same as Illinois (all initial appeals must be filed with health plan) except MOU does not mention timeframes for appeal resolution; paper review unless beneficiary requests in-person review; expedited review is available *Integrated external appeals process:* all adverse internal health plan appeal decisions are automatically sent to Integrated Hearing Officer external to the plan for a phone or in-person hearing – expedited review is available; 60 days to appeal adverse Hearing Officer decision to Medicare Appeals Council for paper review; adverse Appeals Council decision can be appealed to federal district court *Appeals where Medicare and Medicaid services overlap:* same process as above – NY is establishing one integrated appeals process for all Medicare Parts A and B and Medicaid appeals *Continued benefits pending appeal:* benefits continue pending appeal during the internal health plan appeal, the Integrated Hearing Officer hearing, and Medicare Appeals Council review for all prior-approved services if the initial health plan appeal is requested within 10 days of the termination or modification notice *Medicare Part D:* same as California (existing Medicare Part D appeals process continues to apply)

OHIO:	
MOU Signed:	Dec. 11, 2012 3-way contract issued Feb. 11, 2014[57]
Demonstration Duration:	3 years May 1, 2014[58] to Dec. 31, 2016
Target Group:	*Includes:* an estimated 115,000 full benefit dual eligible beneficiaries age 18 and older in 29 counties grouped into 7 regions are eligible to enroll *Excludes:* dual eligible beneficiaries with other comprehensive coverage, those with developmental disabilities who are served through an ICF/DD or § 1915(c) HCBS waiver, those on a Medicaid spend down, and PACE or Independence at Home enrollees
Geographic Area:	29 counties grouped into 7 regions: -Central: Delaware, Franklin, Madison, Pickaway and Union counties -East Central: Portage, Stark, Summit and Wayne counties -Northeast: Cuyahoga, Geauga, Lake, Lorain, and Medina counties -Northeast Central: Columbiana, Mahoning and Trumbull counties -Northwest: Fulton, Lucas, Ottawa and Wood counties -Southwest: Butler, Clermont, Clinton, Hamilton and Warren counties -West Central: Clark, Greene and Montgomery counties
Enrollment:	Initial enrollment period is voluntary, followed by three passive enrollment periods in which the remaining beneficiaries in the target population will be automatically enrolled Beneficiaries first will be passively enrolled in a Medicaid managed care plan, with enrollment effective May 1, 2014 in the Northeast region, June 1, 2014 in the Northwest, Northeast Central, and Southwest regions; and July 1, 2014 in the East Central, Central, and West Central regions. Beneficiaries also will be able to voluntarily enroll in the demonstration for their Medicare benefits between May and Dec. 2014. Beneficiaries who do not voluntarily enroll in the demonstration for their Medicare benefits will be passively enrolled beginning in Jan. 2015.[59] The MOU provides that beneficiaries will receive notices 60 days prior to passive enrollment. Beneficiaries may opt out of the demonstration prior to passive enrollment and thereafter on a monthly basis Ohio may separately apply for a § 1915(b)/(c) waiver to require beneficiaries to enroll in a Medicaid managed care plan if they opt out of the financial alignment demonstration Intelligent assignment for passive enrollment will consider previous managed care enrollment and historic provider utilization
Financing:	Capitated with savings percentage (1% in year one, 2% in year two, and 4% in year three) applied upfront to baseline Medicare and Medicaid contributions; capitation rate quality withhold same as in California (1% in year 1, 2% in year 2, 3% in year 3)
Medicare baseline for capitated payments:	Same as California
Medicare risk adjustment:	Same as California

OHIO:	
Medicaid baseline for capitated payments:	Medicaid capitation rates under § 1915(b) waiver that would apply to beneficiaries who are in target population but not enrolled in demonstration
Medicaid risk adjustment:	Rating categories with financial incentives for HCBS over institutional care[60] and member enrollment mix adjustment to account for plans with greater proportion of high risk/high cost beneficiaries
Risk sharing:	Required minimum medical loss ratio of 90%
Care Delivery Model:	Integrated Care Delivery System Plans will offer care management services to coordinate medical, behavioral health, LTSS and social needs Requires contracts with Area Agencies on Aging to coordinate home and community-based waiver services for beneficiaries over age 60
Participating Health Plans:	-Central and Southwest regions: Aetna and Molina -East Central and Northeast Central regions: CareSource and United -Northeast region: Buckeye/Centene, CareSource, and United -Northwest region: Aetna and Buckeye/Centene -West Central region: Buckeye/Centene and Molina
Benefits:	Includes all Medicare and Medicaid services, except Medicare hospice and Medicaid habilitation services and targeted case management for beneficiaries with developmental disabilities; includes Medicaid home and community-based waiver services except for beneficiaries with developmental disabilities, with services to be defined in Ohio's expected § 1915(b)/(c) waiver application; plans have discretion to offer flexible benefits as appropriate to beneficiary needs
Continuity of Care:	Beneficiaries identified for high risk care management have a 90 day transition period for maintaining current physician services; other beneficiaries have one year. HCBS waiver enrollees maintain current waiver service levels for one year and providers for either one year or 90 days, depending on the type of service
Ombuds Program:	Ohio's existing Office of the State Long-term Care Ombudsman will offer individual advocacy and independent systemic oversight in the demonstration. Ohio has been awarded CMS funding to support its ombuds program.[61]
Stakeholder Engagement:	Same as California
Appeals:	*Notice:* same as California (single integrated notice) *Timeframe to request initial appeal:* same as Michigan (90 days) *Internal health plan appeal:* initial appeals for Medicare Parts A and B services must be filed with health plan; initial appeals for Medicaid services may be filed with health plan or beneficiary may directly request fair hearing; health plan to resolve appeals within 15 days (standard) or 72 hours (expedited) *External Medicare appeals:* same as California (health plan automatically sends appeal to Medicare IRE if initial denial upheld; beneficiary may then request Office of Medicare Hearings and Appeals review) *External Medicaid appeals:* beneficiary may request fair hearing initially or after health

plan appeal; fair hearings to be resolved within 90 days in year 1, 60 days in year 2 and 30 days in year 3

Appeals where Medicare and Medicaid services overlap: plan to be bound by decision most favorable to beneficiary

Continued benefits pending appeal: benefits continue pending internal health plan appeals and Medicaid fair hearings; payments for continued benefits while appeals are pending are not recouped based on appeal outcome

Medicare Part D: same as California (existing Medicare Part D appeals process continues to apply)

SOUTH CAROLINA:	
MOU Signed:	Oct. 25, 2013 3-way contract not yet available
Demonstration Duration:	3 years July 1, 2014 to Dec. 31, 2017
Target Group:	*Includes:* an estimated 53,600 full benefit dual eligible beneficiaries ages 65 and older who reside in the community at the time of enrollment (includes Community Choices (elderly/disabled) waiver, HIV/AIDS waiver, and Mechanical Ventilation waiver participants) are eligible to enroll; Medicare Advantage and PACE enrollees may enroll in the demonstration if they disenroll from their current program; beneficiaries who transition from an ICF/DD or nursing facility to the community may elect to enroll and also may be eligible for passive enrollment; beneficiaries already enrolled in the demonstration who later enter a nursing facility or hospice program or begin receiving ESRD services may remain in the demonstration *Excludes:* dual eligible beneficiaries with other comprehensive coverage, residents of an ICF/DD or nursing facility and beneficiaries receiving hospice or ESRD services at the time of demonstration eligibility determination, those on a Medicaid spend down, and those receiving Medicaid HCBS through a waiver other than the 3 listed above
Geographic Area:	Statewide, divided into two regions: -Region 1/Upstate: Abbeville, Aiken, Anderson, Bamberg, Barnwell, Cherokee, Chester, Edgefield, Fairfield, Greenville, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Oconee, Pickens, Richland, Saluda, Spartanburg, Union, and York counties -Region 2/Coastal: Allendale, Beaufort, Berkeley, Calhoun, Charleston, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Florence, Georgetown, Hampton, Horry, Jasper, Lee, Marion, Marlboro, Orangeburg, Sumter, and Williamsburg counties
Enrollment:	Initial enrollment period is voluntary, followed by three passive enrollment periods in which the remaining beneficiaries in the target population will be automatically enrolled Voluntary enrollment will begin no sooner than July 1, 2014 and extend through Dec. 31, 2014. Passive enrollment will be phased in as follows: enrollment effective Jan. 1, 2015 for beneficiaries in the Upstate Region (Region 1) who are not served through HCBS waivers; enrollment effective March 1, 2015 for beneficiaries in the Coastal Region (Region 2) who are not served through HCBS waivers; and enrollment effective May 1, 2015 for beneficiaries statewide who receive HCBS waiver services. Beneficiaries subject to Medicare reassignment effective Jan. 1, 2015 will be eligible for passive enrollment no earlier than Jan. 1, 2016. Beneficiaries will receive enrollment notices 60 days and 30 days prior to passive enrollment Beneficiaries may opt out of the demonstration until the last day of the month prior to enrollment and thereafter on a monthly basis South Carolina must submit a § 1932 Medicaid state plan amendment and concurrent authority for the 3 affected § 1915(c) waivers prior to Jan. 1, 2014 Passive enrollment will be based on an "intelligent assignment" algorithm that will consider existing provider relationships, including HCBS providers; previous history with another Medicare Advantage or Medicaid managed care plan within the past year; household members currently assigned to a demonstration plan; and relative case mix of each demonstration plan

SOUTH CAROLINA:	
Financing:	Capitated with savings percentage (1% in year one, 2% in year two, 4% in year three) applied upfront to baseline Medicare and Medicaid contributions; capitation rate qualify withhold same as in California (1% in year 1, 2% in year 2, 3% in year 3); the state and health plans will provide financial incentives to providers that achieve NCQA patient centered medical home certification Plans may receive up to $3,000 per enrollee as a one-time enhanced transition coordination fee for successfully moving a beneficiary from a nursing facility to the community for at least 12 months through SC's Money Follows the Person program.
Medicare baseline for capitated payments:	Same as California[62]
Medicare risk adjustment:	Same as California
Medicaid baseline for capitated payments:	Historical state FFS spending for state plan and HCBS waiver services trended forward
Medicaid risk adjustment:	Rating categories with financial incentive for 90 days following transition to community from nursing facility and financial penalty for 90 days following transition from community to nursing facility[63]
Risk sharing:	MLR of 85% required beginning in CY 2015
Care Delivery Model:	Coordinated and Integrated Care Organizations (CICOs) must offer providers that are medical homes and will offer care coordination of medical and behavioral health, preventive services, prescription drugs, LTSS, social supports, and enhanced benefits. The HCBS waiver case manager will be a member of the multidisciplinary care team, responsible for advocating for LTC in the care coordination process. HCBS authority will be transitioned from the state to plans over the course of the demonstration: in phase I (July 1 to Dec. 31, 2014), the state will maintain contractual relationships with HCBS providers, and plans will receive payment for those services and process provider payments. The state will develop the waiver care plan and recommended service authorizations with concurrence by the plan in a three-way conference between the state reviewer, waiver care manager, and plan designee. If there is disagreement, the plan may request review from the demonstration ombudsman which has authority to make a final decision. The waiver case manager will work with the plan care coordinator to integrate HCBS into the single overall care plan. In phase II (2015), plans that have completed the benchmark review will assume responsibility for case management services and most HCBS. Plans will perform LOC reassessments, contract with HCBS providers, set provider rates subject to state minimum levels, develop HCBS care plans and service authorizations with state concurrence, and subcontract with the University of SC's Center for Disability Resources for self-direction services. In phase III (2016), plans that have completed the final benchmark review will assume all responsibility needed to adequately coordinate HCBS, including self-direction, and may elect to assume responsibility for provider credentialing and monitoring. A readiness review will precede each phase.
Participating Health Plans:	Absolute Total Care, Advicare, Molina Healthcare of South Carolina, Select Health of South Carolina, WellCare Health Plans[64]

SOUTH CAROLINA:	
Benefits:	Plans will provide all Medicare and Medicaid benefits, other than Medicare hospice. Includes home and community-based waiver services for Community Choices (elderly/disabled), HIV/AIDS, and Mechanical Ventilation waivers. All enrollees who meet the level of care criteria for HCBS will access waiver services without a waiting list Plans must provide a new palliative care benefit for enrollees with a serious, chronic or life-threatening illness who may not meet hospice criteria. Plans have discretion to offer flexible benefits as appropriate to beneficiary needs
Continuity of Care:	Beneficiaries must be able to maintain a current course of treatment with an out-of-network provider, including behavioral health and LTSS, and must maintain current service authorization levels for all direct care waiver services during a 180 day transition period unless significant change has occurred and is documented during the LTC LOC assessment.
Ombuds Program:	State intends to support an independent ombuds program outside of the state Medicaid agency to advocate and investigate on behalf of demonstration enrollees, safeguard due process, identify systematic problems, and provide arbitration between the state and plans as needed during the HCBS transition
Stakeholder Engagement:	Same as California
Appeals:	*Notice:* Same as California (single integrated notice) *Timeframe to request initial appeal:* Same as Illinois (60 days) *Internal health plan appeal:* Same as Illinois (initial appeal must be filed with health plan) except that expedited appeals are to be resolved within 72 hours *External Medicare appeals:* same as California except that Office of Medicare Hearing and Appeals review not mentioned in MOU *External Medicaid appeals:* Same as Illinois except that beneficiary has 30 days from internal appeal decision to request fair hearing for Medicaid-only services and expedited appeals are to be resolved within 72 hours *Appeals where Medicare and Medicaid services overlap:* if plan upholds denial of overlapping Medicare-Medicaid services, appeal will be automatically forwarded to IRE. Beneficiary then has 30 days from notice of right to fair hearing following IRE adverse disposition to request fair hearing for Medicare-Medicaid overlapping services. *Continued benefits pending appeal:* Medicare services will be required to continue pending resolution of internal plan appeal. Medicaid services and Medicare-Medicaid overlapping services will continue pending internal plan appeal if internal plan appeal is filed within 10 days of notice. Medicaid services continue pending fair hearing disposition if fair hearing is requested within 10 days of internal appeal decision. Medicare-Medicaid overlapping services continue pending IRE decision and then during subsequent fair hearing if requested within 10 days. *Medicare Part D appeals:* Same as California (existing Medicare Part D appeals process continues to apply)

TEXAS:	
MOU Signed:	May 23, 2014 3-way contract not yet available
Demonstration Duration:	3 years March 1, 2015 to Dec. 31, 2018
Target Group:	*Includes:* an estimated 168,000 full benefit dual eligible beneficiaries with disabilities age 21 and older who qualify for SSI benefits or Medicaid home and community-based STAR+PLUS waiver services; PACE and Independence at Home enrollees may enroll in the demonstration if they disenroll from their current program; beneficiaries enrolled in a Medicare Advantage plan not operated by the same parent organization that operates a STAR+PLUS Medicare-Medicaid Plan may enroll in the demonstration if they disenroll from their existing plan *Excludes:* dual eligible beneficiaries who are residents of an ICF/DD or receive services through the Community Living and Support Services, Deaf Blind with Multiple Disabilities Program, Home and Community-Based Services or Texas Home Living Program § 1915(c) waivers
Geographic Area:	6 counties: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant; CMS and the state may change and/or add up to 2 additional counties to the demonstration if, before the scheduled start date, a situation arises that would limit beneficiary choice or the quality or availability of services would decrease in any service area – such a change is subject to ongoing stakeholder discussions and must be effectuated by Jan. 1, 2016
Enrollment:	Initial enrollment period is voluntary, followed by passive enrollment phased-in over at least 6 months during which the remaining beneficiaries in the target population will be automatically enrolled Voluntary enrollment will be effective March 1, 2015. For the first 6 months of the demonstration, CMS and the state will monitor plans' capacity to manage voluntary and passive enrollments; depending on plan capacity, beneficiaries will be passively enrolled into plans, considering the number of voluntary enrollments and the opt-out rate for each plan. In Harris County, passive enrollment will not exceed 5,000 beneficiaries per month per plan. In Bexar, Dallas, El Paso, Hidalgo, and Tarrant counties, passive enrollment will not exceed 3,000 beneficiaries per plan per month. Beneficiaries subject to Medicare reassignment effective Jan. 1, 2015 will be eligible for passive enrollment no earlier than Jan. 1, 2016. Beneficiaries will receive enrollment notices 60 days and 30 days prior to passive enrollment Beneficiaries may opt out of the demonstration until the last day of the month prior to enrollment and thereafter on a monthly basis Texas's existing § 1115 Medicaid demonstration waiver requires Medicaid managed care enrollment; the waiver expires Sept. 30, 2016 and must be renewed to continue the financial alignment demonstration Passive enrollment will be based on an "intelligent assignment" algorithm that prioritizes continuity of providers and/or services and considers beneficiaries' previous managed care enrollment and historic provider utilization
Financing:	Capitated with savings percentage (1.25% in year one(a), 2.75% in year one(b), 3.75% in year two, 5.5% in year three) applied upfront to baseline Medicare and Medicaid contributions; capitation rate qualify withhold same as in California (1% in year 1, 2% in year 2, 3% in year 3)[65]

TEXAS:	
Medicare baseline for capitated payments:	Same as California[66]
Medicare risk adjustment:	Same as California
Medicaid baseline for capitated payments:	Capitation rates in the state's Medicaid § 1115 managed care demonstration that would otherwise apply, adjusted to add historical costs for benefits and Medicare cost-sharing not included in the Medicaid demonstration capitation rates
Medicaid risk adjustment:	Rating categories consistent with the state's § 1115 Medicaid demonstration with financial incentives for HCBS over NF care[67]
Risk sharing:	Plans must pay an "Experience Rebate" to the state, which will be distributed back to the Medicare and Medicaid programs, if plan net income before taxes is greater than specified percentages for each demonstration year;[68] beginning in year 2, the amount of administrative expenses used to determine net income before taxes will be capped
Care Delivery Model:	STAR+PLUS Medicare-Medicaid Plans will provide care management of medical and behavioral health, prescription drug, and LTSS.
Participating Health Plans:	Bexar County: Amerigroup, Molina, Superior Dallas County: Molina, Superior El Paso County: Amerigroup, Superior Harris County: Amerigroup, Molina, United Hidalgo County: Health Spring, Molina, Superior Tarrant County: Amerigroup, Health Spring[69]
Benefits:	Plans will provide all Medicare and Medicaid benefits, other than Medicare hospice. Includes STAR+PLUS home and community-based waiver services Plans have discretion to offer flexible benefits as appropriate to beneficiary needs
Continuity of Care:	Beneficiaries must be able to maintain their current providers and service authorizations up to 90 days, with further details to be specified in the 3-way contract; in addition, beneficiaries receiving LTSS at the time of enrollment, including nursing facility services, will maintain service authorization up to 6 months, and beneficiaries being treated for a terminal illness at the time of enrollment shall have continued access to covered services for 9 months
Ombuds Program:	The state Health and Human Services Commission Office of the Ombudsman will support individual advocacy in the demonstration, provide feedback on plan performance issues to CMS and the state, and gather and report data.
Stakeholder Engagement:	Same as California
Appeals:	*Notice:* Same as California (single integrated notice) *Timeframe to request initial appeal:* 60 days to file health plan appeal for Medicare or Medicaid benefits; 90 days to request Medicaid fair hearing *Internal health plan appeal:* initial Medicare appeal is filed with health plan; initial

TEXAS:	
	Medicaid appeal is filed with health plan or beneficiary may directly request fair hearing; health plan appeals must be resolved within 30 calendar days for standard appeals and 72 hours for expedited appeals except that appeals related to an ongoing emergency or denial of continued hospitalization must be resolved no later than one business day *External Medicare appeals:* same as California *External Medicaid appeals:* Same as California except that Independent Medical Review not mentioned *Appeals where Medicare and Medicaid services overlap:* not mentioned in MOU *Continued benefits pending appeal:* Medicare services will be required to continue pending resolution of internal plan appeal. Medicaid services will continue pending internal plan appeal and fair hearing if aid pending request is timely. Payments will not be recouped based on the appeal outcome. *Medicare Part D appeals:* Same as California (existing Medicare Part D appeals process continues to apply)

VIRGINIA:	
MOU Signed:	May 21, 2013 3-way contract issued Dec. 4, 2013[70]
Demonstration Duration:	3 years April. 1, 2014 to Dec. 31, 2017[71]
Target Group:	*Includes:* an estimated 78,600 full benefit dual eligible beneficiaries age 21 and older in 104 localities grouped into 5 regions are eligible to enroll; PACE and Independence at Home enrollees may participate if they disenroll from their current program *Excludes:* dual eligible beneficiaries with other comprehensive coverage, those served in a state mental hospital, state hospital, ICF/DD, residential treatment facility or long stay hospital (nursing facility residents are included), § 1915(c) HCBS waiver participants (other than the Elderly or Disabled with Consumer Direction waiver), hospice patients, those with end stage renal disease at the time of demonstration enrollment, those on a Medicaid spend down, those who are eligible for Medicaid for less than 3 months, those whose only Medicaid eligibility is retroactive, and enrollees in the Virginia Birth-Related Neurological Injury Compensation Program or the Money Follows the Person Program
Geographic Area:	104 localities in 5 regions:[72] -Central Virginia: Amelia, Brunswick, Caroline, Charles City, Chesterfield, Cumberland, Dinwiddie, Essex, Goochland, Greensville, Hanover, Henrico, King and Queen, King George, King William, Lancaster, Lunenburg, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Powhatan, Prince Edward, Prince George, Richmond Co., Southampton, Spotsylvania, Stafford, Surry, Sussex, Westmoreland, Colonial Heights, Emporia, Franklin City, Fredericksburg, Hopewell, Petersburg, Richmond City -Northern Virginia: Arlington, Culpepper, Fairfax County, Fauquier, Loudoun, Prince William, Alexandria, Fairfax City, Falls Church, City of Manassas, Manassas Park -Tidewater: Accomack, Gloucester, Isle of Wight, James City County, Mathews, Northampton, York , Chesapeake, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach, Williamsburg -Western/Charlottesville: Albemarle, Augusta, Buckingham, Fluvanna, Greene, Louisa, Madison, Nelson, Orange, Rockingham, Charlottesville, Harrisonburg, Staunton, Waynesboro -Roanoke: Alleghany, Bath, Bedford County, Botetourt, Craig, Floyd, Franklin County, Giles, Henry, Highland, Montgomery, Patrick, Pulaski, Roanoke County, Rockbridge, Wythe, Bedford City, Buena Vista, Covington, Lexington, Martinsville, Radford, Roanoke City, Salem
Enrollment:	Enrollment will be conducted in two phases. Each phase will include an initial voluntary enrollment period, followed by passive enrollment in which the remaining beneficiaries in the target population will be automatically enrolled In Phase I (Central VA and Tidewater), voluntary enrollment will be effective no sooner than April 2014 (as revised).[73] Initial passive enrollment for remaining Phase I beneficiaries will be effective July 2014.[74] The dates for advance notice have not been updated since CMS and the state decided to delay enrollment. Phase II (Western/Charlottesville, Northern VA, and Roanoke) also will have voluntary and passive enrollment periods, but the dates have not been updated to reflect the delay subsequent to the MOU. Beneficiaries subject to Medicare drug plan reassignment effective January 2014 will not be passively enrolled in 2014. Beneficiaries may opt of the demonstration prior to passive enrollment and thereafter on a monthly basis

VIRGINIA:	
	Virginia's § 1932(a) state plan amendment has been approved by CMS and provides for voluntary enrollment in Medicaid managed care.[75] The state also must amend its § 1915(c) waivers affected by the demonstration in the next update or scheduled renewal, whichever is sooner Passive enrollment intelligent assignment will prioritize the following: (1) beneficiaries in NFs will be assigned to a plan with that NF in-network; (2) beneficiaries in HCBS waiver will be assigned to plan that includes current adult day health care provider in-network; (3) if more than one plan includes NF or adult day health care provider, assignment to the plan in which beneficiary has been assigned in the last 6 months; (4) other beneficiaries will be assigned to a plan to which they have been assigned in the last 6 months
Financing:	Capitated with savings percentage (1% in year one, 2% in year two, 4% in year three) applied upfront to baseline Medicare and Medicaid contributions, except that savings in year three will be reduced to 3% if 1/3 of plans experience losses exceeding 3% of revenue in all regions in which those plans participate in year one based on at least 20 months of data;[76] capitation rate quality withhold same as in California (1% in year 1, 2% in year 2, 3% in year 3)
Medicare baseline for capitated payments:	Same as California[77]
Medicare risk adjustment:	Same as California
Medicaid baseline for capitated payments:	Historical state spending for state plan and HCBS waiver services trended forward
Medicaid risk adjustment:	Rating categories with financial incentives for HCBS over institutional care[78] and member enrollment mix adjustment to account for plans with greater proportion of high risk/high cost beneficiaries and to account for the relative risk/cost differences of major sub-populations (e.g. nursing facility residents and beneficiaries receiving HCBS)
Risk sharing:	Required minimum medical loss ratio of 90%
Care Delivery Model:	Commonwealth Coordinated Care plans will provide care management services to coordinate medical, behavioral health, substance use, LTSS, and social needs
Participating Health Plans:	Humana Health Plan, VA Premier Health Plan, HealthKeepers
Benefits:	Includes all Medicare and Medicaid state plan services and Elderly or Disabled with Consumer Direction § 1915 home and community-based waiver services except Medicaid targeted case management services and case management services for beneficiaries in assisted living (hospice patients are excluded from the demonstration target population); in limited cases, dental services will be carved out of the demonstration; plans have discretion to offer flexible benefits as appropriate to beneficiary needs
Continuity of Care:	Beneficiaries retain access to current providers for 180 days from demonstration enrollment; beneficiaries retain access to services in existing plans of care and prior authorizations until authorizations expire or 180 days from demonstration enrollment, whichever is sooner, except that beneficiaries in nursing facilities at the time of

VIRGINIA:	
	demonstration implementation may remain as long as they continue to meet level of care criteria, unless they prefer to move to another facility or the community
Ombuds Program:	Virginia intends to support an independent ombuds outside of the state Medicaid agency to advocate and investigate on behalf of demonstration enrollees, safeguard due process, identify systemic problems, and gather and report data. Virginia has been awarded CMS funding to support its ombuds program.[79]
Stakeholder Engagement:	Plans must establish an independent beneficiary advisory committee that provides input to the governing board and includes beneficiaries with disabilities in the plan governance structure
Appeals:	*Notice:* same as California (single integrated notice) *Timeframe to request initial appeal:* same as Illinois (60 days) *Internal health plan appeal:* same as Illinois (initial appeal must be filed with health plan) except that appeals are to be resolved in 30 days (standard) or 72 hours (expedited) *External Medicare appeals:* same as California *External Medicaid appeals:* beneficiary may request fair hearing within 60 days of plan appeal decision; to be resolved within 90 days of hearing request in year 1, 75 days in year 2, and 30 days in year 3 *Appeals where Medicare and Medicaid services overlap:* to be defined in 3-way contract; will automatically be sent to IRE, and beneficiary also may request fair hearing; plan to be bound by decision most favorable to beneficiary *Continued benefits pending appeal:* same as Massachusetts (health plans must provide continuing benefits for all prior approved Medicare Parts A and B and Medicaid services while health plan appeals are pending; beneficiaries may request continuation of previously authorized services for Medicaid appeals while fair hearings are pending *Medicare Part D:* same as California (existing Medicare Part D appeals process continues to apply)

WASHINGTON (managed FFS model):	
MOU Signed:	Oct. 24, 2012; final demonstration agreement signed June 28, 2013[80]
Demonstration Duration:	3 years July 1, 2013[81] to Dec. 31, 2016
Target Group:	*Includes:* an estimated 21,000 full benefit dual eligible beneficiaries who are considered high cost/high risk and eligible for Medicaid health home services[82] statewide, except in 2 urban counties where the state proposes testing a capitated model, are eligible to enroll in the managed FFS demonstration; Medicare Advantage and PACE enrollees and beneficiaries receiving hospice services may participate if they disenroll from their existing program *Excludes:* dual eligible beneficiaries with other comprehensive coverage
Geographic Area:	Statewide except in 2 urban counties (King and Snohomish), divided into the following coverage areas: -Coverage Area 1: Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and Thurston counties -Coverage Area 2: Island, San Juan, Skagit, and Whatcom counties -Coverage Area 4: Pierce County -Coverage Area 5: Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum counties -Coverage Area 6: Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Stevens, Spokane, and Whitman counties -Coverage Area 7: Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla and Yakima counties
Enrollment:	Eligible beneficiaries are automatically enrolled in a health home network with beneficiaries retaining the choice about whether to receive health home services State is identifying eligible beneficiaries on a monthly basis and sending outreach materials one month prior to passive enrollment; earliest effective enrollment date was July 2013 for beneficiaries in coverage areas 4, 5, and 7 and Oct. 2013 for beneficiaries in coverage areas 1, 2, and 6 CMS approved Washington's Medicaid health home state plan amendment in June 2013 for counties in coverage areas 4, 5, and 7[83] and in Dec. 2013 for counties in coverage areas 1, 2, and 6[84]
Financing:	Managed FFS; providers continue to receive FFS reimbursement (except existing capitated behavioral health plans continue); state eligible for retrospective performance payment if savings targets and quality standards met
Medicare baseline for capitated payments:	N/A
Medicare risk adjustment:	N/A
Medicaid baseline for capitated	N/A

WASHINGTON (managed FFS model):	
payments:	
Medicaid risk adjustment:	N/A
Risk sharing:	N/A
Care Delivery Model:	Health home care coordination organizations coordinate all Medicare and Medicaid services among existing primary, acute, specialist, behavioral health, and LTSS providers
Participating Health Plans:	-Coverage Area 1: Molina Healthcare of Washington; provisional designation to Community Health Plan of Washington, Coordinated Care Corporation, United Behavioral Health, and UnitedHealthcare of Washington[85] -Coverage Area 2: provisional designation to Community Health Plan of Washington, Coordinated Care Corporation, Molina Healthcare of Washington, Northwest Regional Council, and UnitedHealthcare of Washington[86] -Coverage Area 4: Community Health Plan of Washington, United Behavioral Health (Optum Pierce), and UnitedHealthcare of Washington[87] -Coverage Area 5: Community Health Plan of Washington, Coordinated Care Corporation, United Behavioral Health, and United Healthcare of Washington[88] -Coverage Area 6: Molina Healthcare of Washington; provisional designation to Community Choice Healthcare Network, Community Health Plan of Washington, Coordinated Care Corporation, and UnitedHealthcare of Washington[89] -Coverage Area 7: Community Health Plan of Washington, Coordinated Care Corporation, Southeast Washington Aging and Long-Term Care (Yakima County), United Behavioral Health, and United Healthcare of Washington[90] Provisional designation is conditioned on satisfactory submission of a corrective action plan and implementation timeline
Benefits:	Adds Medicaid health home services but otherwise does not change Medicare and Medicaid benefits packages
Continuity of Care:	Beneficiaries will retain access to their current choice of Medicare and Medicaid providers
Ombuds Program:	Not addressed in MOU
Stakeholder Engagement:	Health home networks must ensure meaningful beneficiary input, with specifics to be determined in the state's health home network qualification process. State will include beneficiaries on its advisory team.
Appeals:	No changes from existing Medicare and Medicaid appeals systems. State and health home providers are to assist beneficiaries with exercising appeal rights.

WASHINGTON (capitated model):	
MOU Signed:	Nov. 25, 2013 3-way contract not yet finalized
Demonstration Duration:	3 years Feb. 1, 2015 to Dec. 31, 2017[91]
Target Group:	*Includes:* an estimated 27,000 full benefit adult dual eligible beneficiaries ages 21 and older in 2 urban counties are eligible to enroll in the capitated demonstration; includes Aging and Long-Term Support Administration Community Options Program Entry System (COPES) § 1915(c) HCBS waiver enrollees; beneficiaries who receive Medicaid personal care services, including those with developmental disabilities; and those in a Medicare Advantage plan operated by the same organization as a demonstration plan; PACE participants and beneficiaries in a Medicare Advantage plan operated by a parent company that is not offering a demonstration plan may enroll in the demonstration if they disenroll from their current program *Excludes:* dual eligible beneficiaries with developmental disabilities who receive institutional care or DD HCBS waiver services; Money Follows the Person participants; those receiving hospice services at the time of enrollment; Medicaid spend down SLMB Plus beneficiaries; and those with other comprehensive coverage
Geographic Area:	King and Snohomish counties
Enrollment:	Voluntary enrollment effective no earlier than July 2014, with plan marketing no earlier than June 2014 Three phases of passive enrollment effective no earlier than Sept. 2014 (phase 1), Nov. 2014 (phase 2), and Jan. 2015 (phase 3); enrollment of newly eligible beneficiaries will be monthly as of Feb. 2015; notices will be sent 60 and 30 days prior to passive enrollment. Beneficiaries will be randomly assigned to a passive enrollment phase, considering the number of voluntary enrollments prior to phase 2 and the disenrollment rate for each plan. American Indians and Alaska Natives are exempt from passive enrollment. Beneficiaries subject to Medicare plan reassignment effective Jan. 2014 will not be subject to passive enrollment in 2014. Beneficiaries eligible for Medicare plan reassignment effective Jan. 2015 who are eligible for the demonstration will be eligible for passive enrollment no earlier than Jan. 2015. Beneficiaries may opt out of the demonstration prior to passive enrollment and thereafter on a monthly basis The state must amend its § 1915(c) waiver by April 1, 2014 and submit a § 1932(a) state plan amendment. Passive enrollment plan assignments will consider the number of voluntary enrollments prior to phase 2 and each plan's disenrollment rate ADRCs, operated by the AAAs, will provide independent enrollment assistance and options counseling
Financing:	Capitated with savings percentage (1% in year one,[92] 2% in year two, and 3% in year three) applied upfront to baseline Medicare and Medicaid contributions; capitation rate quality withhold same as in California (1% in year 1, 2% in year 2, 3% in year 3)

WASHINGTON (capitated model):	
Medicare baseline for capitated payments:	Same as California except that Medicare Advantage risk score coding intensity adjustment factor will apply beginning in calendar year 2014[93]
Medicare risk adjustment:	Same as California
Medicaid baseline for capitated payments:	Historical state FFS and encounter data trended forward
Medicaid risk adjustment:	Rating categories[94]
Risk sharing:	Minimum medical-loss ratio of 85-90%
Care Delivery Model:	HealthPath Washington Medicare-Medicaid Integration Plans will provide health screenings and risk assessments, care coordination, and intensive care management and integrate medical, behavioral health, and LTSS. Beneficiaries will be assigned to 1 of 3 tier levels based on screening, assessment, and utilization data: Tier 1 (supported self-intervention – have care manager, care plan, and interdisciplinary care team and receive referral assistance when appropriate); Tier 2 (disease/episodic care management – receive care management services dedicated to problem-solving interventions and prevention and wellness messaging and condition-specific educational materials and have care plan and care team); Tier 3 (intensive care management for enrollees with special health care needs – have intensive care coordinator, care plan, access to high touch intensive care management care team with face to face interactions, and health action plan that identifies what the enrollee plans to do to improve or self-manage health conditions and actions of the intensive care coordinator) Care manager/intensive care coordinator shall make referral to state within 5 days of identifying through the care coordination process or by the enrollee that there are unmet LTSS needs. For beneficiaries newly eligible for HCBS waiver services, the demonstration plan will be responsible for waiver service planning. For beneficiaries already eligible for HCBS waiver services, the demonstration plan will maintain the existing HCBS waiver service plan and providers through the authorization or continuity of care period, whichever is later.
Participating Health Plans:	Regence Blue Shield and United Health Care[95]

WASHINGTON (capitated model):	
Benefits:	Includes all Medicare Parts A, B, and D services (except hospice), Medicaid state plan services (except those listed below) and HCBS COPES waiver services Services that remain FFS: 24 hour crisis intervention, involuntary treatment act-related transportation for judicial review, abortion, transportation other than ambulance or HCBS wavier, dental, child care/infant case management/maternity support, neurodevelopmental center services, health department or family planning clinic services when client self-refers, pharmaceuticals related to services under separate contract with state, weight loss or reduction surgery, urinalysis for drug screening for pregnant or parenting women and those received opiate substitution treatment, and prenatal diagnosis genetic counseling Plans have discretion to offer flexible benefits as appropriate to address beneficiary needs Plans may waive beneficiary Medicaid prescription drug and HCBS waiver service cost-sharing amounts Beneficiaries shall decide what LTSS to receive to maintain independence and quality of life, subject to coverage rules, and be able to hire, fire, and supervise personal care workers
Continuity of Care:	Beneficiaries must maintain current providers and service authorizations for 180 days or until completion of care plan whichever is later, unless enrollee agrees to earlier transition, for ESRD services, nursing facilities, adult family homes, and ALFs; and for 90 days or after completion of a care plan whichever is later, unless enrollee agrees to earlier transition, for all other services; plans will maintain LTSS providers (including home and community-based waiver services and PCS) for the duration of the existing authorization period or the demonstration continuity of care period, whichever is later (except 180 days for adult family homes and ALFs); plans may choose to pay established out-of-network providers indefinitely
Ombuds Program:	State Office of Insurance Commissioner, Statewide Health Insurance Benefits Advisors, and Consumer Advocacy Unit will provide individual advocacy and systemic oversight by phone, online and through state health analysts
Stakeholder Engagement:	Plans must establish an independent enrollee advisory committee that meets at least quarterly and includes beneficiaries, caregivers, and key community stakeholders
Appeals:	*Notice:* same as California (single integrated notice) *Timeframe to request initial appeal:* same as Michigan (90 days) *Internal health plan appeal:* same as Illinois (initial appeals must be filed with plan); standard appeals to be resolved within 14 calendar days of plan receipt of appeal unless plan notifies enrollee that extension is necessary and in enrollee's best interest; appeals must be resolved within a maximum of 45 calendar days from plan receipt of appeal; expedited appeals to be resolved no later than 72 hours of plan receipt of appeal *External Medicare appeals:* same as California (health plan automatically sends appeal to Medicare IRE if initial denial upheld; existing Medicare timeframes for appeal resolution apply; beneficiary may then request ALJ, appeals board, and judicial review) *External Medicaid appeals:* health plan automatically sends appeal to state Medicaid Independent Review Organization if initial denial upheld; existing Medicaid timeframes for appeal resolution apply; beneficiary may then request state administrative hearing; beneficiary or plan may appeal to state Board of Appeals; beneficiary may then seek judicial review in state court. *Appeals where Medicare and Medicaid services overlap:* default to Medicare appeals

process, with further detail to be specified in 3-way contract; beneficiaries may choose to request state IRO review concurrently with automatic IRE review; plan bound by ruling most favorable to beneficiary.

Continued benefits pending appeal: Medicare and Medicaid benefits continue pending appeal at plan level; for subsequent appeal levels, existing Medicaid rules apply to Medicaid service appeals

Medicare Part D appeals: same as California (existing Medicare Part D appeals process continues)

Endnotes

[1] For background on the demonstrations, *see* 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/issue-brief/explaining-the-state-integrated-care-and-financial/.

[2] *See* Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for Dual Eligible Beneficiaries* (Aug. 2013), available at http://www.kff.org/medicaid/issue-brief/medicaids-role-for-dual-eligible-beneficiaries/; Kaiser Family Foundation, *Medicare's Role for Dual Eligible Beneficiaries* (April 2012), available at http://www.kff.org/medicare/issue-brief/medicares-role-for-dual-eligible-beneficiaries/.

[3] Kaiser Commission on Medicaid and the Uninsured, *Development of the Financial Alignment Demonstrations for Dual Eligible Beneficiaries: Perspectives from National and State Disability Stakeholders* (July 2013), available at http://kff.org/medicaid/issue-brief/development-of-the-financial-alignment-demonstrations-for-dual-eligible-beneficiaries-perspectives-from-national-and-state-disability-stakeholders/.

[4] CMS, Medicare and Medicaid Coordination Office, Financial Alignment Initiative, Funding to Support Options Counseling for Medicare-Medicaid Enrollees, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOptionsCounselingforMedicare-MedicaidEnrollees-.html.

[5] *See, e.g.*, Virginia Commonwealth University Partnership for People with Disabilities, *A Closer Look at the Centers' for Medicare and Medicaid Services' Definition of Person-Centered Planning*, available at http://www.medicaid.gov/mltss/docs/PCP-CMSdefinition04-04.pdf.

[6] State Medicaid spending qualifies for federal matching funds based upon the state's Federal Medical Assistance Percentage (FMAP). For more information about the FMAP, *see* Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)* (Sept. 2012), available at http://www.kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/.

[7] CMS, Medicare-Medicaid Coordination Office, Financial Alignment Initiative, Funding to Support Ombudsman Programs, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html.

[8] MassHealth Demonstration to Integrate Care for Dual Eligibles, Open Meeting presentation at 17 (Oct. 16, 2013), available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/materials-from-previous-meetings.html; Calduals Ombudsman Resources, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/IllinoisContract.pdf.

[9] California's three-way contract templates are available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/California.html; Illinois' three-way contract is available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/IllinoisContract.pdf; Massachusetts' three-way contract is available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf; Ohio's three-way contract is available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioContract.pdf; Virginia's three-way contract is available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioContract.pdf.

[10] Washington's final demonstration agreement is available at http://www.adsa.dshs.wa.gov/duals/documents/WA%20Final%20Demonstration%20Agreement.pdf.

[11] The states' MOUs with CMS are available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html. All information in the Appendix is from the states' MOUs unless otherwise indicated.

[12] Templates available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/California.html.

[13] California revised its start date from October 2013 to January 2014 and then to April 2014. CalDuals, "Coordinated Care Initiative to begin no earlier than April 2014," posted Aug. 16, 2013, available at http://www.calduals.org/2013/08/16/coordinated-care-initiative-to-begin-no-earlier-than-april-2014/; CalDuals, News & Updates, "Demo to start January 2014," posted May 6, 2013, available at http://www.calduals.org/news-and-updates/.

[14] CCI Enrollment Timeline by County and Population (revised April 1, 2014), available at http://www.calduals.org/2014/04/02/revised-enrollment-chart-by-county-available-here/.

[15] Cal Duals, Proposed LA County Enrollment – Draft Revised Version (Feb. 18, 2014), available at http://www.calduals.org/implementation/policy-topics/la-county-enrollment-strategy/.

[16] Available at http://www.calduals.org/dhcs-cci-amendment-to-1115-waiver/.

[17] In California's demonstration, in calendar year 2014, CMS will apply "an appropriate Medicare Advantage coding intensity adjustment reflective of all prime contractor plan enrollees." In 2015 and 2016, CMS will apply "the prevailing Medicare Advantage coding intensity adjustment factor."

[18] California's Medicaid rating categories include institutionalized (90 or more days), HCBS High (high utilizers), HCBS Low (low utilizers), and Community Well (no HCBS).

[19] In Phase I, California's risk adjustment methodology will be applied monthly and retroactively to match actual plan enrollment, continuing through each county's enrollment phase-in period (except San Mateo) for a minimum of one year, ending at the start of the next fiscal quarter. Phase II will last for one fiscal quarter (except two quarters in San Mateo) in which the risk adjustment methodology will be applied prospectively at the start of the quarter and risk category weighting will be based on enrollment in the month preceding the quarter and applied retroactively. In Phase III, plan rates will be based on a targeted relative mix of the population (based on plan enrollment leading up to the start of Phase III and including an assumed shift in population mix based on assumptions about the plan's ability to promote community services and prevent or delay institutional placement) and will not be adjusted during the year (however, if the population mix results in greater than 2.5% impact on the Medicaid rate paid as compared to the rate that would have been paid based on the actual mix, then the plan and Medicaid will share equally in any cost increases or decreases beyond 2.5%, regardless of actual plan gain or loss).

[20] California's limited down-side risk corridor applies county-specific interim savings percentages to establish initial capitation rates; if plan costs exceed the initial capitation rates (excluding Part D), Medicare and Medicaid will reimburse the plan 67% of the costs above the initial capitation rates, provided that total federal and state payments to the plan cannot exceed the demonstration minimum savings percentage for the applicable year. California's limited up-side risk corridor is as follows: difference between demonstration minimum savings percentage and county specific savings percentage, plans retain 100% (if county savings percentage is the same as the demonstration minimum savings percentage, this band is based on the difference between the minimum savings percentage and maximum demonstration savings percentages of 1.5% in year one, 3.5% in year two, and 5.5% in year three); from upper limit of first band applying the same number of percentage points, Medicare and Medicaid share in 50% of plan savings and plan shares in the other 50%; for all amounts above the upper limit of the second band, plans retain 100%.

[21] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html.

[22] Calduals Ombudsman Resources, available at http://www.calduals.org/implementation/policy-topics/ombudsman-resources/.

[23] Available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/IllinoisContract.pdf.

[24] CMS announced that Illinois' demonstration start date has been revised from October 2013 to January 2014. Email from Daniel Farmer, Special Assistant to the Director, Medicare-Medicaid Coordination Office (May 31, 2013) (on file with author); subsequently, Illinois changed its start date to February 2014, and then to March 2014. *See* Medicare-Medicaid Alignment Initiative Implementation Status and County Plan Participation (March 1, 2014), available at http://www2.illinois.gov/hfs/PublicInvolvement/cc/mmai/Pages/MMAIImplementationStatus.aspx.

[25] Illinois beneficiaries enrolled in a Medicare Advantage plan operated by the same parent organization as a demonstration plan will be passively enrolled into that demonstration plan.

[26] Medicare-Medicaid Alignment Initiative Implementation Status and County Plan Participation (March 1, 2014), available at http://www2.illinois.gov/hfs/PublicInvolvement/cc/mmai/Pages/MMAIImplementationStatus.aspx.

[27] MMAI April 18, 2013, Stakeholders Meeting, Questions and Answers, items 61 and 62, available at http://www2.illinois.gov/hfs/SiteCollectionDocuments/MMAI_QA_041813.pdf. Beneficiaries required to enroll in a Medicaid managed care plan will be locked in for one year, after an initial 90 day change period, with an annual open enrollment period.

[28] IL Dep't of Healthcare and Family Services, Path to Transformation IL § 1115 waiver proposal, available at http://www2.illinois.gov/hfs/publicinvolvement/1115/pages/1115.aspx#toc379811249.

[29] Illinois' Medicaid rating categories will be stratified by age (21-64 and 65+), geographic region, and care setting, including nursing facility (except that the HCBS waiver rate applies for the first three months after transition from waiver to nursing facility), HCBS waiver, waiver plus (for the first three months for beneficiaries moving from a nursing facility to a HCBS waiver), and community (do not meet nursing home level of care, reside in a nursing facility or qualify for an HCBS waiver).

[30] MMAI County Plan Participation, http://www2.illinois.gov/hfs/PublicInvolvement/cc/mmai/Pages/MMAIImplementationStatus.aspx.

[31] Available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html.

[32] Available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/related-information.html.

[33] Although Massachusetts' MOU with CMS provided for an April 1, 2013 start date, the state and CMS subsequently agreed to delay implementation until July 1, 2013, and again until October 1, 2013. Massachusetts Executive Office of Health and Human Services, One Care Timeline Update, accessed June 6, 2013, available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/related-information.html.

[34] MassHealth presentation at slide 7, Open Meeting, July 29, 2013, available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/materials-from-previous-meetings.html.

[35] *Id.*

[36] MassHealth Demonstration to Integrate Care for Dual Eligibles, Open Meeting presentation at slide 12 (Oct. 16, 2013), available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/materials-from-previous-meetings.html.

[37] MassHealth presentation, Open Meeting, Feb. 21, 2014, available at http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/140221-masshealth-presentation.pdf.

[38] Massachusetts Executive Office of Health and Human Services, One Care Timeline Update, accessed Sept. 9, 2013, available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/related-information.html. Prior to announcing its revised enrollment effective dates, Massachusetts had decided to delay passive enrollment of beneficiaries in the high community need and community high behavioral health need categories until calendar year 2014. MassHealth presentation at slide 7, Open Meeting, May 17, 2013, available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/materials-from-previous-meetings.html; *see also* MassHealth Demonstration to Integrate Care for Dual Eligibles, Open Meeting presentation at slide 17 (Oct. 16, 2013), available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/materials-from-previous-meetings.html.

[39] Massachusetts revised its 2013 savings to zero. MassHealth presentation at slide 5, Open Meeting, May 17, 2013, available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/materials-from-previous-meetings.html. Demonstration year one in Massachusetts lasts from 2013 through December 2014.

[40] Massachusetts anticipates savings of greater than 4% in year 3 (approximately 4.2%) to make up for foregone savings in year one. Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals, Updated Rate Report, May 15, 2013 at 18, available at http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/duals-demo-cy2013-payment-rates.pdf.

[41] Massachusetts' Medicaid rating categories initially included facility-based care (long-term stay of more than 90 days), high community needs (skilled need seven days a week; 2 or more ADL limitations and need for skilled nursing 3 or more days a week; or 4 or more ADL limitations), community high behavioral health (based on specific diagnosis of ongoing chronic condition), and community other. Massachusetts subsequently refined its rating categories so that the high community needs and community high behavioral health categories each will be split to separate beneficiaries with certain chronic diagnoses that lead to costs considerably above average for the overall rating category, with the result that the high community needs group will be divided into highest community need (for beneficiaries with certain diagnoses such as quadriplegia, ALS, and respirator dependence, that lead to costs considerably above average for this rating category) and medium/high community need, and the community high behavioral health group will be divided into community highest behavioral health (for beneficiaries with co-occurring substance abuse and serious mental illness) and community medium/high behavioral health. MassHealth presentation at slide 7, Open Meeting, Feb. 21, 2014, available at http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/140221-masshealth-presentation.pdf.

[42] Massachusetts' high cost risk pools apply to the facility-based care and high community needs rating categories. A portion of the base Medicaid capitation rate for each of these rating categories will be withheld from all ICOs and placed into a risk pool that will be divided among ICOs based on their percent of total costs above a threshold amount for select Medicaid LTSS.

[43] Massachusetts' risk corridor tiers have been revised as follows: greater than 20% gain or loss, plans bear entire risk/reward; 3%-20% gain or loss, plans bear 50% of risk/reward and state and CMS share in other 50%; 1% to 3% gain or loss, plans bear 10% of risk/reward and state and CMS share in other 90%; 0 to 1% gain or loss, plans bear entire risk/reward. MassHealth presentation at slide 3, Open Meeting, June 28, 2013, available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/materials-from-previous-meetings.html.

[44] Dental Services in One Care (Nov. 2013), available at http://www.communitycatalyst.org/initiatives-and-issues/initiatives/voices-for-better-health/dual-agenda-newsletter/the-dual-agenda-december-4-2013/body/Dental-Services-in-One-Care_Nov-2013.pdf.

[45] MassHealth Demonstration to Integrate Care for Dual Eligibles, Open Meeting presentation at slide 17 (Oct. 16, 2013), available at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/materials-from-previous-meetings.html.

[46] In 2015, CMS will apply an appropriate adjustment based on expected proportion of target population with prior Medicare Advantage experience on a county-specific basis; in 2016, CMS will apply an appropriate adjustment reflective of all demonstration enrollees; after 2016, CMS will apply the prevailing adjustment to all enrollees.

[47] Michigan's rating categories are tier 1 (meet NF LOC and occupy a NF bed certified for Medicare and Medicaid; separate rates for publicly owned and privately owned NFs); tier 2 (meet NF LOC, do not live in NF, and enrolled in 1915(c) ICO waiver); tier 3 (do not meet tier 1 or tier 2 criteria); rates may vary by age and will vary by geographic region. For up to 3 months following the transition of a tier 2 or 3 enrollee to a NF, payment will be based on the tier 2 or 3 rate. A transition case rate will be paid after transition of a tier 1 enrollee to the community if the ICO received 3 consecutive tier 1 payments for the enrollee and provided transition services.

[48] Michigan's year 1 risk corridor bands are net income before taxes as % of revenue less than or equal to 3% or greater than 9%, ICO bears entire risk/reward; greater than 3% and less than or equal to 9%, ICO bears 50%, Medicare bears percentage based on Medicare share of combined capitation payments excluding Part D, Medicaid bears percentage based on Medicaid share of combined capitation payments excluding Part D.

[49] MI Dep't of Comm'y Health, MI Health Link Region 4 Implementation Forum presentation (April 8, 2014), available at http://www.michigan.gov/documents/mdch/MI_Health_Link__Forum_Presentation_4.08.14__452964_7.pdf.

[50] While the MOU provided for a July 1, 2014 start date, CMS and the state subsequently modified the state date to October 2014 (email from Daniel Farmer, CMS, Jan. 23, 2014, on file with author) and again to February 2015 (email from NY Medicaid Redesign Team, July 2, 2014, on file with author).

[51] *Id.*

[52] MOU provided for Sept. 1, 2014, but CMS and the state subsequently modified to Jan. 1, 2015. *Id.*

[53] Centers for Medicare and Medicaid Services, Special Terms and Conditions, New York State Dep't of Health, Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration (April 1, 2013), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-f-shrp-ca.pdf.

[54] In NY's demonstration, in CY 2014 and 2015, CMS will apply "an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis." After CY 2015, CMS will apply "the prevailing Medicare Advantage coding intensity adjustment to all FIDA Plan Participants."

[55] NY's rating categories include community non-nursing home certifiable (more than 120 days community-based LTSS but do not require nursing home level of care) and nursing home certifiable.

[56] NY Fully Integrated Duals Advantage Demonstration Frequently Asked Questions, Question 6 (Sept. 2013), available at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm.

[57] Available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioContract.pdf.

[58] Ohio revised its demonstration start date from September 2013 to March 2014 and again to May 2014 for voluntary enrollment and Jan. 1, 2015 for passive enrollment. Emails from Daniel Farmer, Special Assistant to the Director, Medicare-Medicaid Coordination Office (May 31, 2013 and Jan. 23, 2014) (on file with author).

[59] MyCare Ohio, Enrollment Update (Jan. 2014), available at http://medicaid.ohio.gov/Portals/0/For%20Ohioans/Programs/MyCareOhio/EnrollmentUpdate012014.pdf.

[60] Ohio's rating categories include community well (varies by age group (18-44, 45-64, 65+) and geographic region) and nursing facility level of care (waiver enrollment or 100 or more days in nursing facility, single rate for each region, plan continues to receive nursing facility rate for three months after a beneficiary is determined to no longer meet this level of care).

[61] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html.

[62] In CY 2014, CMS will apply an "appropriate coding intensity adjustment based on the expected proportion of the target population with prior Medicare Advantage experience on a county-specific basis." In CY 2015, CMS will apply "the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2014." After CY 2015, CMS will apply "the prevailing Medicare Advantage coding intensity adjustment for all Enrollees."

[63] South Carolina's rating categories include nursing facility based care (stay of more than 100 days); HCBS (meets level of care requirement for nursing facility and/or HCBS waiver); HCBS plus (moving from nursing facility to waiver for first 3 months of transition); and community (do not meet criteria for another category).

[64] South Carolina Medicaid Healthy Connections Prime, Health Plan Announcement, available at https://msp.scdhhs.gov/SCDue2/.

[65] Year 1(a) is March, 2015-Dec. 2105. Year 1(b) is Jan. 2016-Dec. 2016.

[66] In CY 2015, CMS will apply an "appropriate coding intensity adjustment based on the expected proportion of the target population with prior Medicare Advantage experience on a county-specific basis." In CY 2016, CMS will apply "the prevailing Medicare Advantage coding intensity adjustment proportionate to the anticipated percent of enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2015." After CY 2016, CMS will apply "the prevailing Medicare Advantage coding intensity adjustment" to all enrollees.

[67] Texas's rating categories include HCBS (includes those who receive HCBS waiver services and seniors and adults with disabilities who qualify for NF LOC but do not reside in a NF), Other Community Care (receive Medicaid state plan services only and do not reside in NF), and Nursing Facility (receive state plan services only and reside in NF). Rating categories may be updated to be consistent with the § 1115 demonstration, subject to CMS approval. For the first 3 months after a beneficiary transitions to a NF, the plan will be paid the HCBS rate. For the first 3 months after a beneficiary transitions out of a NF to the community, the plan will be paid the NF rate.

[68] Plans retain 100% of net income before taxes equal to or less than 3% of total plan revenues; the experience rebates that plans must pay are 20% for the portion of net income before taxes greater than 3% and less than or equal to 5% of total plan revenues, 40% for the portion greater than 5% and less than or equal to 7%, 60% for the portion greater than 7% and less than or equal to 9%, 80% for the portion greater than 9% and less than or equal to 12%, and 100% for the portion greater than 12%. Net income before taxes is an aggregate excess of revenues over allowable expenses.

[69] Texas Health and Human Services Commission, Medicaid and CHIP, Dual Eligible Integrated Care Project, Geographic Area, Participating Counties with number of clients covered and health plans, available at http://www.hhsc.state.tx.us/medicaid/managed-care/dual-eligible/.

[70] Available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioContract.pdf.

[71] Email from Daniel Farmer, Special Assistant to the Director, Medicare-Medicaid Coordination Office (Jan. 23, 2014) (on file with author).

[72] Virginia Medicare-Medicaid Financial Alignment Demonstration Regions, updated Jan. 11, 2013, available at http://www.dmas.virginia.gov/Content_atchs/altc/altc-anst6.pdf.

[73] The MOU provides for voluntary enrollment effective Feb. 2014, but the state and CMS subsequently revised the effective date. Email from Daniel Farmer (Jan. 23, 2014) (on file with author).

[74] *Id.*

[75] Virginia state plan amendment 13-03 (approved June 12, 2013), available at http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/VA/VA-13-03-Att.pdf.

[76] Demonstration year one in Virginia encompasses February 2014 through December 2015.

[77] In Virginia's demonstration, in calendar year 2014, CMS will apply "an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis." After calendar year 2014, CMS will apply "the prevailing Medicare Advantage coding intensity adjustment for all [e]nrollees."

[78] Virginia's rating categories include community well ages 21-64, community well age 65+, nursing facility level of care ages 21-64, and nursing facility age 65+. Beneficiaries are eligible for the nursing facility categories if they are enrolled in an HCBS waiver or spend 20 or more consecutive days in a nursing facility. Plans will continue to receive the nursing facility rate for two months after a beneficiary is determined to no longer meet that level of care. Rates within each category will vary by region.

[79] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html.

[80] Washington's final demonstration agreement is available at http://www.adsa.dshs.wa.gov/duals/documents/WA%20Final%20Demonstration%20Agreement.pdf.

[81] Although Washington's MOU with CMS provided for an April 1, 2013 start date, the state and CMS subsequently agreed to delay implementation until July 1, 2013. Washington Health Care Authority Stakeholder Notice (Feb. 4, 2013), available at http://www.communitycatalyst.org/doc_store/publications/StakeholdernoticeHealth%20Homes.pdf; see also Final Demonstration Agreement between CMS and State of Washington Regarding a Federal-State Partnership to Test a Managed FFS Financial Alignment Model for Medicare-Medicaid Enrollees (June 28, 2013), available at http://www.adsa.dshs.wa.gov/duals/documents/WA%20Final%20Demonstration%20Agreement.pdf.

[82] Chronic conditions included in WA's health homes eligibility criteria include mental health conditions, substance use disorder, asthma, diabetes, heart disease, cancer, cerebrovascular disease, coronary artery disease, dementia or Alzheimer's disease, intellectual disability, HIV/AIDS, renal failure, chronic respiratory conditions, neurological disease, gastrointestinal, hematological, and musculoskeletal conditions. CMS/WA Final Demonstration Agreement at 5.

[83] WA state plan amendment 13-08 (June 28, 2013), available at http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-08-Ltr.pdf.

[84] WA state plan amendment 13-17 (Dec. 11, 2013), available at http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-17-HHSPA.pdf.

[85] Washington State Health Care Authority, RFA #12-005 Qualified Health Homes Release C (Aug. 9, 2013), http://www.hca.wa.gov/Documents/health_homes/ASAAnnouncement_1_2_6.pdf.

[86] *Id.*

[87] Washington State Health Care Authority, RFA #12-005 Release A (Feb. 1, 2013), http://www.hca.wa.gov/Documents/health_homes/coveragearea4_asa_announcement.pdf.

[88] Washington State Heath Care Authority, RFA #12-005 Release B (April 30, 2013), http://www.hca.wa.gov/Documents/health_homes/ASAAnnouncementReleaseB.pdf.

[89] Washington State Health Care Authority, RFA #12-005 Qualified Health Homes Release C (Aug. 9, 2013), http://www.hca.wa.gov/Documents/health_homes/ASAAnnouncement_1_2_6.pdf.

[90] Washington State Heath Care Authority, RFA #12-005 Release B (April 30, 2013), http://www.hca.wa.gov/Documents/health_homes/ASAAnnouncementReleaseB.pdf.

[91] The MOU originally called for enrollment in July 2014, but Washington subsequently amended its earliest effective enrollment date to February 1, 2015 (www.altsa.dshs.wa.gov/duals).

[92] Demonstration year 1 in Washington is July 1, 2014 to Dec. 31, 2015.

[93] In calendar year 2014, CMS will apply an "appropriate" coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis. In calendar year 2015, CMS will apply an appropriate coding intensity adjustment reflective of all demonstration enrollees. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment.

[94] Washington's rating categories are medical and chemical dependency (institutional LOC and non-institutional LOC), mental health (disabled according to SSI definition and non-disabled), and LTSS (institutional LOC, HCBS institutional level of care, non-institutional LOC). In July and August 2014, rates will be based on an average mix of acuity with adjustments for geography, age and gender and will be paid at the non-institutional rate (to the extent that beneficiaries who meet an institutional level of care enroll, institutional rates will be applied retroactively). The mental health component of the rate will be risk adjusted based on historical claims and encounter data, using age, gender, diagnosis and medication data. The LTSS component of the rate will be risk adjusted based on age, gender, and functional assessment level. The medical/chemical dependency rate will not be risk adjusted by diagnosis. Rates will vary by county as determined by the state and by age, and gender as determined necessary by the state and reviewed by CMS.

[95] WA State Health Care Authority, "Health Care Authority, DSHS announce apparently successful bidders for HealthPath Washington" (June 6, 2013), available at http://www.altsa.dshs.wa.gov/duals/documents/Bidder%20awards%20on%20Strategy%20II%20duals%20project.pdf.