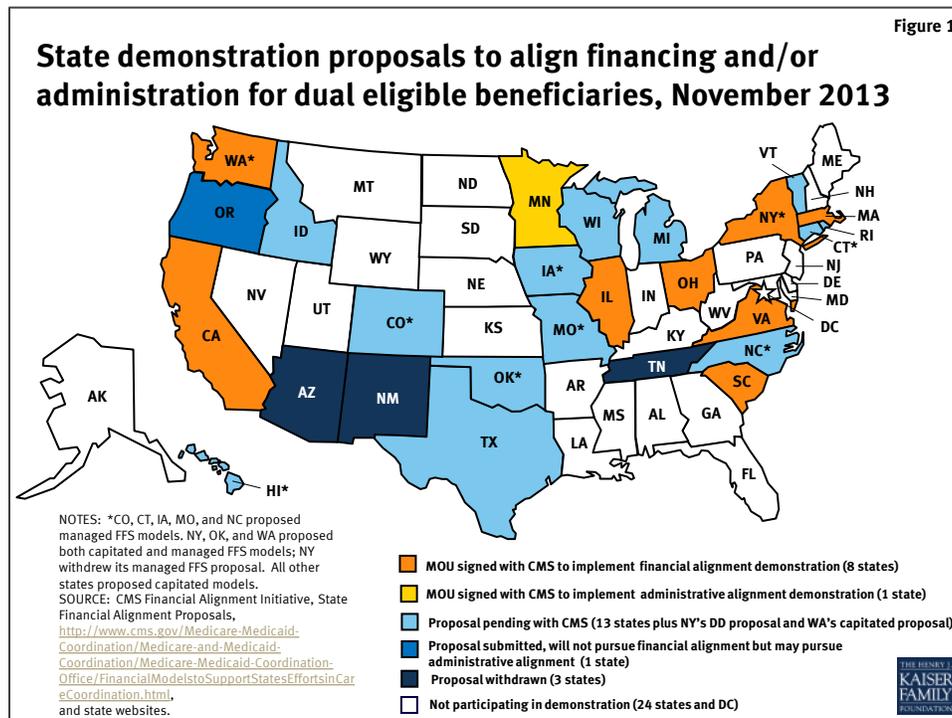


November 2013 | Issue Brief

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

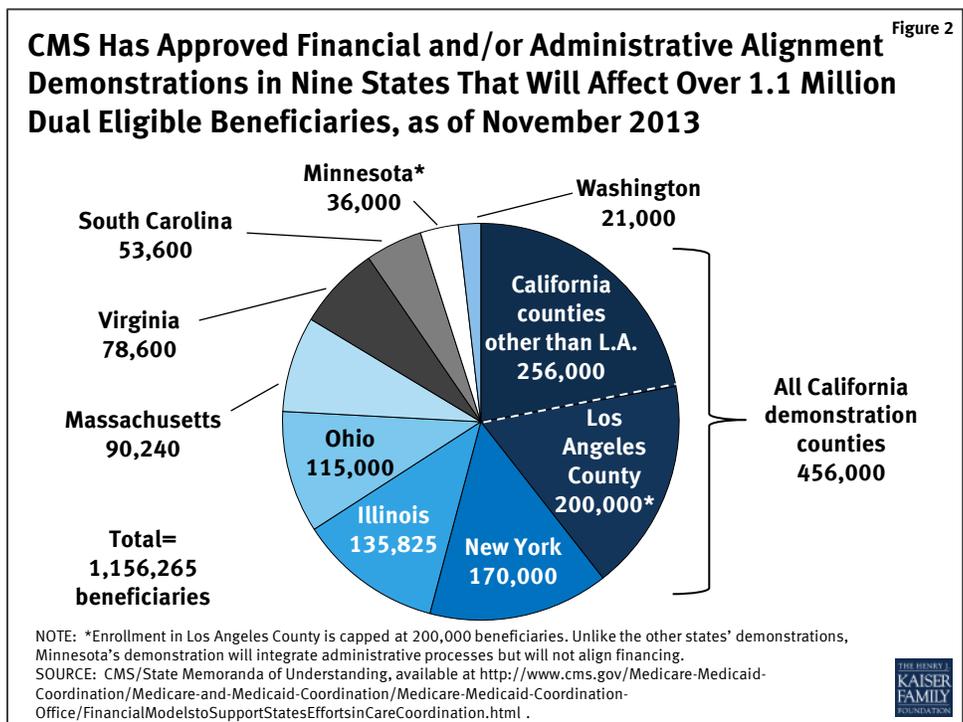
The Centers for Medicare and Medicaid Services (CMS) has finalized memoranda of understanding (MOUs) with nine states to implement demonstrations to integrate care and align financing and/or administration for people who are dually eligible for Medicare and Medicaid: California, Illinois, Massachusetts, New York, Ohio, South Carolina, and Virginia will test a capitated financial alignment model, Washington is testing a managed fee-for-service (FFS) financial alignment model, and Minnesota will test the integration of administrative functions without financial alignment.¹ Washington's proposal to test a capitated model, New York's proposal to test a capitated model for beneficiaries with developmental disabilities who require long-term services and supports (LTSS), and proposals from 13 other states are pending with CMS (Figure 1). These three year demonstrations, implemented beginning in July 2013, are introducing changes in the care delivery systems through which beneficiaries receive services. The demonstrations also are changing the payment approach and financing arrangements among CMS, the state, and providers. This issue brief compares key provisions of the approved demonstrations.



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 among 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 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.

Based on new authority in the Affordable Care Act, CMS is testing capitated and managed FFS financial alignment models and seeking to improve care and control costs for the dual eligible population. Key features of the approved demonstrations are summarized in Table 1 on the next page.

CMS has stated that it plans to limit enrollment in the demonstrations to no more than two million dual eligible beneficiaries nationally. As of November 2013, CMS has approved demonstrations in nine states in which an estimated over 1.1 million beneficiaries are eligible to enroll (Figure 2). (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 nearly 40 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 states with approved demonstrations (Figure 2).



**Table 1:
State Financial/Administrative Alignment Demonstrations Approved by CMS, November 2013**

State	Estimated Number of Beneficiaries Eligible for Demonstration	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
California	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
Illinois	135,825	Adult dual eligible beneficiaries in 21 counties grouped into 2 regions	Capitated	February 2014	1% in year 1 3% in year 2 5% in year 3
Massachusetts	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
Minnesota	36,000	Dual eligible beneficiaries ages 65 and over enrolled in the Minnesota Senior Health Options program statewide	Capitated (Medicaid MCOs that also qualify as Medicare Advantage D-SNPs)	September 2013	N/A (Minnesota's demonstration will test the integration of administrative functions without financial alignment)
New York	170,000	Adult dual eligible beneficiaries in 8 counties who require nursing facility or nursing home diversion and transition home and community-based waiver services or more than 120 days of community-based LTSS ^f	Capitated	July 2014	1% in year 1 1.5% in year 2 3% in year 3, except that savings in year 3 will be reduced to 2.5% if at least 1/3 of plans experience losses exceeding 3% of revenue in year 1 (July 2014-Dec. 2015) ^g
Ohio	115,000	Adult dual eligible beneficiaries in 29 counties grouped into 7 regions	Capitated	March 2014	1% in year 1 2% in year 2 4% in year 3
South Carolina	53,600	Dual eligible beneficiaries ages 65 and over statewide who live in the community at the time of enrollment	Capitated	July 2014	1% in year 1 2% in year 2 4% in year 3
Virginia	78,600	Adult dual eligible beneficiaries in 104 localities grouped into 5 regions	Capitated	February 2014	Same as Ohio, except that savings in year 3 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 1 (Feb. 2014-Dec. 2015) ^h
Washington	21,000	High cost/high risk adult dual eligible beneficiaries statewide except in 2 urban counties ⁱ	Managed FFS	July 2013	N/A

(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 in determining 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 New York’s capitated proposal for beneficiaries who have developmental disabilities and need LTSS remains pending with CMS. ^g This determination will be based on at least 15 months of data (demonstration year 1 in New York encompasses July 2014 through December 2015). ^h This determination will be based on at least 20 months of data (demonstration year 1 in Virginia encompasses February 2014 through December 2015). ⁱ Washington’s final demonstration agreement provides that it may implement its managed FFS model in the 2 excluded counties (King and Snohomish) beginning by Jan. 1, 2014 if it no longer seeks to implement the capitated model there. Washington subsequently revised the target start date for its capitated model to April 2014. 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>. ^j Washington’s capitated proposal remains pending with CMS.

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 15, 22, 28, 32, 33, 34, 42, 48, and 53.

The states’ target populations for their demonstrations vary, with Massachusetts focusing on non-elderly people with disabilities, Washington targeting high cost/high risk beneficiaries, and New York focusing 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. Minnesota targets elderly beneficiaries, and South Carolina targets elderly beneficiaries who live in community-based settings at the time of enrollment. California, Illinois, Ohio, and Virginia focus on both elderly and non-elderly beneficiaries. Each state’s demonstration is limited to certain parts of the state, except that Minnesota and South Carolina’s demonstrations are statewide.

Enrollment in Washington’s managed FFS demonstration began in July 2013, and enrollment in Massachusetts’ capitated demonstration began in October 2013. The earliest effective enrollment dates in the other capitated states are in 2014: February 2014 in Illinois and Virginia, March 2014 in Ohio, April 2014 in California, and July 2014 in New York and South Carolina (Table 1). (Minnesota’s administrative alignment demonstration will affect beneficiaries who are already enrolled in the state’s Senior Health Options program; the demonstration is effective September 2013.) Anticipated program savings from the financial alignment demonstrations, from increased care coordination and use of home and community-based services (HCBS) instead of institutional care and decreased emergency room visits and avoidable hospitalizations, will be deducted up-front from the Medicare and Medicaid contributions to health plans in the capitated model. (See Table 1 and Appendix and the discussion below for further information on demonstration financing.) Savings will be determined retrospectively in the managed FFS model.

Many aspects of the demonstrations continue to be developed, including how beneficiaries will be notified, counseled, and enrolled; how the demonstrations will be monitored and overseen; how beneficiary ombuds programs will be implemented; and how the demonstrations will be 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 reporting.

Additional details about major provisions of the MOUs for each approved financial alignment demonstration are summarized in the Appendix at the end of the paper and discussed below. Key comparison points include:

- **Target population:** The Massachusetts demonstration targets non-elderly dual eligible beneficiaries in certain counties, while the California, Illinois, Ohio, and Virginia demonstrations focus on dual eligible beneficiaries, including those under and over age 65, in selected regions of those states. Minnesota’s demonstration targets beneficiaries age 65 and older statewide. South Carolina’s demonstration focuses on elderly beneficiaries statewide who are living in the community at the time of enrollment. New York’s demonstration encompasses elderly and non-elderly beneficiaries who require nursing facility services, nursing home diversion and transition waiver services, or more than 120 days of community-based LTSS, in certain counties. All seven capitated financial alignment demonstrations exclude beneficiaries with developmental disabilities (DD), although New York submitted a separate capitated proposal that focuses on this population, which is still pending CMS approval. Illinois, Ohio, New York, South Carolina, and Virginia include beneficiaries who receive services through certain non-DD Medicaid HCBS waivers, while California and Massachusetts do not. Washington’s managed FFS model focuses specifically on high cost/high risk beneficiaries with chronic conditions.
- **Enrollment:** Illinois, Massachusetts, New York, Ohio, South Carolina, and Virginia’s demonstrations will begin with a voluntary enrollment period, with subsequent passive enrollment periods in which the remaining beneficiaries will be automatically assigned to a managed care plan (for more information, see the Appendix). In California, enrollment in Los Angeles County also will begin on a voluntary basis before moving to passive enrollment, but elsewhere in California, beneficiaries will be automatically enrolled in the demonstration without an initial voluntary enrollment period. During the voluntary enrollment periods, beneficiaries will be able to “opt in” to the demonstration and select among the demonstration plans. States are to develop “intelligent assignment” algorithms to preserve continuity of providers and services when assigning beneficiaries to plans; the MOUs do not specify whether CMS must approve these algorithms or whether or how the algorithms will be evaluated.³ For its first round of passive enrollment, effective January 2014, Massachusetts will use beneficiaries’ past use of primary care services when assigning plans.⁴ South Carolina will consider existing provider relationships (including HCBS), history with a plan within the past year, other household members’ plan enrollment, and plans’ relative case mix.

Beneficiaries in the seven capitated financial alignment states retain the right to opt out of the demonstration at any time but must take affirmative action to do so. In addition, Ohio’s MOU indicates that it may pursue additional waiver authority from CMS to require beneficiaries to enroll in managed care plans for their Medicaid benefits if they opt out of the financial alignment demonstration, and California has filed an

amendment to its existing § 1115 waiver seeking to do so. New York's existing § 1115 waiver already requires beneficiaries in the financial alignment demonstration area who receive more than 120 days of LTSS to enroll in a Medicaid managed long-term care plan even if they opt out of the financial alignment demonstration.⁵ While Illinois' 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 if they opt out of the financial alignment demonstration.⁶ By contrast, Massachusetts, South Carolina, and Virginia allow beneficiaries who opt out of the demonstration to remain in the FFS delivery system for both their Medicare and Medicaid benefits.

In Washington's managed FFS model, eligible beneficiaries are automatically enrolled in a health home network but retain the choice about whether to receive Medicaid health home services; other services will continue to be provided on a FFS basis.

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 seven capitated financial demonstrations will use 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.⁷ Massachusetts requires its plans to contract with community-based organizations to provide Long-Term Supports coordinators as independent members of the care team, 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, and Virginia's 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). California also permits its plans to subcontract with other Medicare Advantage plans to offer a variety of benefits packages to enrollees. The demonstration health plans (and subcontractors in Los Angeles County) are listed in the Appendix.

Washington's managed FFS demonstration will use health home care coordination organizations to manage services among existing Medicare and Medicaid providers. While the seven capitated financial alignment states' managed care plans will coordinate all Medicare and Medicaid benefits included in the demonstrations and financed through their capitated payments, Washington's health home networks will coordinate Medicare and Medicaid services, which will continue to be financed on a FFS basis.

Minnesota's administrative alignment demonstration will maintain the Senior Health Options program delivery system in which Medicaid MCOs have contracts with the state and also are qualified as Medicare Advantage Special Needs Plans focused on dual eligible beneficiaries (D-SNPs) that have contracts with CMS.

- **Benefits:** The seven capitated financial alignment demonstrations include nearly all Medicare and Medicaid services in the plans' benefits package and capitated payment (see Appendix for benefit exclusions) and allow plans to offer additional benefits as appropriate to beneficiary needs. In addition, Massachusetts' demonstration offers 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.

Washington's managed FFS demonstration adds Medicaid health home services but does not otherwise 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.

- **Financing:** California, Illinois, Massachusetts, New York, Ohio, South Carolina, and Virginia will test 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. The baseline capitation payment for Medicare Parts A and B services will be determined using a blend of the Medicare Advantage benchmarks and the Medicare FFS standardized county rates weighted by whether eligible beneficiaries who are expected to transition into the demonstration are enrolled in a Medicare Advantage plan or Medicare FFS in the prior year. Plans will not submit bids, as they would in Medicare Advantage, but rather will be paid the full benchmark amount. Medicare Advantage baseline spending will include costs that would have occurred absent the demonstration, such as quality bonus payments for applicable Medicare Advantage plans. The baseline capitation payment for Medicare Part D services will be the national average monthly bid amount as well as the average projected low-income cost sharing subsidy and the average projected federal reinsurance amounts. The baseline Medicaid capitation payment will be based on historic state spending in Illinois, Massachusetts, South Carolina, and Virginia, on the managed care waiver capitation rate that would apply to eligible beneficiaries if they were not enrolled in the demonstration in California and Ohio, and on a blend of the Medicaid managed long-term care capitation rate that would apply to enrollees in the demonstration area and estimates of FFS costs for services excluded from managed long-term care capitation rate in New York.

The baseline Medicare payment will be risk-adjusted using CMS's existing Medicare Advantage Hierarchical Condition Categories model. Because most demonstration enrollees are expected to come from the FFS Medicare system, CMS will not apply the coding intensity adjustment factor to Medicare Advantage risk scores initially in most states (in calendar year 2013 in California, Massachusetts, Ohio, and Virginia and in calendar year 2014 in Illinois⁸) but will do so in future years and beginning in demonstration year one (2014) in New York and South Carolina. The baseline Medicaid payment will be risk adjusted in California, Illinois, and South Carolina by using rating categories with financial incentives for HCBS over institutional care (see Appendix for more details); in Massachusetts by using rating categories and high cost risk pools for certain LTSS; in Ohio and Virginia by using rating categories with financial incentives for HCBS over institutional care and member enrollment mix adjustment to account for plans with a greater proportion of high cost/high risk beneficiaries; and in New York by using rating categories risk adjusted similar to the model used for that state's Medicaid managed long-term care plans. Illinois, New York, Ohio, South Carolina, and Virginia require plans to meet a minimum medical loss ratio, while Massachusetts will use risk corridors in the first year of the demonstration only, and California will use limited risk corridors in all years.

Subsequent to the signing of its MOU, Massachusetts revised its rating categories and risk corridors.

Demonstration savings 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. Sources of federal savings include the Medicare program and the federal contribution to the state's Medicaid program; the source of state savings is the state's contribution to the Medicaid program.⁹ None of the MOUs explicitly states the basis for the savings percentages, although Illinois' MOU does note 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 the highest of the approved demonstrations to date. (California's maximum demonstration-wide savings percentages, along with county-specific interim savings percentages, will be used in determining the demonstration's risk corridors.)

All seven capitated financial alignment demonstrations also 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. South Carolina plans must provide financial incentives to providers that achieve NCQA patient-centered medical home certification.

By contrast, Washington will test CMS's managed FFS model in which providers will continue to receive FFS reimbursement for both Medicare and Medicaid-covered services. Any demonstration savings in Washington 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.

- ***Ombuds program:*** California and Ohio's MOUs indicate that existing state ombuds offices will offer individual advocacy and independent systemic oversight in the demonstrations, and Illinois, New York, South Carolina, and Virginia's MOUs indicate that they intend to support an independent ombuds program for their demonstrations. Massachusetts recently selected its demonstration ombudsman.¹⁰ 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. Washington's MOU does not mention an ombuds program. CMS has announced a funding opportunity for states with MOUs to support the planning, development, and provision of independent ombudsman services in the demonstrations.¹¹
- ***Appeals:*** New York's demonstration 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 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 for Medicaid services but not for Medicare services.)

Minnesota’s demonstration will build on the integrated appeals system already established in the Senior Health Options program by adding a single integrated notice of appeal rights and standardizing the timeframes to request Medicare and Medicaid appeals.

Illinois, Massachusetts, South Carolina, and Virginia require beneficiaries to first exhaust an internal health plan appeal before proceeding to external appeals, while Ohio allows beneficiaries to choose whether to file an internal health plan appeal or to proceed directly to a fair hearing for Medicaid-covered services. Illinois, Massachusetts, Ohio, South Carolina, and Virginia 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 will continue the existing Medicare and Medicaid appeals processes at least through demonstration year one and will work to create a more integrated appeals process. 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.

Washington’s managed FFS demonstration does not make any changes to the existing Medicare and Medicaid appeals systems.

LOOKING AHEAD

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 remain to be specified in the three-way contracts between CMS, the state, and demonstration plans in the capitated model,¹² in Washington’s managed FFS final demonstration agreement with CMS,¹³ and in additional policy guidance and other materials. Some areas to consider as the demonstrations are implemented include:

- how beneficiaries will be notified about these new models;
- what assistance will be available for beneficiaries to obtain options counseling from independent sources as they make this important choice;
- what the sources of program savings will be;
- how beneficiaries’ access to medically necessary services and supports will be ensured;
- how the demonstrations will affect beneficiary access to HCBS;
- what grievance and appeals process will be available to beneficiaries and how easy it will be to navigate;
- how plans and providers will accommodate the needs of beneficiaries with disabilities; and
- how the demonstrations will be overseen and evaluated.

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.

This issue brief was prepared by MaryBeth Musumeci of the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured.

APPENDIX: KEY PROVISIONS OF CMS APPROVED FINANCIAL ALIGNMENT DEMONSTRATIONS FOR DUAL ELIGIBLE BENEFICIARIES BY STATE, NOVEMBER 2013¹⁴

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 November 2013, the nine states include:

- [California](#)
- [Illinois](#)
- [Massachusetts](#)
- [Minnesota](#)
- [New York](#)
- [Ohio](#)
- [South Carolina](#)
- [Virginia](#)
- [Washington](#)

CALIFORNIA:	
MOU Signed:	March 27, 2013
Demonstration Duration:	3 years April 1, 2014 ¹⁵ to Dec. 31, 2016
Target Group:	<p><i>Includes:</i> 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</p> <p><i>Excludes:</i> 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</p>
Geographic Area:	8 counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara
Enrollment:	<p>California has not yet revised its MOU enrollment timeline to reflect its April 2014 implementation date. The MOU provides that for all counties except Los Angeles and San Mateo, beneficiaries currently in Medicare FFS will be passively enrolled over a 12 month period (details vary by county); all San Mateo County beneficiaries currently in Medicare FFS will be passively enrolled in one month; the initial enrollment period in Los Angeles County¹⁶ is voluntary for three months (California proposes April, May, and June 2013), followed by a 12 month passive enrollment period for beneficiaries currently in Medicare FFS, with enrollment capped at 200,000; notices will be sent 90, 60, and 30 days prior to passive enrollment</p> <p>Beneficiaries in certain rural zip codes where only one demonstration plan operates, those enrolled in a Medicare Advantage Plan in 2013, and those in certain non-profit prepaid health plans are exempt from passive enrollment</p> <p>Beneficiaries may opt out of the demonstration prior to passive enrollment and thereafter on a monthly basis</p> <p>California's demonstration is contingent upon CMS approval of an amendment to the state's existing § 1115 waiver,¹⁷ which seeks to require beneficiaries to enroll in a Medicaid managed care plan if they opt out of the financial alignment demonstration</p>
Financing:	<p>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 21), 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</p> <p>Plans must provide incentive payments from quality withhold funds to county behavioral health agencies based on achievement of service coordination measures</p>
<i>Medicare baseline for capitated payments:</i>	<p>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;¹⁸ Part D = national average monthly bid amount plus average projected low income cost sharing subsidy and average projected federal reinsurance amounts</p>

CALIFORNIA:	
<i>Medicare risk adjustment:</i>	CMS Hierarchical Condition Categories model used for Medicare Advantage plans
<i>Medicaid baseline for capitated payments:</i>	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)
<i>Medicaid risk adjustment:</i>	Rating categories with financial incentives for HCBS over institutional care ¹⁹ to be implemented in each county in 3 phases ²⁰
<i>Risk sharing:</i>	Limited risk corridors in all years ²¹
Care Delivery Model:	<p>Cal MediConnect plans will provide person-centered medical homes, care coordination and integrated medical, behavioral health, and LTSS</p> <p>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</p> <p>Prime contractor plans may subcontract with other Medicare Advantage plans to offer multiple plan benefit packages</p>
Participating Health Plans:	<ul style="list-style-type: none"> -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 -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

CALIFORNIA:

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
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:	<p><i>Notice:</i> single integrated notice</p> <p><i>Timeframe to request initial appeal:</i> 60 days for Medicare-covered service; 90 days for Medicaid-covered service</p> <p><i>Internal health plan appeal:</i> 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</p> <p><i>External Medicare appeals:</i> 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</p> <p><i>External Medicaid appeals:</i> 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</p> <p><i>Appeals where Medicare and Medicaid services overlap:</i> to be determined in 3-way contract; beneficiaries will retain right to Medicaid fair hearing</p> <p><i>Continued benefits pending appeal:</i> current rules continue to apply (available for Medicaid services but not for Medicare services)</p> <p><i>Medicare Part D appeals:</i> existing Medicare Part D appeals process continues</p> <p>Existing appeals process for county-authorized IHSS and behavioral health services also remains unchanged.</p>

ILLINOIS:	
MOU Signed:	Feb. 22, 2013
Demonstration Duration:	3 years Feb. 1, 2014 ²² to Dec. 31, 2016
Target Group:	<p><i>Includes:</i> 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</p> <p><i>Excludes:</i> 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</p>
Geographic Area:	<p>21 counties grouped into 2 regions:</p> <p>Greater Chicago region: Cook, Lake, Kane, DuPage, Will, and Kankakee counties</p> <p>Central Illinois region: Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford, Menard, and Stark counties</p>
Enrollment:	<p>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;²³ passive enrollment not to exceed 5,000 beneficiaries per plan per month in Greater Chicago and 3,000 in Central Illinois</p> <p>Illinois has not yet revised its MOU enrollment timeline to reflect its February 2014 implementation date. The MOU provides that beneficiaries may begin to elect voluntary enrollment 60 days prior to an effective date of February 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 May 2014)²⁴</p> <p>Beneficiaries may opt out of the demonstration prior to passive enrollment and thereafter on a monthly basis</p> <p>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 plan²⁵</p>
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
<i>Medicare baseline for capitated payments:</i>	Same as California, except that Medicare Advantage risk score coding intensity adjustment factor will apply after calendar year 2014
<i>Medicare risk adjustment:</i>	Same as California
<i>Medicaid baseline for capitated payments:</i>	Historical state spending for state plan and HCBS waiver services trended forward

ILLINOIS:	
<i>Medicaid risk adjustment:</i>	Rating categories with financial incentives for HCBS over nursing facility care ²⁶
<i>Risk sharing:</i>	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, HealthSpring, Healthcare Service Company/Blue Cross Blue Shield, Humana, IlliniCare/Centene, and Meridian -Central Illinois region: Health Alliance Medical Plan and Molina
Benefits:	Includes all Medicare and Medicaid services except Medicare hospice; includes Medicaid HCBS 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
Stakeholder Engagement:	Plans must establish an independent beneficiary advisory committee that meets quarterly
Appeals:	<i>Notice:</i> same as California <i>Timeframe to request initial appeal:</i> 60 days <i>Internal health plan appeal:</i> all initial appeals must be filed with health plan; appeals to be resolved within 15 business days (standard) or 24 hours (expedited) <i>External Medicare appeals:</i> same as California <i>External Medicaid appeals:</i> 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 <i>Appeals where Medicare and Medicaid services overlap:</i> 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 <i>Continued benefits pending appeal:</i> health plans must provide continuing benefits for 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 <i>Medicare Part D:</i> same as California

MASSACHUSETTS:	
MOU Signed:	Aug. 22, 2012; 3-way contract signed July 16, 2013 ²⁷ (initial term through Dec. 31, 2014)
Demonstration Duration:	3 years Oct. 1, 2013 ²⁸ to Dec. 31, 2016
Target Group:	<i>Includes:</i> an estimated 90,240 full benefit dual eligible beneficiaries ages 21 to 64 in 8 full counties and 1 partial county ²⁹ are eligible to enroll; Medicare Advantage, PACE, and Independence at Home enrollees may participate if they disenroll from their existing plan <i>Excludes:</i> 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 to begin 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 (45,019 beneficiaries subject to auto-assignment): ³⁰ initial notice sent in late October 2013 for first passive group (an estimated 8,600 beneficiaries in community-other rating category) with enrollment effective January 2014. ³¹ The effective enrollment date is tentatively April 2014 for the second passive group and July 2014 for the third passive group. ³² Beneficiaries will 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
Financing:	Capitated with savings percentage (0 in 2013, 1% in 2014 (remainder of year one), ³³ 2% in year two, and >4% in year three ³⁴) applied upfront to baseline Medicare and Medicaid contributions; capitation rate quality withhold same as in California
<i>Medicare baseline for capitated payments:</i>	Same as California
<i>Medicare risk adjustment:</i>	Same as California
<i>Medicaid baseline for capitated payments:</i>	Historical state spending data trended forward
<i>Medicaid risk adjustment:</i>	Rating categories ³⁵ and high cost risk pools for certain Medicaid LTSS ³⁶
<i>Risk sharing:</i>	Risk corridors in first year only ³⁷

MASSACHUSETTS:	
Care Delivery Model:	<p>One Care plans will provide patient-centered medical homes that integrate primary care and behavioral health services, care coordination, and clinical care management</p> <p>Requires Long-Term Supports Coordinators from community-based organizations independent of health plans as members of the care team</p>
Participating Health Plans:	<p>-Essex, Franklin, Middlesex, Norfolk, and Plymouth (partial) counties: Commonwealth Care Alliance</p> <p>-Hampden and Hampshire counties: Commonwealth Care Alliance and Fallon Total Care/Fallon Community Health Plan</p> <p>-Suffolk County: Commonwealth Care Alliance and Network Health/Tufts Health Plan</p> <p>-Worcester County: Commonwealth Care Alliance, Fallon Total Care/Fallon Community Health Plan, and Network Health/Tufts Health Plan</p>
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
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, ³⁸ not addressed in MOU
Stakeholder Engagement:	Same as California
Appeals:	<p><i>Notice:</i> same as California</p> <p><i>Timeframe to request initial appeal:</i> same as Illinois</p> <p><i>Internal health plan appeal:</i> same as Illinois except that appeals are to be resolved in 30 days (standard) or 72 hours (expedited)</p> <p><i>External Medicare appeals:</i> same as California</p> <p><i>External Medicaid appeals:</i> beneficiary may request fair hearing after adverse health plan appeal</p> <p><i>Appeals where Medicare and Medicaid services overlap:</i> to be addressed in 3-way contract; health plan bound by decision most favorable to beneficiary</p> <p><i>Continued benefits pending appeal:</i> 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</p> <p><i>Medicare Part D:</i> same as California</p>

MINNESOTA:	
MOU Signed:	Sept. 12, 2013
Demonstration Duration:	3 years Sept. 13, 2013 to Dec. 31, 2016
Target Group:	<i>Includes:</i> 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
<i>Medicare baseline for capitated payments:</i>	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.
<i>Medicare risk adjustment:</i>	Same as above.
<i>Medicaid baseline for capitated payments:</i>	Same as above. Plan contracts with the state as Medicaid MCOs continue to apply.
<i>Medicaid risk adjustment:</i>	Same as above.
<i>Risk sharing:</i>	Same as above.

(continued next page)

MINNESOTA:	
Care Delivery Model:	<p>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.</p> <p>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.</p> <p>There are 3 ICSP models:</p> <p>(1) HCH-Based Virtual ICSPs, which provide payments to primary care providers to incentivize better care coordination;</p> <p>(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 delivery; and</p> <p>(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.</p>
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:	<p>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.</p> <p>Medicaid benefits will continue to be provided per the Medicaid MCO contracts with plans.</p>
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:	<p>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.</p> <p><i>Notice:</i> same as California</p> <p><i>Timeframe to request initial appeal:</i> 90 days</p> <p><i>Internal health plan appeal:</i> not specified in MOU</p> <p><i>Integrated external appeals process:</i> not specified in MOU</p> <p><i>Appeals where Medicare and Medicaid services overlap:</i> not specified in MOU</p> <p><i>Continued benefits pending appeal:</i> not specified in MOU</p> <p><i>Medicare Part D:</i> same as California</p>

NEW YORK:	
MOU Signed:	Aug. 26, 2013
Demonstration Duration:	3 years July 1, 2014 to Dec. 31, 2017
Target Group:	<p><i>Includes:</i> 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</p> <p><i>Excludes:</i> 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</p>
Geographic Area:	8 counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, Westchester
Enrollment:	<p>Initial enrollment period is voluntary, followed by passive enrollment periods in which the remaining beneficiaries in the target population will be automatically enrolled.</p> <p>Beneficiaries receiving community-based LTSS will be notified no earlier than April 1, 2014 about the opportunity to voluntarily enroll in the demonstration with enrollment effective no earlier than July 1, 2014. Those that do not voluntarily enroll will be notified no earlier than July 1, 2014 about passive enrollment, which will begin no earlier than Sept. 1, 2014.</p> <p>Beneficiaries receiving facility-based LTSS will be notified no earlier than July 1, 2014 about the opportunity to voluntarily enroll in the demonstration with enrollment effective no earlier than Oct. 1, 2014. Those that do not voluntarily enroll will be notified no earlier than Oct. 1, 2014 about passive enrollment, which will begin no earlier than Jan. 1, 2015.</p> <p>Passive enrollment for each group will be phased in over a minimum 4 month period.</p> <p>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</p> <p>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.</p> <p>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.</p>
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

NEW YORK:					
<i>Medicare baseline for capitated payments:</i>	Same as California except that Medicare Advantage risk score coding intensity adjustment factor will apply beginning in CY 2014 ³⁹				
<i>Medicare risk adjustment:</i>	Same as California				
<i>Medicaid baseline for capitated payments:</i>	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				
<i>Medicaid risk adjustment:</i>	Rating categories ⁴⁰ risk adjusted similar to the model used for MLTC capitated rates				
<i>Risk sharing:</i>	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:	<table border="0"> <tr> <td style="vertical-align: top;"> 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 </td> <td style="vertical-align: top;"> Independence Care Systems Integra MetroPlus Montefiore North Shore LIJ HealthPlan, Inc. Senior Whole Health United Healthcare Village Care MAX VNYSNY Choice Wellcare </td> </tr> <tr> <td colspan="2" style="text-align: right; vertical-align: top;"> Participation is subject to plans meeting readiness review requirements, and the final plan announcement is expected in the second quarter of CY 2014.⁴¹ </td> </tr> </table>	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. ⁴¹	
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. ⁴¹					
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				

NEW YORK:

<p>Ombuds Program:</p>	<p>NY is creating a new independent FIDA participant ombudsman to help beneficiaries access care through the demonstration, provide individual advocacy and systemic oversight, and gather and report data</p>
<p>Stakeholder Engagement:</p>	<p>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.</p>
<p>Appeals:</p>	<p><i>Notice:</i> same as California</p> <p><i>Timeframe to request initial appeal:</i> same as Illinois</p> <p><i>Internal health plan appeal:</i> same as Illinois except does not mention timeframes for appeal resolution; paper review unless beneficiary requests in-person review; expedited review is available</p> <p><i>Integrated external appeals process:</i> 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</p> <p><i>Appeals where Medicare and Medicaid services overlap:</i> same process as above – NY is establishing one integrated appeals process for all Medicare Parts A and B and Medicaid appeals</p> <p><i>Continued benefits pending appeal:</i> 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</p> <p><i>Medicare Part D:</i> same as California</p>

OHIO:	
MOU Signed:	Dec. 11, 2012
Demonstration Duration:	3 years March 1, 2014 ⁴² to Dec. 31, 2016
Target Group:	<p><i>Includes:</i> an estimated 115,000 full benefit dual eligible beneficiaries age 18 and older in 29 counties grouped into 7 regions</p> <p><i>Excludes:</i> 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</p>
Geographic Area:	<p>29 counties grouped into 7 regions:</p> <ul style="list-style-type: none"> -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:	<p>Initial enrollment period is voluntary, followed by three passive enrollment periods in which the remaining beneficiaries in the target population will be automatically enrolled</p> <p>Ohio has not yet revised its MOU enrollment timeline to reflect its March 2014 implementation date. 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 three passive enrollment periods: initial notice sent 60 days prior for passive enrollment effective April 2014 (as revised)⁴³ for the Northeast region; the second passive enrollment group includes the Northwest, Northwest Central, and Southwest regions; and the third passive enrollment group includes the East Central, Central, and West Central regions.</p> <p>Beneficiaries may opt out of the demonstration prior to passive enrollment and thereafter on a monthly basis</p> <p>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</p>
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
<i>Medicare baseline for capitated payments:</i>	Same as California
<i>Medicare risk adjustment:</i>	Same as California
<i>Medicaid baseline for capitated payments:</i>	Medicaid capitation rates under § 1915(b) waiver that would apply to beneficiaries who are in target population but not enrolled in demonstration

OHIO:	
<i>Medicaid risk adjustment:</i>	Rating categories with financial incentives for HCBS over institutional care ⁴⁴ and member enrollment mix adjustment to account for plans with greater proportion of high risk/high cost beneficiaries
<i>Risk sharing:</i>	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
Stakeholder Engagement:	Same as California
Appeals:	<i>Notice:</i> same as California <i>Timeframe to request initial appeal:</i> same as Minnesota <i>Internal health plan appeal:</i> 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) <i>External Medicare appeals:</i> same as California <i>External Medicaid appeals:</i> 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 <i>Appeals where Medicare and Medicaid services overlap:</i> plan to be bound by decision most favorable to beneficiary <i>Continued benefits pending appeal:</i> 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 <i>Medicare Part D:</i> same as California

SOUTH CAROLINA:	
MOU Signed:	Oct. 25, 2013
Demonstration Duration:	3 years July 1, 2014 to Dec. 31, 2017
Target Group:	<p><i>Includes:</i> 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); 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</p> <p><i>Excludes:</i> 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</p>
Geographic Area:	<p>Statewide, divided into two regions:</p> <p>-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</p> <p>-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</p>
Enrollment:	<p>Initial enrollment period is voluntary, followed by three passive enrollment periods in which the remaining beneficiaries in the target population will be automatically enrolled</p> <p>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</p> <p>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</p> <p>Beneficiaries may opt out of the demonstration until the last day of the month prior to enrollment and thereafter on a monthly basis</p> <p>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</p>

SOUTH CAROLINA:	
Financing:	<p>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; the state and health plans will provide financial incentives to providers that achieve NCQA patient centered medical home certification</p> <p>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.</p>
<i>Medicare baseline for capitated payments:</i>	Same as California ⁴⁵
<i>Medicare risk adjustment:</i>	Same as California
<i>Medicaid baseline for capitated payments:</i>	Historical state FFS spending for state plan and HCBS waiver services trended forward
<i>Medicaid risk adjustment:</i>	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 ⁴⁶
<i>Risk sharing:</i>	MLR of 85% required beginning in CY 2015
Care Delivery Model:	<p>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.</p> <p>The HCBS waiver case manager will be a member of the multidisciplinary care team, responsible for advocating for LTC in the care coordination process.</p> <p>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.</p>
Participating Health Plans:	Absolute Total Care, Advicare, Molina Healthcare of South Carolina, Select Health of South Carolina, WellCare Health Plans ⁴⁷

SOUTH CAROLINA:	
Benefits:	<p>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</p> <p>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</p>
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:	<p><i>Notice:</i> Same as California</p> <p><i>Timeframe to request initial appeal:</i> Same as Illinois</p> <p><i>Internal health plan appeal:</i> Same as Illinois except that expedited appeals are to be resolved within 72 hours</p> <p><i>External Medicare appeals:</i> same as California except that Office of Medicare Hearing and Appeals review not mentioned in MOU</p> <p><i>External Medicaid appeals:</i> 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</p> <p><i>Appeals where Medicare and Medicaid services overlap:</i> 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.</p> <p><i>Continued benefits pending appeal:</i> 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.</p> <p><i>Medicare Part D appeals:</i> Same as California</p>

VIRGINIA:	
MOU Signed:	May 21, 2013
Demonstration Duration:	3 years Feb. 1, 2014 to Dec. 31, 2017
Target Group:	<p><i>Includes:</i> an estimated 78,600 full benefit dual eligible beneficiaries age 21 and older in 104 localities grouped into 5 regions; PACE and Independence at Home enrollees may participate if they disenroll from their current program</p> <p><i>Excludes:</i> 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</p>
Geographic Area:	<p>104 localities in 5 regions:⁴⁸</p> <p>-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</p> <p>-Northern Virginia: Arlington, Culpepper, Fairfax County, Fauquier, Loudoun, Prince William, Alexandria, Fairfax City, Falls Church, City of Manassas, Manassas Park</p> <p>-Tidewater: Accomack, Gloucester, Isle of Wight, James City County, Mathews, Northampton, York, Chesapeake, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach, Williamsburg</p> <p>-Western/Charlottesville: Albemarle, Augusta, Buckingham, Fluvanna, Greene, Louisa, Madison, Nelson, Orange, Rockingham, Charlottesville, Harrisonburg, Staunton, Waynesboro</p> <p>-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</p>
Enrollment:	<p>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</p> <p>In Phase I (Central VA and Tidewater), beneficiary outreach for voluntary enrollment will begin no sooner than January 2014, with enrollment effective the following month (no sooner than February 2014). Initial passive enrollment notice for remaining Phase I beneficiaries will be sent no sooner than May 2014, with enrollment effective July 2014. In Phase II (Western/Charlottesville, Northern VA, and Roanoke), beneficiary outreach for voluntary enrollment will begin no sooner than May 2014, with enrollment effective the following month (no sooner than June 2014). Initial passive enrollment notice for remaining Phase II beneficiaries will be sent August 2014 with enrollment effective October 2014. Beneficiaries subject to Medicare drug plan reassignment effective January 2014 will not be passively enrolled in 2014.</p> <p>Beneficiaries may opt of the demonstration prior to passive enrollment and thereafter on a monthly basis</p> <p>Virginia's § 1932(a) state plan amendment has been approved by CMS and provides for voluntary enrollment in Medicaid managed care.⁴⁹ The state also must amend its § 1915(c) waivers affected by the demonstration in the next update or scheduled renewal, whichever is sooner</p>

VIRGINIA:	
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; ⁵⁰ capitation rate quality withhold same as in California
<i>Medicare baseline for capitated payments:</i>	Same as California ⁵¹
<i>Medicare risk adjustment:</i>	Same as California
<i>Medicaid baseline for capitated payments:</i>	Historical state spending for state plan and HCBS waiver services trended forward
<i>Medicaid risk adjustment:</i>	Rating categories with financial incentives for HCBS over institutional care ⁵² 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)
<i>Risk sharing:</i>	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 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
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

VIRGINIA:

Appeals:

Notice: same as California

Timeframe to request initial appeal: same as Illinois

Internal health plan appeal: same as Illinois 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

Medicare Part D: same as California

WASHINGTON:	
MOU Signed:	Oct. 24, 2012; final demonstration agreement signed June 28, 2013
Demonstration Duration:	3 years July 1, 2013 ⁵³ to Dec. 31, 2016
Target Group:	<i>Includes:</i> an estimated 21,000 full benefit dual eligible beneficiaries who are considered high cost/high risk and eligible for Medicaid health home services ⁵⁴ 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 <i>Excludes:</i> 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, Grant, Ferry, 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; the demonstration may expand to King and Snohomish counties by Jan. 1, 2014, if CMS and the state agree to do so, and the state no longer seeks to implement a capitated model there ⁵⁵ In June 2013, CMS approved Washington's Medicaid health home state plan amendment for counties in coverage areas 4, 5, and 7; implementation of the demonstration in additional counties is contingent upon CMS approval of a health home SPA there ⁵⁶
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
<i>Medicare baseline for capitated payments:</i>	N/A
<i>Medicare risk adjustment:</i>	N/A

WASHINGTON:	
<i>Medicaid baseline for capitated payments:</i>	N/A
<i>Medicaid risk adjustment:</i>	N/A
<i>Risk sharing:</i>	N/A
Care Delivery Model:	Health home care coordination organizations will coordinate all Medicare and Medicaid services among existing primary, acute, specialist, behavioral health, and LTSS providers
Participating Health Plans:	<p>-Coverage area 1: Coordinated Care Corporation and Molina Healthcare of Washington; provisional designation to Community Health Plan of Washington, United Behavioral Health, and UnitedHealthcare of Washington</p> <p>-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</p> <p>-Coverage areas 4 and 5: Community Health Plan of Washington, Coordinated Care Corporation, Optum Regional Support Network, and UnitedHealthcare of Washington</p> <p>-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</p> <p>-Coverage area 7: same as coverage areas 4 and 5, plus Southeast Washington Aging and Long-Term Care</p> <p>Provisional designation is conditioned on satisfactory submission of a corrective action plan and implementation timeline</p>
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.

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 Virginia's MOU (at p. 59) states that "[f]urther details will be agreed to and provided by CMS and the Commonwealth in future technical guidance." South Carolina's MOU (p. 65) has a similar statement.
- ⁴ 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>.
- ⁵ 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.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-f-shrp-ca.pdf>.
- ⁶ 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.
- ⁷ 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.medicare.gov/mltss/docs/PCP-CMSdefinition04-04.pdf>.
- ⁸ These dates are from the MOUs but may be updated given most states' recent announcements to postpone their enrollment dates.
- ⁹ 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/>.
- ¹⁰ 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>.
- ¹¹ CMS, Funding Opportunity: Support for Demonstration Ombudsman Programs Serving Medicare-Medicaid Enrollees (June 27, 2013), available at <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-06-27.html>.
- ¹² 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>.
- ¹³ Washington's final demonstration agreement is available at <http://www.adsa.dshs.wa.gov/duals/documents/WA%20Final%20Demonstration%20Agreement.pdf>.
- ¹⁴ 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.
- ¹⁵ 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/>.
- ¹⁶ California released its proposed enrollment approach for Los Angeles County on July 3, 2013. The public comment period closed on August 2, 2013, and the final proposal is subject to CMS approval. Available at <http://www.calduals.org/wp-content/uploads/2013/07/LAC-Enrollment-Strategy-070113-v.-2.pdf>.
- ¹⁷ California Bridge to Reform Demonstration Amendment Coordinated Care Initiative (June 18, 2013), available at <http://www.calduals.org/wp-content/uploads/2013/07/CA-Bridge-to-Reform-Demo-No.-11-W-00193-9-Amdnd-CCI.pdf>.

¹⁸ 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.”

¹⁹ California’s Medicaid rating categories include institutionalized (90 or more days), HCBS High (high utilizers), HCBS Low (low utilizers), and Community Well (no HCBS).

²⁰ 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).

²¹ 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%.

²² 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.

²³ 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.

²⁴ Email from Daniel Farmer, Special Assistant to the Director, Medicare-Medicaid Coordination Office (May 31, 2013) (on file with author).

²⁵ 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.

²⁶ 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).

²⁷ 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-medicare-related-information.html>.

²⁸ 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-medicare-related-information.html>.

²⁹ 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-medicare/materials-from-previous-meetings.html>.

³⁰ *Id.*

³¹ 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>.

³² 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>.

³³ 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.

³⁴ 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>.

³⁵ 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 and medium/high community need, and the community high behavioral health group will be divided into community highest behavioral health and community medium/high behavioral health. 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>.

³⁶ 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.

³⁷ 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>.

³⁸ 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 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."

⁴⁰ 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.

⁴¹ 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.

⁴² Ohio revised its demonstration start date from September 2013 to March 2014. Email from Daniel Farmer, Special Assistant to the Director, Medicare-Medicaid Coordination Office (May 31, 2013) (on file with author).

⁴³ *Id.*

⁴⁴ 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).

⁴⁵ 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."

⁴⁶ 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).

⁴⁷ South Carolina Medicaid Healthy Connections Prime, Health Plan Announcement, available at <https://msp.scdhhs.gov/SCDue2/>.

⁴⁸ Virginia Medicare-Medicaid Financial Alignment Demonstration Regions, updated Jan. 11, 2013, available at http://www.dmas.virginia.gov/Content_atchs/altc/altc-anst6.pdf.

⁴⁹ 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>.

⁵⁰ Demonstration year one in Virginia encompasses February 2014 through December 2015.

⁵¹ 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."

⁵² 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.

⁵³ 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 \(June 28, 2013\)](http://www.adsa.dshs.wa.gov/duals/documents/WA%20Final%20Demonstration%20Agreement.pdf), available at <http://www.adsa.dshs.wa.gov/duals/documents/WA%20Final%20Demonstration%20Agreement.pdf>.

⁵⁴ 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.

⁵⁵ CMS/WA Final Demonstration Agreement at 8-9. Washington subsequently revised the target start date for its capitated model to April 2014. 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>.

⁵⁶ *Id.* at 9.