MACPAC
Medicaid and CHIP Payment and Access Commission

## Financial Alignment Demonstration Status Update

MACPAC has developed this series of tables to make it easier for policy makers, researchers, and others to compare the design of the Financial Alignment Initiative for individuals dually eligible for Medicaid and Medicare in participating states.

State policies are dynamic. If you would like to clarify or update the data presented here, please send a brief explanation and contact information to comments@macpac.gov.

## Demonstration Overview:

Individuals who are dually eligible are low-income seniors and individuals with disabilities who are enrolled in both Medicaid and Medicare. Although dually eligible enrollees represent a relatively small share of the enrollees in each program, they account for a disproportionately large share of the expenditures in each.

According to the Centers for Medicare & Medicaid Services (CMS), the Financial Alignment Initiative aims to better integrate primary, acute, and behavioral health care, and long-term services and supports (LTSS) for enrollees who are dually eligible for Medicaid and Medicare. By financially aligning the two programs and increasing care coordination for this population, the agency aims to improve enrollee experiences, health outcomes, and save money for states and the federal government.

CMS and the states are testing two types of models under the Financial Alignment Initiative:

- **Capitated**: The state, CMS, and a managed care plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive and coordinated care to dually eligible individuals. The design of these demonstrations incorporates elements from existing care-coordination models for dually eligible individuals, such as the Program of All-Inclusive Care for the Elderly (PACE) and dual-eligible special needs plans (D-SNPs), a type of Medicare Advantage plan.

- **Managed fee for service (FFS)**: The state and CMS enter into an agreement by which the state would be eligible to benefit from savings that have resulted from care coordination initiatives designed to improve quality and reduce costs for both the Medicaid and Medicare programs. State use of primary care case management (PCCM), health homes, or other related FFS-based care management are examples of models that provide relevant experience for implementing a managed FFS model for delivering care to dually eligible individuals.

CMS has contracted with an independent evaluator (RTI International) to measure, monitor, and evaluate the impact of each state demonstration in quarterly reports as well provide a final evaluation report. Core quality measures will be used to assess plan performance and outcomes as well as calculate quality withhold payments.

**Key:** [1]

**Table 1. Summary of Financial Alignment Initiative progress:** This table provides an at-a-glance overview of implementation milestones states have reached.

**Table 2. Demonstration model**: This table is limited to states testing the capitated model because this model represents the trend towards increased managed care for dually eligible enrollees that many states are now considering.

**Table 3. Target population**: All states limit their demonstrations to dually eligible enrollees who are eligible for full Medicaid benefits, as well as consider other restrictions on types of dually eligible enrollees who can enroll (e.g., only dually eligible enrollees under age 65 can enroll in the Massachusetts demonstration).

**Table 4. Enrollment process**: Each state capitated demonstration project is testing the concept of passive enrollment. Each demonstration has a period of voluntary enrollment in which a dually eligible beneficiary may enroll in the managed care plan of his or her choice. Once the voluntary period has expired, an independent enrollment broker will enroll the beneficiary in a managed care plan participating in the state demonstration, based on a number of factors included in an auto-assignment algorithm.

**Table 5. Benefit design**: All of the demonstration programs emphasize care coordination services, including the development of individualized care teams to assess the needs and establish care plans for every participating enrollee as part of their benefit design.

**Table 6. Provider conditions**: Demonstration states are testing the ability of managed care plans to develop appropriate provider networks that include providers who often serve dually eligible enrollees, such as those that provide LTSS, yet who are often not part of the managed care system.

**Table 7. Beneficiary rights**: Currently Medicare and Medicaid have different grievances and appeals processes. The demonstrations are testing how to better integrate the appeals systems from both programs. All of the participating states have also developed independent ombudsman programs to investigate and advocate on behalf of demonstration enrollees.

**Table 8. Payment policies**: Each program must develop a three-way contract that aligns the financial incentives for both Medicaid and Medicare, including shared savings between both programs.

---

[1] Details of each state's demonstration project are from the state's Memorandum of Understanding with CMS, which can be found at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html

MACPAC
Medicaid and CHIP Payment and Access Commission

**Table 1. Key Features of State Proposed Capitated and Managed Fee-for-Service Financial Alignment Demonstration Models[1]**

| | Status | | | | | | Financing | | Scale (in thousands) | | Current Managed Care Experience | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Design contract | Submitted proposal to CMS | Withdrew proposal | Signed MOU | Signed contracts with health plans or Final Demonstration Agreement with CMS | Start date | Capitated model | Managed FFS model | Full-benefit dual eligibles (FY 2010) | Target population | Dual eligibles enrolled in comprehensive risk-based MCOs (July 2010) | D-SNPs |
| *AZ* | | ✓ | ✓ | | | | ✓ | | *119* | *115* | ✓ | ✓ |
| CA | ✓ | ✓ | | ✓ | ✓ | 4/2014 | ✓ | | 1,231 | 456 | ✓ | ✓ |
| CO | ✓ | ✓ | | ✓ | | 7/2014 | | ✓ | 70 | 48 | ✓ | ✓ |
| CT | ✓ | ✓ | | | | 1/2014 | | ✓ | 79 | 57 | | ✓ |
| *HI* | | ✓ | ✓ | | | | ✓ | | *31* | *24* | ✓ | ✓ |
| IA | | ✓ | | | | 1/2013 | | ✓ | 71 | 63 | | ✓ |
| *ID* | | ✓ | ✓ | | | *3/2014* | ✓ | | *22* | *18* | | ✓ |
| IL | | ✓ | | ✓ | ✓ | 3/2014 | ✓ | | 307 | 136 | | ✓ |
| MA | ✓ | ✓ | | ✓ | ✓ | 10/2013 | ✓ | | 248 | 110 | ✓ | ✓ |
| MI | ✓ | ✓ | | ✓ | | 1/2015 | ✓ | | 240 | 100 | | ✓ |
| *MN* | ✓ | ✓ | ✓ | ✓[2] | | *9/2013* | ✓ | | *129* | *93* | ✓ | ✓ |
| MO | | ✓ | | | | 10/2012 | | ✓ | 164 | 6 | | ✓ |
| NC | ✓ | ✓ | | | | 1/2013 | | ✓ | 253 | 222 | | ✓ |
| *NM* | | ✓ | ✓ | | | | ✓ | | *39* | *39* | ✓ | ✓ |
| NY | ✓ | ✓ | ✓[3] | ✓ | | 10/2014 | ✓ | | 694 | 134 | ✓ | ✓ |
| OH | | ✓ | | ✓ | | 5/2014 | ✓ | | 222 | 114 | | ✓ |
| OK | ✓ | ✓ | | | | 7/2013 | | ✓ | 99 | 99 | | |
| *OR* | ✓ | ✓ | ✓ | | | | ✓ | | *65* | *68* | ✓ | ✓ |
| RI | | ✓ | | | | 9/2013 | ✓ | | 36 | 23 | | |
| SC | ✓ | ✓ | | ✓ | | 7/2014 | ✓ | | 135 | 54 | | ✓ |
| *TN* | ✓ | ✓ | ✓ | | | | ✓ | | *157* | *136* | ✓ | ✓ |
| TX | | ✓ | | ✓ | | 3/2015 | ✓ | | 421 | 168 | ✓ | ✓ |
| VA | | ✓ | | ✓ | ✓ | 4/2014 | ✓ | | 124 | 77 | | ✓ |
| *VT* | ✓ | ✓ | ✓ | | | | ✓ | | *28* | *22* | ✓ | |
| WA | ✓ | ✓ | | ✓✓[4] | | 7/2013 | ✓ | ✓ | 129 | 115 | ✓ | ✓ |
| *WI* | ✓ | ✓ | ✓ | | | | ✓ | | *195* | *6* | ✓ | ✓ |
| **TOTAL** | **15** | **26** | **10** | **13** | **4** | | **20** | **7** | **4,363** | **1,982** | **14** | **23** |

Notes: Shaded states have withdrawn from the Financial Alignment Initative, and their full-benefit dual eligibles and target population are not included in the total counts. Several of the withdrawn states have indcated they will continue to develop an integrated care model for dual eligibles as part of the State Demonstration to Integrate Care for Dual Eligibles authority. CMS is the Centers for Medicare & Medicaid Services. MOU is a memorandum of understanding that the state signs with CMS that establishes the parameters of the state demonstration project. FFS is fee for service. MCOs are Medicaid managed care organizations. D-SNPs are Medicare Advantage dual eligible special needs plans.

1 As of May 2014

2 Minnesota signed an MOU with CMS that is not part of the Financial Alignment Demonstration and instead focuses on aligning administrative aspects between the Medicaid and Medicare programs.

3 NY withdrew only its managed FFS model portion of their proposal to focus on the capitated Fully-Integrated Duals Advantage Plan (FIDA) demonstration project.

4 MOUs have been signed for both the managed FFS model and capitated model (capitated model in 2 counties in the state, which has a separate MOU from the managed FFS model being tested in the rest of the state)

MACPAC
Medicaid and CHIP Payment and Access Commission

## Table 2. State Demonstration Model

| | Type of demonstration model | Duration of demonstration |
|---|---|---|
| **California** | Capitated | Demo Year 1: Apr 1, 2014-Dec 31, 2014<br>Demo Year 2: Jan 1, 2015-Dec 31, 2015<br>Demo Year 3: Jan 1, 2016-Dec 31, 2016 |
| **Illinois** | Capitated | Demo Year 1: Mar 1, 2014-Dec 31, 2014<br>Demo Year 2: Jan 1, 2015-Dec 31, 2015<br>Demo Year 3: Jan 1, 2016-Dec 31, 2016 |
| **Massachusetts** | Capitated | Demo Year 1: Oct 1, 2013-Dec 31, 2014<br>Demo Year 2: Jan 1, 2015-Dec 31, 2015<br>Demo Year 3: Jan 1, 2016-Dec 31, 2016 |
| **Michigan** | Capitated | Demo Year 1: Jan 1, 2015-Dec 31, 2015<br>Demo Year 2: Jan 1, 2016-Dec 31, 2016<br>Demo Year 3: Jan 1, 2017-Dec 31, 2017 |
| **Ohio** | Capitated | Demo Year 1: Mar 1, 2014-Dec 31, 2014<br>Demo Year 2: Jan 1, 2015-Dec 31, 2015<br>Demo Year 3: Jan 1, 2016-Dec 31, 2016 |
| **New York** | Capitated | Demo Year 1: Oct 1, 2014-Dec 31, 2015<br>Demo Year 2: Jan 1, 2016-Dec 31, 2016<br>Demo Year 3: Jan 1, 2017-Dec 31, 2017 |
| **South Carolina** | Capitated | Demo Year 1: Jul 1, 2014-Dec 31, 2015<br>Demo Year 2: Jan 1, 2016-Dec 31, 2016<br>Demo Year 3: Jan 1, 2017-Dec 31, 2017 |
| **Texas** | Capitated | Demo Year 1a: Mar 1, 2015-Dec 31, 2015<br>Demo Year 1b: Jan 1, 2016-Dec 31, 2016<br>Demo Year 2: Jan 1, 2017-Dec 31, 2017 Demo Year 3: Jan 1, 2018-Dec 31, 2018 |
| **Virginia** | Capitated | Demo Year 1: Apr, 2014-Dec 31, 2015<br>Demo Year 2: Jan 1, 2016-Dec 31, 2016<br>Demo Year 3: Jan 1, 2017-Dec 31, 2017 |
| **Washington**[1] | Capitated | Demo Year 1: Jul 1, 2014-Dec 31, 2015<br>Demo Year 2: Jan 1, 2016-Dec 31, 2016<br>Demo Year 3: Jan 1, 2017-Dec 31, 2017 |

1 Although this table presents information on the state's capitated model demonstration project, the state is testing both the capitated and managed fee-for-service models as part of the Financial Alignment Initiative. On June 28, 2013, Washington became the first state to sign a final demonstration agreement with CMS to begin implementation of its managed fee-for-service model on July 1, 2013.

MACPAC
Medicaid and CHIP Payment and Access Commission

**Table 3. State Demonstration Target Population**

| | Eligible Participants | Estimated Number of Enrollees | Geographic Coverage Area |
|---|---|---|---|
| **California** | Full-benefit dual eligibles, age 21 and older at time of enrollment, who reside in a demonstration county | Estimated 456,000 enrollees are eligible for the demonstration | The demonstration is available in eight counties: Alameda, Los Angeles, Riverside, San Bernardino, Santa Clara, Orange, San Mateo, and San Diego. |
| **Illinois** | Full-benefit dual eligibles, age 21 and older at time of enrollment, who reside in a demonstration county (excludes individuals with developmental disability (DD) who receive DD services in an institution or througha home and community-based (HCBS) waiver) | Estimated 136,000 enrollees are eligible for the demonstration | The demonstration is available in 21 counties grouped into 2 regions of the state (Greater Chicago region and Central Illinois region). |
| **Massachusetts** | Full-benefit dual eligibles, age 21 to 64, who are not currently enrolled in a home and community-based waiver program nor living in an intermediate care facility for persons with intellectual disabilities (ICF/ID) | Estimated 110,000 enrollees are eligible for the demonstration | The demonstration is available statewide, with state demonstration areas including all areas of Massachusetts that have one or more successful Integrated Care Organization (ICO) bids. |
| **Michigan** | Full-benefit dual eligibles, age 21 and older at time of enrollment, who reside in one of four demonstration regions | Estimated 100,000 enrollees are eligible for demonstration | The demonstration is available in 25 counties grouped into 4 regions of the state. |
| **Ohio** | Full-benefit dual eligibles, age 18 and older at time of enrollment, who reside in an Integrated Care Delivery System (ICDS) demonstration county | Estimated 114,000 enrollees are eligible for the demonstration | The demonstration is available in 29 counties grouped into 7 regions of the state (Central, East Central, Northeast, Northeast Central, Northwest, West Central, and Southwest). |
| **New York** | Full-benefit dual eligibles, age 21 and older, and reside in a Fully-Integrated Duals Advantage (FIDA) Demonstration county. Must also meet one of the following criteria:<br>• eligible for facility-based long-term services and supports (LTSS);<br>• eligible for the Nursing Home Transition & Diversion waiver; or<br>• require community-basedLTSS for more than 120 days | Estimated 170,000 enrollees are eligible for the demonstration | The demonstration area consists of 8 counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. |
| **South Carolina** | Full-benefit dual eligibles, age 65 and older living in the community at the time of enrollment of demonstration (exclude individuals participating in HCBS waivers other than Community Choices Waiver, HIV/AIDs Waiver, and Mechanical Ventilation Waiver) | Estimated 53,600 enrollees eligible for demonstration | The demonstration is available statewide. |
| **Texas** | Full-benefit dual eligibles, age 21 and older and Full-benefit dual eligibles, age 21 and older, who are required to enroll in the state's Section 1115 waiver program and are living in one of the six counties of the state participating in the demonstration | Estimated 168,000 enrollees eligible for demonstraitons | The demonstration is currently available in 6 counties: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant. |
| **Virginia** | Full-benefit dual eligibles, age 21 and older, who reside in specific regions of the state (includes those enrolled in Elderly or Disabled with Consumer Direction (EDCD) Waiver and those residing in nursing facilities) | Estimated 77,000 enrollees are eligible for the demonstration | The demonstration area consists of five geographic regions in the state: Central Virginia, Northern Virginia, Tidewater, Western/Charlottesville, and Roanoke. |
| **Washington**[1] | Full-benefit dual eligibles, age 21 and older | Estimated 27,000 enrollees are eligible for the demonstration. | The demonstration is available in King and Snohomish counties. |

1 This table presents information only on the state's capitated model demonstration project, although the state is testing both the capitated and managed fee-for-service models as part of the Financial Alignment Initiative.

**Table 4. State Demonstration Enrollment Process**[1]

| | Voluntary Enrollment | Passive Enrollment Process | Notice | Auto-Assignment Priorities | Enrollment Assistance |
|---|---|---|---|---|---|
| **California** | Voluntary enrollment begins April 1, 2014. | Passive enrollment periods are specific to each county. Beneficiaries eligible for Part D reassignment or enrolled in a Medicare Advantage plans in 2014 have different passive enrollment periods than individuals enrolled in Medicare FFS.<br>• Enrollees can change plans or opt out of the demonstration at any time, which is effective on the first of the following month. | • Beneficiaries receive 3 notices prior to passive enrollment:<br>o 1st: 90 days prior to the date of enrollment,<br>o 2nd: 60 days prior to passive enrollment and identifies the plan in which the beneficiary would be enrolleed unless he or she selects another plan or opts out of the demonstration<br>o 3rd: 30 days prior to passive enrollment | The state plans to auto-assign enrollees based on an algorithm that considers several factors. Algorithm factors prioritize continuity of care, including:<br>o using the most recent 12 months of Medicare and Medicaid claims history data to identify most frequently used providers, and<br>o determining whether an individual is currently residing in a long-term care facility. | Independent enrollment broker |
| **Illinois** | Voluntary enrollment begins March 2014. | Passive enrollment begins June 2014 and will be phased in over several months. Individuals enrolled in a Medicare Advantage plan that is operated by the same parent organization as a demonstration plan will be passively enrolled into that demonstration plan.<br>• Enrollees can change plans or opt out of the demonstration at any time, which is effective on the first of the following month. | • Beneficiaries will receive 2 notices prior to passive enrollment.<br>o 1st: At least 60 days and no more than 90 days prior to the passive enrollment period.<br>o 2nd: At least 30 days prior to the passive enrollment period. | The state plans to auto-assign enrollees based on an algorithm that considers several factors. Algorithm factors prioritize beneficiaries' previous managed care enrollment and historic provider utilization. | Independent enrollment broker |
| **Massachusetts** | Voluntary enrollment begins October 1, 2013. | First phase of passive enrollment begins January 2014.<br>• Will initially conduct three passive enrollment periods (January, April and July 2014) but enrollees categorized as having high care need in the community will not be auto-assigned until calendar year (CY) 2015.<br>• Enrollees can opt-out of the demonstration on a month-to-month basis at any time during the year, although coverage will continue through the end of the month. | • Beneficiaries will receive 2 notices prior to passive enrollment:<br>o 1st: At least 60 days prior to the passive enrollment period,<br>o 2nd: At least 30 days prior to the passive enrollment period | The state plans to auto-assign enrollees based on an algorithm that considers several factors. Such factors may include, but not be limited to, past provider relationships. | Independent enrollment broker; the state Aging and Disability Resource Networks (ADRNs) can inform enrollees of their enrollment options. |
| **Michigan** | Two-phase voluntary enrollment process based on participating regions of state. Phase One begins January 1, 2015 and Phase Two begins May 1, 2015. | Two-phase passive enrollment process, based on regions of state. Phase One begins April 1, 2015 and Phase Two begins July 1, 2015. | • Beneficiaries will receive 2 notices prior to passive enrollment:<br>o 1st: At least 60 days prior to the passive enrollment period,<br>o 2nd: At least 30 days prior to the passive enrollment period | The state plans to auto-assign enrollees based on an algorithm that considers several factors. Algorithm factors will consider the beneficiaries' previous managed care enrollment, enrollments of individuals who share a common case number for Medicaid eligibility, and ICO measures for quality, administration, and capacity, as data become available. | Independent enrollment broker |
| **Ohio** | Voluntary enrollment begins March 2014. | Phased-in passive enrollment begins April 2014<br>• There will be 3 passive enrollment periods for those who have not made plan selection.<br>• Enrollees can opt-out of the demonstration on a month-to-month basis at any time during the year, although coverage will continue through the end of the month. | • Beneficiaries will receive 2 notices prior to passive enrollment:<br>o 1st: At least 60 days prior to the passive enrollment period,<br>o 2nd: At least 30 days prior to the passive enrollment period | The state plans to auto-assign enrollees based on an algorithm that considers several factors. Algorithm factors will consider the beneficiaries' previous managed care enrollment and historic provider utilization. | Independent enrollment broker |
| **New York** | Population phase-in enrollment process beginning October 1, 2014. | • Enrollment for community-based LTSS enrollees, with open enrollment beginning October 1, 2014 and passive enrollment beginning January 1, 2015.<br>• Enrollees can opt-out of the demonstration on a month-to-month basis at any time during the year, although coverage will continue through the end of the month. | • The state will provide 2 notices of the requirement to select a plan or opt out of the demonstration:<br>o 1st: At least 60 days before the effective date of the passive enrollment period<br>o 2nd: At least 30 days before the effective date of the passive enrollment period | The state plans to auto-assign enrollees based on an algorithm that considers several factors. Algorithm factors prioritize previous managed care enrollment and historic utilization of certain provider types. | Independent enrollment broker |
| **South Carolina** | Voluntary enrollment begins July 1, 2014. | • There will be 3 separate waves of passive enrollment based on the region of the state:<br>o Upstate Region start January 1, 2015 (exclude beneficiaries in 3 applicable HCBS waivers)<br>o Coastal Region start March 1, 2015 (exclude beneficiaries in 3 applicable HCBS waivers<br>o HCBS waiver beneficiaries start May 1, 2015.<br>• Enrollees can opt-out of the demonstration on a month-to-month basis at any time during the year, although coverage will continue through the end of the month. | • The state will provide 2 notices of the requirement to select a plan or opt out of the demonstration:<br>o 1st: At least 60 days before the effective date of the passive enrollment period<br>o 2nd: At least 30 days before the effective date of the passive enrollment period | The state plans to auto-assign enrollees based on an algorithm that considers several factors. Algorithms factors prioritize previous managed care enrollment and historic utilization of certain provider types. At minimum, enrollees' assignment will consider:<br>o existing provider relationships,<br>o previous history with another product of the health plan (e.g. Medicare Advantage), and<br>o household members currently assigned to a participating plan. | Independent enrollment broker |

| | Voluntary Enrollment | Passive Enrollment Process | Notice | Auto-Assignment Priorities | Enrollment Assistance |
|---|---|---|---|---|---|
| **Texas** | Voluntary enrollment begins March 1, 2015. | For the first 6 months of the demonstration, CMS and the state will monitor each STAR+PLUS MMPs' ability to manage opt-in and passive enrollments/<br>o For Harris County, the passive enrollment phase-in will occur over a period of at least six months and will not exceed 5,000 beneficiaries per month per STAR+PLUS MMP.<br>o In the remaining 5 participating counties of Bexar, Dallas, El Paso, Hidalgo, and Tarrant counties, the passive enrollment phase-in will occur over a period of at least six months and will not exceed 3,000 beneficiaries per month per STAR+PLUS MMP per county. | • The state will provide 2 notices of the requirement to select a plan or opt out of the demonstration:<br>o 1st: At least 60 days before the effective date of the passive enrollment period<br>o 2nd: At least 30 days before the effective date of the passive enrollment period | The state plans to auto-assign enrollees based on an algorithm that considers several factors. Algorithm factors prioritize continuity of providers and services, previous managed care enrollment, and historic utilization of certain provider types. | Independent enrollment broker; the state Department of Aging and Disability Services will work with Health and Human Services Commission, the Texas State Health Insurance Assistance Program, Aging and Disability Resource Centers, the enrollment broker, and other local partners to ensure ongoing outreach, education, and support to beneficiaries eligible for the demonstration. |
| **Virginia** | Regional phase-in enrollment process; each phase includes opt-in and passive enrollment period with first phase beginning April 1, 2014. | • Phase I enrollment for Central Virginia and Tidewater regions:<br>o First effective date for opt-in enrollment no sooner than April 1, 2014.<br>o Passive enrollment begins May 1, 2014, with a July 1, 2014 service effective date<br>• Phase II enrollment for Western/Charlottesville, Northern Virginia, and Roanoke regions:<br>o First effective date for opt-in enrollment no sooner than June 1, 2014.<br>o Passive enrollment begins August 1, 2014 with an October 1, 2014 service effective date.<br>• Enrollees can opt-out of the demonstration on a month-to-month basis at any time during the year, although coverage will continue through the end of the month.<br>• The state will provide 2 notices of the requirement to select a plan or opt out of the demonstration:<br>o 1st: At least 60 days before the effective date of the passive enrollment period<br>o 2nd: At least 30 days before the effective date of the passive enrollment period | • Beneficiaries will receive 2 notices prior to passive enrollment:<br>o 1st: At least 60 days prior to the passive enrollment period,<br>o 2nd: At least 30 days prior to the passive enrollment period | The state plans to auto-assign enrollees based on an algorithm that considers several factors. Algorithm factors prioritize previous managed care enrollment and historic utilization of certain provider types. At a minimum, enrollees' assignment will consider:<br>o current nursing facility,<br>o current adult day health care provider,<br>o plan in which their providers participate, and<br>o plan previously enrolled in last 6 months (first look to Medicare then Medicaid plans). | Independent enrollment broker |
| **Washington**[2] | Voluntary enrollment begins July 1, 2014. | • There will be 3 separate waves of passive enrollment based on random assignment.<br>• Enrollees can opt-out of the demonstration on a month-to-month basis at any time during the year, although coverage will continue through the end of the month.<br>• Plan to use random assignment | • The state will provide 2 notices of the requirement to select a plan or opt out of the demonstration:<br>o 1st: At least 60 days before the effective date of the passive enrollment period<br>o 2nd: At least 30 days before the effective date of the passive enrollment period | The state plans to auto-assign enrollees to participating plans using random assignment. | Independent enrollment broker |

1 On August 23, 2012, CMS announced a funding opportunity through which states that have signed MOUs can apply for additional funding to support outreach and education for dual eligible enrollees for the Financial Alignment Demonstration through the State Health Insurance Programs (SHIPs) and the Aging and Disability Resource Centers (ADRCs). http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOptionsCounselingforMedicare-MedicaidEnrollees-.html.

2 This table presents information only on the state's capitated model demonstration project, although the state is testing both the capitated and managed fee-for-service models as part of the Financial Alignment Initiative.

MACPAC
Medicaid and CHIP Payment and Access Commission

**Table 5. State Demonstration Benefit Design**

| | Model of Care | Covered Servies | Care-Coordination Elements |
|---|---|---|---|
| **California** | Use Medicare Advantage (MA) special needs plan (SNP) model-of-care components (11 clinical and non-clinical elements).<br>Supplemental information in each of the 11 elements specific to integrated benefits and services. | Plans required to provide all covered Medicare services (except Medicare hospice benefit, which will remain through Medicare fee for service (FFS)), Medicaid state plan services, and services defined in the approved 1115(a) waiver (minimum requirements to be defined in the three-way contract), including:<br>• preventive, restorative, and emergency oral health benefits;<br>• preventive, restorative, and emergency vision benefits; and,<br>• non-emergency, accessible medical transportation so that enrollees have timely access to scheduled and unscheduled medical care appointments.<br>Specialty mental health and substance use services financed by county mental health and substance use agencies carved out and plans have local behavioral health memorandum of understanding (BH-MOU).<br>Plans required to enter into a MOU with participating counties to have them perform specific tasks for IHSS services. | Plans required to offer an interdisciplinary care team for each enrollee.<br>Enrollees must undergo a health risk assessment by the plan.<br>• For enrollees identified as higher risk, the assessment tool will be used within 45 calendar days of enrollment.<br>• For enrollees in nursing facilities or identified as lower risk, the assessment tool will be used within 90 calendar days of enrollment.<br>• Reassessments conducted at least annually.<br>The state will design, develop, and test a universal assessment process for long-term services and supports (LTSS) in 2015.<br>• Plans required to develop risk stratification levels of members, using historical Medicaid and Medicare data upon enrollment. |
| **Illinois** | Use MA SNP model-of-care components (11 clinical and non-clinical elements). | Plans required to provide all covered Medicare services (except Medicare hospice benefit, which will remain through Medicare FFS) and Medicaid state plan services.<br>• Plans have the discretion to offer flexible benefits as appropriate to address the enrollee's needs.<br>Plans will offer integrated primary and behavioral health care services, with an emphasis on co-location of such services. | All enrollees will be assigned a care coordinator and care team.<br>Care coordinator to enrollee ratios vary based on enrollee risk-level.<br>Plans administer health risk questionnaire within 60 days after enrollment.<br>Enrollees stratified into 3 levels of intervention depending on initial health risk questionnaire: low-, moderate-, and high-risk.<br>Plans review enrollee care plans at least every 30 days for high-risk enrollees and at least every 90 days for moderate-risk enrollees. |
| **Massachusetts** | Use MA SNP model-of-care components (11 clinical and non-clinical elements). | Plans required to provide all covered Medicare services; Medicaid state plan services; and demonstration-specific supplemental services. The supplemental services include:<br>• diversionary behavioral health services (e.g., acute treatment services for substance abuse, psychiatric day treatment);<br>• community support services (e.g., day services, respite care); and<br>• expanded state plan services (e.g., preventive, restorative, and emergency oral health benefits). | Plans required to offer care coordination services to all enrollees through a care coordinator for medical and behavioral services and an Independent Living and LTSS Coordinator (contracted from community-based organizations) for LTSS.<br>Each enrollee will receive an initial assessment of medical, behavioral health, and LTSS needs, using the Minimum Data Set-Home Care (MDS-HC) tool, and upon enrollment, the plan will perform an in-person comprehensive assessment that will be the starting point for an individualized care plan. |
| **Michigan** | Use MA SNP model-of-care components (11 clinical and non-clinical elements). | Plans required to provide all covered Medicare services, Medicaid state plan services • ICOs will also be required to provide services as defined in the approved 1915(b) and 1915(c) waivers.<br>• The state will continue to contract directly with Prepaid Inpatient Health Plans (PIHPs) for delivery of specific behavioral health, substance use disorder and intellectual and developmental disability Medicaid services, and payment through these contracts is not included in the payment to ICOs. | The Care Bridge is the coordination framework for the plans, which will include an electronic Integrated Care Bridge Record.<br>The integrated care team will be led by the plan's care coordinator, who must also collaborate with the Prepaid Inpatient Health Plan (PIHP) supports coordinator and the LTSS supporst coordinator. The care coordinator will also develop an individual integrated care plan for each enrollee within 90 days of enrollment. The assessment process for each enrollee includes 3 steps: (1) over the phone screening, (2) in-person Level 1 assessment, and (3) in-person Level 2 assessment for persons with LTSS needs. |
| **Ohio** | Use MA SNP model-of-care components (11 clinical and non-clinical elements). | Plans are required to provide all covered Medicare services; Medicaid state plan services; and services defined in the approved 1915(b) and 1915(c) waivers.<br>Integrated Care Delivery System (ICDS) plans have discretion to use capitated payment to offer additional flexible benefits, as specified in the enrollee's individualized care plan.<br>Habilitation and targeted case management services for individuals with developmental disabilities are excluded. | Plans must establish a trans-disciplinary care management team for each enrollee.<br>A comprehensive assessment for each enrollee must be completed within 90 days of enrollment date and at least once every 12 months after initial assessment date.<br>• Completed in person for highest risk enrollees and all enrollees receiving 1915(c) HCBS waiver services, and completed over the phone for enrollees with low to medium risk levels.<br>Plans develop risk or acuity stratification levels for resource allocation and targeting interventions for enrollees at greatest risk.<br>Plans coordinate with Medicaid health homes for eligible enrollees and contract with Area Agencies on Aging for waiver service coordination for individuals over age 60. |
| **New York** | Use MA SNP model-of-care components (11 clinical and non-clinical elements). | Plans required to provide all covered Medicare services and Medicaid state plan services (except Medicare and Medicaid hospice benefit, out-of-network family planning, directly observed therapy for tuberculosis, and methadone maintenance treatment which will remain through FFS). | Plans must establish an interdisciplinary care team for each enrollee.<br>Health risk assessments to be completed by the plan's care management team for each enrollee to develop the enrollee's plan of care.<br>Identification strategy to consider medical, behavioral health, substance use, and LTSS needs of each enrollee |

| | Model of Care | Covered Servies | Care-Coordination Elements |
|---|---|---|---|
| **South Carolina** | Use model of care (MOC) that is consistent with MA SNP MOC and includes 13 clinical and non-clinical elements. | Plans required to provide all covered Medicare services (except Medicare hospice, which will remain Medicare FFS) and Medicaid state plan services.<br>Plans also required to cover palliative care benefit. | Plan must establish a multidisciplinary team for each enrollee.<br>Plans work with the state to complete a universal health screen within 30 days of enrollment (in person or over the phone). Will identify LTSS needs to determine if long-term care level of care assessment is needed.<br>Plans supplement initial screen with predictive modeling to stratify enrollees into one of three levels of risk (low, medium, or high) based on risk of institutionalization and/or avoidable hospitalization.<br>Enrollees at low-risk have comprehensive assessment within 90 days of enrollment; enrollees with medium to high levels of risk assessed within 60 days.<br>Long-term care level of care assessment for all enrollees identified as high risk.<br>Plans have access to Phoenix/Care Call systemthat is used to monitor HCBS services and collect data on enrollee experiences, access and utilization of services. |
| **Texas** | Use MA SNP model-of-care components (11 clinical and non-clinical elements). | • The STAR+PLUS MMPs will be also required to provide services as defined in the approved Section 1115 waiver program.<br>• Enrollees in Dallas County will not access behavioral health services through the NorthSTAR program. Enrollees who choose to disenroll from the demonstration will continue to have access to NorthSTAR services. | • STAR+PLUS MMPs are required to address the following components as part of their comprehensive care management programs:<br>o risk stratification - enrollees will be stratified into 2 risk levels, with Level 1 the highest risk and Level 2 moderate and lower risk enrollees<br>o Comprehensive health risk assessmen no later than 90 days after the individual's enrollment<br>o Plan of care developed within 90 days of enrollment.<br>o Service coordination team - to ensure the integration of the enrollee's medical, behavioral health, substance use, LTSS, and social needs<br>o Service coordinators - must have experience in meeting the needs of individuals with disabilities and vulnerable populations who have chronic or complex conditions.<br>o Self direction - allow enrollees opportunity to direct their own services, including both employer and budget authority. |
| **Virginia** | Use MA SNP model-of-care components (11 clinical and non-clinical elements).<br>Additional state MOC requirements, including:<br>• hospital and nursing facility transition,<br>• enhanced care management for vulnerable subpopulations, and partnering with community care management providers. | Plans required to provide all covered Medicare services and Medicaid state plan services (including medically necessary acute care services provided under the state plan for Medicaid assistance).<br>• Also required to cover LTSS provided under the Elderly or Disabled with Consumer Direction (EDCD) Waiver program<br>• Plans allowed to use telehealth and remote patient monitoring services (e.g., transferring vital signs).<br>• Skilled nursing level care may be provided in a long-term care facility without preceding acute care inpatient stay<br>Following services will be carved out:<br>• targeted case management,<br>• dental, and<br>• case management for participants of auxiliary grants | Plans must establish an interdisciplinary care team for each enrollee.<br>Health risk assessments to be completed by the plan's care management team for each enrollee to develop the enrollee's plan of care.<br>Identification strategy to consider medical, behavioral health, community-based or facility-based LTSS, and social needs of each enrollee. |
| **Washington**[1] | Use MA SNP model-of-care components (11 clinical and non-clinical elements).<br>Additional four state-specific elements include: integrated delivery system and care coordination; health action plan; person-centered care; and transitional care. | Plans required to provide all covered Medicare services and Medicaid state plan services.<br>Certain services will be carved out to Medicare and Medicaid FFS, including such services as transportation and dental services. | Plans must establish an interdisciplinary care team for each enrollee.<br>Each enrollee will receive initial screenings and ongoing health risk assessments of medical, behavioral health and LTSS needs, which will be used as the starting point for creating an individualized care plan (ICP).<br>State plans to also rely on PRISM, which is a web-based tool used for predictive modeling and clinical decision support.<br>Enrollees to be stratified into 3 tiers of risk:<br>• Tier one: Enrollees who do not fall under Tier Two or Three.<br>• Tier two:Enrollees who have chronic diseases that pose low to moderate risk for acute episodes and have LTSS needs.<br>• Tier three: Enrollees who have PRISM high risk scores, at least one chronic disease and LTSS needs. |

1 This table presents information only on the state's capitated model demonstration project, although the state is testing both the capitated and managed fee-for-service models as part of the Financial Alignment Initiative.

**Table 6. State Demonstration Provider Conditions**

| | Provider Adequacy | Required Contract Agencies | Overlapping Service Restrictions | Continuity of Care |
|---|---|---|---|---|
| **California** | Provider network adequacy requirements follow Medicaid standards for Medicaid-only services and Medicare standards for Medicare services. | Plans are required to contract with all Multipurpose Senior Services Program (MSSP) organizations in good standing with the California Department of Aging.<br>Plans must contract with all willing, licensed, and certified Community-Based Adult Services (CBAS) centers located in the covered counties and adjacent areas that are located not more than 60 minutes driving time away from the enrollee's residence. | Overlapping services subject to the more stringent of the applicable Medicaid and Medicare standards. | Plans must allow enrollees to maintain current providers at the time of enrollment for:<br>• up to 6 months for Medicare services if certain criteria are met (e.g., beneficiary has an existing relationship with the provider prior to enrollment)<br>• up to 12 months for Medicaid services if certain criteria are met:<br>• Continuity of care provisions for inhome suport services (IHSS) providers, durable medical equipment, transportation, and other ancillary services will follow current state law. |
| **Illinois** | Provider network adequacy requirements follow Medicaid standards for Medicaid-only services and Medicare standards for Medicare services.<br><br>Plans must establish medical homes for enrollees, with a focus on federally qualified health centers (FQHCs), community mental health centers, primary care physician-centered medical groups, and private practice primary care provider (PCP) offices. | Plans required to contract with all nursing facilities and supportive living facilities for the first year of the demonstration.<br>Plans required to operate a SNFist program, which is an adequate network of providers who specialize in medical care for the nursing home population | Overlapping services will be subject to Medicaid standards. | Plans required to offer a 180-day transition period for enrollees to maintain a current course of treatment with an out-of-network provider. The 180-day period applies to all providers, including long-term service and support (LTSS) and behavioral health providers. |
| **Massachusetts** | Provider network adequacy requirements follow Medicaid standards for Medicaid-only services and Medicare standards for Medicare services. | Plans required to have the following provider standards within a 15-mile radius or 30 minutes from the enrollee's ZIP code of residence:<br>• At least two PCPs;<br>• At least two outpatient behavioral health providers;<br>• Two hospitals (when feasible);<br>• Two nursing facilities; and<br>• Two community LTSS Providers per covered service. | Overlapping services will be subject to Medicaid standards, so long as standards are at least as stringent as Medicare standards. Otherwise, Medicare standards or an alternative standard that meets or exceeds Medicare and Medicaid standards shall apply. | Integrated Care Organizations (ICO)s must allow enrollees to maintain their current providers at the time of their enrollment for up to 90 days or until the ICO completes an initial assessment of the enrollee's service needs, whichever is longer. |
| **Michigan** | Provider network adequacy requirements follow Medicaid standards for Medicaid-only services and Medicare standards for Medicare services. | Each enrollee will have a choice of at least two providers for each service type. When an ICO cannot assure choice within 30 miles for each enrollee, it may requires a rural exception from the state. | Overlapping services subject to the more stringent of the applicable Medicaid and Medicare standards. | Plans are required to allow for continuation of coverage for existing providers, for a minimum number of days, depending upon the provider type and whether enrollee is enrolled in habilitation supports waiver or enrollees are receiving services through a PIHP |

| | Provider Adequacy | Required Contract Agencies | Overlapping Service Restrictions | Continuity of Care |
|---|---|---|---|---|
| **Ohio** | Provider network adequacy requirements follow Medicaid standards for Medicaid-only services and Medicare standards for Medicare services. | • At least two community LTSS providers in each region for the following services: enhanced community living, homemaker,waiver transportation, nutritional consultation, assisted living, social work counseling, out of home respite, home medical equipment and supplemental adaptive and assistive devices, independent living assistance and community transition.<br>• At least one adult day health and one assisted living provider within 30 miles of each zip code within the region.<br>• At least two community LTSS agency providers in each region for the following services: personal care and waiver nursing.<br>• At least five community LTSS independent providers, in addition to self-directed care options in which and enrollee can choose his or her provider, in each region for the following services: personal care, home care attendant, and waiver nursing.<br>• At least one community LTSS provider in each Integrated Care Delivery System (ICDS) region for the following services: pest control, home delivered meals, emergency response, home modifications maintenance and repairs and chore services. | Overlapping services subject to the more stringent of the applicable Medicaid and Medicare standards. | State developed transition requirements, by specific provider type:<br>• Physicians: 90-day transition high-risk enrollees and 365 days for all other enrollees<br>• Nursing Home and Assisted Living Facilities: Provider maintained at current rate for entirety of demonstration<br>• Home and Community-Based (HCBS) Waiver Services: Self-direct services: Maintain services at current level with current providers at current Medicaid reimbursement rate. All other waiver services: Maintain service at current level for 365 days and current provider for 90 days.<br>• Medicaid Community Behavioral Health Organizations: Maintain current provider. |
| **New York** | Provider network adequacy requirements follow Medicaid standards for Medicaid-only services and Medicare standards for Medicare services.<br><br>Include minimum appointment availability standards for physical and behavioral health services and minimum access standards for LTSS. | Each enrollee will have a choice of at least two providers for each service type. | Overlapping services subject to the more stringent of the applicable Medicaid and Medicare standards. | Plans must allow enrollees to maintain their current providers (except nursing facilities) at the time of their enrollment for up to 90 days or until the plan completes an initial assessment of the enrollee's service needs, whichever is longer.<br>For nursing facility services, plans must allow enrollees to maintain current providers for the duration of the demonstration. |
| **South Carolina** | Provider network adequacy requirements follow Medicaid standards for Medicaid-only services and Medicare standards for Medicare services.<br><br>Plans must operate networks from which enrollees can choose a provider that acts as a medical home. | Plans must operate networks from which enrollees can choose a provider that acts as a medical home. | Overlapping services subject to the more stringent of the applicable Medicaid and Medicare standards. | Plans must allow enrollees to maintain current providers and preauthorized services for 180 days from enrollment, including LTSS and behavioral health providers. |
| **Texas** | Provider network adequacy requirements follow Medicaid standards for Medicaid-only services and Medicare standards for Medicare services unless Medicaid standards for such services are more stringent. | MMPs are the plans that are already contracted with the state as existing STAR+PLUS managed care organizations (procured in 2011). A nursing facility must be offered a network provider agreement if it holds a valid certification and license and it contracts with Texas Department of Aging and Disability Services September 1, 2013.<br>Plans must ensure that enrollees have access to at least one LTSS provider of each service type required by the state in the network within 75 miles of the enrollee's residence.<br>Plans must ensure that enrollees have access to behavioral health providers within 75 miles of the enrollee's residence. | Overlapping services subject to the more beneficiary-friendly of the applicable Medicaid and Medicare standards. | Plans must allow enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to 90 days.<br>• Plan is also required to ensure that all enrollees who receiving LTSS continue to receive those services for up to six months after enrollment<br>• Exception shall be made for an enrollee who has been diagnosed with and is receiving treatment for a terminal illness in which case the plan will continue to cover such services for 9 months from the time of enrollment. |
| **Virginia** | Provider network adequacy requirements follow Medicaid standards for Medicaid-only services and Medicare standards for Medicare services.<br><br>Plan must meet Medicare requirements when requires a more rigorous network adequacy standard than Medicaid | For Medicaid-only services, each enrollee will have a choice of at least two providers for each service type located no more than 30 minutes travel time for enrollees in urban areas and 60 minutes of travel time for enrollees in rural areas. | Overlapping services will be subject to Medicaid standards, so long as standards are at least as stringent as Medicare standards. Otherwise, Medicare standards or an alternative standard that meets or exceeds Medicare and Medicaid standards shall apply. | Plans must allow enrollees to maintain current providers and preauthorized services for 180 days from enrollment.<br>Enrollees in nursing facilities may remain in the facility for the duration of the demonstration, as long as the facility continues to meet the state criteria for nursing home care. |

| | Provider Adequacy | Required Contract Agencies | Overlapping Service Restrictions | Continuity of Care |
|---|---|---|---|---|
| **Washington**[1] | Provider network adequacy requirements follow Medicaid standards for Medicaid-only services and Medicare standards for Medicare services. | • Skilled Nursing Facilities – at least one skilled nursing facility within 20 miles of an enrollee's location of choice.<br>•Residential Providers – enrollees to move into a residential placement within one week of referral or request and have the choice of three different residential options<br>• In-Home Personal Care Provider Network – The Medicare-Medicaid Integration Plan (MMIP) will develop contracts with both agency and individual providers.<br>• Other LTSS Providers – contract for services identified in the HCBS waiver, and will have access to at least two of each provider type in the geographic area<br>• Mental Health Service Clinic Sites (clinics that perform assessments and provide mental health services) - Urban: 1 within 10 miles for 90% of enrollees in the service area; Rural: 1 within 25 miles for 90% of enrollees in the service area.<br>• Chemical Dependency Treatment Facilities - Urban: 1 within 10 miles for 90% of enrollees in the service area; Rural: 1 within 25 miles for 90% of enrollees in the service area.<br>•Outpatient Dialysis Services - Urban: 2 within 10 miles for 90% of Enrollees in the MMIP's service area; Rural: 1 within 25 miles for 90% of Enrollees in the MMIP's service area | Overlapping services will be subject to Medicaid standards, so long as standards are at least as stringent as Medicare standards. Otherwise, Medicare standards or an alternative standard that meets or exceeds Medicare and Medicaid standards shall apply. | Plans must allow enrollees to maintain current providers and preauthorized services for 90 days from enrollment or until the plan completes an initial assessment of the enrollee's service needs, whichever is longer. |

1 This table presents information only on the state's capitated model demonstration project, although the state is testing both the capitated and managed fee-for-service models as part of the Financial Alignment Initiative.

MACPAC
Medicaid and CHIP Payment and Access Commission

**Table 7. State Demonstration Beneficiary Rights**

| | Ombudsman[1] | Grievance and Appeals |
|---|---|---|
| **California** | The state will support an ombudsman to support individual advocacy and independent systematic oversight for the demonstration, focusing on compliance with principles of community integration, independent living, and person-centered care in the home and community-based (HCBS) context. | Initial appeals must be filed within 90 days to the health plan.<br>2nd level appeals for Medicare benefits automatically sent to Medicare Independent Review Entity (IRE). For certain Medicaid benefits, members may request an Independent Medical Review (IMR) and an IMR may not be requested if a state fair hearing has already been requested.<br>3rd level appeals for Medicare benefits are made to the Office of Medicare Hearings and Appeals. Medicaid-only benefits are appealed to the state fair hearing.<br>Overlapping services will be defined and have a designated appeal pathway as specified in the three-way contract<br>State work with stakeholders and CMS to integrate the appeals process based on the current MA appeals process in future years of demonstration. |
| **Illinois** | The state will support an independent ombudsman to advocate and investigate on behalf of demonstration enrollees. | Initial appeals must be filed within 60 days to the health plan.<br>Initial appeals for Medicare services will be made to the plan and then auto-forwarded to the IRE if denied.<br>2nd level appeals for Medicaid services, the enrollee can request a state fair hearing.<br>Overlapping services will be defined and have a designated appeal pathway as specified in the three-way contract.<br>Plans must continue to provide benefits pending resolution of the appeal process. For Medicaid-only and Medicare-Medicaid overlap services, continuation of services is required only if the request for an appeal is filed with the demonstration plan within 10 calendar days of the notice of action. |
| **Massachusetts** | MOU does not contain language for ombudsman but Implementation Council discussed creation of demo ombudsman in Feb. 15, 2013 meeting.<br>The council recommended that organization outside of state government should select ombudsman.<br>• Contract awarded to Disability Policy Consortium in October 2013. | Initial appeals must be filed within 60 days to the health plan.<br>2nd level appeals for Medicare services forwarded to the IRE and appeals for Medicaid-only services forwarded to the MassHealth Board of Hearings (BOH).<br>Overlapping services will be auto-forwarded to the IRE and maybe also be filed with the BOH.<br>All appeals (excluding Part D appeals) must be resolved (at each level) within 30 days of submission.<br>Plans must continue to provide benefits pending resolution of the appeal process. |
| **Michigan** | The state will support an independent ombudsman to advocate and investigate on behalf of demonstration enrollees. | Initial appeals must be filed within 90 days to the health plan.<br>2nd level appeals for Medicare services auto-forwarded to the IRE and appeals for Medicaid services will be made by enrollees to the Michigan Administrative Hearing System (MAHS).<br>Continuation of benefits will be required to be provided pending internal plan appeals as well as those requests made to the MAHS.<br>Plans will notify enrollees of appeal rights through a single notice specific to the service in question, which will be developed jointly by the state and CMS. |
| **Ohio** | The state has expanded the role of the pre-established Ohio Office of the State Long-term Care Ombudsman Program from focusing primarily on long-term care facilities to also providing systematic oversight of plans' support for other home and community-based services and supports. | Initial appeals must be filed within 90 days to the health plan.<br>2nd level appeals for Medicare services auto-forwarded to the IRE and appeals for Medicaid services will be made by enrollees to the Bureau of State Hearings.<br>Continuation of benefits will be required to be provided pending internal plan appeals as well as those requests made to the Bureau of State Hearings.<br>Plans will notify enrollees of appeal rights through a single notice specific to the service in question, which will be developed jointly by the state and CMS. |

| | | |
|---|---|---|
| **New York** | The state will support an independent ombudsman to advocate and investigate on behalf of demonstration enrollees. | Initial appeals must be filed within 60 days to the health plan.<br>2nd level appeals automatically forwarded to the Integrated Administrative Hearing Officer at the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance to render decision within 90 calendar days of request for the first year of the demonstration and 30 calendar days of request for the second and third year of the demonstration.<br>Third level appeals to the Medicare Appeals Council within 60 days with decision within 90 calendar days. |
| **South Carolina** | The state will support an independent ombudsman to advocate and investigate on behalf of demonstration enrollees. | Initial appeals must be filed within 60 days to the health plan.<br>2nd level appeals for Medicare services automatically forwarded to the IRE and appeals for Medicaid-only services can be appealed to the state fair hearing process within 30 days of the date of the plan's internal appeal decision.<br>Overlapping services will be auto-forwarded to the IRE. If the resolution is not in favor of the enrollee, enrollee can then request a state fair hearing within 30 days of the IRE decision. |
| **Texas** | The state will support an independent ombudsman to advocate and investigate on behalf of demonstration enrollees. | Initial appeals must be filed within 60 days to the health plan.<br>2nd level appeals for Medicare services auto-forwarded to the IRE and appeals for Medicaid-only services can be appealed to the state fair hearing process within 60 days of the date of the plan's internal appeal decision.<br>Plans will notify enrollees of appeal rights through a single notice specific to the service in question, which will be developed jointly by the state and CMS. |
| **Virginia** | The state will support an independent ombudsman outside of the state Medicaid agency to advocate on behalf of the demonstration enrollees, including HCBS and nursing facility-based enrollees. | Initial appeals must be filed within 60 days to the health plan.<br>2nd level appeals for Medicare services auto-forwarded to the IRE and appeals for Medicaid-only services can be appealed to the state fair hearing process within 60 days of the date of the plan's internal appeal decision.<br>Overlapping services will be auto-forwarded to the IRE and may also be filed through the state fair hearing process (plan will be bound by the ruling that is most favorable to the enrollee).<br>Appeal resolution time frames – all plan internal appeals must be resolved within 30 days.<br>Appeals to state fair hearing process resolved within 90 days of date of filing the appeal for first year, within 75 days of the appeal filing for the second year, and within 30 days of the appeal filing for subsequent years thereafter. |
| **Washington**[2] | The state will support an independent ombudsman to advocate and investigate on behalf of demonstration enrollees. | Initial appeals must be filed within 90 days to the health plan.<br>2nd level appeals for Medicare services auto-forwarded to the IRE and appeals for Medicaid services will be made by enrollees to the state's independent review organization<br>Overlapping services will be auto-forwarded to the IRE. If the resolution is not in favor of the enrollee, enrollee can then request a state fair hearing within 30 days of the IRE decision. |

1 On June 27, 2013, the Department of Health and Human Services announced a funding opportunity through which states

2 This table presents information only on the state's capitated model demonstration project, although the state is testing both

**Table 8. State Demonstration Payment Policies**

| | Baseline Costs | Savings Percentages | Quality Withold | Rate Cells | Risk Adjustment | Risk Sharing |
|---|---|---|---|---|---|---|
| **California** | Medicaid capitation rates associated with the contracts that support the 1115(a) demonstration program that would apply for enrollees in the target population but who choose not to participate in the demo. | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 4 percent | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | Plans paid as a single, blended rate that takes into account the relative risk of the population actually enrolled and is weighted accordingly. The population categorized into four risk adjustment population categories.<br>• Institutionalized: individuals in long-term care aid codes and/or residing in a long-term care facility for 90 or more days<br>• Home and community-based (HCBS) High: High utilizers of HCBS. These are individuals who meet one or more of the following criteria:<br>o individuals who receive community based adult services<br>o individuals who are clients of MSSP; or<br>o individuals who receive IHSS and are classified under the IHSS program as "severely impaired"<br>• HCBS Low: Low utilizers of HCBS. These individuals are IHSS recipients and classified under the IHSS program as "not severely impaired"<br>• Community Well: all other individuals living in the community with no Medi-Cal covered HCBS | Relative cost factors (RCF) established for each population group.<br>Plan specific relative mix factor (RMF) computed through the use of RCFs and the mix of population category enrollees in the plan, and then multiplied by the established capitation rate to determine the risk-adjusted payment rate for each plan.<br>Process administered by county and include 3 distinct phases:<br>• Phase I: Applied monthly and retroactively through each county's phase-in period for a minimum of one year.<br>• Phase II: For one fiscal quarter. Applied prospectively at the start of the quarter based on the preceding month of enrollment.<br>• Phase III: Rates based on targeted relative mix of the population and will not be adjusted during the year. If the population mix for the plan results in a greater than 2.5 percent impact to Medicaid component of the rate paid as compared to the rate that would have been paid based on the actual mix, the plan and state share equally in any cost increases/decreases beyond the 2.5 percent. | Limited risk corridors for Medicare and Medicaid in all demo years. Risk corridors will be reconciled after application of risk adjustment and as if plan had received full quality withhold payment.<br>Limited down-side risk corridor: If plan costs exceed initial capitation rate, Medicaid and Medicare, in proportion to their contribution to the initial capitation rate, will reimburse the plan 67% of the costs above the initial capitation rates.<br>Limited up-side risk corridor: If the plan costs are lower than the initial capitation rates, this risk corridor will be applied in 3 bands, including the plan retaining 100 percent of the excess or Medicaid and Medicare retaining 50 percent of the excess. |
| **Illinois** | Historical state data Trend rates developed by state actuaries based on state plan and HCBS wavier services, with oversight from CMS contractor and staff | Demo Year 1: 1 percent<br>Demo Year 2: 3 percent<br>Demo Year 3: 5 percent | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | The rate cells are stratified by age (21-64 and 65+), geography (greater Chicago and Central Illinois), and setting of care as follows:<br>• Nursing Facility (NF): individuals residing in a NF on the first of the month in which the payment is made (transition from waiver - paid at wavier rate cell for 3 months)<br>• Waiver: individuals enrolled in a qualifying HCBS waiver on the first of the month in which the payment is made (transition from a NF to a qualifying waiver - paid at Waiver Plus)<br>• Waiver Plus: individuals moving from the NF to a qualifying waiver for the first 3 months of transition<br>• Community: individuals who do not meet the state's nursing home level of care and do not reside in a NF or qualify for an HCBS waiver | Rate cell structure | Beginning in calendar year 2014, plans must meet a Target Medical Loss Ratio (TMLR) threshold of 85 percent.<br>If the medical loss ratio (MLR) calculated annually is less than the TMLR, the plan shall remit to the state and CMS an amount equal to the difference between the calculated MLR and the TMLR multiplied by the revenue.<br>Any remittance would be distributed back to Medicare and Medicaid proportionally. |
| **Massachusetts** | Historical state data; trend factors developed by state actuaries with oversight from CMS | Demo Year 1: 0 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 4 percent | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | F1: Facility-based care: have a long-term facility stay of more than 90 days<br>C3: High community needs: have a skilled need to be met seven days a week; or two or more activities of daily living (ADL) limitations and skilled nursing need three or more days a week; or four or more ADL limitations<br>• C3B: Highest community need<br>• C3A: Medium/High Community Need<br>C2: Community behavioral health: have ongoing, chronic behavioral health condition such as schizophrenia<br>• C2B: Community Highest BH<br>• C2A: Community Medium/High BH<br>C1: Community other: all other enrollees. | Rate cells plus a high-cost risk pool (HCRP) for select long-term services and supports (LTSS) spending above a defined threshold.<br>The HCRP will apply to the facility-based care and high community needs rate cells.<br>HCRP will be used until an enhanced risk adjustment methodology is developed.<br>2 risk pools in CY 2013: (1) C3 – High community needs HCRP, and (2) F1 – Facility-based care HCRP.<br>Certain amount withheld from capitation paid to plans to fund pools.<br>• Any excess pool amounts will be distributed back to plans based on proportion of their contributions. | Risk corridor established for Demo Year 1. Medicare and Medicaid responsibility is in proportion to contribution to the capitated rate, not including Part D. Maximum Medicare payment or recoupment limited to 1 percent of the risk-adjusted Medicare baseline.<br>• Between 0 and 3 percent savings/loss, plans at risk for 100 percent.<br>• Between 3 and 20 percent savings/loss, plans at risk for 50 percent, CMS and state share other 50 percent (after applying 0 to 5 percent category).<br>• Greater than 20 percent savings/loss, plans at risk for 100 percent (after applying other categories).<br>• If Medicare trend estimate turns out to be over or under, risk-sharing will begin earlier than 3 percent (can be as low as 0.5 percent |

| | Baseline Costs | Savings Percentages | Quality Withold | Rate Cells | Risk Adjustment | Risk Sharing |
|---|---|---|---|---|---|---|
| **Michigan** | State fee-for-service (FFS) costs on historical state data (2010 to 2013). Updates to the Medicaid portion of the rates will be updated using updated state FFS data | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 4 percent | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | Tier 1: Enrollees who meet the nursing level of care (LOC) and are residing in a nursing facility.<br>Tier 2: Enrollees who meet the nursing LOC and are residing anywhere but a nursing facility and are enrolled in the ICO 1915(c) waiver.<br>Tier 3: Enrollees who do not meet the criteria for Tier 1 or 2.<br>For enrollees transitioning from Tiers 2 or 3 to Tier 1, the previous Tiers 2 or 3 rates will continue to be applied for up to 3 months. For enrollees transtioning from Tier 1 to Tiers 2 or 3, a transition case rate will be paid after the transition to the community setting and the ICO has provided transitional servcies | Rate cell structure | Risk corridor established for Demo Year 1 only: o If net income (as a percent of revenues) is 3 percent or less, the ICO gets 100 percent.<br>o If net income is between 4 and 9 percent of revenues, the ICO gets 50 percent and CMS and the state split the remaining 50 percent, which is based on the Medicaid or Medicare share of the capitation payments (excluding Part D).<br>o If net income is greater than 9 percent, the ICO gets 100 percent.<br>Beginning Demo Year 2, the ICO will be required to meet a minimum medical loss ratio (MMLR) threshold of 85 percent. If an ICO has a MMLR below 85 percent of the joint Medicaid and Medicare payment, then the plan must remit the amount by which the 85 percent threshold exceeds the plan's actual MMLR multiplied by total applicable revenue. |
| **Ohio** | Medicaid capitation rates through the 1915(b) waiver program that would apply for enrollees in the target population but not enrolled in the demo | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 4 percent | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | Nursing facility level of care (NFLOC): Enrollee meets a NFLOC as determined through waiver enrollment or 100 or more consecutive days in a NF; single rate cell for each of the 7 regions.<br>Community well: Enrollee does not meet a NFLOC standard; three age group (18 to 44, 45 to 64, 65+) rate cells for each of the 7 regions.<br>Transitional policy: Plan receives higher NFLOC rate for 3 months when enrollee transitions from NFLOC to community well category. | A member enrollment mix adjustment used for NFLOC rate cell. The relative risk differences of identifiable subpopulations are measured based on particular waiver enrollment and nursing facility placement.<br>Plans with a greater proportion of high-risk individuals get more revenue than plans with lower-risk individuals; adjustments will be budget neutral. | Each plan must meet Minimum Medical Loss Ratio (MMLR) threshold (as a percentage of the gross joint Medicare and Medicaid payments) beginning in calendar year 2014.<br>• If a plan's MMLR is between 85 and 90 percent, state and CMS may require a corrective action plan or levy a fine. Medicaid and Medicare split amount based on each program's percent of revenue to plans.<br>• If a plan's MMLR is below 85 percent, the plan must remit the difference between the plan's actual MMLR and the 85 percent threshold multiplied by the total applicable revenue. Medicaid and Medicare split amount based on each program's percent of revenue to plans. |
| **New York** | Blend of Medicaid capitation rates and FFS claims that would apply to enrollees in the demonstration area who choose not enroll in the demo<br>• The largest component will be based on the Medicaid Long Term Care (MLTC) capitation payments that would have been in effect in absence of the demo.<br>• For services not in the MLTC rate or populations not covered by MLTC, the baseline will be based on FFS experience. Baseline data will be based on FFS data for CY 2010-2013. | Demo Year 1: 1 percent<br>Demo Year 2: 1.5 percent<br>Demo Year 3: 3 percent | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | Community Non-nursing Home Certifiable: Individuals who require more than 120 days of community-based LTSS, but who do not meet a nursing home level of care (NHLOC) standard.<br>Nursing Home Certifiable: Individuals who meet the standard NHLOC.<br>One rate cell will be determined for the entire demonstration area. | The risk adjustment methodology for each rate cell substantially similar to the model currently uses in the Medicaid Managed Long-Term Care Program (MMLTC). Historical functional status and diagnostic data, in conjunction with MLTC plan encounter data and FFS data to identify appropriate predictors of variation in Medicaid costs for demo enrollees and develop a risk adjustment model.<br>Demonstration will explore options to mitigate risk to FIDA plans receiving a disproportionate share of high cost individuals, which may include mandating a minimum level of reinsurance that each plan must maintain. | Each plan required to meet a target medical loss ratio (TMLR) threshold (85 percent) that regulates the minimum amount that must be used for expenses related to the care of enrollees.<br>• If a plan has a MLR less than 85 percent, the plan must remit to CMS and the state an amount equal to the difference between the MLR and the TMLR (expressed as a percentage) multiplied by the total applicable revenues.<br>If one-third of participating plans experience annual losses in demo year 1 exceeding 3 percent of revenue, the savings percentage in demo year 3 will be reduced to 2.5 percent. |
| **South Carolina** | Historical state data; trend factors developed by state actuaries and based on state plan and HCBS waiver services, with oversight from CMS | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 4 percent | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | NF1: Nursing facility-based Care: Enrollee needs more than 100 days of facility stay.<br>H1: Home and Community Based Services: Enrollee meets level of care criteria for nursing facility placement or applicable HCBS waiver.<br>H2: Home and Community Based Plus: Individuals who are moving from NF1 to qualifying HCBS waiver for 1st 3 months of transition.<br>C1: Community Tier: Individuals who do not meet NF1, H1, or H2 criteria.<br>Enhanced payment rate for 90 days following transition from nursing facility and penalty includes payment at a lower rate for 90 days in cases where an individual moves from the community or HCBS to a nursing facility. | Rate cell structure | Each plan required to meet a target medical loss ratio (TMLR) threshold (85 percent) that regulates the minimum amount that must be used for expenses related to the care of enrollees.<br>• If a plan has a MLR less than 85 percent, the plan must remit to CMS and the state an amount equal to the difference between the MLR and the TMLR (expressed as a percentage) multiplied by the total applicable revenues.<br>Any remittance would be distributed back to Medicare and Medicaid proportionally |

MACPAC
Medicaid and CHIP Payment and Access Commission

| | Baseline Costs | Savings Percentages | Quality Withold | Rate Cells | Risk Adjustment | Risk Sharing |
|---|---|---|---|---|---|---|
| **Texas** | Medicaid capitation rates through the Section 1115 waiver program that would otherwise apply for beneficiaries in the target population but not enrolled in the demonstration Rates will be adjusted to add historical costs for Medicare cost sharing that are currently not in the underlying Medicaid capitation rates. | Demo Year 1a: 1.25 percent<br>Demo Year 1b: 2.75 percent<br>Demo Year 2: 3.75 percent<br>Demo Year 3: 5.5 percent | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | HCBS: Enrollees who receive state plan services as well as Section 1115 waiver HCBS, and elderly adults who qualify for nursing facility level of care but do not reside in a nursing facility.<br>• For the first three months after an enrollee transitions into a nursing facility, the MMP will be paid the HCBS rate.<br>• Other Community Care (OCC): Enrollees who receive state plan services only and do not reside in a nursing facility.<br>• Nursing Facility: Enrollees who receive state plan services only and reside in a nursing facility.<br>• For the first three months after an enrollee transitions out of a nursing facility, the MMP will be paid the nursing facility rate. | Rate cell structure | One-sided experience rebate applied ot each plan that puts a limit (Admin Cap) on the amount of administrative expenses that can be used to calculate the plan's net income before taxes when determining the experience rebate The Experience Rebate will be calculated in accordance with a tiered rebate method:<br>1. The plan retains all net income before taxes that is equal to or less than 3% of the total revenues;<br>2. The state or CMS and the plan share portion of the net income before taxes that is over 3% and less than or equal to 5% of the total revenues received by the plan, with 80% to the plan and 20% to the state or CMS.<br>3. The state or CMS and the plan will share portion of the net income before taxes that is over 5% and less than or equal to 7% of the total revenues received by the plan, with 60% to the plan and 40% to the state or CMS.<br>4. The state or CMS and the plan will share portion of the net income before taxes that is over 7% and less than or equal to 9% of the total revenues received by the plan, with 40% to the plan and 60% to the state or CMS.<br>5. The state or CMS and the plan will share that portion of the net income before taxes that is over 9% and less than or equal to 12% of the total revenues received by the plan, with 20% to the plan and 80% to the state or CMS.<br>6. The state or CMS will recoup the entire portion of the net income before taxes that exceeds 12% of the total revenues received by the plan. |
| **Virginia** | Medicaid FFS data for CY 2010-2013, as available at the point of rate setting each year The state will develop the baseline and trend forward; CMS actuaries will validate the estimated project costs (absent of demo) | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 4 percent | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | Community well (age 21-64): Enrollees age 21-64 who do not meet NFLOC standard.<br>Community well (age 65+): Enrollees age 65 and older who do not meet a NFLOC standard.<br>Nursing facility level of care (NFLOC) (age 21-64): Eenrollees age 21-64 meeting a NFLOC through waiver enrollment or 20 or more consecutive days in a nursing facility.<br>Nursing facility level of care (NFLOC) (age65+): Enrollees age 65 and older meeting a NFLOC through waiver enrollment or 20 or more consecutive days in a nursing facility.<br>Transitional policy: Plan receives higher NFLOC rate for two months when enrollee transitions from NFLOC to community well category.<br>Rates vary by five regions. | A member enrollment mix adjustment used for NFLOC rate cells.<br>The relative risk/cost differences of identifiable subpopulations are measured based on particular waiver enrollment and nursing facility placement and the historical costs associated with nursing facility and NCBS.<br>Plans with a greater proportion of high-risk individuals get more revenue than plans with lower-risk individuals at the beginning of the rating period or enrollment within the year; adjustments will be budget neutral | Each plan must meet Minimum Medical Loss Ratio (MMLR) threshold (as a percentage of the gross joint Medicare and Medicaid payments) beginning in calendar year 2014.<br>• If a plan's MMLR is between 85 and 90 percent, state and CMS may require a corrective action plan or levy a fine. Medicaid and Medicare split amount based on each program's percent of revenue to plans.<br>• If a plan's MMLR is below 85 percent, the plan must remit the difference between the plan's actual MMLR and the 85 percent threshold multiplied by the total applicable revenue. Medicaid and Medicare split amount based on each program's percent of revenue to plans.<br>If one-third of participating plans experience annual losses in demo year 1 exceeding 3 percent of revenue, the savings percentage in demo year 3 will be reduced to 3 percent. |
| **Washington**[1] | Historical state data; trend factors developed by state actuaries with oversight from CMS.<br>Baseline applied in future years unless more recent historical data are available | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | Demo Year 1: 1 percent<br>Demo Year 2: 2 percent<br>Demo Year 3: 3 percent | Medical and chemical dependency: institutional level of care vs. non-institutional level of care.<br>Mental health: qualify under Supplemental Security Income (SSI) disability determination vs. not considered disabled under SSI disability determination criteria<br>LTSS: institutional level-of-care receiving services in an institutional setting versus institutional level-of-care receiving services in a home and community-based setting versus non-institutional level-of-care | Rate cell structure | Each plan required to meet a target medical loss ratio (TMLR) threshold (85 percent) that regulates the minimum amount that must be used for expenses related to the care of enrollees.<br>• If a plan has a MLR less than 85 percent, the plan must remit to CMS and the state an amount equal to the difference between the MLR and the TMLR (expressed as a percentage) multiplied by the total applicable revenues.<br>• If a plan has a MLR that is between 85 and 90 percent of the joint CMS and state payment to the plan, the plan must remit 50 percent of the amount by which the 90 percent threshold exceeds the plan's actual MLR multiplied by the total applicable revenues. |

1 This table presents information only on the state's capitated model demonstration project, although the state is testing both the capitated and managed fee-for-service models as part of the Financial Alignment Initiative.