

November 2013 | Issue Brief

Long-Term Services and Supports in the Financial Alignment Demonstrations for Dual Eligible Beneficiaries

EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) and selected states are implementing demonstrations, beginning in 2013, to integrate care and align financing for beneficiaries who are dually eligible for Medicare and Medicaid. Seven states (CA, IL, MA, NY, OH, SC, VA) are testing a capitated model in which managed care plans will provide and coordinate Medicare and Medicaid acute, physical health, behavioral health, pharmacy, and long-term services and supports (LTSS). For many dual eligible beneficiaries, the financial alignment demonstrations will be the first time that LTSS will be coordinated with other health care services. This issue brief compares the treatment of LTSS in the seven approved capitated financial alignment demonstrations.

Target Population: While all of the demonstrations will include some beneficiaries who use LTSS, New York focuses solely on beneficiaries who require extended use of LTSS. None of the demonstrations approved to date, however, will include beneficiaries with developmental disabilities (DD).

Delivery System: All of the demonstrations will offer a new care delivery system to affected beneficiaries, but the states differ as to whether they will require beneficiaries to enroll in Medicaid managed care to receive LTSS. Four of the six demonstrations (CA, IL, NY, OH) already require or are seeking CMS approval to require beneficiaries to enroll in Medicaid managed care plans to receive Medicaid LTSS, even if beneficiaries opt out of the demonstration for their Medicare benefits; the other states allow beneficiaries to opt out of the demonstration for both their Medicare and Medicaid benefits.

Benefits and Financing: The demonstrations also differ in the extent to which they provide financial incentives for HCBS over institutional care. All seven of the demonstrations include nursing facility services in their capitated rates and benefits packages. Five of the demonstrations (IL, NY, OH, SC, VA) also include at least some non-DD Medicaid home and community-based waiver services, while two (CA and MA) do not include any waiver services. Four states (IL, OH, SC, VA) offer temporarily enhanced payment rates after beneficiaries transition from a nursing facility level of care to the community and/or temporarily reduced payment rates after transition from the community to an institutional level of care.

Service Coordination: A minority of states require specific contracting provisions related to LTSS coordination and expanded LTSS benefits. Massachusetts is the only demonstration state to require that health plans include an independent Long-Term Supports Coordinator as part of the care team for beneficiaries who need LTSS, while two other states (CA and OH) require their health plans to coordinate

specific services with certain community-based or governmental entities. Two states (MA and OH) will offer expanded LTSS, beyond their existing Medicaid benefits package, in their demonstration benefits packages. All states allow plans to provide supplemental benefits, which could include services not traditionally covered by Medicare or Medicaid, and require that beneficiaries have the option to self-direct services.

Rating Categories: All seven demonstrations take beneficiary use of LTSS into account in some way when determining how the baseline Medicaid payment rate to health plans will be risk adjusted, although the number of rating categories and LTSS-related criteria used to define them vary among the states. Four states (IL, OH, SC, VA) provide for plans to receive a different rate for a certain period of time after a beneficiary's level of care or care setting changes.

Quality Measures: All seven capitated demonstrations have state-specific quality measures that appear related to LTSS, with significant variation in the number and level of detail among the states, ranging from one measure directly relevant to LTSS in Massachusetts to multiple measures directly related to LTSS in South Carolina and Virginia. Six states (IL, MA, NY, OH, SC, VA) have at least one quality withhold measure relevant to LTSS, while one state (CA) does not.

The states are entering the demonstrations with different shares of their Medicaid LTSS dollars currently devoted to HCBS instead of institutional care. The demonstrations offer the potential opportunity to reduce costs through the increased use of HCBS over institutional care and the use of LTSS as a means of avoiding expensive inpatient hospitalizations and emergency room visits. The changes in the existing care delivery system as a result of the demonstrations also present the potential risk of disrupting established provider relationships and services for vulnerable beneficiaries who rely on HCBS to live in the community. As the demonstrations are implemented, the states' and beneficiaries' experiences in these areas will be important factors to assess when evaluating the impact of the demonstrations.

**Executive Summary Table:
LTSS in the Capitated Financial Alignment Demonstrations**

| State | Target Population | Requires Medicaid managed care enrollment* | Includes NF and HCBS waiver services | Financial incentives for HCBS | Requires self-direction option | Requires contracting for service coordination |
|-------|--|--|---|---|--------------------------------|--|
| CA | Adult dual eligible beneficiaries in 8 counties | Yes | NF only | Not mentioned in MOU | Yes | Yes – plans must have MOUs with county mental health and substance use agencies for behavioral health services and county social service agencies for IHSS |
| IL | Adult dual eligible beneficiaries in 21 counties | Yes | NF and HCBS waiver (except DD) | Temporary enhanced rate after transition from NF to community and reduced rate after transition from community to NF; LTSS quality withhold measure | Yes | Not mentioned in MOU |
| MA | Non-elderly adult dual eligible beneficiaries in 8 full and 1 partial counties | No | NF only (may seek to include HCBS waiver in the future) | LTSS quality withhold measure | Yes | Yes – plans must provide Long-Term Supports coordinator from independent community-based organization as a member of the care team |
| NY | 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 | Yes | NF and HCBS nursing facility diversion and transition waiver only | LTSS quality withhold measures | Yes | Not mentioned in MOU |
| OH | Adult dual eligible beneficiaries in 29 counties | Yes | NF and HCBS waiver (except DD) | Single rating category for beneficiaries in NF or receiving waiver services; temporary enhanced rate after no longer require NF level of care; LTSS quality withhold measures | Yes | Yes – plans must contract with Area Agency on Aging to coordinate home and community-based waiver services for beneficiaries over age 60 |
| SC | Elderly dual eligible beneficiaries who live in the community when enrolled | No | NF and HCBS elderly/disabled, HIV/AIDS, and mechanical ventilation waivers only; phases in transition of HCBS from state to plans | Temporary enhanced rate after transition from NF to community and reduced rate after transition from community to NF; one-time enhanced coordination fee after 1 year transition from NF to community; LTSS quality withhold measures | Yes | Not mentioned in MOU |
| VA | Adult dual eligible beneficiaries in 104 localities | No | NF and HCBS elderly/disabled with consumer direction waiver** | Single rating category for beneficiaries in NF or receiving waiver services; temporary enhanced rate after transition from NF to community; LTSS quality withhold measures | Yes | Not mentioned in MOU |

NOTES: *CMS approval is necessary for states to require beneficiaries to enroll in Medicaid managed care, even if beneficiaries opt out of the financial alignment demonstration for their Medicare benefits. **Excludes targeted case management and assisted living case management services
SOURCE: KCMU analysis of CMS-state MOUs, available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html>.

INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) and selected states are implementing demonstrations, beginning in 2013, to integrate care and align financing for beneficiaries who are dually eligible for Medicare and Medicaid.¹ Seven states (CA, IL, MA, NY, OH, SC, VA) are testing a capitated model in which managed care plans will provide and coordinate Medicare and Medicaid acute, physical health, behavioral health, pharmacy, and long-term services and supports (LTSS) in exchange for capitated payments from CMS for Medicare-covered services and from the state for Medicaid-covered services. One state (WA) is testing a managed fee-for-service (FFS) model in which Medicare and Medicaid services for high cost/high risk beneficiaries with chronic conditions will be coordinated through Medicaid health homes, and one state (MN) is testing alignment of administrative aspects of the Medicare and Medicaid programs, without financial alignment, for elderly beneficiaries.

For many dual eligible beneficiaries, the financial alignment demonstrations will be the first time that LTSS will be integrated and coordinated with other health care services. This presents the potential to realize cost savings, for example by promoting the use of home and community-based services (HCBS) over institutional care and by ensuring that adequate LTSS are provided as a preventive measure to avoid expensive inpatient hospitalizations and emergency room visits. The demonstrations also present some potential risks, for example, the possible disruption of established provider relationships which could interfere with continuity of care for vulnerable beneficiaries who rely on LTSS to maintain their independence in the community.²

This issue brief compares the treatment of LTSS in the seven states with approved capitated financial alignment demonstrations. (Beneficiaries in WA's managed FFS demonstration will continue to access LTSS on a FFS basis with coordination provided by health homes. Beneficiaries in MN's administrative alignment demonstration will continue to access LTSS through existing Medicaid managed care plans that also qualify as Medicare Advantage D-SNPs.)

BACKGROUND

LONG-TERM SERVICES AND SUPPORTS

LTSS provide assistance with activities of daily living (such as eating, bathing, or dressing) and instrumental activities of daily living (such as preparing meals or housecleaning) for people with physical or cognitive functional limitations that result from age or disability.³ LTSS are provided in institutional settings, such as nursing facilities, and home and community-based settings, such as apartments or group homes. LTSS include a range of services, such as residential services, adult day health care programs, home health aide services, personal care services, and case management services, among others.⁴ Over the last few decades, CMS and states have been working to rebalance Medicaid LTSS spending toward HCBS and away from institutional services. The move toward HCBS is motivated by beneficiary preferences, states' community integration obligations under the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision,⁵ and the lower cost of HCBS relative to comparable institutional services.

Medicaid is the primary payer for LTSS, financing 40 percent of institutional and HCBS nationally in 2011. Medicare offers limited post-acute coverage of LTSS, paying for 21 percent of long-term care services in 2011. (Figure 1)

Over time, the proportion of Medicaid LTSS dollars spent on HCBS has increased relative to spending on institutional services.⁶ In FY 2011, HCBS accounted for 45 percent of total Medicaid LTSS spending nationally, up from 32 percent in FY 2002. (Figure 2)

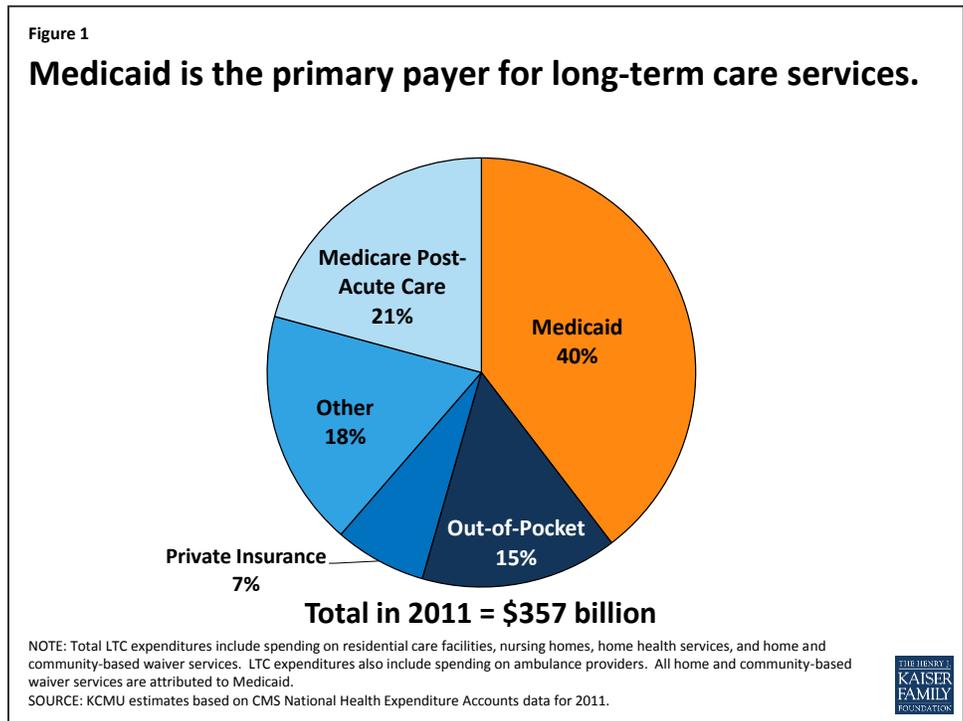


Table 1 on the following page shows the distribution of Medicaid LTSS spending between institutional and HCBS in the seven states that are implementing capitated financial alignment demonstrations for dual eligible beneficiaries. Of these states, as of FY 2011, only California spends more than half (57.8%) of its Medicaid LTSS dollars on HCBS. Three states (MA, 48.3%; VA, 47.1%; and NY, 46.5%) are approaching the halfway mark, with more than 45 percent of their Medicaid LTSS spending devoted to HCBS. Three states (SC, 40.2%; IL, 38.0%; OH 35.9%) spend more than one-third of their Medicaid LTSS dollars on HCBS.

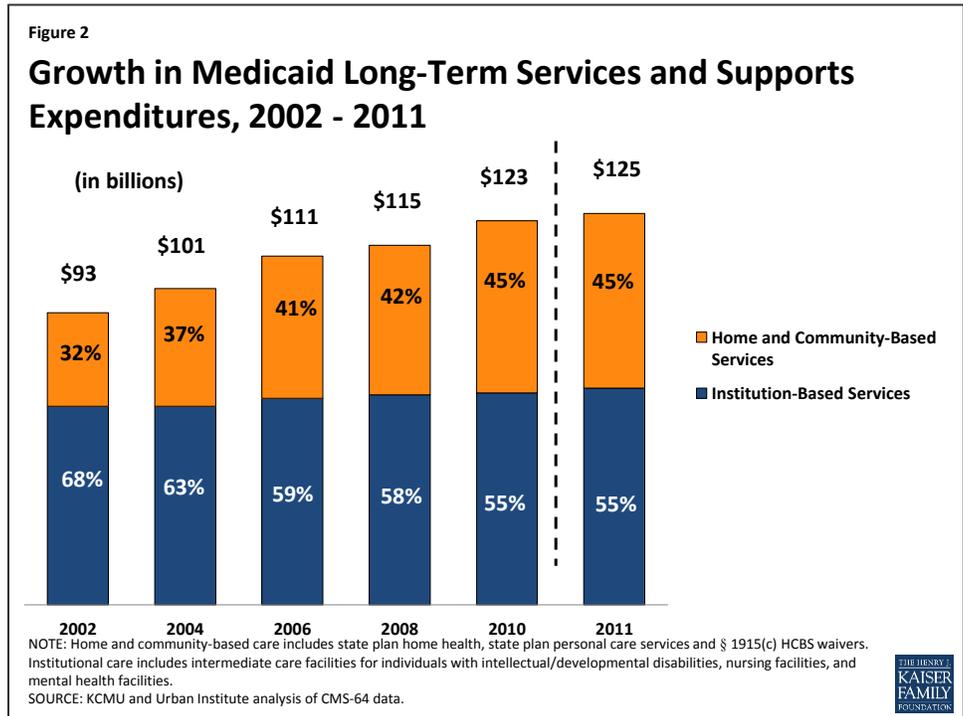


Table 1: Distribution of Medicaid LTSS Spending By Care Setting in States with Capitated Financial Alignment Demonstrations, FY 2011

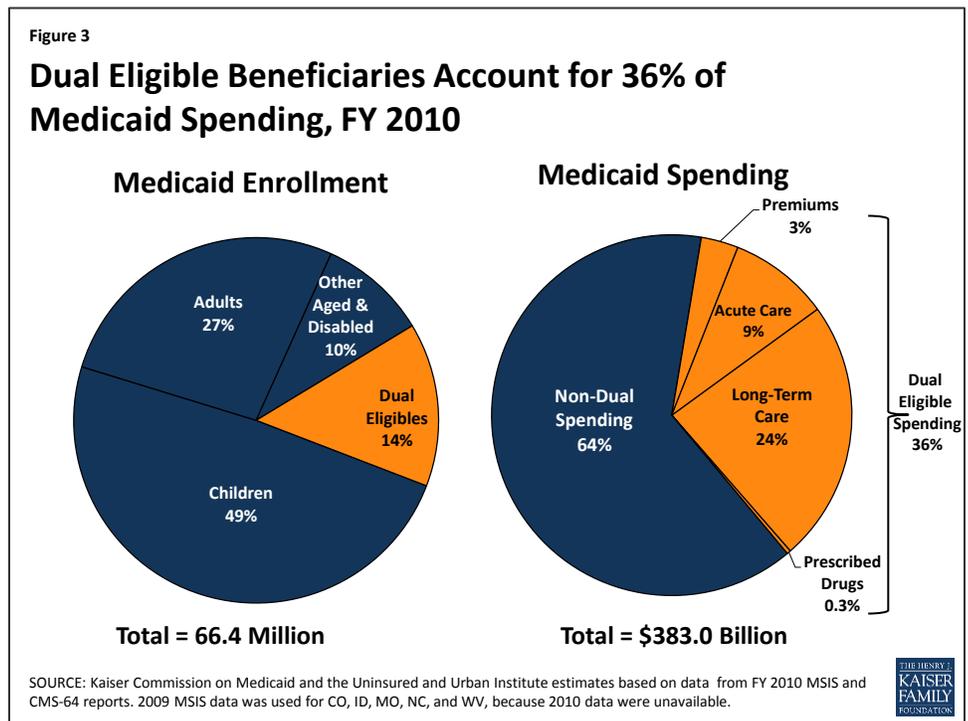
| State | Nursing Facility services | ICF/DD services | Mental health facility services | Home health and personal care services | Total |
|----------------|---------------------------|-----------------|---------------------------------|--|-------|
| California | 33.8% | 5.4% | 3.0% | 57.8% | 100% |
| Illinois | 36.2% | 23.3% | 2.5% | 38.0% | 100% |
| Massachusetts | 43.6% | 4.4% | 3.7% | 48.3% | 100% |
| New York | 35.0% | 16.4% | 2.2% | 46.5% | 100% |
| Ohio | 43.4% | 11.9% | 8.8% | 35.9% | 100% |
| South Carolina | 44.5% | 11.4% | 3.8% | 40.2% | 100% |
| Virginia | 35.7% | 12.2% | 5.0% | 47.1% | 100% |
| All states | 41.5% | 11.0% | 2.8% | 44.7% | 100% |

NOTES: Spending includes state and federal expenditures except for administrative costs, accounting adjustments and expenditures in the U.S. Territories. Figures may not sum to totals due to rounding. Mental health facility services include inpatient psychiatric services for beneficiaries ages 21 and younger and other mental health facility services for beneficiaries ages 65 and older. Home health and personal care services also include targeted case management, hospice, HCBS for people who are elderly and have functional disabilities and services provided through HCBS waivers.

SOURCE: KCMU/Urban Institute estimates based on data from CMS form 64 (as of 8/24/12)

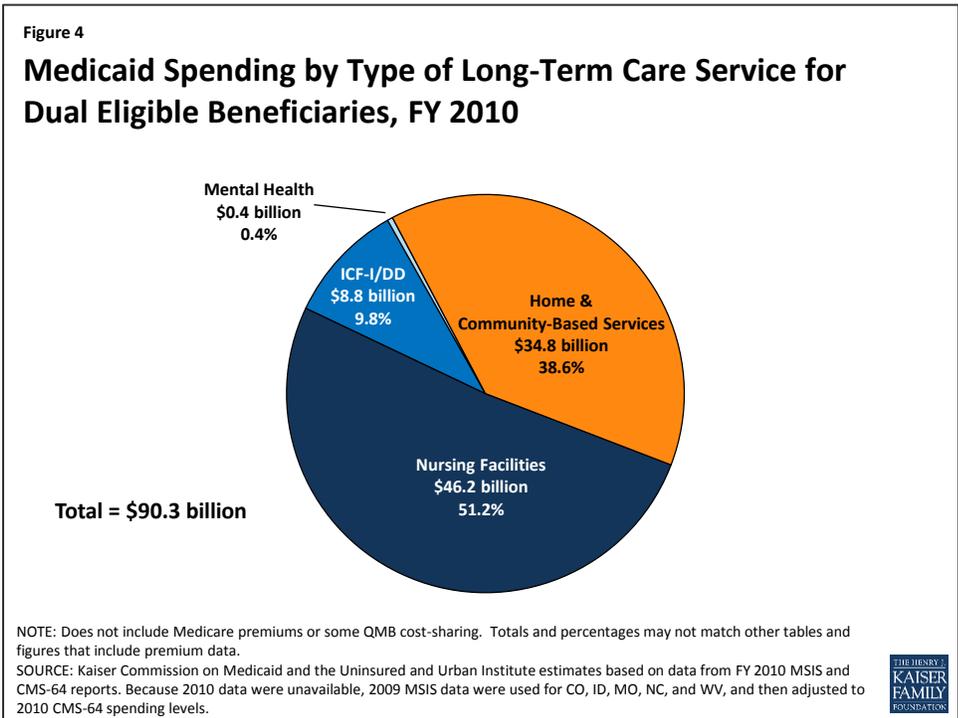
DUAL ELIGIBLE BENEFICIARIES

Dual eligible beneficiaries include over 9.6 million seniors and younger people with significant disabilities who are among the poorest and sickest beneficiaries covered by either Medicare or Medicaid.⁷ They account for a disproportionate share of Medicaid spending relative to their enrollment. In FY 2010, they comprised 14 percent of Medicaid beneficiaries but accounted for 36 percent of Medicaid spending nationally. (Figure 3) While dual eligible beneficiaries also account for a disproportionate share of Medicare spending (31% in 2008) relative to enrollment (20% in 2008), their Medicare spending is concentrated on primary, acute, and prescription drug services rather than LTSS.⁸ In FY 2008, six percent of total Medicare spending on dual eligible beneficiaries went to skilled nursing facility services and five percent went to home health services.⁹



Due to Medicare’s limited coverage of long-term care services, Medicaid is the main source of LTSS coverage for dual eligible beneficiaries. In FY 2010, 24 percent of total Medicaid spending was for LTSS for dual eligible beneficiaries.¹⁰ (Figure 3)

The distribution of Medicaid LTSS spending for dual eligible beneficiaries favors institutional services, with less than half of expenditures going to HCBS. In FY 2010, over 38 percent of all Medicaid spending for dual eligible beneficiaries nationally went to HCBS, while 61 percent went to institutional care. (Figure 4)



LTSS IN THE FINANCIAL ALIGNMENT DEMONSTRATIONS

The capitated financial alignment model that is being tested in California, Illinois, Massachusetts, New York, Ohio, South Carolina and Virginia involves a three-way contract between CMS, the state, and participating health plans.¹¹ CMS and the states are jointly selecting and monitoring the participating plans. Plans will receive prospective capitated payments from CMS for services traditionally covered by Medicare and from the state for services traditionally covered by Medicaid.¹² The plans will be responsible for providing nearly all services traditionally covered by Medicare and Medicaid, integrating LTSS with primary, acute, and behavioral health services in the benefits package.

CMS and states anticipate savings in the financial alignment demonstrations from increased care coordination and use of HCBS as an alternative to institutional care and decreased emergency room visits and avoidable inpatient hospitalizations. The Medicare and Medicaid payment rates to health plans in the capitated model are intended to allow both CMS and the state to share in program savings, and CMS has stated that it will not approve a demonstration unless the capitated rate provides upfront savings to both CMS and the state. Savings are derived by reducing CMS’s and the state’s respective baseline contributions to the plans by a savings percentage for each year. The specific savings percentages vary by state.¹³ The following discussion compares key aspects of the states’ demonstrations relating to LTSS.

INCLUSION OF BENEFICIARIES WHO USE LTSS IN DEMONSTRATION TARGET POPULATIONS

The states’ target populations for their demonstrations vary, with California, Illinois, Ohio, and Virginia including both elderly and non-elderly beneficiaries, Massachusetts focusing on non-elderly people with

disabilities, and South Carolina targeting elderly beneficiaries who reside in the community at the time of enrollment. While those states will have some beneficiaries who require LTSS in their demonstrations, New York's demonstration targets only beneficiaries who use LTSS, by 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. Most states' demonstrations are limited to certain geographic areas within the state; only South Carolina's is statewide.

The main population who uses LTSS and is excluded from all seven capitated demonstrations approved to date is people with developmental disabilities (DD), although New York submitted a separate capitated proposal that focuses on this population, which is still pending CMS approval. (Table 2)

REQUIRED ENROLLMENT IN MEDICAID MANAGED LTSS PLANS

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. However, four of the seven capitated demonstrations approved to date (CA, IL, NY, OH) already require or are seeking CMS approval to require beneficiaries to enroll in Medicaid managed care plans to receive Medicaid LTSS, even if beneficiaries opt out of the demonstration for their Medicare benefits. Opting out of the demonstration would enable these beneficiaries to receive their Medicare benefits in the traditional FFS system or in a capitated Medicare Advantage plan. By contrast, three states (MA, SC, VA) allow beneficiaries who opt out of the financial alignment demonstration to remain in the FFS delivery system for both their Medicare and their Medicaid benefits.¹⁴ (Table 2)

Among the states requiring dual eligible beneficiaries to enroll in Medicaid managed care plans to receive LTSS:

- New York's existing § 1115 waiver already requires beneficiaries in the financial alignment demonstration geographic 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.¹⁵
- California has filed an amendment to its existing § 1115 waiver seeking to require beneficiaries to enroll in managed care plans for their Medicaid benefits, including LTSS, even if they opt out of the financial alignment demonstration.¹⁶
- Ohio's financial alignment memorandum of understanding (MOU) with CMS indicates that the state may seek additional waiver authority to require beneficiaries to enroll in managed care plans for their Medicaid benefits even if they opt out of the financial alignment demonstration.¹⁷
- While Illinois' MOU does not mention mandatory Medicaid managed care enrollment, a question and answer document released by the state indicates that beneficiaries receiving LTSS will be required to enroll in a Medicaid managed care plan if they opt out of the financial alignment demonstration.¹⁸

Requiring Medicaid managed care enrollment regardless of whether beneficiaries enroll in the financial alignment demonstrations means that beneficiaries in those states will experience a change in the delivery system through which they receive LTSS, even if they choose to remain in the Medicare FFS delivery system. The move to Medicaid managed care for receipt of LTSS raises the same potential benefits (e.g., increased use

of HCBS as an alternative to institutional services) and risks (e.g., disruption of established HCBS provider relationships for vulnerable beneficiaries who rely on these services to live independently in the community) as the move to managed care through the financial alignment demonstrations.

Table 2: Target Population and Medicaid Managed LTSS Enrollment in the Capitated Financial Alignment Demonstrations

| State | Target Population | Includes DD population/services | Requires Medicaid managed care enrollment* |
|-------|--|---------------------------------|--|
| CA | Adult dual eligible beneficiaries in 8 counties | No | Yes |
| IL | Adult dual eligible beneficiaries in 21 counties | No | Yes |
| MA | Non-elderly adult dual eligible beneficiaries in 8 full and 1 partial counties | No | No |
| NY | 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 | No** | Yes |
| OH | Adult dual eligible beneficiaries in 29 counties | No | Yes |
| SC | Elderly dual eligible beneficiaries statewide who live in the community when enrolled | No | No |
| VA | Adult dual eligible beneficiaries in 104 localities | No | No |

NOTES: *CMS approval is necessary for states to require beneficiaries to enroll in Medicaid managed care, even if beneficiaries opt out of the financial alignment demonstration for their Medicare benefits.
 ** NY submitted a separate demonstration proposal targeting beneficiaries with DD who use more than 120 days of community-based LTSS, which is pending CMS approval.

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

LTSS IN THE DEMONSTRATION BENEFITS PACKAGES

The seven capitated financial alignment demonstrations approved to date include in the plans’ benefits packages nearly all services traditionally covered by Medicare and Medicaid. Regarding LTSS specifically, all seven demonstrations include nursing facility services in their capitated rates and benefits packages. Five of the demonstrations (IL, NY, OH, SC, VA) also include at least some non-DD Medicaid home and community-based waiver services in their capitated rates and benefits packages, while two (CA and MA) do not. Including both institutional and HCBS in the capitated rate and benefits package could financially incentivize plans to promote the use of HCBS over institutionalization, as HCBS typically are less expensive than comparable institutional services. South Carolina’s MOU also provides that beneficiaries who meet the level of care criteria for home and community-based waiver services will be able to access those services without a waiting list.¹⁹

Four of the states (CA, MA, OH, SC) with capitated demonstrations are expanding or considering expanding their traditional Medicaid benefits package through their demonstrations. The expanded benefits in two of these states include community-based LTSS: Massachusetts is requiring its plans to offer additional diversionary behavioral health and community support services, and Ohio is considering including additional (unspecified) HCBS. In addition, all seven capitated demonstrations allow plans the discretion to offer supplemental benefits beyond the scope of the integrated benefits package, as appropriate for beneficiary needs. These supplemental benefits could include services that traditionally are not covered by Medicare or Medicaid. Finally, all seven capitated demonstrations require health plans to allow beneficiaries to self-direct their HCBS. Self-direction of HCBS can include employer authority, through which beneficiaries select and dismiss their providers, such as personal care attendants, and/or budget authority, through which beneficiaries control the allocation of funds available for HCBS. (Table 3)

South Carolina's demonstration is unique in that it provides for a phased transition of HCBS from the state to the health plans. In the first phase, from July through December 2014, the state will maintain its contracts with HCBS providers, while health plans will process provider payments for services. Also during the first phase, the state will develop the beneficiary's waiver services care plan and recommend service authorization levels with concurrence by the health plan. If the health plan disagrees, it may request review by the demonstration ombudsman which has authority to make a final decision. The waiver case manager will work with the health plan care coordinator to integrate waiver services into the beneficiary's overall care plan. In the second phase, in 2015, plans will assume responsibility for case management services and most HCBS; perform level of care 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 for self-directed services. In the third phase, in 2016, plans will assume all responsibility for HCBS coordination, including self-direction, and may elect to assume responsibility for provider credentialing and monitoring. Plans must pass a readiness review before each phase.

SERVICE COORDINATION PROVISIONS RELEVANT TO LTSS

All seven capitated financial alignment 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.²⁰ The participating health plans in all seven capitated financial alignment demonstrations will use a care team that includes the beneficiary, providers, and other people selected by the beneficiary to develop a service plan to meet the beneficiary's needs as identified in an assessment.

Massachusetts is the only demonstration state to require that health plans include an independent Long-Term Supports Coordinator as part of the care team for beneficiaries who need LTSS; in Massachusetts, plans are required to contract with community-based organizations to fill this role.

Two other states with capitated demonstrations approved to date (CA and OH) require their health plans to coordinate specific services with certain community-based or governmental entities: Ohio requires its plans to contract with Area Agencies on Aging to coordinate home and community-based waiver services for beneficiaries over age 60, while California requires its plans to establish MOUs with county behavioral health

agencies that provide specialty mental health services and with county social services agencies to coordinate In Home Supportive Services (IHSS). (Table 3)

| Table 3: LTSS in the Capitated Financial Alignment Demonstrations Benefits Packages | | | | | | |
|--|------------------------------------|---|--|---------------------------------------|--------------------------------|--|
| State | Nursing facility services included | Home and community-based waiver services included | Traditional Medicaid benefits package expanded | Plans can offer supplemental benefits | Self-direction option required | Required contracting/ service coordination |
| CA | Yes | No | Yes – plans must provide dental, vision, and non-emergency medical transportation services | Yes | Yes | Yes – plans must have MOUs with county mental health and substance use agencies for behavioral health services and county social service agencies for IHSS |
| IL | Yes | Yes (except DD) | Not mentioned in MOU | Yes | Yes | Not mentioned in MOU |
| MA | Yes | No (may seek to include in the future) | Yes – plans must provide diversionary behavioral health and community support services and (unspecified) expanded Medicaid state plan benefits | Yes | Yes | Yes – plans must provide Long-Term Supports coordinator from independent community-based organization as a member of the care team |
| NY | Yes | Yes (nursing facility diversion and transition waiver services only) | Not mentioned in MOU | Yes | Yes | Not mentioned in MOU |
| OH | Yes | Yes (except DD) | Yes – expects to require plans to provide (unspecified) expanded Medicaid state plan benefits and additional HCBS | Yes | Yes | Yes – plans must contract with Area Agency on Aging to coordinate home and community-based waiver services for beneficiaries over age 60 |
| SC | Yes | Yes (for elderly/disabled, HIV/AIDS, and mechanical ventilation waivers only) | Yes – plans must provide palliative care benefit | Yes | Yes | Not mentioned in MOU |
| VA | Yes | Yes (for elderly/ disabled with consumer direction waiver*) | Not mentioned in MOU | Yes | Yes | Not mentioned in MOU |
| NOTE: *Excludes targeted case management and assisted living case management services | | | | | | |
| SOURCE: KCMU analysis of states’ financial alignment demonstration memoranda of understanding with CMS, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html . | | | | | | |

MEDICAID RATING CATEGORIES RELEVANT TO LTSS USE

All of the seven capitated financial alignment demonstrations approved to date take beneficiary use of LTSS into account in some way when determining how the baseline Medicaid payment rate to health plans will be risk adjusted.²¹ Risk adjustment is important so that plans with greater numbers of high cost/high need beneficiaries are treated equitably, and plans do not have a financial incentive to restrict services for beneficiaries with high needs. Four states (CA, MA, NY, SC) have constructed their Medicaid rating categories solely based on the beneficiary's intensity of LTSS use and/or care setting, while three states (IL, OH, VA) take beneficiary age and geographic region into account in addition to intensity of LTSS use and/or care setting. Details about the states' Medicaid rating categories are provided in Table 4 on the following page.

The number of Medicaid rating categories and the LTSS-related criteria used to define those categories vary among the seven states. For example, Massachusetts has rating categories for beneficiaries who have behavioral health diagnoses that are separate from those for beneficiaries who use other community-based LTSS. Massachusetts' rating categories also distinguish among the "highest" versus the "high/medium" use of LTSS within each category.

Five states (CA, IL, MA, NY, SC) use different Medicaid rating categories for beneficiaries who reside in a nursing facility and those who receive HCBS. By contrast, two states (OH and VA) have a single rating category that applies to beneficiaries who require a nursing facility level of care, regardless of whether they are served in an institutional or community-based setting. (Virginia's rating categories also distinguish between elderly and non-elderly beneficiaries who require a nursing facility level of care.)

The states also differ in the length of time that they require beneficiaries to reside in a nursing facility in order to qualify for that rating category. For example, Ohio and South Carolina require a stay of more than 100 days, Massachusetts requires more than 90 days, California requires 90 or more days, and Virginia requires 20 or more days.

Four states (IL, OH, SC, VA) provide for plans to receive a different rate for a certain period of time after a beneficiary's level of care changes. Among these states:

- Illinois health plans will continue to receive the HCBS waiver rate for three months after a beneficiary transitions from waiver services to a nursing facility to incentivize the use of HCBS over institutional care. Illinois' rating categories also include a "waiver plus" category that allows plans to receive a different rate from the rate associated with the "waiver" category for the first three months after a beneficiary transitions from a nursing facility to a community-based setting.
- Ohio health plans will continue to receive the nursing facility level of care payment rate for three months after a beneficiary no longer requires that level of care.

- South Carolina plans will receive an enhanced payment rate for 90 days following a beneficiary's transition from a nursing facility to the community and will incur a financial penalty for 90 days following transition from the community to a nursing facility. South Carolina plans also may receive a one-time enhanced transition coordination fee, up to \$3,000 per enrollee, for successfully moving a beneficiary from a nursing facility to the community for at least 12 months.
- Virginia health plans will continue to receive the nursing facility level of care payment rate for two months after a beneficiary no longer requires that level of care.

Three states (MA, OH, VA) also include risk-sharing provisions that specifically take LTSS use into account. Massachusetts requires a capitated rate withhold from plans to fund a high cost risk pool that will be distributed to plans in proportion to their share of total costs above a threshold amount for certain LTSS. Ohio and Virginia use a member enrollment mix adjustment to account for plans that have a greater proportion of high cost/high risk beneficiaries. (Table 4)

Table 4: LTSS-Related Financing Provisions in Capitated Financial Alignment Demonstrations

| State | Medicaid Rating Categories | Other Risk-Sharing Provisions |
|--|---|---|
| CA | <ol style="list-style-type: none"> 1. Institutionalized (90 or more days) 2. HCBS high utilizers 3. HCBS low utilizers 4. Community-well (no HCBS use) | Limited risk corridors in all years |
| IL | <p>By age (21-64, 65+), geographic region, and care setting, including:</p> <ol style="list-style-type: none"> 1. Nursing facility (except that HCBS waiver rate applies for first 3 months after transition from waiver to nursing facility) 2. HCBS waiver 3. Waiver plus (applies for first 3 months after transition from nursing facility to community) 4. Community (do not meet nursing facility level of care, reside in a nursing facility, or qualify for HCBS waiver) | Required minimum 85% MLR |
| MA | <ol style="list-style-type: none"> 1. Facility-based care (more than 90 days) 2. Community needs (daily skilled need, or 2 or more ADL limitations and skilled need 3 or more days/week, or 4 or more ADL limitations) <ol style="list-style-type: none"> A. Highest community needs (beneficiaries with costs considerably above average for overall rating category) B. Medium/high community needs 3. Community behavioral health: (specific diagnosis of ongoing chronic condition) <ol style="list-style-type: none"> A. Community highest behavioral health (beneficiaries with costs considerably above average for overall rating category) B. Community medium/high behavioral health 4. Community other | <p>Part of the base Medicaid capitated rate for the facility and high community need rating categories will be withheld from all plans, placed into a risk pool, and divided among plans based on their share of total costs above a threshold amount for select Medicaid LTSS</p> <p>Risk corridors in first year only</p> |
| NY | <ol style="list-style-type: none"> 1. Community non-nursing home certifiable (more than 120 days community-based LTSS but do not require nursing facility level of care) 2. Nursing facility certifiable | <p>Required minimum 85% MLR</p> <p>May require plans to maintain minimum level of reinsurance</p> |
| OH | <ol style="list-style-type: none"> 1. Community well (varies by age group (18-44, 45-64, 65+) and geographic region) 2. Nursing facility level of care (waiver enrollment or 100+ days in nursing facility – single rate for each region, plans continue to receive nursing facility rate for 3 months after beneficiary no longer meets nursing facility level of care) | <p>Member enrollment mix adjustment to account for plans with greater proportion of high risk/high cost beneficiaries</p> <p>Required minimum 90% MLR</p> |
| SC | <ol style="list-style-type: none"> 1. Nursing facility-based care (more than 100 days) 2. HCBS (meets LOC for NF or HCBS waiver) 3. HCBS plus (enhanced payment for beneficiaries moving from NF to waiver for first 3 months of transition) 4. Community (do not meet criteria for another category) <p>Also includes payment at lower rate for 90 days when beneficiary moves from community or HCBS waiver to NF</p> <p>Also offers one-time enhanced transition fee up to \$3,000 per enrollee for moving beneficiary from NF to community for at least 12 months</p> | Required minimum 85% MLR beginning in CY 2015 |
| VA | <p>Rating categories will vary by geographic region and care setting, including:</p> <ol style="list-style-type: none"> 1. Community well ages 21-64 2. Community well ages 65+ 3. Nursing facility level of care ages 21-64 4. Nursing facility level of care ages 65+ <p>Beneficiaries meet nursing facility rating category if enrolled in HCBS waiver or 20+ consecutive days in nursing facility. Plans continue to receive nursing facility rate for 2 months after beneficiary no longer meets that level of care.</p> | <p>Member enrollment mix adjustment to account for plans with greater proportion of high risk/high cost beneficiaries</p> <p>Required minimum 90% MLR</p> |
| <p>SOURCE: KCMU analysis of states' financial alignment demonstration memoranda of understanding with CMS, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html.</p> | | |

QUALITY MEASURES RELATED TO LTSS

Further development of quality measures related to dual eligible beneficiaries and LTSS has been cited as a need. For example, the National Committee for Quality Assurance has observed that “[e]xisting [quality] measures do not fully address the complex characteristics of people with Medicare and Medicaid (i.e., use of LTSS, functional decline, frailty, multiple coexisting conditions)” and that “we do not have measures that capture coordination of care across medical and long-term services and supports... .”²² A National Quality Forum workgroup also has identified “implementation and system structures to ensure connection between the health system and LTSS” as a “measurement gap area.”²³

The demonstration MOUs contain some quality measures for each state’s demonstration, with additional quality measures to be specified in the three-way contracts between CMS, the state, and the health plans. The quality measures are important for several aspects of the demonstrations. First, CMS and the states will use the quality measures as part of their oversight of the health plans’ performance in the demonstration to ensure that plans are meeting their contractual obligations and that beneficiaries are receiving the services to which they are entitled. Second, the ACA’s § 1115A waiver authority, which is being used to implement the demonstrations, requires the Health and Human Services Secretary to evaluate the demonstrations. The evaluation must include an analysis of the quality of care provided, patient level outcomes and “patient-centeredness criteria,” and changes in Medicare and Medicaid spending.²⁴ In addition, some of the quality measures will be used to determine whether plans can earn back the withheld portion of their capitated rates. The quality withhold amounts are one percent of the plan’s capitated rate in year one of the demonstration, two percent in year two, and three percent in year three.

The MOUs contain both “core” quality measures that CMS plans to apply to all approved demonstrations as well as measures that will evaluate aspects of the demonstration unique to each state. Among the core measures, four appear to relate to LTSS: risk stratifications that use factors related to behavioral health or LTSS; care coordinator training in supporting self-direction; plan management of care transitions; and beneficiary survey questions (CAHPS) for certain LTSS and populations. None of the CMS core measures is identified as a quality withhold measure. (Table 5)

All seven capitated demonstrations have state-specific quality measures that appear related to LTSS, ranging from one measure directly relevant to LTSS in Massachusetts (percent of beneficiaries with LTSS needs who have LTSS coordinator) to multiple measures directly related to LTSS in Virginia and South Carolina (ranging from beneficiary use of self-direction to increases and decreases in authorizations of specific HCBS to movement between institutional and community-based care settings to level of care assessments). Four states’ MOUs (CA, OH, SC, VA) also indicate that CMS and the state will “monitor other measures related to community integration” during the course of the demonstrations. (Table 5)

In addition, six states (IL, MA, NY, OH, SC, VA) have at least one quality withhold measure relevant to LTSS, while one state (CA) does not. These include, for example, measures related to beneficiary transitions between institutional and community-based settings or receipt of home and community-based waiver services (IL, SC, VA) and the number of beneficiaries who qualify for a nursing home level of care and live in the community (NY and OH). Massachusetts will use the percent of beneficiaries with LTSS needs who have an independent

Long-Term Supports coordinator assigned (in demonstration year one) and a quality of life measure (to be determined in the three-way contract, in years two and three) as quality withhold measures. (Table 5)

| Table 5: Selected Quality Measures Related to LTSS in the Capitated Financial Alignment Demonstrations | | |
|--|--|---|
| State | Quality Withhold Measures | Other Quality Measures |
| All states - CMS core measures | No CMS core measures are specified as quality withhold measures | <ul style="list-style-type: none"> Percent of risk stratifications using behavioral health or LTSS data/indicators (not mentioned in MA's MOU) Percent of care coordinators who have completed state-based training for supporting self-direction (not mentioned in NY's MOU) Plan manages care transition process, identifies problems that could cause transitions, and where possible prevents unplanned transitions CAHPS supplemental questions for home health services, nursing facilities, and people with mobility impairments |
| CA* | No quality withhold measures related to LTSS identified in MOU | <ul style="list-style-type: none"> IHSS utilization Nursing facility utilization Unmet LTSS needs (ADLs, IADLS, IHSS functional level) LTSS beneficiary satisfaction with case manager, home worker, personal care attendant |
| IL | <ul style="list-style-type: none"> Number of beneficiaries moving from institutional to wavier services (excluding institutional stays of 90 days or less) - years 2 and 3 | <ul style="list-style-type: none"> Number of beneficiaries moving from institutional to waiver services, community to waiver services, community to institutional care, and waiver to institutional care (excluding institutional stays ≤90 days) Beneficiary perception of quality of life |
| MA | <ul style="list-style-type: none"> Tracking of demographic information, including disability type - year 1 Percent of beneficiaries with LTSS needs who have LTSS coordinator - year 1 Quality of life measure, TBD in 3-way contract - years 2 and 3 | <ul style="list-style-type: none"> Documented discussion of beneficiary rights and choice of providers |
| NY | <ul style="list-style-type: none"> Number of NF certifiable beneficiaries who lived outside NF during the measurement year as proportion of NF certifiable participants who lived outside NF during previous year Participants who remained stable or improved in ADL functioning between previous and most recent assessment | <ul style="list-style-type: none"> Percent of beneficiaries directing their own personal assistance services each year Number of beneficiaries who did not reside in NF >100 continuous days in a year as a proportion of total number of beneficiaries in plan Number of participants who were discharged to community setting from NF and who did not return to NF during current year as proportion of number of beneficiaries who resided in NF during previous year (>100 continuous days) Percent of beneficiaries who reside in NF, wish to return to community and were referred to preadmission screening team or Money Follows the Person |
| OH* | <ul style="list-style-type: none"> Number of beneficiaries who did not reside in NF as proportion of total number of beneficiaries in plan (>100 continuous day stay) Number of beneficiaries who lived outside NF during current year as proportion of beneficiaries who lived outside NF during previous year (>100 continuous day stay) | <ul style="list-style-type: none"> Percent of all long-stay NF residents whose need for help with late-loss ADLs increased when compared with previous assessment (bed mobility, transferring, eating, toileting) Number of beneficiaries who were discharged to community setting from NF and did not return to NF during current year as proportion of number of beneficiaries who resided in NF during previous year Number of beneficiaries who were in NF during current year, previous year or combination of both years who were discharged to community setting for at least 9 months during current year as proportion of number of enrollees who resided in NF during current year, previous year or combination of both years (100+ days) |

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Table 5 (continued):

| State | Quality Withhold Measures | Other Quality Measures |
|-------|---|---|
| SC* | <ul style="list-style-type: none"> • Percent of enrollees newly approved or eligible for HCBS with plan of care jointly approved by waiver case manager, state, and health plan and included in overall care plan within 30 days of waiver enrollment; and percent of enrollees already receiving HCBS with plan of care included in overall care plan within 30 days of health plan enrollment – year 1 • Health plan has work plan and systems in place to ensure smooth transitions among hospitals, NF and community – year 1 • Percent of adjudicated claims including HCBS case management submitted to plans paid timely – years 1, 2, and 3 • Percent of enrollees eligible for HCBS with a waiver care plan within specified timeframes; and percent of enrollee waiver care plans that contain documented discussion of care goals within specified timeframes – years 2 and 3 • Percent of enrollees who transition to and from hospitals, NF and community; proportion of those who transition among settings who return to an institutional or community setting; and percent of care transitions recorded and transmitted to plan care coordinator – years 2 and 3 | <ul style="list-style-type: none"> • CAHPS supplemental questions for home health, NF, and people with mobility impairments • Percent of risk stratifications using behavioral health or LTSS data or indicators • Percent of care coordinators that have undergone state training for supporting self-direction • Percent of enrollees whose doctor has done a functional status assessment for ADLs • Percent of medium and high risk enrollees able to identify care coordinator and/or HCBS case manager • Number of enrollees transitioning from institutional care to waiver services, community to waiver services, community to institutional care, and waiver services to institutional care (excluding institutional stays of less than 90 days) • Number and percent of all enrollees referred to LTSS; NF; and HCBS • Percent of enrollees who require HCBS as indicated by care assessment and care plan and receive services within 90 days of enrollment • Percent of enrollees receiving HCBS who are <ul style="list-style-type: none"> ○ are satisfied or very satisfied with those services ○ use self-direction ○ experience decrease in authorization of attendant care or companion service hours, compared across demonstration years ○ experience decrease or increase in authorization of personal care or respite care hours, compared across demonstration years ○ experience decrease in HCBS authorization ○ experience increase in non-self-directed HCBS authorization • Number/percent of care coordinator actions/care decisions in response to critical incident reports by in-home care providers and/or changes in conditions identified by waiver case managers • Number of enrollees who use assisted living, other congregate housing and independent living options • Number and percent of care coordinators who are trained on how to make appropriate waiver referrals and use automated HCBS systems • Percent of enrollees who have waiver case manager participating on care team • Percent of enrollees using palliative care benefit who indicate they are uncomfortable due to pain whose pain was brought to comfortable level within 48 hours |

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Table 5 (continued):

| Quality Withhold Measures | Other Quality Measures |
|--|--|
| <p>VA*</p> <ul style="list-style-type: none"> • Plan has established work plan and systems in place for ensuring smooth transitions to and from hospital, NF and community – year 1 • Percent of beneficiaries who transition to and from hospital, NF and community – years 2 and 3 | <ul style="list-style-type: none"> • Percent of waiver beneficiaries who: <ul style="list-style-type: none"> ○ use self-directed services ○ experience decrease in authorization of personal care hours ○ experience increase in authorization of personal care hours ○ experience decrease in authorization of respite hours ○ experience increase in authorization of respite hours • Number of beneficiaries moving from institutional care to waiver services, community to waiver services, community to institutional care, and waiver services to institutional care (> 90 day stay) • Number and percent of: <ul style="list-style-type: none"> ○ all new enrollees who have LOC indicating need for institutional or waiver services ○ waiver participants who received annual LOC evaluation of eligibility within 1 year of initial evaluation or last annual evaluation using state approved forms ○ completed LOC forms entered into computer system for standardized review ○ LOC reviews that computer system indicates do not meet LOC criteria sent for higher review • Number and percent of waiver beneficiaries who: <ul style="list-style-type: none"> ○ did not meet LOC criteria after higher level review who were terminated from waiver after completion of appeals process if any ○ have service plans adequate and appropriate to their needs and personal goals as indicated in assessment ○ received services of the type specified in service plan ○ received services in the scope specified in service plan ○ received services in the amount specified in service plan ○ received services for the duration specified in service plan ○ received services in the frequency specified in service plan ○ records contain appropriately completed and signed form that specifies that choice was offered between institutional and waiver services; and that choices was offered among waiver services ○ records document that choice of waiver providers was provided to beneficiary <p>Virginia’s MOU also contains a number of measures related to licensing and certification of waiver services providers.</p> |

*MOU indicates that CMS will work closely with state to monitor other measures related to community integration

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

LOOKING AHEAD

The financial alignment demonstrations could be significant for dual eligible beneficiaries who rely on LTSS because they may be the first time that these beneficiaries will be able to have their LTSS integrated and coordinated with their other health care services. The demonstrations offer the potential opportunity to reduce costs through the increased use of HCBS over institutional care and the use of LTSS as a means of avoiding expensive inpatient hospitalizations and emergency room visits. The changes in the existing care delivery system as a result of the demonstrations also present the potential risk of disrupting established provider relationships and services for vulnerable beneficiaries who rely on HCBS to live in the community. In addition, the states are entering the demonstrations with different shares of Medicaid LTSS dollars currently devoted to HCBS instead of institutional care. There are some similarities among the states’ treatment of LTSS in their demonstrations, for example by generally excluding people with DD and DD waiver services, allowing plans to offer supplemental benefits, and requiring that beneficiaries have the option to self-direct their services. There

also are some differences, such as whether states will require beneficiaries to enroll in Medicaid managed care to receive LTSS, whether benefits packages include both nursing facility services and HCBS, how beneficiary use of LTSS factors into Medicaid rating categories, and how LTSS quality will be measured in the demonstrations. As the demonstrations are implemented, the states' and beneficiaries' experiences in these areas will be important factors to assess when evaluating the impact of the demonstrations.

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

ENDNOTES

¹ For additional information about the demonstrations, see Kaiser Commission on Medicaid and the Uninsured, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS* (Nov. 2013), available at <http://www.kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/>.

² For disability community perspectives on potential benefits and risks related to the financial alignment demonstrations, with an emphasis on non-elderly beneficiaries and those who use long-term services and supports, see Kaiser Commission on Medicaid and the Uninsured, *Development of the Financial Alignment Demonstrations for Dual Eligible Beneficiaries: Perspectives from National and State Disability Stakeholders* (July 2013), available at <http://www.kff.org/medicaid/issue-brief/development-of-the-financial-alignment-demonstrations-for-dual-eligible-beneficiaries-perspectives-from-national-and-state-disability-stakeholders/>.

³ For additional background, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid Long-Term Services and Supports: An Overview of Funding Authorities* (Sept. 2013), available at <http://www.kff.org/medicaid/fact-sheet/medicaid-long-term-services-and-supports-an-overview-of-funding-authorities/>; Kaiser Commission on Medicaid and the Uninsured, *Five Key Facts About the Delivery and Financing of Long-Term Services and Supports* (Sept. 2013), available at <http://www.kff.org/medicaid/fact-sheet/five-key-facts-about-the-delivery-and-financing-of-long-term-services-and-supports/>.

⁴ For examples of home and community-based LTSS, see Victoria Peebles and Alex Bohl, CMS/Mathematica Policy Research, *The HCBS Taxonomy: A New Language for Classifying Home and Community-Based Services* (Aug. 2013), available at http://www.mathematica-mpr.com/publications/PDFs/health/max_ib19.pdf?spMailingID=7043783&spUserID=MTgoODk4MzU1MwS2&spJobID=90194295&spReportId=OTaxOTQvOTUS1.

⁵ In *Olmstead v. L.C.*, the Supreme Court held that the unjustified institutionalization of people with disabilities violates the Americans with Disabilities Act. 527 U.S. 581 (1999), available at <http://www.law.cornell.edu/supct/html/98-536.ZS.html>.

⁶ For more information about national and state historical trends in Medicaid HCBS enrollment and spending, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home and Community-Based Services Programs: 2009 Data Update* (Dec. 2012), available at <http://www.kff.org/medicaid/report/medicaid-home-and-community-based-service-programs/>.

⁷ Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for Dual Eligible Beneficiaries* at 1 (Aug. 2013), available at <http://www.kff.org/medicaid/issue-brief/medicaids-role-for-dual-eligible-beneficiaries/>.

⁸ Kaiser Family Foundation, *Medicare's Role for Dual Eligible Beneficiaries* at 2 (April 2012), available at <http://www.kff.org/medicare/issue-brief/medicares-role-for-dual-eligible-beneficiaries/>.

⁹ *Id.*

¹⁰ Kaiser Commission on Medicaid and the Uninsured, *Medicaid in a Historic Time of Transition: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014* at 9 (Oct. 2013), available at <http://www.kff.org/medicaid/report/medicaid-in-a-historic-time-of-transformation-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2013-and-2014/>.

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- ¹¹ See generally Kaiser Commission on Medicaid and the Uninsured, *Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries* (Sept. 2012), available at <http://www.kff.org/medicaid/issue-brief/explaining-the-state-integrated-care-and-financial/>.
- ¹² 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/>.
- ¹³ See Kaiser Commission on Medicaid and the Uninsured, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS* (Sept. 2013), available at <http://www.kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/>.
- ¹⁴ See *Introduction to One Care: MassHealth Plus Medicare* at 13-14, available at <http://www.mass.gov/eohhs/docs/masshealth/onecare/one-care-bk.pdf>. Massachusetts is using § 1915(a) authority to enroll dual eligible beneficiaries in Medicaid managed care. Virginia is using § 1932 state plan amendment (SPA) authority to enroll dual eligible beneficiaries in Medicaid managed care. Its SPA has been approved by CMS and provides for voluntary Medicaid managed care enrollment. 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>. SC also will use § 1932 state plan authority for Medicaid managed care. See South Carolina MOU at 6, 41.
- ¹⁵ Centers for Medicare and Medicaid Services, Special Terms and Conditions, New York State Dep't of Health, Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration (April 1, 2013), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-f-shrp-ca.pdf>.
- ¹⁶ 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>.
- ¹⁷ MOU between CMS and Ohio Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees at 5 (III.B.7.) (Dec. 11, 2012).
- ¹⁸ 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.
- ¹⁹ SC MOU at 15.
- ²⁰ See, e.g., Virginia Commonwealth University Partnership for People with Disabilities, *A Closer Look at the Centers' for Medicare and Medicaid Services' Definition of Person-Centered Planning*, available at <http://www.medicaid.gov/mltss/docs/PCP-CMSdefinition04-04.pdf>.
- ²¹ The baseline Medicare payment will be risk-adjusted using CMS's existing Medicare Advantage Hierarchical Condition Categories model.
- ²² National Committee for Quality Assurance, *Integrated Care for People with Medicare and Medicaid: A Roadmap for Quality* at 9 (March 2013), available at <http://www.ncqa.org/portals/o/public%20policy/NCQA%20White%20Paper-Integrated%20Care%20for%20People%20with%20Medicare%20and%20Medicaid.pdf>.
- ²³ *Id.* at 14.
- ²⁴ The MOUs provide that the demonstration 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. For a summary of CMS's § 1115A demonstration authority, see Kaiser Commission on Medicaid and the Uninsured, *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS*, Appendix A (Oct. 2012), available at <http://www.kff.org/Medicaid/8369.cfm>.