

medicaid
and the uninsured

December 2012

Washington's Managed FFS Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries

Executive Summary

Washington is the first state to sign a memorandum of understanding (MOU) with the Centers for Medicare and Medicaid Services (CMS) to test a managed fee-for-service (FFS) financial alignment model for beneficiaries who are dually eligible for Medicare and Medicaid, beginning on April 1, 2013. (Washington's proposal to test a capitated model is still pending with CMS.) Washington's managed FFS demonstration uses Medicaid health home services to coordinate care for high risk/high cost dual eligible beneficiaries with chronic conditions. This policy brief summarizes the MOU terms in the following key areas:

Enrollment: Washington's demonstration will focus on full benefit high cost/high risk dual eligible beneficiaries who are eligible for Medicaid health home services. The state will identify and automatically enroll eligible beneficiaries into a health home network, but beneficiaries will retain the choice about whether to receive health home services.

Care Delivery Model: Washington's demonstration uses health home care coordination organizations to coordinate Medicare and Medicaid services for dual eligible beneficiaries. A health home care coordinator will provide an in-person health screening and develop a health action plan with beneficiaries who elect to receive health home services.

Benefits: Washington's demonstration adds Medicaid health home services but otherwise does not change the existing Medicare and Medicaid benefits packages.

Financing: Health home providers will receive a per member per month payment from the state for demonstration enrollees who receive Medicaid health home services. Other providers will continue to receive FFS payments from CMS for Medicare Parts A and B services, Medicare Part D payments for prescription drugs, and FFS and capitated payments from the state for Medicaid state plan and waiver services. The state will be eligible to share in demonstration savings through a retrospective performance payment if quality and savings criteria are met.

Beneficiary Protections: The existing Medicare and Medicaid grievance and appeals procedures will continue under the demonstration. The MOU includes provisions regarding health home providers' obligation to comply with the Americans with Disabilities Act. The state will include beneficiaries on its advisory team to provide feedback on the demonstration, and health home networks also must provide mechanisms for beneficiary input.

Monitoring and Evaluation: The state will be responsible for day-to-day monitoring of demonstration health homes with periodic reports to CMS. CMS will fund an external evaluation of the demonstration.

Washington's demonstration is distinctive for its use of the new Medicaid health home services state plan option offered by the Affordable Care Act. Important components to assess as the demonstration is implemented include the effectiveness of Washington's health home care coordination organizations in improving care for beneficiaries and coordinating services among existing FFS providers, who may be outside the health home care coordination organization, and the source and extent of any demonstration savings.

Introduction

In late October 2012, Washington became the first state to sign a memorandum of understanding (MOU) with the Centers for Medicare and Medicaid Services (CMS) to test a managed fee-for-service (FFS) financial alignment model for people who are dually eligible for Medicaid and Medicare.¹ Just over half the states submitted proposals to CMS in spring 2012 to integrate care and align financing for dual eligible beneficiaries.² The initiative began in April 2011 when CMS awarded design contracts to 15 states to design new service delivery and payment models for this population.³ Subsequently, CMS issued a July 2011 State Medicaid Director letter inviting any interested state to submit a letter of intent to test its proposed capitated and/or managed FFS financial alignment models for dual eligible beneficiaries.⁴ In late August 2012, Massachusetts became the first state to finalize an MOU with CMS to implement its demonstration of the capitated financial alignment model,⁵ and 23 other states' proposals remain active with CMS.⁶ (Washington's managed FFS MOU represents CMS's approval of one part of its proposal; Washington also has proposed testing fully and partially capitated financial alignment models in certain urban counties, which is still pending before CMS.⁷)

Washington's managed FFS demonstration is distinctive for its use of Medicaid health home services to coordinate care for high risk/high cost beneficiaries with chronic conditions. Health home services are a Medicaid state plan option newly offered to states by the Affordable Care Act (ACA). The ACA also authorizes an enhanced federal matching rate of 90 percent for Medicaid health home services during the first two years that a state's health home state plan amendment (SPA) is in effect.⁸

This policy brief summarizes key aspects of Washington's managed FFS demonstration, including the target population; enrollment; care delivery model; benefits package; continuity of care provisions; financing; grievance and appeals system; disability accommodations; stakeholder engagement; oversight, reporting and quality measures; evaluation; governing authority and waivers; and implementation plans. The Appendix describes how the state's eligibility for a retrospective performance payment will be calculated. The goals of Washington's managed FFS demonstration, as articulated in its MOU with CMS, are summarized in Text Box 1, and key features of Washington's demonstration are summarized in Text Box 2.

Text Box 1:

Washington's Managed FFS Demonstration Goals

- Improve beneficiary experience in accessing care
- Promote person-centered health action planning
- Promote independence in the community
- Improve quality of care
- Assist beneficiaries in getting the right care at the right time and place
- Reduce health disparities
- Improve transitions among care settings
- Achieve cost savings for state and federal government through improvements in health and functional outcomes

Text Box 2:

Key Features of Washington's Managed FFS Demonstration

- Targets full benefit high risk/high cost dual eligible beneficiaries who are eligible for Medicaid health home services except in certain urban counties where the state proposes testing a capitated financial alignment model
- Provides for automatic enrollment into a health home network with beneficiaries retaining the choice about whether to receive health home services
- Establishes health home care coordination organizations that will coordinate primary, acute, prescription drug, behavioral health and long-term services and supports across Medicare and Medicaid
- Adds Medicaid health home services but otherwise does not change the existing Medicare and Medicaid benefits packages
- Continues fee-for-service provider reimbursement (except existing capitated behavioral health plans) and makes the state eligible for a retrospective performance payment if savings targets and quality standards are met

Target Population

Washington’s managed FFS demonstration will focus on an estimated 21,000 high cost/high risk full benefit dual eligible beneficiaries throughout the state.⁹ The target population will include beneficiaries who presently receive Medicare and Medicaid benefits on a fee-for-service basis (with the exception of Washington’s existing capitated behavioral health plans, which will continue) and who do not have other comprehensive private or public insurance. Medicare Advantage and Program of All-Inclusive Care for the Elderly (PACE) enrollees and beneficiaries receiving hospice services are ineligible for the demonstration unless they disenroll from their existing program.

All demonstration enrollees must be eligible for Medicaid health home services, which requires the presence of at least two chronic conditions, one chronic condition and the risk of another, or one serious and persistent mental health condition. The demonstration will be implemented in counties with qualified health home providers, which is expected to be statewide with the exception of certain urban counties in which the state has proposed testing CMS’s capitated financial alignment model.¹⁰

Enrollment

Washington will identify and automatically enroll eligible beneficiaries into a health home network, but beneficiaries will retain the choice about whether to receive health home services. The state will use a web-based clinical decision support tool (PRISM) that integrates primary and behavioral health information to identify beneficiaries who are most in need of care coordination based on risk scores for enrollment in the demonstration.¹¹

The MOU provides that auto-enrollment will proceed in phases with the state identifying eligible beneficiaries on a monthly basis. American Indians and Alaska natives are exempt from automatic enrollment but may choose to affirmatively enroll in the demonstration. The state’s Medicaid customer service center will facilitate beneficiary enrollment and disenrollment; 1-800-MEDICARE call center staff also will have information about the demonstration to assist beneficiaries. The MOU requires that beneficiary notices contain certain elements, listed in Text Box 3. Figure 1 includes key events in the enrollment process, and Figure 2 illustrates the demonstration care delivery model.

Once enrolled, the health home network “lead entity” will assign beneficiaries to a subcontracted health home care coordination organization that will be responsible for outreach to the beneficiary. The MOU envisions that the assignment process will match beneficiaries with organizations that provide most of their services and optimize beneficiary choice. Beneficiaries will then elect to receive demonstration health home services by completing a health action plan with the health home care coordination organization. Beneficiaries may change to another health home care coordination organization within the network or choose to stop receiving health home services at any time. Disenrollment will be requested by phone or in writing, with the assistance of the health home care coordinator or network lead.

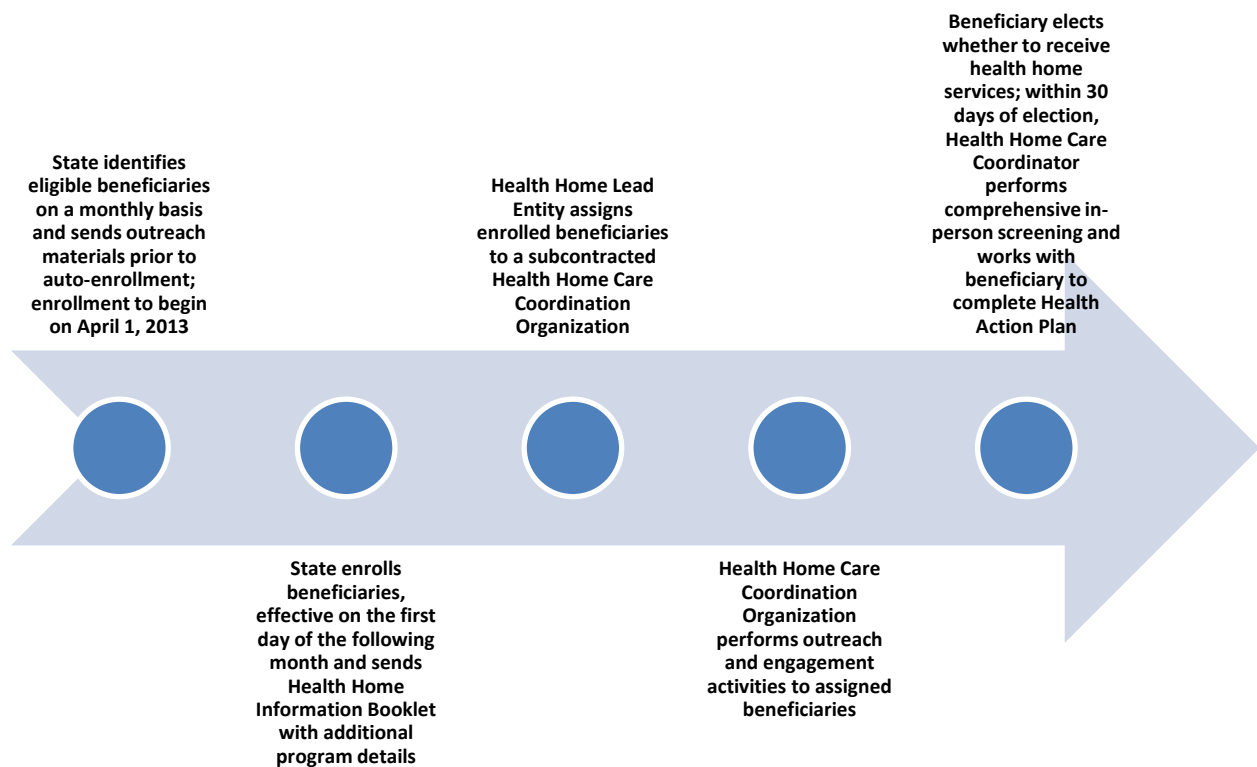
Text Box 3:

Required Content of Washington’s Managed FFS Demonstration Notices to Beneficiaries:

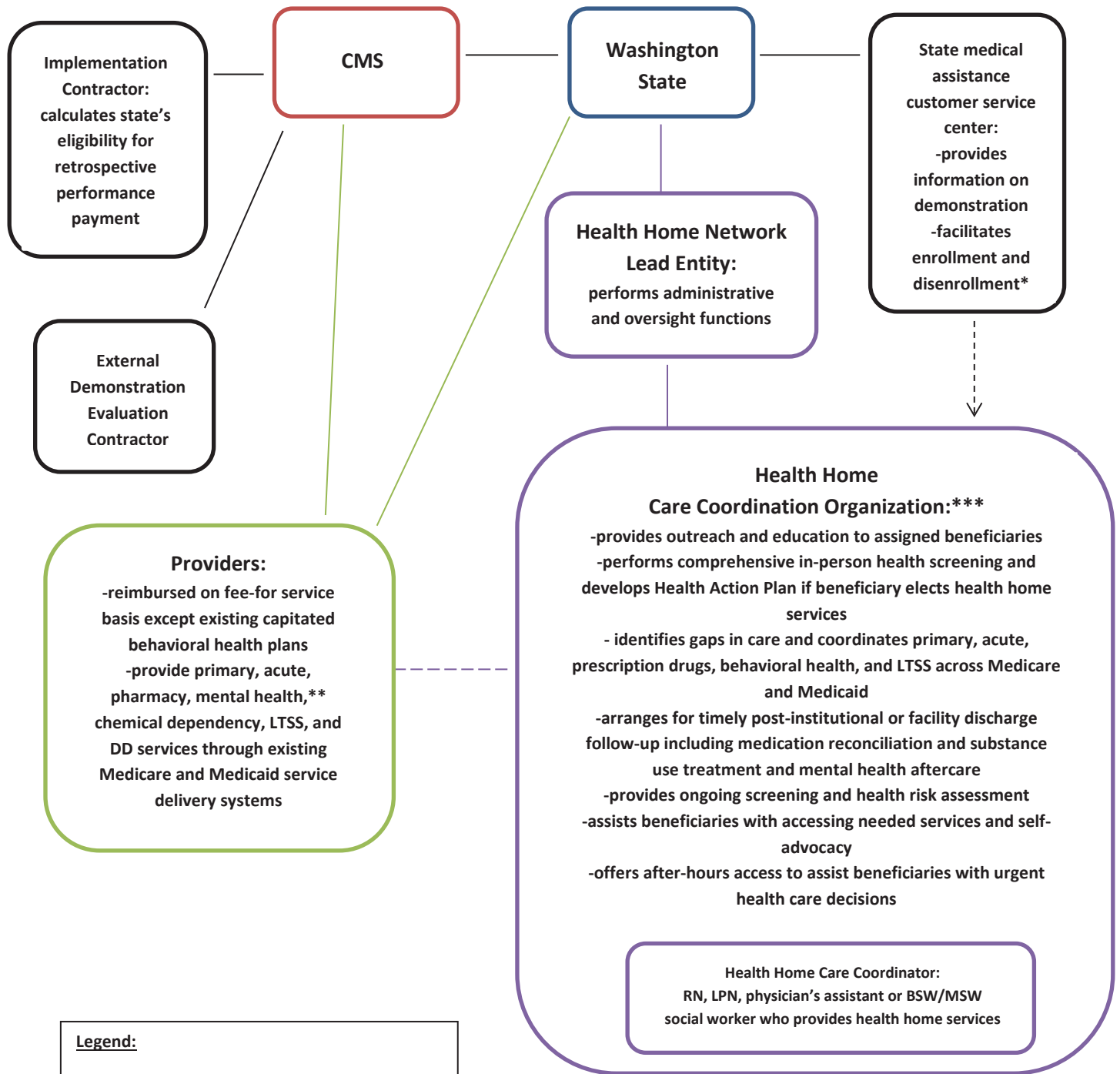
- A statement that beneficiaries’ full Medicare and Medicaid benefits remain unchanged
- Notification that beneficiaries maintain their choice of providers
- A description of new benefits and services provided by the demonstration
- Resources for beneficiaries to obtain additional information about the demonstration
- The date the demonstration will begin
- Information about beneficiary appeal rights

Figure 1:

Key Events for Dual Eligible Beneficiaries Affected by Washington’s Managed FFS Demonstration



**Figure 2:
Washington’s Managed FFS Demonstration to Integrate Care for Dual Eligible Beneficiaries:
Care Delivery Model**



Legend:

- = care coordination entities (solid line indicates contractual relationship, dashed line indicates care coordination function)
- = provider payment for services
- = contractor providing administrative services to support demonstration

*1-800-MEDICARE call center representatives also will provide demonstration information
 **Existing specialty managed care plans continue to provide mental health services
 ***Must include local community agencies, such as those that authorize Medicaid or state funded mental health, LTSS, chemical dependency and medical services; entities that may be part of a Health Home Network include Regional Support Networks (specialty behavioral health plans), community mental health agencies, AAAs, substance use treatment providers, public health districts, primary care clinics (including rural care clinics and FQHCs), hospitals, regional health alliances, and community supports that assist with housing.

Care Delivery Model

Washington’s managed FFS demonstration uses Medicaid health home services to coordinate care for dual eligible beneficiaries across Medicare and Medicaid. As envisioned by the MOU, the health home will be the central point for coordinating person-centered care and accountable for reducing preventable hospital admissions and readmissions and avoidable emergency room visits; providing timely post discharge follow up; and improving patient outcomes by mobilizing and coordinating primary, medical, specialist, behavioral health and long-term services and supports (LTSS). The health home network lead entity will provide administrative and oversight functions and subcontract with organizations that will directly provide health home care coordination services. The MOU provides that health home networks must include local community agencies that provide or authorize Medicaid or state or federally funded mental health, chemical dependency, medical or LTSS.

Health home care coordination organizations will assign a care coordinator to provide health home services to beneficiaries. If an eligible beneficiary elects to receive health home services, the care coordinator will provide an in-person health screening and develop a health action plan with the beneficiary. The screening results will be used to make referrals to necessary providers and assist the beneficiary with developing health action plan goals. Beneficiaries will determine whether their health action plan goals may be shared with other service providers. The screening and health action plan components are listed in Text Box 4. The care coordinator also will coordinate services among the beneficiary’s primary care and specialty providers and other providers, including any home and community-based services waiver case managers, and accompany the beneficiary to critical appointments as necessary to achieve the health plan goals. Care coordinators are expected to be embedded in community-based settings. The state will provide training for the health home lead and care coordination entities.¹²

Text Box 4:
Screening and Health Action Plan Components for
Washington’s Managed FFS Demonstration:

The **health screening** is to identify:

- physical and behavioral health needs
- chronic conditions
- gaps in care
- functional impairments
- need for assistance with activities of daily living
- beneficiary activation level
- opportunities to address potentially avoidable use of emergency room, inpatient hospital and institutional services

The **health action plan** must contain:

- at least one beneficiary-prioritized goal to improve health
- actions the beneficiary is taking to achieve the goal
- actions of the health home care coordinator (including the use of health, social or community resources and services) that support the health action plan

Benefits Package

Washington’s managed FFS demonstration adds Medicaid health home services but otherwise does not change the existing Medicare and Medicaid benefits packages. The Medicaid health home services to be provided are listed in Text Box 5. The state will be responsible for ensuring person-centered care coordination and facilitating access to all necessary Medicare and Medicaid services.

Text Box 5:

Health Home Services in Washington’s Managed FFS Demonstration Benefits Package

- comprehensive care management, using team-based strategies
- care coordination and health promotion
- comprehensive transitional care between care settings
- individual and family supports
- referral to community and social support services
- use of a web-based clinical decision support tool and other health information technology to improve communication and coordination of services and link services as feasible and appropriate

Continuity of Care

Washington’s managed FFS demonstration will not affect beneficiaries’ existing choice of Medicare and Medicaid providers. Beneficiaries also will have the right to choose a different health home care coordination organization at any time, to be effective on the first day of the following month, or to not receive health home services.

Financing

Health home providers will receive a per member per month payment from the state for demonstration enrollees who receive Medicaid health home services. Under Washington’s demonstration, providers will continue to receive FFS payments from CMS for Medicare Parts A and B services, Medicare Part D payments for prescription drugs, and FFS and capitated payments from the state for Medicaid state plan and waiver services.¹³ (Washington’s capitated behavioral health plans will continue.) (Figure 3).

The state will be eligible to share in demonstration savings through a retrospective performance payment if quality and savings criteria are met. Demonstration Medicare savings will be calculated based on a comparison of actual spending for demonstration enrollees to expected spending in the absence of the demonstration as determined by spending for a comparison group of beneficiaries; any increase in federal Medicaid spending may be deducted from Medicare savings under certain circumstances. More details about the calculation of the retrospective performance payment are

contained in the Appendix. The retrospective performance payment shall not exceed six percent of total Medicare expenditures for the demonstration population and will be calculated on an annual basis.¹⁴ The same Medicare savings cannot be shared more than once; instead, savings may be attributed only to the demonstration or only to another Medicare shared savings initiative. The state will not be at risk for any Medicare cost increases during the demonstration, but increased Medicare costs may trigger corrective action or termination of the demonstration by CMS. The state is primarily responsible for new investments and operating costs of the demonstration, subject to federal Medicaid matching funds. Notably, Medicaid health home services are eligible for enhanced federal matching funds of 90 percent for the first two years that a state's health home SPA is in effect. The demonstration quality measurement groups are listed in Text Box 6.

Text Box 6:

Quality Measurement Groups for Washington's Managed FFS Demonstration (scored from 0 to 100):

I. Model Core Measures:

- all cause hospital readmissions (reporting only in year 1, benchmark measurement in years 2 and 3)
- ambulatory care-sensitive condition hospital admission (reporting year 1, benchmark years 2 and 3)
- ED visits for ambulatory care-sensitive conditions (reporting year 1, benchmark years 2 and 3)
- follow up after hospitalization for mental illness (reporting year 1, benchmark years 2 and 3)
- depression screening and follow up care (reporting year 1, benchmark year 2)
- care transition record transmitted to health care professional (reporting years 2 and 3)
- screening for fall risk (reporting year 3)
- initiation and engagement of alcohol and other drug dependent treatment (reporting year 3)

II. State-Specific Process Measures:

- % beneficiaries with health action plan within 60 days of assignment to care coordination organization (reporting year 1, benchmark years 2 and 3) - required
- state delivery of training for health home networks on disability and cultural competence and health action planning (benchmark years 1, 2, 3) – required

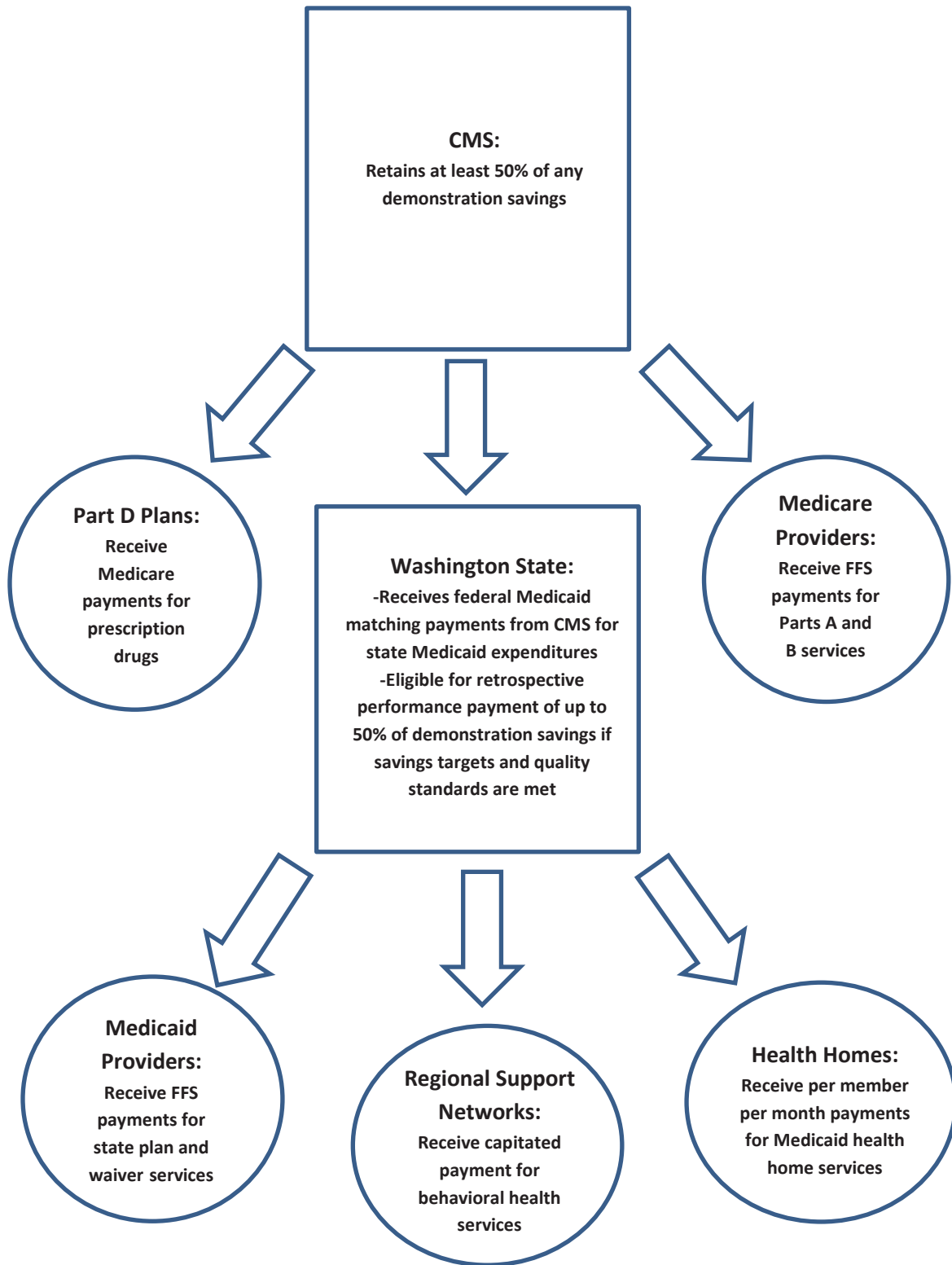
Plus, state selects at least one of the following 3 measures:

- % beneficiaries with 30 days between hospital discharge to first follow up visit (benchmark years 1, 2, 3)
- % hospital admission notifications occurring within specified timeframe (reporting year 1, benchmark years 2 and 3)
- % health homes with agreement to receive data from beneficiaries' Part D plans (reporting year 1, benchmark years 2 and 3)

III. State-Specific Demonstration Measures:

- state to select and CMS to approve 3 to 5 measures tailored to target population and overall demonstration, to be specified in final demonstration agreement, including at least one measure for LTSS and/or community integration

**Figure 3:
Washington’s Managed FFS Demonstration to Integrate Care for Dual Eligible Beneficiaries:
Financing Arrangements**



Grievances and Appeals

The existing Medicare and Medicaid grievance and appeal procedures and timeframes will not change under the demonstration.¹⁵ The MOU envisions the state and health home services providers assisting beneficiaries with exercising their appeal and grievance rights under Medicare and/or Medicaid as appropriate.

Disability Accommodations

Health home services providers must accommodate beneficiaries with disabilities and comply with the provisions of the Americans with Disabilities Act (ADA). The MOU specifies that providers must demonstrate a commitment and the ability to accommodate enrollees' physical access and flexible scheduling needs; and communicate with beneficiaries in a manner that accommodates individual needs, including providing interpreters for beneficiaries who are deaf or hard of hearing.¹⁶ In addition, demonstration outreach and education materials must be accessible to people with disabilities and will be available in alternative formats, such as large font, upon beneficiary request. CMS and the state will work with stakeholders, including beneficiaries, to further develop learning opportunities, monitoring mechanisms and quality measures to ensure health home services provider compliance with the ADA.¹⁷

Stakeholder Engagement

The state will include beneficiary participation on its advisory team to provide regular feedback on the demonstration and also will use focus groups, surveys, and community meetings to solicit beneficiary feedback. Health home networks must establish mechanisms to ensure meaningful beneficiary input and involvement in planning and process improvements, the specifics of which will be addressed in the state's health home network qualification process.

Oversight, Reporting and Quality Measures

The state will be responsible for day-to-day monitoring of demonstration health homes with periodic reports to CMS. The state in coordination with CMS will implement a health home quality strategy including a core set of demonstration quality measures and state-specific measures that health home providers must report as a condition of receiving payment for services. The state's retrospective performance payment will be contingent upon the state meeting quality thresholds and tiered to quality thresholds. (See Text Box 6 and Appendix.) CMS and the state will continue their other regular Medicare and Medicaid monitoring and oversight activities independent of the demonstration.

Demonstration Evaluation

CMS will fund an external evaluation of the demonstration that will include analysis of the impact on person-level health outcomes and beneficiary experience of care; changes in patterns of primary, acute and LTSS use and expenditures; and any shifting of services between medical and non-medical expenses.¹⁸ Key evaluation issues are listed in Text Box 7. The final evaluation report will be a public document. Beneficiaries who are eligible for the demonstration but disenroll or elect to not receive health home services remain attributed to the demonstration for purposes of the evaluation and

determination of the retrospective performance payment (with no impact on the services available to those beneficiaries or provider reimbursement). The evaluation will identify differences in outcomes for beneficiaries who choose to enroll and those who choose to disenroll. CMS and the state will meet at least annually to review interim evaluation findings, including care quality measures and the state's eligibility for a retrospective performance payment. The state also will participate in all CMS evaluations of health home SPAs. In addition, the state will use CAHPS beneficiary and caregiver surveys to evaluate the demonstration.

Text Box 7:

Key Demonstration Evaluation Issues:

- Beneficiary health status and outcomes
- Beneficiary satisfaction and experience
- Quality of care across settings
- Beneficiary access to and utilization of care across settings
- Administrative and systems changes and efficiencies
- Overall costs or savings for Medicare and Medicaid

Governing Authority and Waivers

CMS must approve a Medicaid health home SPA in each county in which the managed FFS demonstration will be implemented. The Medicare shared savings program/ACO statutory and regulatory provisions are waived to the extent that they are inconsistent with the MOU or final demonstration agreement. All other existing Medicare and Medicaid provisions continue to apply during the demonstration.

Demonstration Implementation

Washington's managed FFS demonstration will last from April 1, 2013 through December 31, 2016, unless terminated or extended.¹⁹ The state may apply to extend the demonstration, which will be granted at CMS's sole discretion.

The state must satisfy all demonstration readiness requirements before the execution of a final demonstration agreement with CMS to implement the demonstration. The readiness review will take place prior to signing the final demonstration agreement, and any identified gaps must be addressed for implementation to proceed. The readiness review may include provider capacity to meet beneficiary

needs under the health home model; provider and beneficiary materials; state training modules; monitoring and oversight processes; and data systems.

Looking Ahead

Washington’s demonstration is distinctive for its use of Medicaid health home services, a new state plan option offered by the Affordable Care Act. The MOU for Washington’s managed FFS demonstration provides additional information that was previously unavailable about how CMS and the state envision the demonstration working. The Washington MOU also provides insight into the framework and policy decisions that CMS may apply when developing MOUs to implement financial alignment demonstrations for dual eligible beneficiaries in other states that submitted managed FFS proposals. Additional details remain to be specified in the final demonstration agreement and the state’s Medicaid health home SPAs; for example, the extent of the health home entities’ authority to encourage existing FFS providers, who may not be part of the health home care coordination organization, to cooperate in efforts to coordinate services for beneficiaries is not yet clear.

The effectiveness of health home care coordination organizations in improving care for beneficiaries, the source and extent of any savings realized by the demonstration, how the demonstration will work for beneficiaries in nursing facilities, the extent to which care coordinators will influence beneficiaries’ selection of providers and Part D plans, and whether there is a high enough care coordinator to beneficiary ratio for the demonstration to succeed all are important issues to assess as the demonstration is implemented to ensure that the needs of this vulnerable population are met.

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

Appendix:
**Calculation of State's Eligibility for Retrospective Performance Payment in
Washington's Managed FFS Demonstration**

Any retrospective performance payment to the state is contingent upon the demonstration achieving overall savings – that is, Medicare savings may be offset by any increases in federal Medicaid expenditures. (Figure 4) Medicare savings will be calculated based on a comparison of actual spending for demonstration enrollees to expected spending in the absence of the demonstration as determined by spending for a comparison group of beneficiaries. CMS and its external evaluator will use a comparison group of dual eligible beneficiaries in other states or regions of states that are not testing financial alignment models who meet the eligibility criteria for Washington's demonstration. The comparison group will be matched to Washington's demonstration group based on Medicare and Medicaid expenditures, long-term care service users by type of provider, managed care penetration rates, and other criteria, including timeliness of data reporting, and weighted to account for the distribution of beneficiary characteristics (such as, demographics, health and disability status, health care market and local economic characteristics by county). Expected spending for the demonstration group absent the demonstration will be based on a trend in the comparison group.

Actual Medicare spending under the demonstration will be compared to expected Medicare spending for demonstration enrollees absent the demonstration, based on the comparison group, to determine if the demonstration has yielded Medicare savings. If Medicare savings exist, that amount must be compared to the Medicare Minimum Savings Rate (MSR) based on the demonstration population size for that year. The state is ineligible for a retrospective performance payment if Medicare demonstration savings are less than the MSR. The minimum MSR will be two percent. MSRs are listed in Text Box 8.

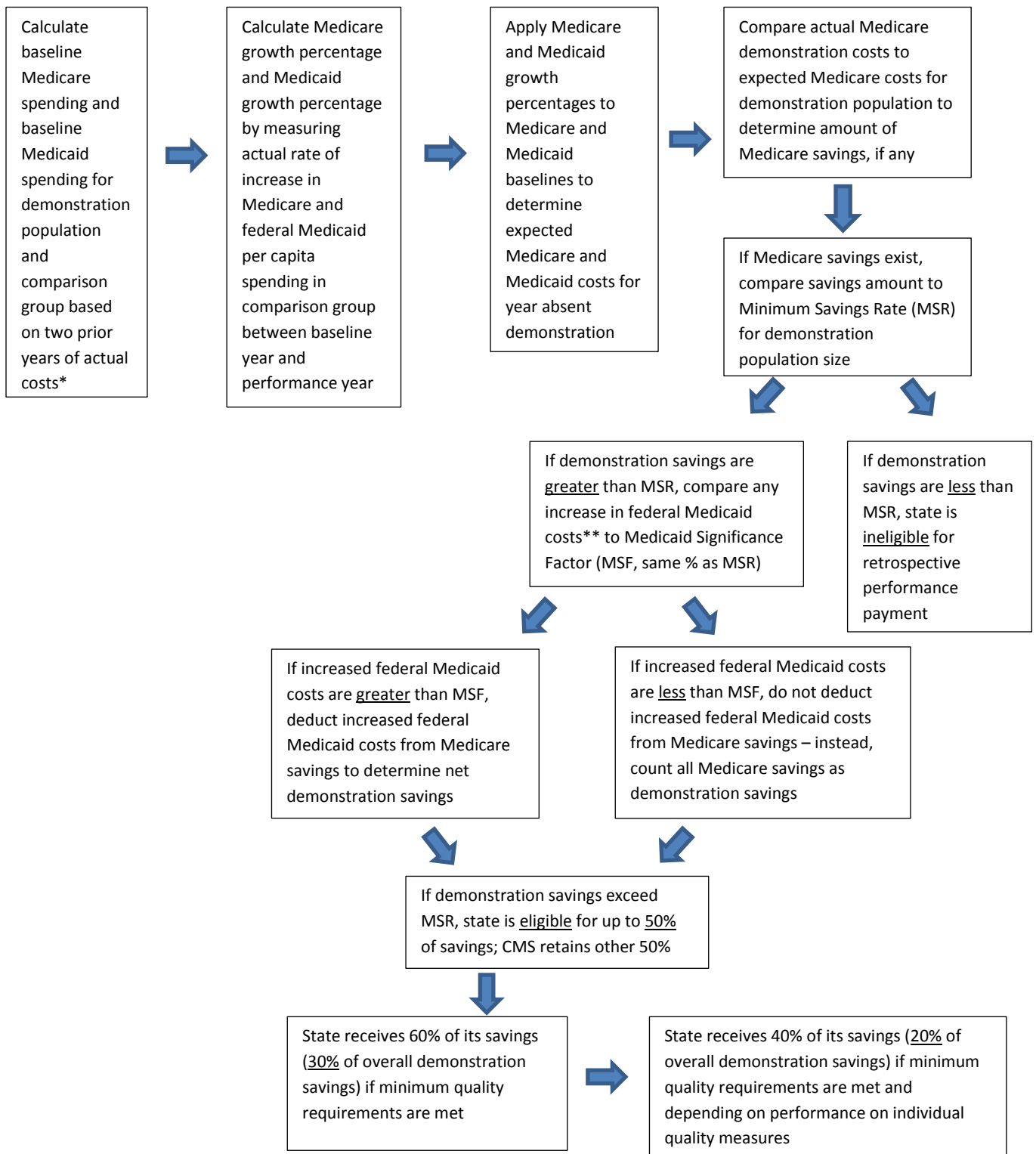
Text Box 8:	
Medicare Minimum Savings Rates (MSR) for Washington's Managed FFS Demonstration:	
5,000 beneficiaries =	MSR 4.5%
10,000 beneficiaries =	MSR 3.2%
20,000 beneficiaries =	MSR 2.45%
50,000+ beneficiaries =	MSR 2.00%

If Medicare demonstration savings exceed the MSR for the demonstration population size, any increase in federal Medicaid costs may have to be deducted to determine net demonstration savings. Whether to deduct increased federal Medicaid costs is determined by comparing increased federal Medicaid costs to the Medicaid Significance Factor (MSF), which will be the same percentage as the MSR. If the increase in federal Medicaid costs is less than the MSF, CMS will not deduct increased federal Medicaid costs from Medicare demonstration savings for purposes of calculating the

retrospective performance payment. However, if increased federal Medicaid costs from the demonstration exceed the MSF, those costs will be deducted from the Medicare demonstration savings to establish net federal demonstration savings.

If Medicare demonstration savings exceed the MSR, the state qualifies to receive up to 50 percent of the federal savings. Of that amount, the state is eligible to receive 60 percent of its portion of the demonstration savings if minimum quality requirements are met (based on a weighted average of the measurement group scores compared to a minimum quality threshold). If the minimum quality requirements are met or exceeded, the state also is eligible to receive up to 40 percent of its portion of the demonstration savings depending upon the points it earned for individual quality measures. Because established quality metric benchmarks do not exist for the demonstration population, CMS will establish benchmarks for each measure based on an analysis of the state's quality performance.

**Figure 4:
Washington’s Managed FFS Demonstration to Integrate Care for Dual Eligible Beneficiaries:
State Eligibility for Retrospective Performance Payment**



*All beneficiary expenditures will be capped at the 99th percentile of costs and adjustments will be made for changes in federal or state policies that could affect calculations.

**The federal Medicaid increase will be determined based on all federal Medicaid costs, including new health home payments and will follow the comparison group and adjustment approaches described for the Medicare savings calculation.

Endnotes

¹ Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and the State of Washington Regarding a Federal-State Partnership to Test a Managed Fee-for-Service Financial Alignment Model for Medicare-Medicaid Enrollees (Oct. 24, 2012), available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf>.

² For an overview of these demonstrations, see Kaiser Commission on Medicaid and the Uninsured, *Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries* (Oct. 2012), available at <http://www.kff.org/Medicaid/8368.cfm>. For a summary of the 26 states' proposals to CMS, 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* (Oct. 2012), available at <http://www.kff.org/Medicaid/8369.cfm>. For background on the dual eligible population, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for Dual Eligible Beneficiaries* (April 2012), available at <http://www.kff.org/medicaid/7846.cfm>; Kaiser Family Foundation, *Medicare's Role for Dual Eligible Beneficiaries* (April 2012), available at <http://www.kff.org/medicare/8138.cfm>.

³ For background on the state design contract proposals, see Kaiser Commission on Medicaid and the Uninsured, *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS* (Aug. 2011), available at <http://www.kff.org/medicaid/8215.cfm>.

⁴ For background on the states' letters of intent, see Kaiser Commission on Medicaid and the Uninsured, *Financial Alignment Models for Dual Eligibles: An Update* (Nov. 2011), available at <http://www.kff.org/medicaid/8260.cfm>. For a summary of CMS's guidance on the capitated financial alignment model, see Kaiser Commission on Medicaid and the Uninsured, *An Update on CMS's Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees* (April 2012), available at <http://www.kff.org/medicaid/8290.cfm>.

⁵ For a summary of the Massachusetts MOU, see Kaiser Commission on Medicaid and the Uninsured, *Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries* (Oct. 2012), available at <http://www.kff.org/medicaid/8291.cfm>. For a comparison of key features of Massachusetts' and Washington's MOUs, see Kaiser Commission on Medicaid and the Uninsured, *Massachusetts and Washington: Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared* (Dec. 2012), available at <http://www.kff.org/medicaid/8395.cfm>.

⁶ Financial alignment proposals are pending from AZ, CA, CO, CT, HI, IA, ID, IL, MI, MO, NC, NY, OH, OK, RI, SC, TN, TX, VA, VT, and WI; MN and OR have indicated that they will not pursue financial alignment, although they may pursue administrative or programmatic alignment in some form. NM's proposal has been withdrawn. CMS Financial Alignment Initiative, State Financial Alignment Proposals, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>, and state websites.

⁷ For more information about Washington's capitated financial alignment proposal, 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* (Oct. 2012), available at <http://www.kff.org/Medicaid/8369.cfm>.

⁸ For more information about Medicaid health homes, see Kaiser Family Foundation, *Medicaid's New "Health Home" Option* (Jan. 2011), available at <http://www.kff.org/medicaid/8136.cfm>.

⁹ Washington defines high cost/high risk beneficiaries as those whose medical expenses in the next 12 months, based on their disease profile and pharmacy utilization, are expected to be 50 percent greater than other beneficiaries; or those who have had two or more hospitalizations in the previous 15 months.

¹⁰ The MOU provides that Washington may expand its managed FFS demonstration to the excluded counties beginning by November 1, 2013 if CMS and the state agree that the state has capacity, the state no longer seeks to test the capitated model, and the state engages stakeholders before expansion of the demonstration.

¹¹ PRISM includes Medicare and Medicaid claims data, encounter data, and assessment information for predictive modeling of risk factors, clinical indicators, gaps in care and drivers of health care utilization.

¹² Training topics will include administration and activation of the patient activation measure tool; beneficiary and family engagement; cultural and disability competence; care coordination strategies; standardized screening and measurement tools; health promotion and disease prevention; Medicare benefits and appeal processes; and health action planning. Training will be provided through regional forums, training events, webinars, routine online training and case review.

¹³ 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/medicaid/8352.cfm>.

¹⁴ Payments will be made nine to 11 months after the end of each demonstration year.

¹⁵ For more information about the Medicaid appeals process, including state fair hearings and the procedures for Medicaid managed care appeals, see Kaiser Commission on Medicaid and the Uninsured, *A Guide to the Medicaid Appeals Process* (March 2012), available at <http://www.kff.org/medicaid/8287.cfm>.

¹⁶ The MOU also mentions the provision of interpreters for non-English speakers.

¹⁷ The MOU also mentions provider compliance with the federal Civil Rights Act.

¹⁸ Evaluation methods will include site visits; qualitative analysis of program data; collection and analysis of focus group and key informant interview data (with advocacy organizations and other stakeholders); tracking changes in select quality utilization and cost measures over the course of the demonstration; evaluating the demonstration's impact on quality, utilization and cost; and calculating savings attributable to the demonstration.

¹⁹ CMS or the state must provide 90 days' advance notice to each other and 60 days' notice to beneficiaries and the general public if CMS or the state terminates the demonstration for any reason (30 days' notice will be provided if the termination is for cause). Five months before suspension or termination of the demonstration, the state must provide a draft phase-out plan, subject to a 30 day public comment period and tribal consultation prior to CMS submission. CMS must approve the phase-out plan prior to implementation. If the state terminates its health home SPAs, the demonstration also will terminate.

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