

Building State Capacity to Implement Integrated Care Programs for Medicare-Medicaid Enrollees

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Across the country state Medicaid agencies are partnering with the federal government to build new approaches to integrated care for Medicare-Medicaid enrollees (also known as “dual eligibles”). Leading this activity is the Centers for Medicare & Medicaid Services’ (CMS) Medicare-Medicaid Coordination Office (MMCO), which is charged with improving care for this population through new capitated or managed fee-for-service models that integrate financing and service delivery.¹ Only a few states—such as Massachusetts and Minnesota—have integrated programs for Medicare-Medicaid enrollees, so experience in administering these programs is limited. Thus, the states pursuing these new models are examining what internal capacity they need for successful program design and implementation.

Several factors may impede states’ ability to build the capacity they need. For example, staffing constraints may mean that finding resources to manage and administer new programs will be difficult, especially as some states near the January 1, 2014 deadline to expand Medicaid eligibility. Also, few states have experience with Medicare policy, and acquiring this knowledge requires considerable commitment from state staff. In addition, states implementing capitated financial alignment models may have the added challenge of overseeing managed care plans that have little experience providing integrated benefits or long-term services and supports (LTSS).

A recent report, *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports*, offers a lens through which to examine state capacity for integrated care programs.² Both integrated care and Medicaid managed long-term services and supports (MLTSS) programs enroll large numbers of beneficiaries with complex care needs who use LTSS, and most Medicaid-only MLTSS programs also include Medicaid acute care services. Many capacities outlined for MLTSS also apply to integrated care models.

IN BRIEF

The success of integrated care initiatives for Medicare-Medicaid enrollees will depend in large part on the skills and knowledge of state Medicaid staff. Expertise in Medicare policy; the ability to conduct robust managed care oversight, data analysis and reporting; and the development of new communication strategies will be critical to program implementation.

This technical assistance brief, made possible through support from The SCAN Foundation, examines key areas where states will need to build their internal capacity as they pursue integrated care programs for Medicare-Medicaid enrollees. Focus areas include: basic organizational capacity (leadership, staffing, and knowledge); contract development; data analysis and information systems; stakeholder communication; rate setting; and quality measurement.

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Basic Organizational Capacity: Leadership, Staffing, and Knowledge

The following questions can help state Medicaid agencies assess issues related to basic organizational capacity such as the strength of their leadership; ability to collaborate effectively with other state agencies; and knowledge they will need to work with new programs and populations and infrastructure.

A solid understanding of the Medicare program will be essential to implementing and operating almost all elements of an integrated care program for individuals dually eligible for Medicare and Medicaid.

What Are Essential Elements of Program Leadership?

Approaches to leadership vary, but one element is critical to get integrated care programs off the ground: securing internal buy-in. Genuine enthusiasm for change must come from the top of an organization and is essential to drive collaboration and reach common goals. Key aspects of effective leadership include the ability to:

- Articulate the value and return on investment that an integrated model will bring to Medicaid beneficiaries as well as to agency staff;
- Communicate a detailed plan outlining specific staff requirements, duties, and contingency plans in the event of a delayed schedule or other factors that modify the original plan;
- Create a culture of camaraderie and enthusiasm. For example, a senior staff member involved in California's integrated care initiative noted that staff participate in a weekly touch base meeting before the start of their workday. Although early morning meetings are challenging, program leadership was dedicated to making every participant feel valued, and now

this meeting is well-attended and has helped to foster a culture dedicated to collaboration.³

What do State Medicaid Staff Need to Know to Operate an Integrated Delivery System?

Many states are developing integrated care programs from scratch, and will be responsible for monitoring structures and processes that will be new to many, if not all, staff. Similar to building MLTSS programs, staff should have strong qualifications in core oversight functions including program management, oversight of contracts, provider network adequacy, quality assessment, and consumer protections.⁴

A solid understanding of the Medicare program will be essential to implementing and operating almost all elements of an integrated care program. Medicaid agency staff responsible for program operations, including call center staff, would likely benefit from training on basic Medicare policy, how integrated care may change care delivery for Medicaid beneficiaries, program goals, and related operational changes. Depending on available resources, states may consider bringing in Medicare experts

Building Organizational Capacity – Real World Examples

- **Massachusetts** restructured MassHealth to support its integrated care program by consolidating oversight and management of key units under the deputy Medicaid director for policy and programs. Under this new structure, policy and program staff are better able to collaborate throughout the development and implementation of new initiatives. It also better supports integration efforts between various program areas and advances policies and programs that comprehensively address members' needs. Within this unit, a new team will oversee health plans with dedicated program management staff taking on daily responsibilities related to the integrated care program.
- **Ohio** is establishing a Quality Oversight Committee for its Integrated Care Delivery System (ICDS) program that will include:
 - The director and staff from Ohio Medicaid; Department of Aging; Department of Mental Health; Department of Alcohol and Drug Addiction Services;
 - The ICDS chief executive operations officers and the program director; and
 - 15 enrollees (one from each plan in each region).
- **California** had strong public support from the secretary of its Health and Human Services Agency. Soon after California announced its intent to submit a proposal for a Financial Alignment Demonstration, the secretary organized a large public kick-off meeting to explain the value of the program for Medicare-Medicaid enrollees in California. In addition, the California Department of Health Care Services has hired several senior leadership staff with relevant Medicare-Medicaid managed care experience to work on its Financial Alignment Demonstration, "Cal MediConnect."

to provide targeted training, sending staff to Medicare managed care conferences, or consulting with their external quality review organizations regarding Medicare policy. CMS has also produced several briefs to help states learn Medicare basics.^{5,6}

Does the Medicaid Agency Have the Resources to Implement the Integrated Care Initiative?

Some states may reorganize or reallocate current staffing within the agency, especially if a state has or is developing MLTSS simultaneously. For example, a state could create a dedicated unit responsible for all managed care oversight that includes all Medicaid managed care compliance and monitoring duties, including those for integrated programs. Several states with MLTSS programs have consolidated contract monitoring functions for those programs with Medicaid managed care operations to streamline monitoring and data analysis, reduce duplication of effort, and use staff resources more efficiently.⁷ States building integrated care programs need staff skilled in:

- Managed care oversight;
- Quality assurance/improvement;
- Program integrity;
- Marketing, outreach and education;
- Legal and public affairs;
- Finance and budget;
- Eligibility and enrollment; and
- Data analytics for complex populations.

States should identify and draw upon existing staff from across their Medicaid agencies who have these skills. States that are able to hire new staff will need to conduct a thorough gap analysis to identify essential missing skills and expertise and then target their recruitment efforts.

In some states, finding staff with necessary skills may require building inter-departmental or inter-agency teams. Reaching out to state partners that support high-need populations through other programs would give the Medicaid agency access to new knowledge and ensure that the new integrated care program will align with other initiatives. Building a working team with staff from agencies such as aging, mental health, public health, disabilities, housing, and insurance/managed care would involve these agencies in program planning and provide a conduit for ongoing communication.

Contract Development, Compliance Monitoring, and Oversight

Robust contractor oversight might be the most important element of successful Medicaid managed care programs. States are slowly but increasingly using Medicaid managed care arrangements to deliver acute services and LTSS to high-need, high-cost populations. Questions to help states assess their capacity to monitor integrated managed care arrangements include:

Does the State Have Experience Monitoring Managed Care Programs for Complex Populations?

Monitoring managed care arrangements for complex populations requires more intensive resources than monitoring programs that enroll healthier populations (like parents and young children) because of their higher service utilization; need for comprehensive care coordination and social services; and potential functional impairments. Before procurement, states could build internal expertise by:

- Familiarizing themselves with other states' Medicaid managed care contract language and strategies to evaluate performance of and collaborate with health plans;

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Clearly defining expectations for plan duties and performance is important for integrated care programs, especially those contracting with plans that have limited experience serving Medicare-Medicaid enrollees.

- Attending training opportunities offered through CMS and other external organizations;
- Conducting an environmental scan of provider availability to determine current capacity and reasonable provider network expectations; and
- Identifying necessary plan capabilities for managing and building networks to provide LTSS and behavioral health services.

Does the State Have Experience with Medicare Advantage?

Medicare Advantage (MA) requirements provide the foundation for risk-based integrated care models. Many plans that will be participating in integrated programs are already Medicare Advantage Special Needs Plans for Medicare-Medicaid enrollees (D-SNPs). Knowledge of MA market characteristics, Medicare managed care contracting and network adequacy requirements, as well as Medicare-Medicaid policy interactions will help states assume new responsibilities for contract development, monitoring and oversight. States need to either buy or build this expertise. For example, they could recruit new staff with specific MA experience or build collaborative MA-SNP committees to

work on specific topics that would educate state staff by virtue of their participation.

How Can the State Proactively Assume New Oversight Duties?

Clearly defining expectations for plan duties and performance is important for integrated care programs, especially those contracting with plans that have limited experience serving Medicare-Medicaid enrollees. Health plans also recognize the need for and appreciate clear contract requirements, goals and expectations.¹⁰ States should consider devising a plan for monitoring performance and compliance before program launch. Key contract areas requiring close monitoring in integrated care programs include:

- Health plan care coordination resources and processes through the entire care continuum;
- Provider network adequacy, particularly for LTSS, behavioral health, transportation and durable medical equipment, to promote access for a diverse population;
- Provision of social support services to keep individuals at home or in the community;
- Beneficiary protections, including a grievances and appeals process, and

Strategies for Effective Contract Oversight

- **Massachusetts** partnered with CMS to develop the first Financial Alignment Demonstration readiness review tool that promotes person-centered approaches to independent living, beneficiary empowerment, and recovery-oriented models of behavioral health care.⁸ Example categories and criteria in the readiness review include: (1) *Assessment* – the enrollee has an understanding of and engagement in recovery-oriented activities; (2) *Care Coordination* – process in place to ensure access to an Individualized Care Team; and (3) *Organizational Structure and Staffing* – specific requirements for care coordinator training program.
- **Arizona** operates a division of 70 staff whose sole responsibility is oversight and contractor monitoring or health plan performance, including plans that enroll Medicare-Medicaid enrollees and provide MLTSS.⁹ Arizona monitors performance through a combination of written reports, regular on-site reviews, and an internal data review process. Examples of monitored performance standards include: (1) percent of claims paid on time; (2) tracking of grievances and appeals; (3) standards related to LTSS, including initial contact with individuals who are determined to need LTSS; (4) staff ratios; and (5) timing of reassessments.
- **Texas**, in its final Financial Alignment Demonstration proposal to CMS, described how it will leverage existing infrastructure and knowledge from its STAR+PLUS program, which serves Medicaid beneficiaries with complex care needs. Texas completed comprehensive readiness reviews of all STAR+PLUS health plans in early 2012, which could assist the state in identifying high-priority areas in an integrated care program to help focus readiness reviews or contract requirements.

access to information; and

- Provision of person-centered care, including functional assessments, care planning and enrollee communication.

Also, states can require that bidders describe their proposed mechanisms for serving Medicare-Medicaid beneficiaries in their responses (i.e., bids) in the state procurement process. The plans' responses to questions in the procurement can help states think through operational processes and additional requirements to develop for contract standards.

Data Analysis and Information Systems

States will need to develop the capacity for collecting and analyzing linked Medicare and Medicaid data, as well as to store and manage that data. This will help to ensure robust plan contract monitoring and oversight as states learn to use this data to track health plan performance. In addition, states will use linked Medicare-Medicaid data to target care management interventions and other services. Some states have sought expertise from universities or researchers to complete these types of analyses.

What Types of Data Analyses Will the Medicaid Agency Need to Do?

CMS' MMCO launched the State Data

Resource Center to help state Medicaid agencies obtain and use Medicare Parts A, B, and D data for Medicare-Medicaid care coordination.¹⁵ Once states obtain Medicare data, they will need to develop new data files with linked Medicare and Medicaid beneficiary information and develop policies and procedures for health plan report submission, monitoring, and evaluation. States with limited managed care experience will benefit from talking with experienced states about how to set requirements and report Medicaid and Medicare data. Challenges with developing this expertise include: (1) creating in-house capabilities to track timeliness, quality, and completeness of health plans' report submission; and (2) analyzing encounter data to monitor service use, cost patterns, quality measures, and other performance indicators at plan and program levels.

What Are the Information System Requirements?

Information systems need to support enrollment activities, provide sufficient capacity for large linked datasets, and securely transmit beneficiary information to health plans or providers as appropriate. For example, some states that plan to passively enroll some beneficiaries are examining complicated options for intelligent assignment algorithms that will take into account beneficiary preferences and care patterns.¹⁶ In addition, states may consider

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Linking Medicare and Medicaid Data Supports Integrated Care

- **Washington** uses a web-based clinical decision support and predictive modeling tool called PRISM (Predictive Risk Intelligence System) to identify Medicaid beneficiaries at high risk and in need of care interventions. PRISM stores integrated information from primary, acute, social services, behavioral health, and LTSS payment and assessment data systems. The state recently added Medicare data to its integrated data warehouse.¹¹
- **Minnesota** collects Medicare and Medicaid integrated encounter data directly from participating plans in the Minnesota Senior Health Options (MSHO) program. For other populations, the state has a database that links Medicare fee-for-service (FFS) data to Medicaid managed care encounters or Medicaid FFS data. Minnesota also created a linked data file of encounter data and FFS claims for MSHO plans accepting new enrollees to establish care plans as soon as possible after enrollment.¹²
- **California**, with co-funding from The SCAN Foundation, developed an integrated database of Medi-Cal and Medicare claims and assessment data for LTSS recipients, through a partnership between the California Department of Health Care Services and the California Medicaid Research Institute (CAMRI) at the University of California. Using this data, CAMRI analyzed program spending from 2005-2008 for Medicaid beneficiaries receiving LTSS, including Medicare-Medicaid enrollees.^{13,14}

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developing a set of core data elements or a uniform assessment tool to capture information across all health plans and other entities.

In addition, states will want to be familiar with CMS' Health Plan Management System (HPMS).¹⁷ Health plans that participate in Financial Alignment Demonstrations will be required to upload information to HPMS, which CMS uses to monitor plan compliance with Medicare Advantage and Part D contract requirements, as well as to communicate with and submit information to these plans. State staff will want to use the system to review information submitted by Medicare-Medicaid plans, including Model of Care requirements, Part D formularies, and other related information to help monitor plans.

Stakeholder Outreach and Communication

To succeed, integrated care programs require effective communication between the state, health plans, providers, and beneficiaries about planned changes to service delivery. State staff may have to assume more active roles in outreach and communication than they have held in traditional Medicaid managed care programs. Questions related to new outreach and communication approaches include:

How Can the State Facilitate Communication with Health Plans?

In the months before and immediately after the program launch, states should hold regular meetings with health plans to ensure that the policies and procedures being developed are actually put in place and function as intended. Many health plans in integrated care programs may be Medicare Advantage plans with experience managing Medicare-covered services, but not Medicaid services. Even D-SNPs may have only limited experience in managing Medicaid services¹⁸ and may not be familiar with state oversight rules or Medicaid behavioral health and LTSS providers and

services. Suggestions to states from health plans to facilitate communication include:¹⁹

- Help plans to develop consumer advisory boards;
- Hold meetings with and solicit feedback from plans during program design and development;
- Assist plans in communicating the plan's care management objectives to providers; and
- Use state ties to providers to encourage plan-provider communication, build new relationships and establish shared goals for plans and providers.

What Outreach Efforts Will Help a State Improve Coordination Between Medicare and Medicaid Providers?

The often limited interaction between providers primarily paid by Medicare and Medicaid-funded LTSS and behavioral health providers can lead to lack of coordination and disruptions in care for Medicaid-Medicare enrollees. LTSS and behavioral health providers are less likely to have experience with managed care plans, and may be skeptical of plans' ability to manage care appropriately. Similarly, Medicare providers may be unfamiliar with Medicaid program rules. States can increase providers' comfort level with integrated initiatives by:

- Creating training and educational materials that clearly describe the value of integrated care;
- Conducting outreach and education to practices, clinics and home- and community-services (HCBS) providers about the integrated care initiatives early on; and
- Sharing draft contract language with provider groups or other relevant stakeholder organizations to gather input on how to communicate these expectations to plans.

What New Approaches Are Essential for Beneficiary Outreach?

Effective communication with Medicare-Medicaid enrollees, families, advocacy

organizations, and providers can help to create stakeholder buy-in for a program that will significantly change how many vulnerable beneficiaries will access and receive care. States will need to take an active role in stakeholder communication, be responsive to stakeholder concerns, and adopt a transparent, “no surprises” approach. The ability to clearly explain how integrated care programs will benefit enrollees is critical. Several resources related to effective communication and stakeholder outreach strategies are available to help states.²⁰ Other approaches to stakeholder engagement include:

- Conducting outreach to organizations that represent Medicare beneficiaries to explain expected interactions with the Medicaid program and Medicaid providers;
- Creating person-centered explanations for how integrated care will improve beneficiary experience (for example, Medicare beneficiary protections, new covered services, a single ID card, and centralized access to information);
- Developing marketing and education materials that clearly explain administrative policies, and how beneficiaries can access both Medicare and Medicaid services; and
- Developing a comprehensive, publicly available communications work plan

that clearly defines all terms the state, provider and plan partners use to describe the program and states the agency’s vision and goals for this program.²⁴

Rate Setting and Quality Measurement

Other elements of integrated care programs that will require new skills and expertise include rate setting and establishment of payment methodologies and quality measurement. State Medicaid agencies need to address questions such as:

What Are the Considerations in the Rate-Setting Process?

Fully integrated, risk-based Medicare-Medicaid programs include funding streams from both programs, and states will need to work with CMS to develop adequate, actuarially sound rates that support access to providers and services. Setting rates to predict service utilization for a complex population with a wide range of health needs is a complex process and states should assess their abilities to:

- Build risk adjustment models for blended rates that reflect use of Medicare acute care and Medicaid LTSS to fully capture health status and service use, and to target payment appropriately;²⁵

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Stakeholder Engagement Informs Program Design

- **Massachusetts** actively engaged with health plans during its Financial Alignment Demonstration readiness review process and supported active collaboration between plans.²¹ This interaction was part of a broader stakeholder engagement process during the development phase of its demonstration. It included: (1) procurement review from several stakeholders; (2) public meetings with advocates, consumers, and family members; (3) providers and health plans; (4) focus groups for Medicare-Medicaid enrollees, and on other key areas such as quality metrics and notice development; and (5) a consumer-majority Implementation Council.
- **South Carolina** held several public meetings to gather input for its proposed Financial Alignment Demonstration about consumer protections, strategies for including HCBS in the integrated model, and strategies to engage stakeholders. They also maintain a comprehensive website with frequent information updates, program developments announcements, and stakeholder resources such as training opportunities.²²
- **Virginia** also held stakeholder meetings to gather input before it signed a Memorandum of Understanding with CMS for its Financial Alignment Demonstration. Separate meetings included enrollees and families; state agencies and contracts; health plans; long-term care and behavioral health providers; and nursing facilities and hospitals. Virginia used a Communications Work Plan Template²³ to convene a multi-agency work group to plan communications activities for its demonstration.

States can review existing federal and state quality measures and program requirements for examples of approaches to quality measurement and specific metrics for integrated care and MLTSS.

- Apportion risk and savings between the state, CMS, and health plans;
- Develop performance targets, quality withholds, and savings percentages; and
- Promote the use of HCBS for Medicare-Medicaid enrollees through payment incentives and savings achieved from decreased use of Medicare services.

Setting rates relies on high quality data, so the key is to understand how to collect, edit, reconcile, and analyze encounter data on costs and utilization. Several states with MLTSS programs work with External Quality Review Organizations (EQROs), actuaries, and other state agencies to conduct in-depth audits or reviews of encounter data and identify and address data reliability issues.

What Should State Program Staff Know About Quality Measurement for Medicare-Medicaid Enrollees?

State Medicaid agencies are seeking to establish measurement strategies that assess whether programs achieve their goal of improving quality and experience of care for Medicare-Medicaid enrollees. Although there is no one set of nationally accepted, standardized measures for integrated care programs, states can review existing federal and state metrics and program requirements for examples of approaches to quality measurement and specific metrics for integrated care and MLTSS. Examples of state-specific MLTSS metrics include those that evaluate timeliness of assessments; care plan development and community service linkages; changes in functional status; nursing facility or other institutional admissions and maintenance of community transition; and member-centeredness of care plan.²⁶

Some states (such as Massachusetts, Minnesota, and Wisconsin) and the federal government (through the Program of All-Inclusive Care for the Elderly or PACE) use quality metrics in integrated care programs. To develop quality measurement strategies states should:

- Understand Medicare Advantage and SNP performance measures required by CMS, including the NCQA structure and process measures for SNPs;²⁷
- Develop a methodology for collecting data on a combination of “core” and state-defined quality measures for Financial Alignment Demonstrations;²⁸ and
- Create measures that assess the degree of patient- and family-centered care to address the unique needs of Medicare-Medicaid enrollees (i.e., measures that reflect the program impact on beneficiaries’ quality of life and experiences of care; changes in LTSS use; changes in behavioral health service use; and overall coordination of care).²⁹

Conclusion

States are seizing unprecedented opportunities to develop integrated care programs to address long-standing, systemic misalignments for Medicare-Medicaid enrollees. To implement these programs, state Medicaid agencies must ensure that their staff has the requisite skills and competencies. Successful program implementation may be largely dependent on a state’s internal capacity to build knowledge of Medicare policy, provide sufficient oversight, develop new reporting and data analysis competencies, and clearly communicate the value of integration to stakeholders.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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Endnotes

¹ This brief focuses on the capitated model, although states may choose between two Financial Alignment Demonstration models (or pursue both, like Washington). The capitated model is based on a three-way contract signed by states, CMS and health plans that will provide comprehensive, integrated Medicare and Medicaid services and align administrative functions between the two programs. Under the managed fee-for-service model, states sign an agreement with CMS to manage an enhanced fee-for-service program that integrates primary, acute, behavioral health and LTSS for Medicare-Medicaid enrollees.

² D. Lipson, J. Libersky, R. Machta, L. Flowers, and W. Fox-Grage. *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports*. AARP Public Policy Institute, 2012. Available at: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicare-managed-ltss-AARP-ppi-health.pdf.

³ Comments from health plan representatives and presenters at a CHCS meeting *Integrated Care and Long-Term Services and Supports: Implementation and Beyond* held on March 7-8, 2013 in Washington, D.C. This meeting was convened by CHCS as part of targeted technical assistance it is providing to 12 of the 15 states participating in CMS' integrated care demonstration. Support for the technical assistance program is provided by The SCAN Foundation and The Commonwealth Fund.

⁴ Lipson op cit.

⁵ J. Libersky and J. Verdier. *Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees*. Integrated Care Resource Center, forthcoming.

⁶ J. Verdier. *Medicare Part D Prescription Drug Coverage for Medicare-Medicaid Enrollees in the Capitated Financial Alignment Demonstration*. Integrated Care Resource Center, March 2013.

⁷ Lipson op cit.

⁸ Massachusetts Readiness Review tool. Available at: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/readiness-review-tool.pdf>.

⁹ Thomas Betlach, Director, Arizona Health Care Cost Containment System. "Building upon the Success of Medicaid Managed Care for Dually-Eligible Beneficiaries: Testimony before the U.S. Special Committee on Aging," July 18, 2012. Available at: <http://www.aging.senate.gov/events/hr249tb.pdf>

¹⁰ *Integrated Care and Long-Term Services and Supports: Implementation and Beyond*. Center for Health Care Strategies meeting, March 7-8, 2013, Washington, D.C.

¹¹ "Memorandum of Understanding (MOU) between the Centers for Medicare & Medicaid Services (CMS) and the State of Washington." Available at:

<http://www.cms.gov/Medicare/Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf>.

¹² *Integrated Care and Long-Term Services and Supports: Implementation and Beyond*. Center for Health Care Strategies meeting, March 7-8, 2013, Washington, D.C..

¹³ R. Newcomer, C. Harrington, J. Stone, et al. *Medicaid and Medicare Spending on Acute, Post-Acute and Long-Term Services and Supports in California*. California Medical Research Institute, December 2012. Available at http://www.thescanfoundation.org/sites/thescanfoundation.org/files/camri_medicare_medicaid_spending-12-12-12.pdf.

¹⁴ J. Stone, R. Newcomer, A. Chattopadhyay, et al. *Studying Recipients of Long-Term Care Services and Supports: A Case Study in Assembling Medicaid and Medicare Claims and Assessment Data in California*. University of California – San Francisco, November 2011. Available at:

http://thescanfoundation.org/sites/thescanfoundation.org/files/CaMRI_Data_Case_Study_Report_3.pdf.

¹⁵ For more information, see the State Data Resource Center website available at: <http://www.statedataresourcecenter.com/>.

¹⁶ In addition, state staff with data-focused duties should be aware of other enrollment or eligibility system changes underway in the state to meet the needs of system changes post-January 1, 2014. Even if Medicare-Medicaid enrollees will not be included in the health insurance marketplaces, many of these changes could impact how states will assess all populations.

¹⁷ HPMS Guidance history, <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/HPMS-Guidance-History.html>

¹⁸ CMS requires health plans that participate in financial alignment models to qualify as Medicare Advantage plans, many of which are likely to be dual eligible Special Needs Plans (D-SNPs).

¹⁹ *Integrated Care and Long-Term Services and Supports: Implementation and Beyond*. Center for Health Care Strategies meeting, March 7-8, 2013, Washington, D.C..

²⁰ Resources from the Center for Health Care Strategies related to effective communication and stakeholder outreach strategies include: S. Barth and B. Ensslin. *A Communications Work Plan to Engage Stakeholders in Medicaid Managed Long-Term Services and Supports Program Development*. Center for Health Care Strategies. May 2013. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261511#UavvBNKG2Xo; A. Lind. *Communicating the Value of Integrated Care for Stakeholders*, November 2011. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261306; and Gore S and Lind A. *Engaging Consumer Stakeholders to Improve Systems of Care for Dual Eligibles*, December 2010. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261210

²¹ *Integrated Care and Long-Term Services and Supports: Implementation and Beyond*. Center for Health Care Strategies meeting, March 7-8, 2013, Washington, D.C..

²² South Carolina Dual Eligible Demonstration (SCDuE) website: <https://misp.scdhhs.gov/scdue/>

²³ Barth, op cit.

²⁴ Barth, op cit.

²⁵ Commonly used risk adjustment models are based on diagnostic data that do not reliably predict LTSS costs, and the predictive power of new models that use LTSS-related measures (e.g., frailty, functional status) has not been widely researched. A single risk adjustment model may not accurately predict LTSS costs across states and some states may need to develop their own models. See: MACPAC Report to the Congress on Medicaid and CHIP, March 2013. Available at <http://www.macpac.gov/reports>.

²⁶ Lipson op cit.

²⁷ http://www.ncqa.org/Portals/0/Programs/SNP/2012/2012_S&P_measures_Memo-Final_4-16-12.pdf

²⁸ A. Lind. *Quality Measurement in Integrated Care for Medicare-Medicaid Enrollees*. Center for Health Care Strategies, January 2013. Available at http://www.chcs.org/usr_doc/Quality_Measurement_in_Integrated_Care.pdf

²⁹ Ibid.