

Financial Alignment Models for Medicare-Medicaid Enrollees: Considerations for Reimbursement

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The more than nine million individuals enrolled in both the Medicare and Medicaid programs (also known as “Medicare-Medicaid enrollees” or “dual eligibles”) receive their care from two separate programs whose providers, benefits, and enrollment policies were not designed to work together. As a result, these individuals tend to receive fragmented, poorly coordinated, and unnecessarily high-cost care.

A number of states and the federal government have tried to improve the system of care for Medicare-Medicaid enrollees by integrating the primary and acute care, long-term services and supports (LTSS), and behavioral health services provided by Medicare and Medicaid into a single program with seamless coverage and access to all services. However, it has been difficult to develop an integrated model of care that can be replicated geographically or scaled to include larger numbers of beneficiaries primarily because of the challenges associated with aligning the financial incentives and reimbursement processes for these programs.

This financial misalignment stems from how the two programs are funded and administered. Medicare services are funded and administered solely by the federal government. In contrast, Medicaid services are funded jointly by the state and federal governments, but administered at the state level. For example, in 2011 an estimated \$319.5 billion was spent on Medicare-Medicaid enrollees’ care,¹ and, as in previous years, Medicare likely paid about half these costs (for most primary and acute care services) and Medicaid paid the other half (for most LTSS).² Historically, states have been reluctant to invest in initiatives that integrate care for Medicare-Medicaid enrollees because the potential savings would likely come from reduced primary and acute care costs, thus benefiting the federal budget, but not state budgets.

Today, states are encouraged by new opportunities for integrating care that were created by the Affordable Care Act (ACA). Most notably, the ACA established the

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Medicare and Medicaid were not originally designed to work together. Thus, the more than nine million individuals enrolled in both programs often receive care that is fragmented, poorly coordinated, and high-cost. Integrating their care is difficult because of the challenges associated with aligning the programs’ financial incentives and reimbursement processes.

New financial alignment models provide states with opportunities to better integrate the care of Medicare-Medicaid enrollees. This brief explores considerations for establishing reimbursement rates and performance incentives for these models. In addition, the brief describes ways that state variability may affect reimbursement methodologies.

Medicare-Medicaid Coordination Office, which is charged with making these two programs work together more effectively while improving care and lowering costs.³ The ACA also established the Center for Medicare and Medicaid Innovation to test care models that improve the delivery and quality of services for Medicare-Medicaid enrollees. The first initiative in this area, *State Demonstrations to Integrate Care for Dual Eligible Individuals*, was launched in April 2011. In a competitive process, 15 states were awarded \$1 million each to design person-centered approaches to better coordinate care for Medicare-Medicaid enrollees.⁴

This brief outlines two new financial alignment models that are available to states integrating care for Medicare-Medicaid enrollees. In addition, it describes possible options for states in setting rates and reimbursement strategies for these two new models.

Financial Alignment Models

The key to making integrated care financially viable for both the state and federal governments, and, subsequently, also for care providers, is to consider the services and funding streams of both programs in the aggregate, rather than as two separate programs. To that end, on July 8, 2011 the Centers for Medicare & Medicaid Services (CMS) announced two financial alignment models, open to all states, to integrate care: (1) a capitated model; and (2) a managed fee-for-service (FFS) model.⁵ Participants in the *State Demonstrations* can implement a model of their choosing, while the additional 22 states that submitted Letters of Intent (LOIs) must select either or both of the financial alignment models. CMS will authorize states to use approved models for up to three years and they will all undergo a rigorous evaluation.

Capitated Model

In the capitated model, the state, CMS, and a health plan (or other entity as agreed upon by CMS) most likely will enter a three-way contract where the plan will provide seamless and comprehensive coverage for integrated Medicare and Medicaid services in return for a combined prospective payment.⁶ The capitated model builds on lessons learned from the Program of All-Inclusive Care for the Elderly (PACE); fully-integrated special needs plans (SNPs); and prior Medicare-Medicaid demonstrations in Massachusetts, Minnesota, New York, and Wisconsin. While these programs have all made strides in integrated care, there has yet to be a scalable, replicable state model of fully-integrated care. The three-way contract is designed to address the fiscal and programmatic challenges in the current contracting models and better align incentives to encourage state and plan participation.

The capitated model will expand Medicare's enrollment, administrative, and benefit rules to create a unified set of rules for the integrated program. Examples of such elements include: enrollment rules, appeals, auditing and marketing rules and procedures. Although there is flexibility within these elements, it will be balanced by contract provisions to ensure that integrated care programs maintain the integrity of established Medicare and Medicaid beneficiary protections around elements such as enrollment, grievances, appeals, and quality.

CMS and the state will select plans through a joint selection process that ensures beneficiaries have access to an adequate network of providers supplying the full continuum of primary, acute, and behavioral health care,

as well as long-term services and supports. The programs will be jointly administered and monitored by CMS and the states.

The state and CMS will jointly develop an actuarially-sound rate that blends Medicare and Medicaid funds and provides a new savings opportunity for both the state and CMS. Plans will be paid on a capitated basis for all Medicare Parts A, B, and D and Medicaid services. Rates will be calculated per baseline spending in both programs and anticipated savings that will result from integrated managed care.⁷ The objective of the three-way contract under this option will be to create a three-way "win-win-win" for all parties and for the beneficiaries, who will receive much better care.

Managed Fee-for-Service Model

Managed FFS is a newly-defined model of care, so easily replicable examples do not yet exist. However, states looking to develop this model can adopt key elements from primary care case management (PCCM),⁸ health homes,⁹ administrative service organizations (ASOs),¹⁰ and related FFS-based care coordination models to impact Medicare expenditures. The managed FFS model will help states with enhanced FFS delivery systems, such as a robust PCCM program, to build on existing systems to integrate care. It also will help states currently redesigning primary care delivery systems through Medicaid health homes and accountable care organizations to integrate care through those models.

For the managed FFS model, it is expected that CMS is likely to establish a retrospective performance payment to states based on the amount of Medicare savings achieved for Medicare-Medicaid enrollees. States would integrate all services (primary, acute, behavioral health, and LTSS) within this model and implement an infrastructure for care coordination.¹¹ States would be eligible for a retrospective performance payment if they meet a target level of savings to Medicare. Further information from CMS on the performance payment calculation is expected in early 2012.

Considerations for Reimbursement Arrangements and Performance Incentives

The processes by which reimbursement arrangements will be made within the capitated model and performance incentives will be calculated in the managed FFS model are still evolving. However, below are some considerations

to help guide states as they begin to develop financing strategies for integrated care models.

Capitated Model: Integrated Rate Setting

As noted earlier, states developing integrated care programs using the capitated model will enter a three-way contract with CMS and contracted health plans. The three-way contract offers the advantage of a single combined benefit package and the ability to set an integrated rate—a single rate that includes funding for both Medicare and Medicaid services.¹² States are very interested in the ability to “share savings” that accrue from better health outcomes. Any “shared savings” that are attributable to the integrated care program are expected to be built into the rate. Establishing an integrated rate is a new frontier and a process that will undoubtedly evolve over time.

How will the rate-setting process work?

It is anticipated that CMS will work closely with each state to develop a single, blended capitation rate covering all services included in the program. This rate is likely to be built from the historic baseline experience in both the Medicare and Medicaid programs. Through this process, CMS and the State will be able to agree on what proportion each payer will contribute to the overall established rate. Reimbursement for Part D services, however, will likely undergo a separate process.

Although further details are forthcoming, it is expected that CMS will work with states to establish mutually agreed-upon assumptions around the financial impact of improved coordination and build state-specific parameters for demonstration rates. State specific parameters may include a mechanism for risk adjustment, rate cells, supplemental benefits, quality thresholds, and efficiency targets.

What factors could go into establishing payments for Medicare-covered services?

Rates will be developed based on baseline spending in both programs and anticipated savings that will result from integrated managed care.¹³ At this time, CMS has not formalized guidance regarding what factors will go into establishing the portion of the rate that would cover Medicare Part A and Part B services; however the existing Medicare Advantage/SNP and Program of All-Inclusive Care for the Elderly (PACE) processes provide examples of

paths that CMS may take or, at the least, options upon which CMS may base its integrated rate development.¹⁴

Medicare Advantage and Special Needs Plans

The Medicare Advantage (MA) rate-setting process has evolved over time and was further amended in the ACA. MA plans (of which SNPs are a subset) propose per-member, per-month (PMPM) rates to CMS for a given geographic region. CMS then compares these proposed rates to a projected benchmark rate for the region.¹⁵ Since setting the integrated rates will be a joint process and a number of states are planning to undergo a joint procurement process, CMS is not likely to ask interested plans to submit bids.

The MA rate-setting process also uses a “star rating” system, in which plans that achieve established quality metrics are awarded “stars” and subsequent bonuses based on accumulated stars. It is not expected that CMS will continue the star rating process in integrated care. To ensure quality in integrated plans, CMS may instead use a performance withholding process where 1, 2, or 3 percent of the PMPM would be withheld from plans, then earned back by a subset of them upon meeting quality targets.

While some parts of the MA rate-setting process will likely not be used when setting integrated rates, one component that may be used is the MA risk-adjustment process. Risk adjustment is used during the MA rate-setting process to adjust payments to health plans based on the expected differential health care costs of their enrollees. It is a systematic way of paying plans that enroll individuals with more acute or complex diagnoses at a higher rate than plans where the majority of their enrollees are healthier and, therefore, expected to be less costly. Risk adjustment helps to prevent adverse selection, in which a plan could attempt to recruit healthier individuals and avoid sicker ones in an effort to keep costs down. It also helps to promote access to health care for all individuals by appropriately reimbursing plans for sicker, more expensive, enrollees.

In 2004, CMS began using the hierarchical condition categories (CMS-HCC) model to adjust Medicare capitation payments for MA plans based on the health expenditure risk of their enrollees.¹⁶ The CMS-HCC model of risk adjustment for MA plans includes enrollees’ diagnoses from the previous year and combines these with demographic information (e.g., gender, age, and Medicaid status) to predict expected costs for each enrollee for the next year. It uses a statistical model that measures incremental predicted costs correlated with a person’s age,

gender, and hierarchical condition category. Predicted costs are highly correlated to the presence of chronic diseases.¹⁷

PACE

The majority of PACE enrollees are covered by both Medicare and Medicaid, and both programs make capitation payments directly to the PACE sites. On average, for PACE participants who are eligible for both Medicare and Medicaid, approximately one-third of the payment for each PACE enrollee comes from Medicare and two-thirds comes from Medicaid.¹⁸

Most PACE enrollees reside in the community (and only a relatively small number have end-stage renal disease (ESRD), a condition which places them into a special rate-setting category). Payments for PACE enrollees are adjusted for individuals' demographic and diagnostic characteristics and include an additional frailty adjuster that reflects the average level of functional impairment for each program's enrollees. Similar to the risk adjustment mechanism used for MA plans, CMS uses the CMS-HCC to adjust payments for enrollees' demographic characteristics and diagnoses. CMS also calculates an organizational-level frailty adjuster, the Health Outcomes Survey-Modified (HOS-M), which is based on PACE enrollees' responses to a survey. This is intended to account for costs related to the functional impairment of the population that is not explained by the CMS-HCC risk adjustment model.

Other PACE enrollees reside in long-term care facilities. Payments for these individuals are based on a separate set of demographic and diagnostic characteristics and do not incorporate an additional risk adjustment factor for frailty. Risk adjustment also greatly impacts how much CMS pays for individuals with ESRD. Payments for these beneficiaries vary depending on whether an enrollee is on dialysis, receiving a transplant or is post-transplant.¹⁹

What factors could go into establishing payments for Medicaid-covered services?

States will likely be responsible for initiating the portion of the rate that covers Medicaid-covered services. Most states have experience with rate setting for other populations; however, rate setting for Medicare-Medicaid enrollees and individuals receiving long-term services and supports will be a new challenge for most states.

Medicaid Managed Care Programs

Most states, especially those interested in pursuing a capitated integrated care model, have experience setting capitation rates for the managed care organizations (MCOs) that provide services for children, pregnant women, and, in a subset of states, seniors and persons with disability. States with Medicaid managed care programs are required by federal regulation to pay capitation rates to their contracted managed care plans that meet CMS actuarial soundness requirements.²⁰ States also have the option to establish additional requirements such as quality incentives, or establish rates that are risk adjusted. Plans may cover services beyond what is required in their contract; however, the cost of these services may not be included in the payment rate.²¹

A recent Kaiser Family Foundation survey of states found that three-quarters of states with capitated managed care use administrative rate setting with actuaries to establish MCO rates. Other states use a negotiation or competitive bid process, and some used a combination of these methods. Further, the survey found that most states adjust capitation rates for eligibility category and age, and about two-thirds of the states adjust rates based on beneficiary health status.²² Many states also have experience risk adjusting for Medicaid managed care programs. Thirteen out of the 22 states that adjust capitation rates for health status use the Chronic Illness and Disability Payment System (CDPS) system. CDPS is free and its diagnostic categorizations are publically available.²³ Half of the states also report having other risk-sharing arrangements with the MCOs such as risk corridors or stop-loss/reinsurance.²⁴

States and the federal government have experience with rate setting and risk adjustment for medical services; however, integrated care requires moving into what is new terrain for most states – the setting of capitation rates for long-term services and supports. A number of states such as Arizona, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, Washington, and Wisconsin have experience establishing reimbursement rates for capitated LTSS and there are a number of lessons to be learned from these states' programs.²⁵ For states without PACE programs or any experience with capitated long-term services and supports, establishing rates for these services and the populations accessing them is an unfamiliar process. Unlike primary and acute care, LTSS is not directly linked to a specific diagnosis. LTSS needs are related to functional status, which is measured in terms of an individual's ability to perform activities of daily living (ADLs).²⁶ ADLs, however, are less objective than diagnoses since they are influenced by an individual's

ability to perform a given activity during an evaluation compared to his or her ability to manage that activity on a daily basis. Functional assessments are also dependent on an individual's will or desire to perform the given activity at a point in time.²⁷ Functional status, however, may be an important consideration for states hoping to accurately predict the costs of Medicare-Medicaid enrollees—especially those receiving LTSS.

In addition to functional status, key issues that states must resolve when setting rates for managed LTSS include:²⁸

- Determining and updating the base rate for Nursing Home Certifiable (NHC) beneficiaries receiving services in the community;
- Adjusting the base rate depending on service need;
- Adjusting the rate for beneficiaries in nursing facilities;
- Adjusting the rate for beneficiaries who are not NHC; and
- Adjusting the rate for the Medicaid acute care portion of the rate.

There are a number of issues yet to be resolved when establishing rates for LTSS; however, integrated care offers an opportunity to advance this practice and better ensure that reimbursement for LTSS is both sufficient and designed to appropriately incentivize care in the enrollees' setting of choice.

PACE

Medicaid rate development for the PACE program also provides an example of how states may develop rates for Medicare-Medicaid enrollees. Thirty-five states currently have PACE programs and in these states, the Medicaid agency negotiates the Medicaid portion of the capitation payment with the PACE plan. No uniform method exists for setting the Medicaid capitation rate and states develop PACE rates to reflect what the state would spend on services for a comparable population. States have the flexibility to define what constitutes a comparable population and base the PACE capitation rate on an estimate of how much Medicaid would have paid for an enrollee in the traditional Medicaid program or in an alternative setting, typically a nursing facility or a home- and community-based services program. Most states, including California and Michigan, see PACE as an alternative to nursing facility care and use that as the comparable population on which to base the PACE rate. Other states use rate-based expenses for an individual enrolled in a home- and community-based program or a combination of these options.²⁹

Managed Fee-for-Service: Performance Incentives

To date, state interest in the capitated financial alignment model has outweighed interest in the managed FFS model. However, the managed FFS option provides states with existing enhanced primary care case management systems or those developing health homes for this population with the opportunity to create programs that would include Medicare services. This model also holds the promise of performance incentives for states that achieve quality improvements and savings targets (e.g., through reduced hospitalizations), thus enabling these states to recoup the upfront and ongoing investments made by their Medicaid programs. Further information from CMS on the quality and savings targets is expected in the upcoming months.

State Variability within the in Financial Alignment Models

The Medicare-Medicaid Coordination Office is working diligently to further define processes and protocols for reimbursement within the financial alignment models. It is anticipated that these processes and protocols will be flexible and provide room for individualization by states. State variability will likely exist in the areas of:

- **Risk Adjustment:** Some states will be in the position to use functional data to set rates at the individual level for Medicaid services, whereas other states will likely rely on rate cells and develop rates based on segmented populations.
- **Rate-Setting Assumptions:** During a joint rate-setting process for capitated plans, CMS and the states likely will need to agree upon the assumptions to be used (e.g., will there be an assumption that hospital stays will be shorter, and if so, by how much?). Rates will not be an accurate reflection of the cost of care unless these assumptions match.
- **Risk-Sharing Arrangements:** Some states traditionally offer MCOs protection against unpredicted loss through arrangements such as risk corridors; however, other states are not inclined to offer such protections. Risk sharing arrangements for integrated care could be especially important to community-based and non-profit plans that may not have deep financial reserves and face a challenge in taking on unmitigated risk.
- **Combined Data:** Some states may be in a position to set rates that are inclusive for both the Medicare and Medicaid services. These states may want to negotiate with CMS around the Medicare portion of the rates;

however, at this time, it is not known whether this will even be a possible option for states. Most states, however, will not have the Medicare data or the resources available to do this.

- **Projected Savings (Capitated)/ Performance Incentives (Managed FFS):** Developing calculations of projected savings and how these will be shared between CMS and the state will likely be a state-specific process.
- **Pay for Performance:** Some states have robust pay for performance arrangements with their health plans and provider communities. If the state has this type of arrangement with current providers and has found this type of arrangement to be successful and would like to continue it, this would likely need to be worked out on a state-specific basis with CMS.
- **Carved-Out Services:** Though integrated care is most effective when all services are included, some states will need to “carve out” or offer certain services through fee-for-service or other contracts instead of within the demonstration for various reasons. Rates will not need to include reimbursement for these services; however, if the state plans to include robust coordination with them, they will still need to be factored into savings calculations. States also need to be mindful of additional administrative expenses that they and their partners will incur in coordinating carved out services.
- **Supplemental Services:** Ideally, integrated programs will not only offer the service packages currently offered by Medicare and Medicaid, but will also offer supplemental services such as dental, vision, and hearing. However, some states already offer these

services to Medicare-Medicaid beneficiaries through their Medicaid state plan, whereas, other states do not. States and CMS will need to determine funding for these additional services on a state-by-state basis.

Conclusion

The new opportunities to improve the care and service delivery for Medicare-Medicaid beneficiaries are unprecedented and the ability for both the states and federal government to integrate financing for these individuals allows for previously unimagined opportunities for innovation. States and CMS have been working hard to incorporate the voices of stakeholders, especially beneficiaries and their caregivers, to make sure that their integrated programs truly embrace the aspiration of integrated care. However, no matter how much effort and good intention states and CMS put into these programs, if reimbursement rates are not adequate, then neither providers nor managed care organizations will be interested in participating. Or, even if they are interested at first, these programs will not be sustainable. Getting the rates right for integrated care is imperative. Proper rates ensure that neither the federal government nor the states are paying too much for services, but they also ensure that MCOs and providers are in the position to provide the right services, at the right time, to the right person.

Endnotes

- ¹ T. Coughlin, T. Waidmann, L. Phadera. *Financing Care for Dual-Eligibles: Challenges and Opportunities*. Kaiser Family Foundation, forthcoming.
- ² J.M. Verdier for the National Health Policy Forum, October 21, 2011. (MedPAC, June 2010). Based on linked Medicare and Medicaid claims data.
- ³ Section 2602 of the Affordable Care Act established the *Federal Coordinated Health Care Office*, which was subsequently renamed the *Medicare-Medicaid Coordination Office*.
- ⁴ Selected states include California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.
- ⁵ Centers for Medicare and Medicaid Services. Letter to State Medicaid Directors: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees. #11-008. July 8, 2011.
- ⁶ Centers for Medicare and Medicaid Services. Letter to State Medicaid Directors: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees. #11-008. July 8, 2011.
- ⁷ Centers for Medicare and Medicaid Services. "Comparison of Existing Managed Care Plan Requirements and Preferred Requirement Standards for Financial Alignment Demonstration Plans" (as of December 20, 2011).
- ⁸ PCCM is a form of managed care in which state Medicaid agencies contract directly with primary care providers who coordinate and authorize the care of Medicaid beneficiaries in return for a case management fee. For more information see: J. Rawlings-Sekunda, D. Curtis, and N. Kaye, "Emerging Practices in Medicaid Primary Care Case Management Programs," National Academy for State Health Policy on behalf of the U.S. Department of Health and Human Services, Office for the Assistant Secretary for Planning and Evaluation, June 2001. Available at www.aspe.hhs.gov/health/reports/PCCM/index.htm.
- ⁹ Health homes are a model of service delivery that facilitates access to and coordination of primary and acute care services, behavioral health care, and long-term services and supports. For more information on health homes within Medicaid see: Kaiser Family Foundation (January 2011). "Medicaid's New 'Health Home' Option." Publication #8136. Available at: kff.org.
- ¹⁰ ASOs provide administrative and structural support such as marketing, provider and member services, claims administration, utilization management, and care coordination among others. This is usually done through a non-capitated contractual arrangement with a state Medicaid program in which the ASO assumes no financial or medical risk. For more information see: National Health Law Program (March 2006). "Administrative Services Organization (ASO): An Alternative to Mandatory Enrollment of Individuals with Disabilities into Managed Care."
- ¹¹ Centers for Medicare and Medicaid Services. Letter to State Medicaid Directors: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees. #11-008. July 8, 2011.
- ¹² At this time it is expected that payments for Medicare Part D will be excluded from the reimbursement rate.
- ¹³ Centers for Medicare and Medicaid Services. "Comparison of Existing Managed Care Plan Requirements and Preferred Requirement Standards for Financial Alignment Demonstration Plans" (as of December 20, 2011).
- ¹⁴ CMS may choose to maintain the existing Medicare Part D rate-setting process. For more information on the Part D risk adjustment under the RxHCC model, go to <http://www.cms.hhs.gov/MedicareAdvgtgSpecRateStats/>.
- ¹⁵ Plans that submit bids above the benchmark must collect the difference in the form of premiums from beneficiaries. Plans that bid below the benchmark split the "savings" with CMS. The Medicare program retains 25 percent of the savings and the plan is required to use the remaining savings to pay additional enrollee costs or expand benefits.
- ¹⁶ G.C. Pope, J. Kautter, M. J. Ingber, S. Freeman, R. Sekar, and C. Newhart. "Evaluation of the CMS-HCC Risk Adjustment Model: Final Report." Prepared by RTI International for the Centers for Medicare & Medicaid Services. March 2011. Available at https://www.cms.gov/MedicareAdvgtgSpecRateStats/06_Risk_adjustment.asp.
- ¹⁷ For more information on Part A and B risk adjustment under the CMS-HCC model, and Part D risk adjustment under the RxHCC model, go to <http://www.cms.hhs.gov/MedicareAdvgtgSpecRateStats/>.
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- ²³ Gifford et al., op cit.
- ²⁴ Gifford et al., op cit.
- ²⁵ Information on select states' long-term services and supports rate-setting processes can be found at http://www.chcs.org/publications3960/publications_show.htm?doc_id=670910.
- ²⁶ The six ADLs are bathing, dressing, eating, transferring, using the toilet, and walking.
- ²⁷ T. Dreyfus and E. B. Davidson. "Risk Adjustment for the Dual Demonstration Program: Breaking New Ground in Massachusetts." Prepared by the BD Group for the Massachusetts Medicaid Policy Institute. Forthcoming.
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- ²⁹ Medicare Payment Advisory Commission (MedPAC) "Report to Congress: Selected Medicare Issues." Appendix B. Medicaid Payments to the Program of All-Inclusive Care for the Elderly. June 1999.

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.

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