

Medicare-Medicaid Financial Alignment Demonstrations – Standards & Conditions

January 2012

Background: On July 8, 2011, CMS released a State Medicaid Director (SMD) letter providing preliminary guidance on two new demonstration models to align financing between Medicare and Medicaid for States pursuing integration of primary, acute, behavioral health and long-term supports and services for their full benefit Medicare-Medicaid enrollees. Since that time, the Medicare-Medicaid Coordination Office (MMCO) has been further developing the operational details and processes necessary for the demonstrations, building on input from States, beneficiary advocates, and other stakeholders.

As indicated in the SMD letter, State demonstration proposals will be evaluated against standards and conditions that CMS will require of all States seeking to be considered for participation in the demonstration. A list of standards and conditions is attached. This list highlights the essential elements that CMS will look for in any State's demonstration proposal. As shown in the steps below, the standards and conditions are an important step – but not the final step – toward demonstration approval.

Summary of Financial Alignment Demonstration Process

1. State Letter of Intent: States interested in pursuing either of the two financial alignment models were required to submit Letters of Intent (LOIs) to CMS by October 1, 2011. Thirty-eight States and the District of Columbia sent LOIs.
2. CMS-State Dialogue: CMS has established lines of communication with all States that submitted LOIs. During the initial calls, CMS:
 - Solicited additional information from the State regarding potential models and implementation timelines; and
 - Walked the State through the proposal instructions and standards and conditions to make clear what CMS will be expecting each of the State models to address.
3. State Planning & Design Process: For those States that determine they would like to pursue a demonstration, the LOI and initial dialogue with CMS initiate a comprehensive planning and design process. States are required to work with stakeholders during the design process and during implementation (for those States that ultimately implement). For the 15 States that received design contracts, this planning process will be a continuation of work initiated through the State Demonstrations to Integrated Care for Dual Eligible Individuals.
4. Demonstration Proposal: The design process will culminate in a State demonstration proposal to CMS. Upon submission (following the 30-day public notice period), CMS will evaluate each proposal as to whether it has met or exceeded the CMS established standards and conditions before the State can enter into a formal Memorandum of Understanding (MOU) with CMS.
5. Memorandum of Understanding: Once a proposal has met the standards and conditions, CMS will work with States to develop a Memorandum of Understanding (MOU) based on the templates provided as part of the July 8, 2011 SMD letter.
6. Contract/Agreement: Following the MOU, States pursuing the capitated model would undergo a process with CMS to select qualified health plans that would result in a 3-way contract among CMS, the State, and plans. The last step for the Managed FFS model is the execution of a final Agreement between CMS and the State.

**Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid
Enrollees
Standards and Conditions
October 2011**

Integration of Benefits

Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services.

Care Model

Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.

Stakeholder Engagement

State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss proposed model with relevant stakeholders. Stakeholders include, but are not limited to, beneficiaries and their families, consumer organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model.

State has also established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis for the duration of the demonstration (i.e., implementation, monitoring and evaluation), including a process for informing beneficiaries (and their representatives) of the changes related to this initiative.

Beneficiary Protections

State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary's needs. At a minimum, States will be required to:

- Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model (e.g., participation on Participating Plan governing boards and/or establishment of beneficiary advisory boards).
- Develop, in conjunction with CMS, uniform/integrated enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech and vision limitations, and limited English proficiency.
- Ensure privacy of enrollee health records and provide for access by enrollees to such records.
- Ensure that all care meets the beneficiary's needs, allows for involvement of caregivers, and is in an appropriate setting, including in the home and community.

- Ensure access to all services in a manner that is sensitive to the beneficiary’s language and culture, including customer service representatives that are able to answer enrollee questions and respond to complaints/concerns appropriately.
- Ensure an adequate and appropriate provider network, as detailed below.
- Ensure that beneficiaries are meaningfully informed about their care options.
- Ensure access to grievance and appeals rights under Medicare and/or Medicaid.
 - *For Capitated Model*, this includes development of a unified set of requirements for Participating Plan complaints and internal appeals processes.
 - *For Managed FFS Model*, the State will ensure a mechanism is in place for assisting the participant in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable.

State Capacity

State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.

Network Adequacy

The demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.

Measurement/Reporting

State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model’s quality and cost outcomes for the target population. These metrics include, but are not limited to beneficiary experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote beneficiaries receiving high quality care and for purposes of the evaluation.

Data

State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:

- Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models;
- Description of any changes to the State plan that would affect Medicare-Medicaid enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.): and
- State supplemental payments to providers (e.g., DSH, UPL) during the three year period.

Enrollment

State has identified enrollment targets for proposed demonstration based on analysis of current target population and has strategies for conducting beneficiary education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.

Expected Savings

Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.

Public Notice

State has provided sufficient public notice, including:

- At least a 30 day public notice process and comment period,
- At least two public meetings prior to submission of a proposal, and
- Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or demonstration proposals.

Implementation

State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones by implementation:

- Continued meaningful stakeholder engagement
- Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments
- Receipt of any necessary State legislative or budget authority
- Joint procurement process (for capitated models only)
- Beneficiary outreach/notification of enrollment processes, etc.