

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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**Center for Medicaid, CHIP and Survey & Certification
Medicare-Medicaid Coordination Office**

SMDL# 11-008
ACA# 18

July 8, 2011

**Re: Financial Models to Support State
Efforts to Integrate Care for Medicare-
Medicaid Enrollees**

Dear State Medicaid Director:

This letter provides preliminary guidance on opportunities to align financing between Medicare and Medicaid to support improvements in the quality and cost of care for individuals enrolled in both programs (also referred to as “Medicare-Medicaid enrollees” or “dual eligibles”). Specifically, the Centers for Medicare & Medicaid Services (CMS) is outlining two models for States pursuing integration of primary, acute, behavioral health and long term services and supports for their full benefit Medicare-Medicaid enrollees.

Section 2602 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), together known as the Affordable Care Act, created the Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office”). The Medicare-Medicaid Coordination Office is charged with making the two programs work together more effectively to improve care and lower costs. Specifically, pursuant to section 2602(c) of the Affordable Care Act, the Office is focused on improving quality and access to care for Medicare-Medicaid enrollees; simplifying processes; and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs, States, and the Federal government.

In partnership with States, CMS is improving the quality of care Medicare-Medicaid enrollees receive by expanding access to seamless, integrated programs. The first initiative in this area, the State Demonstrations to Integrate Care for Dual Eligible Individuals, was launched in April 2011¹ through the Center for Medicare and Medicaid Innovation (“Innovation Center”). CMS is working with fifteen States, competitively selected based on their advanced readiness, to design person-centered approaches to better coordinate care for Medicare-Medicaid enrollees. The overall goal of this initiative

¹ CMS has subsequently launched two additional initiatives to support States’ efforts to improve the quality and costs of care for Medicare-Medicaid enrollees: the availability of Medicare Parts A, B, and D data to States for care coordination purposes and the Alignment Initiative. For more information on all of these initiatives, please see <http://www.cms.gov/medicare-medicaid-coordination>.

is to develop, test and validate fully integrated delivery system and care coordination models that can be replicated in other States. Early work with these States confirms that a key component of such initiatives will be testing new payment and financing models to promote better care and align the incentives for improving care and lowering costs between Medicare and Medicaid.

This letter provides guidance on two financial alignment models that CMS seeks to test with States. Through the Innovation Center, CMS is interested in testing these models across the country in programs that collectively serve up to 1-2 million Medicare-Medicaid enrollees. The models are open to the fifteen States participating in the above mentioned State Demonstrations to Integrate Care for Dual Eligible Individuals as well as any other State that demonstrates it can meet the established standards and conditions and would be ready to implement its proposed demonstration by the end of 2012. Under these models, CMS will work with interested States to combine Medicare and Medicaid authorities to test a new payment and service delivery model to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees in this capitated program. Demonstrations under this program would be limited to no more than three years. All demonstrations will include a rigorous evaluation, the results of which will help inform the potential for future program changes.

CMS is offering streamlined approaches for States interested in testing these two models and technical assistance to support necessary planning activities.

The first model is a capitated approach to integration for Medicare-Medicaid enrollees; the second is a managed fee-for-service (FFS) approach to integration. Under the capitated model, CMS, the State, and health plans² would enter into a three-way contract; the participating plans would receive a prospective blended payment to provide comprehensive seamless, coverage. This model will target aggregate savings through actuarially developed blended rates that will provide a new savings opportunity for both States and the Federal government. Under the managed FFS model, CMS and a State will enter into agreement whereby the State would be eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicaid and Medicare. These models provide States with two new pathways to support integration for Medicare-Medicaid enrollees and provide opportunities to achieve savings as a result of improvements in care delivery. States meeting the necessary criteria will have an option to pursue either or both of these financial alignment models.

This letter provides initial information on aspects of these two models. It is intended to provide sufficient detail to allow States to determine their interest in testing these models and to begin necessary planning activities. Interested States should submit a Letter of Intent, as described below, to initiate the process.

² Eligible health plans include entities currently offering Medicare Advantage or Medicaid managed care and could include other eligible entities assuming they can meet all applicable standards, as agreed upon in writing by CMS and the State.

While this guidance focuses on the new financial alignment model demonstration opportunities, The Medicare-Medicaid Coordination Office is available to provide technical assistance and access to a Resource Center for all States in support of efforts to improve the quality and cost effectiveness of care for Medicare-Medicaid enrollees.

General Information

Throughout this guidance, there will be references to an “integrated program,” which refers to one that encompasses all the medical, behavioral health, and long-term services and supports needed by an individual eligible for both Medicare and Medicaid. CMS is pursuing integrated programs because a comprehensive approach will ensure that the individual has a seamless care experience and that one entity is accountable for the full continuum of care for the Medicare-Medicaid enrollee.

Implementation of these models will rely on effective partnerships with States and success will largely be contingent upon engagement with and the capacity of health care and service providers that support and care for Medicare-Medicaid enrollees in their communities. Medicare-Medicaid enrollees, their families and consumer organizations working with them also have a central role to play in helping to design a person-centered system of care. Therefore, CMS encourages and expects active and meaningful State engagement with stakeholders in both models.

Background

There are over 9 million Medicare-Medicaid enrollees, more than two-thirds of whom receive full benefits from both programs.³ While Medicare-Medicaid enrollees comprise only 16 percent of Medicare and 15 percent of Medicaid enrollees, they account for 27 percent and 39 percent of total Medicare and Medicaid spending respectively.⁴ The majority of these beneficiaries receive their care in uncoordinated systems, which may result in poor quality, or costly care. A priority for CMS and the Department is to significantly increase the number of Medicare-Medicaid enrollees in seamless coordinated care systems that will improve beneficiary experiences and quality outcomes, while also achieving savings for both States and the Federal government.

A longstanding barrier to integration for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. Reforms to improve quality and reduce costs require an investment in the delivery system and care management. Because delivery of services for Medicare-Medicaid enrollees is split between Medicare and Medicaid, States may lack incentives to invest in such initiatives. As a result, these

³ Based on the Centers for Medicare & Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office for Research, Development and Information, July 2010.

⁴ The Medicare Payment Advisory Committee, A Data Book: Healthcare spending and the Medicare program, June 2010 and Kaiser Family Foundation, The Role of Medicare for the People Dually Eligible for Medicare and Medicaid. January 2011.

beneficiaries, arguably those who could benefit the most from an investment in care coordination, are generally excluded from such State programs.

To address this challenge, CMS is announcing two models that will provide opportunities to improve quality and the beneficiary experience while also reducing costs for both States and the Federal government. They are part of a broader agenda for the Medicare-Medicaid Coordination Office, CMS, and the Administration to improve the care, quality, cost, and, ultimately, health for this population.

Capitated Model

One approach to integration is to leverage the significant experience of States in utilizing capitated models to provide care for the Medicaid population. Currently, the most integrated systems for Medicare-Medicaid enrollees are funded through capitated arrangements, which have supported efforts to create flexible, person-centered systems of care. The Program of All Inclusive Care for the Elderly (PACE), Fully Integrated Dual Eligible Medicare Advantage Special Needs Plans, managed long-term care programs in Medicaid, and prior Medicare-Medicaid demonstrations provide important lessons. The capitated model described in this guidance builds on those experiences and is designed to address some of the remaining programmatic and fiscal challenges in current contracting models, and to ensure incentives are aligned to encourage States and plans to participate. Under this model, CMS will test a new capitated payment model utilizing a three-way contract among a State, CMS and health plans to provide integrated benefits to Medicare-Medicaid enrollees.

Plans will receive a blended capitated rate for the full continuum of benefits provided to Medicare-Medicaid enrollees across both programs. The capitated model will target aggregate savings through actuarially developed blended rates that will provide savings for both States and the Federal government. Plans will be required to meet established quality thresholds.

The three-way contract among CMS, the State, and health plans will also test administrative, benefit and enrollment flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees utilizing a simplified and unified set of rules. Such flexibilities will vary by State and may include, but are not limited to: supplemental benefits; enrollment flexibilities; and a single set of appeals, auditing and marketing rules and procedures. Any flexibility will be coupled with specific beneficiary protections that will be included in the contract among the parties.

Plans will be selected through a competitive, joint procurement by States and CMS. CMS and the State will contract with selected high-performing health plans that demonstrate the capacity to provide to enrollees, directly or by subcontracting with other qualified entities, the continuum of Medicare and Medicaid covered services. CMS and the State will ensure that beneficiaries have access to an adequate network of medical and supportive service providers.

Managed FFS Model

Another approach to integration is to design programs built on the existing FFS delivery system. Many States have invested significant resources to organize their delivery system to provide coordinated care for Medicaid beneficiaries through a FFS model. In addition, new CMS programs focused on redesigning the primary care delivery system (e.g., Accountable Care Organizations, Medicaid health homes) offer opportunities for States to improve coordination of care within a managed FFS delivery model. Under this model, CMS will test the impact of establishing a retrospective performance payment to States based on Medicare savings achieved for Medicare-Medicaid enrollees. The State program will ensure seamless integration and access to all necessary services based on the individual's needs through coordination across the two programs. States would make the upfront investment in care coordination and would be eligible for a retrospective performance payment should a target level of savings result to Medicare. Savings determinations will be based on rigorous evaluation of Medicare and Medicaid spending in each State and must be certified by CMS Office of the Actuary (OACT).

States will be eligible for retrospective performance payments based on Medicare savings net of increased Federal Medicaid costs. Performance payments will only be made to States that meet or exceed established quality thresholds for the Medicare-Medicaid enrollees in the program.

Streamlined Process

States that are interested in pursuing these models are asked to submit a Letter of Intent to CMS to begin the planning process by October 1, 2011.

After notifying CMS of its interest to participate, a State will have to demonstrate that it has met or exceeded certain CMS established standards and conditions to begin the formal process of entering into a Memorandum of Understanding (MOU) between the State and CMS. The standards and conditions, which will be provided through supplemental guidance for interested States, will ensure consistency across State initiatives, promote sound management, and ensure beneficiary protections. They may differ slightly between the two models; however, each will include:

- Public notice and meaningful consumer and other stakeholder engagement;
- Enrollment targets and related outreach initiatives;
- Integrated care management across primary, acute, behavioral health and long-term services and supports;
- OACT certifiable estimates of expected savings;
- Integrated beneficiary level claims data to inform program management and evaluation;
- Adequate access to networks of medical and supportive services providers;
- Monitoring and oversight infrastructure;
- Quality measurement infrastructure; and

- Target implementation date by end of 2012.

CMS will work with interested States to determine whether they meet established standards and conditions.

Upon meeting the standards and conditions, CMS and the State will enter into a Memorandum of Understanding (MOU) that will outline the parameters of the initiative.

Enclosed for informational purposes with this letter are draft MOU templates that list, in broad categories, the terms and conditions of the demonstration, including: Statement of Initiative, Program Authority, Contracting Process, Readiness Review, Enrollment, Beneficiary Protections, Administration and Reporting, Quality Management, Financing and Payment, Evaluation, and Oversight Responsibilities. The MOU templates are provided to illustrate roles and responsibilities that CMS and States will undertake as they plan for implementation of these models. CMS is continuing to review the templates, and modifications may be made prior to execution. Additionally, final commitments will be established either: 1) in a three-way contract among CMS, the State, and a health plan under the capitated model; or 2) in a final agreement between CMS and the State under the managed FFS model. The steps in the process for States are listed below. Steps 4-6 apply only to the capitated model.

- 1) Letter of Intent;
- 2) Work with CMS to meet established standards and conditions;
- 3) Sign Memorandum of Understanding with CMS;
- 4) State procurement documents released;
- 5) CMS and the State select qualified plans;
- 6) CMS and the State conduct readiness reviews of each selected plan;
- 7) Three-way contracts signed (capitated model); Final agreement signed (FFS);
and
- 8) Implementation, monitoring, and evaluation.

Quality Measurement and Evaluation

All State programs will be evaluated as to their ability to improve quality and reduce costs. To facilitate evaluation, CMS is requiring States to collect and report all necessary information for the overall evaluation. Participating States will be required to collect and provide individual-level quality, cost, enrollment and utilization data for the purposes of comparing the effects of these models across sub-groups of Medicare-Medicaid enrollees, including those that participate in the integrated model being tested and those that do not. CMS will provide standardized methodologies for tracking key utilization, quality and cost measures.

Additionally participating health plans in the capitated model will be required to provide encounter data in a common format that will facilitate evaluation and an improved understanding of the beneficiary experience in the plan. Participating plans will also be

required to report on certain established quality indicators to allow an evaluation of the impact on quality of care for enrollees.

States and relevant entities will be required to cooperate with CMS or its designated agent conducting the evaluation. This evaluation, and the data gathered for it, will also provide States with information that can help inform continued improvement of a State's integrated program. CMS will provide subsequent guidance on the data requirements and evaluation design.

Support for State Planning Activities

The Medicare-Medicaid Coordination Office, working in collaboration with the Innovation Center, the Center for Medicaid, CHIP & Survey and Certification, and the Center for Medicare, is available to assist States interested in pursuing the two models outlined in this letter. In addition, CMS is in the process of establishing a technical assistance (TA) Resource Center. Interested States will be able to access the TA Resource Center to work through the process of developing a State initiative and meeting the necessary standards and conditions.

Interested States should submit a Letter of Intent via email to Melanie Bella, Director, Medicare-Medicaid Coordination Office, at Melanie.Bella@cms.hhs.gov.

The financial alignment models outlined in this letter are tools to be used as part of an array of integration initiatives to improve the access, quality and costs of care for Medicare-Medicaid enrollees. As we move forward, we remain committed to ensuring that these individuals are able to receive the best care from both programs while maintaining our longstanding commitment to effectively manage Federal resources.

We look forward to working with States, individually and collectively, as part of our ongoing partnership to develop and test initiatives that improve quality and reduce cost for high cost populations, particularly those eligible for both Medicare and Medicaid. If you have questions about this demonstration initiative, please contact Tim Engelhardt, Director of the Models and Demonstrations Group in the Medicare-Medicaid Coordination Office at Tim.Engelhardt@cms.hhs.gov. Questions or comments may also be submitted to the Medicare-Medicaid Coordination mailbox, at MedicareMedicaidCoordination@cms.hhs.gov.

Sincerely,

/s/

Cindy Mann
Director, Center for Medicaid,
CHIP and Survey & Certification

Melanie Bella
Director, Medicare-Medicaid
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Attachments

Page 8 - State Medicaid Director

cc:

CMS Regional Administrators

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ATTACHMENT: Draft Template MOU for Capitated Model

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS) Innovation Center

And

[Name of State]

**Regarding A Federal-State Partnership to Test a Capitated Financial Alignment
Model for Medicare-Medicaid Enrollees**

[Insert Name of Initiative]

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I. STATEMENT OF INITIATIVE

To establish a Federal-State partnership between the Centers for Medicare & Medicaid Services (CMS) and the [Name of State] to implement the [Name of Initiative] to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid enrollees” or “dual eligibles”). The Federal-State partnership will include a three-way contract with Participating Plans that will provide integrated benefits to Medicare-Medicaid enrollees in the geographic area(s). The initiative is intended to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid enrollees, enhance quality of care and reduce costs for both the State and the Federal government.

Individuals who are eligible for Medicare and full Medicaid benefits will be eligible for enrollment in this initiative. State specific eligibility for the initiative is provided in Appendix 3.

Under this initiative, Participating Plans will be required to provide, either directly or through subcontracts, all medically necessary Medicare and Medicaid-covered services under a capitated model of financing. CMS, the State, and the Participating Plans will ensure that beneficiaries have access to an adequate network of medical and supportive services.

CMS and the State shall jointly select and monitor the Participating Plans. Implementation of this initiative will require that CMS approve Participating Plan contracts under demonstration authority for Medicare and demonstration or State Plan authority for Medicaid as described in section 3A and detailed in Appendices 4 and 5.

Key objectives of the initiative are to improve beneficiary experience in accessing care, improve quality, eliminate cost shifting between the two programs and achieve cost savings for States and CMS. The initiative will test the effect of an integrated payment and care model on serving both community and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, financial solvency and network standards. Contract management will focus on performance measurement and continuous quality improvement. Participating Plans will be required to comply with all applicable existing Medicare and Medicaid rules and regulations as well as program specific and evaluation requirements, as will be further specified in a contract to be implemented among the Participating Plans, State and CMS.

As part of this initiative, CMS and the State will test new Medicare and Medicaid payment methodologies designed to support Participating Plans in serving the full range of Medicare-Medicaid enrollees. Such financing approaches will minimize cost-shifting and align incentives between Medicare and Medicaid, and support the best possible health outcomes for enrollees.

CMS and the State will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees, utilizing a simplified and unified set of rules. Such flexibilities may include, but are not limited to,

supplemental benefits, enrollment flexibilities, and a single set of appeals, auditing and marketing rules and procedures. Flexibilities will be coupled with specific beneficiary safeguards and will be included in the contract among the parties.

Preceding the signing of this MOU, the State has undergone necessary planning activities consistent with the CMS checklist of standards and conditions for participation as detailed through supporting documentation provided in Appendix 2. Demonstrations under this initiative would be no longer than three years.

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document details the agreement between CMS and the State regarding the principles under which the initiative will be implemented and operated. (See Appendix 1 for definitions of terms used in this Memorandum of Understanding [MOU].) It also outlines the activities which CMS and the State agree to conduct in preparation for planned implementation of the initiative.

Following the signing of this MOU, CMS and the State will finalize a Participating Plans Procurement Document and will develop an operating manual, which will specify the administrative activities CMS and the State will conduct in support of the initiative. As agreed upon, the operation manual will be appended to the signed MOUs and Plan contracts and are subject to periodic updating. CMS and the State will undergo a joint procurement for Participating Plans and will ultimately enter into a three-way contract with selected plans, as specified below.

III. PROGRAM DESIGN / OPERATIONAL PLAN

A. PROGRAM AUTHORITY

- 1. Medicaid Authority:** The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation except to the extent that variances from these requirements are provided for in Appendix 5. As a term and condition of the initiative, Participating Plans will be required to comply with Medicaid managed care requirements under 42 C.F.R. 438 et. seq., except to the extent that variances from these requirements are provided for in Appendix 4.
- 2. Medicare Authority:** The Medicare portions of the initiative shall operate according to existing Medicare law and regulation, except to the extent that variances from these requirements are provided for in Appendix 5. As a term and condition of the initiative, Participating Plans will be required to comply with Medicare Advantage requirements in Part C and Part D of Title XVIII, and 42 C.F.R. Part 422 and 423, except to the extent that variances from these requirements are provided for in Appendix 4.

B. CONTRACTING PROCESS

1. **Participating Plan Procurement Document:** CMS and the State shall issue a Procurement Document that will include one set of comprehensive purchasing specifications that reflect the integration of Medicare and Medicaid and which incorporates the model application as summarized in the MOU and appendices. All applicable Medicare Advantage requirements and Medicaid managed care requirements shall be incorporated into the Procurement Document.
2. **Participating Plan Selection:** CMS and the State shall contract with qualified Participating Plans on a selective basis. CMS and the State will initiate a joint procurement and select eligible plans through a Participating Plan Selection Committee, comprised of designated representatives from CMS and the State.
3. **Medicare Waiver Approval:** Based on recommendations from the Participating Plan Selection Committee, CMS will prepare a memo seeking formal Administrator approval of Medicare waivers and variances.
4. **Medicaid Waiver and/or Medicaid State Plan Approval:** Based on recommendations from the Participating Plan Selection Committee, CMS will prepare a memo seeking formal Administrator approval of Medicaid waivers and variances.

If the State does not currently have Medicaid managed care authority for Medicaid-Medicare enrollees available under a Medicaid waiver or through the Medicaid State plan, the State will be required to secure such authority or obtain 1915(a) contract authority for the Participating Plans.

5. **Readiness Review:** CMS and the State shall conduct a readiness review of each selected Participating Plan. Prior to the Participating Plan Contract execution, both CMS and the State must agree that a Participating Plan has satisfied all readiness requirements. CMS and the State will collaborate in the design and implementation of the readiness review process and requirements. This readiness review shall include an evaluation of the capacity of each potential Participating Plan and its ability to meet all program requirements.
6. **Participating Plan Contract:** CMS and the State shall develop a single Participating Plan Contract and contract negotiation process that both parties agree is administratively effective and ensures coordinated and comprehensive enforcement and oversight of the Participating Plan Contracts consistent with the desired goal for of administrative efficiencies.

C. ENROLLMENT

1. **Eligible Populations:** Persons in the State who are eligible for Medicare and full Medicaid benefits will be eligible for enrollment in this initiative. Beneficiaries participating in Medicare Advantage, Medicaid managed care and Program of All-inclusive Care for the Elderly (PACE) may participate in this initiative if they disenroll from their existing programs. CMS will work with the State to address participation in other programs or initiatives. State specific eligibility is provided in Appendix 3.

2. **Enrollment and Disenrollment Processes:** CMS and the State agree that enrollment into a Participating Plan may be conducted using a single, seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the Participating Plan at any time. Disenrollment from Participating Plans and transfers from one Participating Plan to another shall be allowed on a month-to-month basis any time in the year throughout the entire duration of the initiative. As mutually agreed upon, CMS and the State may choose to allow for the facilitation of this enrollment utilizing an independent third party entity. Participating Plan enrollments and disenrollments shall become effective on the same day for both Medicare and Medicaid.
3. **Uniform Enrollment/Disenrollment Documents:** CMS and the State shall develop and require the use of single enrollment and disenrollment documentation.
4. **Monitoring, Outreach, and Education:** CMS and the State agree that all outreach and education materials and activities shall require approval by CMS and the State prior to dissemination, and shall be subject to a single set of rules.

D. DELIVERY SYSTEMS AND BENEFITS

1. **Participating Plan Service Capacity:** CMS and the State shall contract with Participating Plans that demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to enrollees, in accordance with the Participating Plan contract. Medicare covered benefits shall be in accordance with 42 C.F.R. 422.101. Medicaid covered benefits shall be in accordance with the requirements in the approved Medicaid State plan. In accordance with the Participating Plan contract, CMS and the State may choose to allow for greater flexibility in offering supplemental benefits that exceed those currently covered by either Medicare or Medicaid to the extent that they are provided under the blended Medicare and Medicaid payment rate specified below. CMS and the State shall establish a process for Participating Plans to notify CMS and the State of all changes to its Provider Network and to provide a contingency plan for assuring continued access to care for enrollees in the case of a Participating Plan provider contract termination and/or insolvency of provider within a Participating Plan Provider Network. CMS, the State and Participating Plans will ensure that beneficiaries have access to an adequate network of medical and supportive service providers that are appropriate and competent for the needs of this population.
2. **Participating Plan Risk Arrangements:** CMS and the State shall require each Participating Plan, as part of the application process, to provide a detailed description of its risk arrangements with all providers under subcontract with the Participating Plan. It will not be acceptable for any incentive arrangements to include any payment or other inducement to withhold, limit or reduce medically necessary services to enrollees.
4. **Participating Plan Financial Solvency Arrangements:** CMS and the State shall establish a standard for all Participating Plans to demonstrate financial solvency that

could include one of the following: 1) the solvency requirements for Medicare Advantage plans at 42 CFR 422.400; or 2) the solvency requirements for Medicaid managed care organizations at 42 USC 1396b(m)(1); or 3) the solvency requirements for PACE providers at 42 CFR 460.80; or 4) or other solvency standard as agreed upon in writing by CMS and the State.

E. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

- 1. Beneficiary Participation on Governing and Advisory Boards:** CMS and the State shall require Participating Plans to establish meaningful beneficiary input processes that may include beneficiary participation on Participating Plan governing boards and/ or establishment of Participating Plan beneficiary advisory boards.
- 2. Enrollee Communications:** CMS and the State agree that all Enrollee materials, in all forms, shall require approval by CMS and the State prior to use. Such materials shall be integrated to the extent possible and include, but not be limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations. Such uniform/ integrated materials will be required to be accessible and understandable to the beneficiaries that will be enrolled in the plan. This includes individuals with disabilities and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid.
- 3. Participating Plan Customer Service Representatives:** CMS and the State shall require Participating Plans to employ customer service representatives who shall answer Enrollee inquiries and respond to Enrollee complaints and concerns.
- 4. Privacy:** CMS and the State shall require all Participating Plans to ensure privacy of enrollee health records, and provide for access by enrollees to such records as specified in the contract.
- 5. Appropriate Care:** CMS, the State, and Participating Plans shall ensure that all care meets the beneficiary's needs, and is provided in a manner that is sensitive to the beneficiary's language and culture, allows for involvement of caregivers, and in an appropriate care setting, including in the home and the community. CMS, the State, and Participating Plans shall ensure that care is person-centered and can accommodate and encourage consumer-direction.

F. INTEGRATED APPEALS

- 1. Participating Plan Complaints and Internal Appeals Processes:** CMS and the State agree to develop a unified set of requirements for Participating Plan complaints and internal appeals processes that incorporate relevant Medicare Advantage, Medicare Part D and Medicaid managed care requirements, which will be specified in the Participating Plan Contract. All Participating Plan Complaints and Internal Appeals processes shall be

subject to the review and prior approval of CMS and the State.

- 2. External Appeals Processes:** CMS and the State agree to utilize a single Appeals process that will be developed utilizing both Medicare and Medicaid requirements. Protocols will be developed to assure coordinated access to the appeals mechanism.

G. ADMINISTRATION AND REPORTING

- 1. Participating Plan Contract Management:** CMS and the State agree to designate representatives to serve on a CMS-State Contract Management team which shall conduct periodic Participating Plan contract management activities related to ensuring access, quality, program integrity, and financial solvency.

These activities shall include but not be limited to:

- Reviewing and analyzing Health Plan Employer Data and Information Set (HEDIS) data, Consumer Assessment of Health Plan Satisfaction (CAHPS) data, Health Outcomes Survey data, enrollment and disenrollment reports, and reports of Enrollee Complaints, reviewing compliance with applicable CMS and/or State Medicaid Agency standards, and initiating programmatic changes and/or changes in clinical protocols, as appropriate.
 - Reviewing and analyzing reports on Participating Plans' fiscal operations and financial solvency, conducting program integrity studies to monitor fraud, waste and abuse as may be agreed upon by CMS and the State, and ensuring that Participating Plans take corrective action, as appropriate.
 - Reviewing and analyzing reports on Participating Plans' network adequacy, including the plans' ongoing efforts to replenish its network.
 - Reviewing any other applicable ratings and measures.
- 2. Day-to-Day Participating Plan Monitoring:** CMS and the State will establish procedures for Participating Plan monitoring that will include responsibilities for day-to-day monitoring. CMS or its contractors may directly communicate with Participating Plans as necessary.
 - 3. Consolidated Reporting Requirements:** CMS and the State shall define and specify in the Participating Plan Contract a Consolidated Reporting Process for Participating Plans that ensures the provision of the necessary data on diagnosis, HEDIS measures, Enrollee satisfaction and evidence-based measures and other information as may be beneficial in order to monitor each Participating Plan's performance. Participating Plans will be required to meet the encounter reporting requirements that are established for the Initiative.

- 4. Accept and Process Assessment Data:** CMS, or its designated agent conducting the evaluation, and the State shall accept and process uniform person-level Enrollee Data, as may be necessary for the purposes of program eligibility, payment, or for evaluation purposes. Sources may be based upon an initial and ongoing assessment process which includes ICD-9 (and ICD-10, as appropriate) diagnoses codes, Health Outcomes Survey for enrollees who are able to self-report, Functional Status elements of the Minimum Data Set (MDS), and/or any other data elements deemed necessary by CMS and the State.

H. QUALITY MANAGEMENT

- 1. Quality Management and Monitoring:** As an Innovation Center demonstration, there will be a rigorous evaluation, which will include quality measures designed to ensure beneficiaries are receiving high quality care. In addition, CMS and the State shall jointly conduct a single comprehensive quality management process in accordance with Medicare Advantage and Medicaid managed care requirements. The reporting frequency and monitoring process will be specified in the Participating Plan Contract.
- 2. External Quality Reviews:** CMS and the State shall coordinate the Participating Plan external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).
- 3. Determination of Applicable Quality Standards:** CMS and the State shall determine applicable quality standards and monitor the Participating Plan's compliance with those standards.

I. FINANCING AND PAYMENT

Blended Medicare and Medicaid Payment: Participating Plans will receive a capitated payment from CMS (for the Medicare portion of services) and the State (for the Medicaid portion of services) as detailed in Appendix 6, the combination of which will make up the full amount paid to the plan for the blended Medicare and Medicaid payment for Medicare-Medicaid enrollees in the geographic area. As agreed upon, CMS and the State shall develop blended Medicare and Medicaid health plan rates that will allow both the State and the Federal government to achieve savings as compared against the lower of expected FFS or managed care spending for Medicare and Medicaid, respectively, for each service area.

J. EVALUATION

- 1. Evaluation Data to be Collected:** CMS and the State shall develop processes and protocols for collecting or ensuring the Participating Plans contractors collect and report to CMS and the State the data needed for the evaluation.

2. Evaluation Contract: CMS or its designated agent will conduct an evaluation to measure the impact of Participating Plans and the effectiveness of the process to enroll beneficiaries into Participating Plans. CMS and the State will collaborate on and coordinate during any evaluation activity.

K. MODIFICATION OR TERMINATION OF AGREEMENT

Either CMS or the State may seek to modify or amend the MOU on a periodic basis per a written request. CMS or the State may elect not to continue the demonstration at any time provided that a minimum of 90 days advance notice is provided to either CMS or the State, 90 day advance notice is given to Participating Plan contractors, and 60 days advance notice is given to enrollees and the general public.

L. SIGNATURES

This MOU is effective on this day forward [insert date] through the end of the demonstration period [insert date].

In Witness Whereof, CMS and [Name of State] have caused this Agreement to be executed by their respective authorized officers:

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

(Authorized Signatory)

(Date)

(Title)

[Name of State], [Name of State Agency]:

(Authorized Signatory)

(Date)

(Title)

[PLACEHOLDER FOR APPENDICES to be provided through planning activities with the State.]

- Appendix 1: Definitions
- Appendix 2: CMS Standards and Conditions Checklist and Supporting State Documentation
- Appendix 3: Details of State Demonstration Area
- Appendix 4: Medicare Authorities and Variances
- Appendix 5: Medicaid Authorities and Variances
- Appendix 6: Payments to Participating Plans
- Appendix 7: Operation Manual

ATTACHMENT : Draft MOU Template for Managed FFS Model

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS) Innovation Center

And

[Name of State]

**Regarding A Federal-State Partnership to Test a Managed Fee-for-Service
Financial Alignment Model for Medicare-Medicaid Enrollees**

[Insert Name of Initiative]

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I. STATEMENT OF INITIATIVE

To establish a Federal-State partnership between the Centers for Medicare & Medicaid Services (CMS) and the [Name of State] to implement the [Name of Initiative] to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid enrollees” or “dual eligibles”). The partnership will provide the State with a new opportunity to establish care management programs for Medicare-Medicaid enrollees that will coordinate services across the two programs to better align benefits, delivery, care coordination, financing and administration. The initiative is intended to alleviate fragmentation and improve coordination of services for Medicare-Medicaid enrollees, enhance quality of care and reduce costs for the State and the Federal government.

Individuals who are eligible for Medicare and full Medicaid benefits in the State will be eligible for enrollment in this initiative. State specific eligibility for the initiative is provided in Appendix 3.

Under this initiative, the State will take accountability for ensuring the effective coordination of all medically necessary Medicare and Medicaid-covered services. In return, the State will be eligible for a retrospective performance payment based on Medicare savings net of increased Federal Medicaid costs. CMS and the State will ensure that beneficiaries have access to interdisciplinary teams of providers to assure the provision of medical and supportive services in a coordinated and clinically effective manner.

The initiative will test new care delivery, payment and financing models to promote better care and align the incentives for improving care and lowering costs between Medicare and Medicaid. Program oversight will focus on performance measurement and continuous quality improvement. States will be expected to comply with all applicable existing Medicaid rules and regulations as well as to assure access to all Medicare covered services. States must also comply with all terms and conditions specific to this initiative and evaluation requirements.

CMS will allow for certain benefit and eligibility flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees. Such flexibilities may include, but are not limited to, benefit and coverage flexibilities to better align Medicare and Medicaid for such enrollees, care management across programs, and eligibility flexibilities to allow States to target Medicare-Medicaid enrollees in a specific geographic area. Flexibilities will be coupled with specific beneficiary safeguards and will be included in a final agreement.

Demonstrations under this initiative would be no longer than three years.

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document details the general principles under which CMS and the State will implement and operate [Insert Name of Initiative]. (See Appendix 1 for definitions of terms used in this Memorandum of Understanding [MOU].) It also outlines the activities which CMS and the State agree to conduct in preparation for planned implementation of the initiative in DATE.

Before this agreement is signed, the State will ensure necessary planning activities consistent with the CMS checklist of standards and conditions for participation as detailed through supporting documentation provided in Appendix 2.

Once the MOU is signed and agreed upon, CMS and the State will enter into a final agreement, which will include an operating manual that will specify the administrative activities CMS and the State will conduct in support of the initiative. As agreed upon, the operation manual will be appended to the signed MOUs and may be subject to periodic updating.

III. PROGRAM DESIGN / OPERATIONAL PLAN

A. PROGRAM AUTHORITY

- 1. Medicaid Authority:** The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation except to the extent that variances from these requirements are provided for in Appendix 4. States proposing to implement managed FFS delivery models, including but not limited to primary care case management or health homes, will submit contracts for these services to CMS for review prior to implementation.
- 2. Medicare Authority:** The Medicare portions of the initiative shall operate according to existing Medicare law and regulation, except to the extent that variances from these requirements are provided for in Appendix 5.

B. ELIGIBILITY

- 2. Eligible Populations:** Individuals who are eligible for Medicare and full Medicaid benefits in the State will be eligible to participate in this initiative. CMS will work with the State to address participation in other programs or initiatives. Beneficiaries participating in Medicare Advantage, Medicaid managed care and Program of All-inclusive Care for the Elderly (PACE) may participate in this initiative if they disenroll from their existing programs. State specific eligibility is provided in Appendix 3.
- 2. Participation Processes:** The State and CMS will agree upon the date in which an individual is determined to have become a participant in the initiative and provide specifications in the Final Agreement. Generally, this will not exceed thirty days after becoming eligible for this initiative (by gaining dual eligible status, by moving into the service area, etc.).
- 3. Uniform Informational Documents:** CMS and the State shall develop and require the use of an informational document which will inform the beneficiary of the goals of the initiative, any operational issues related to receiving care, his/her selection for participation, and other information about his/her rights related to participation and receiving care.
- 4. Outreach and Education:** CMS and the State agree that all outreach and education materials and activities shall require approval by CMS prior to dissemination. Such materials shall be integrated to the extent possible and include, but not be limited to: outreach and education materials; benefit coverage information; and operational letters. Such uniform/ integrated

materials will be required to be accessible and understandable to the beneficiaries. This includes individuals with disabilities and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid.

C. DELIVERY SYSTEMS AND BENEFITS

- 1. Delivery Systems:** The State is accountable for providing or arranging for fully integrated care and must ensure that all benefits are coordinated across Medicare and Medicaid for Medicare-Medicaid enrollees.
- 2. Medicare and Medicaid Benefits.** The State shall demonstrate its ability to assure continued access, directly or by subcontracting with other qualified entities, to the full continuum of Medicare and Medicaid covered services. Medicare covered benefits shall be provided in accordance with existing Medicare FFS rules. Medicaid covered benefits shall be in accordance with the requirements in the approved Medicaid State plan and any applicable waivers.

D. BENEFICIARY PROTECTIONS, PARTICIPATION AND CUSTOMER SERVICE

- 1. Beneficiary Participation:** The State shall demonstrate meaningful beneficiary participation on development and oversight of the initiative.
- 2. Enrollee Service Representatives:** The State shall assure that its enrollee services representatives can answer inquiries and respond to complaints and concerns.
- 3. Appropriate Care:** CMS and the State shall ensure that all necessary care to meet the beneficiary's needs is included in the overall coordination of benefits across Medicare and Medicaid, and is provided in a manner that is sensitive to the beneficiary's language and culture, allows for involvement of caregivers, and in an appropriate care setting, including in the home and the community. CMS and the State shall ensure that care is person-centered and can accommodate and encourage consumer-direction.
- 4. Grievance and Appeals:** The State must assure that individuals have access to all grievance and appeal rights under Medicare or Medicaid, or both, and assist the participant in choosing which to pursue if both are applicable.
- 5. Privacy:** CMS and the State shall ensure privacy of enrollee health records, and provide for access by enrollees to such records.

E. ADMINISTRATION AND REPORTING

- 1. Day-to-Day Monitoring:** CMS and the State shall agree that the State will be responsible for the day-to-day monitoring of the program with periodic reporting to CMS in an agreed upon manner and timeline, which will be specified in the Final Agreement.
- 2. Consolidated Reporting Requirements:** CMS and the State shall define a Consolidated Reporting Process to ensure the provision of necessary data, quality measures, beneficiary

satisfaction and evidence-based measures and other information as may be beneficial in order to monitor the initiative. This process will be specified in the Final Agreement.

- 3. Accept and Process Assessment Data:** CMS, or its designated agent conducting the evaluation, and the State shall accept and process uniform person-level beneficiary data, as may be necessary for the purposes of program eligibility, payment, or evaluation purposes. Sources may be based upon an initial and ongoing assessment process which includes ICD-9 (and ICD-10, as appropriate) diagnoses codes, Health Outcomes Survey for enrollees who are able to self-report, Functional Status elements of the Minimum Data Set (MDS), and/or any other data elements deemed necessary by CMS and the State.

F. QUALITY MANAGEMENT

- 1. Determination of Applicable Quality Standards:** As an Innovation Center demonstration, there will be a rigorous evaluation, which will include quality measures designed to ensure beneficiaries are receiving high quality care. In addition, CMS and the State shall determine applicable quality measures, standards, and reporting requirements, which shall be specified in the Final Agreement, and monitor the program's performance related to those standards. Any performance payment will be contingent upon meeting the established quality standards to assure the demonstrations are not only producing savings but also improving quality of care.
- 2. Quality Management and Monitoring:** CMS and the State shall jointly conduct a single comprehensive quality management process in accordance with related Medicare and Medicaid quality requirements.

G. FINANCING AND PAYMENT

- 1. Medicare and Medicaid Payment:** Participating providers will continue to receive FFS payment from CMS (for the Medicare portion of services) and the State (for the Medicaid portion of services) as detailed in Appendix 6.
- 2. Savings Determination:** Aggregate savings and related savings targets shall reflect Medicare savings net of increased Federal Medicaid costs across the two programs and support quality and performance goals. CMS and the State agree that CMS will be responsible for making the final savings determinations using a methodology and CMS-specified parameters that will be detailed in the Final Agreement.

H. EVALUATION

- 1. Evaluation Data to be Collected:** CMS and the State shall develop processes and protocols for collecting and reporting to CMS the data needed for evaluation, which will be specified in the Final Agreement.
- 2. Evaluation Contract:** CMS or its designated agent will conduct an evaluation to measure the impact of this initiative. CMS and the State will collaborate on and coordinate during any evaluation activity.

I. MODIFICATION OR TERMINATION OF AGREEMENT

Either CMS or the State may seek to modify or amend the MOU on a periodic basis per a written request. CMS or the State may elect not to continue the demonstration at any time provided that a minimum of 90 days advance notice is provided to either CMS or the State Medicaid agency and 60 days advance notice is given to enrollees and the general public.

J. SIGNATURES

This MOU is effective on this day forward [insert date] through the end of the demonstration period [insert date].

In Witness Whereof, CMS and [Name of State] have caused this Agreement to be executed by their respective authorized officers:

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

(Authorized Signatory)

(Date)

(Title)

[Name of State], [Name of State Agency]:

(Authorized Signatory)

(Date)

(Title)

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