Medicare-Medicaid Coordination Office Financial Alignment Demonstration Capitated Model Frequently Asked Questions

Enrollment

1. The January 25, 2012 CMS memo references passive enrollment. For purposes of guidance in this memo, is this phrase being used as it is described in the Medicare Managed Care Manual Chapter 2 section 20.4.2? How does CMS see States potentially using passive enrollment with respect to the dual-eligible integration demo?

   States may request passive enrollment of beneficiaries in demonstration plans. These requests will be reviewed as part of the process of review and approval of demonstration packages and negotiation of each State-specific memorandum of understanding, and are subject to certain beneficiary protections around notice and opt-out opportunities.

   With respect to enrollment for Medicare purposes, *we are using the term "passive enrollment" beyond what is described in 42 CFR 422.60(g) and in section 20.4.2 of Chapter 2 of the Medicare Managed Care Manual. This model is being implemented under the authority of section 1115A of the Social Security Act. Section 1115A(d)(1) permits the Secretary to waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13) and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out Section 1115A with respect to testing models described in section 1115A(b).*

2. Do you have a list of States that allow passive enrollment?

   States do not have any authority over the Medicare program, so it would not be up to a State to "allow" passive enrollment. However, under this demonstration, we will evaluate requests by states that CMS provide for passive enrollment under this demonstration on case by case basis. More information will be available as those passive enrollment requests are received via State demonstration proposals.

3. States set parameters for enrollment in Medicaid, including mandating enrollment into existing plans; do States have authority to mandate enrollment in demonstration plans?

   States have the ability to passively enroll Medicaid beneficiaries into voluntary managed care arrangements as described above, and authority to mandate enrollment in managed care, under section 1915(b) of the Social Security Act and section 1115 of the Social Security Act. As noted above, however, this §1915 and 1115 authority does not extend to Medicare. States will have the opportunity to request passive enrollment in their proposed demonstrations. CMS approval of these passive enrollment requests will be subject to certain beneficiary protections around notice and opt-out opportunities.

4. If a State is considering passive enrollment, are there criteria that will allow certain beneficiaries to stay in their current plan?

   The mechanics and process of passive enrollment will be determined based on the specifics of State requests, but there will be the ability for individuals to decline enrollment in a demonstration plan and remain in their existing coverage, as well as options for those enrolled in

certain plans that also offer demonstration plans to be transitioned to the same organization's demonstration plan.

5. If Medicare Advantage Organizations (MAOs) already have a Dual Eligible Special Needs Plan (D-SNP) and are managing that care, is it CMS' and the States' hope that these MAOs apply for the demonstration project and roll their existing D-SNP members into the demonstration? If not, where is the dual membership today that CMS and the States expect to be part of this demonstration? If yes, will existing MAOs with D-SNPs be allowed to crosswalk their existing membership into a demonstration plan they operate?

   Organizations currently offering D-SNP plans certainly have the flexibility to maintain those plans, provided they can meet all relevant requirements – including securing or renewing a contract that complies with D-SNP requirements with the State by CMS' deadline of July 1, 2012 for contract year 2013. CMS and the States are interested in working with organizations in the demonstration that have previous experience delivering care to this population, including D SNPs, but any plan seeking to participate in the demonstration will be required to meet CMS and State plan selection requirements.

   The mechanics and algorithms used to passively enroll beneficiaries, including whether they will be transitioned between non-demonstration and demonstration plans operated by the same organization, will depend on States' proposals.

6. What are options for those who opt out? Would they go back to their SNPs or Fee-for-Service Medicare?

   CMS is currently working on the mechanics and process of passive enrollment, in conjunction with State-specific requests. Individuals would retain the choice of to where they choose to opt-out. Additional guidance will be forthcoming.

7. MMCO's "Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans" for dual eligibles does not specifically mention whether organizations can participate in both this capitated financial alignment demonstration for duals, and other alternative payment or service delivery models out of the Center for Medicare & Medicaid Innovation (CMMI) such as the Pioneer ACO Model. Can you please verify that organizations cannot participate in both?

   We are not precluding participation in the demonstration by organizations that may wish both to offer demonstration plans and participate in one of CMMI's ACO models. For purposes of the capitated financial alignment demonstration, an entity would need to qualify based on both CMS' and the State's plan selection criteria. State rules on licensure and solvency would apply.

Appeals

1. Will CMS require that the Medicare appeals process, Medicaid appeals process, or both be utilized by entities participating in the demonstration?

   In Attachment 1 of our January 25, 2012 guidance memorandum, we explained that our "preferred requirement standard" represents CMS' starting point for the framework to be utilized under the State demonstrations and that will be discussed in more detail with States as part of their demonstration and MOU development and approval processes. As indicated in that

guidance document, CMS expects that demonstration plans will offer a unified appeals process that will combine some elements of the Medicare system and some elements of the Medicaid system. We expect that there will be some variation by State, but that core beneficiary protections will remain.

Benefits/Medical Necessity

1. How will a demonstration plan determine whether a certain item or service is medically necessary?

   We expect Medicare criteria to be used for services for which Medicare is primary and Medicaid criteria to be used for long term supports and services not covered under Medicare. More information is to be determined by a given State and CMS as a part of the MOU negotiation process that will follow the State submission of a proposal.

Credentialing

1. We understand that network adequacy requirements for medical services will be based on Medicare standards. Will medical providers also need to meet Medicare credentialing standards?

   In Attachment 1 of our January 25, 2012 guidance memorandum, we explained that our "preferred requirement standard" represents CMS' starting point for the framework to be utilized under the State demonstrations and that will be discussed in more detail with States as part of their demonstration and MOU development and approval processes. For credentialing, we indicated in that guidance that our preferred standard is that the State Medicaid credentialing standards apply, as Medicare standards essentially require plans to meet State standards. States and CMS may clarify this approach as part of the MOU negotiation process.

State Contracting

1. May the State Medicaid Agency limit the demonstration to only one plan where all full duals in the State will join to receive Medicare and Medicaid benefits?

   Generally, States proposing to conduct passive enrollment will need to have a minimum of two demonstration plans available to all duals eligible for the demonstration plan in order to preserve beneficiary choice consistent with Medicaid rules. If a State already has a Medicaid waiver/exception to only operate one plan (e.g., in a rural area of the State), we would honor that waiver/exception.

2. May the State Medicaid Agency limit their contracts to plans that participate in the demonstration?

   The State has discretion to select the health plans with which it will contract, and CMS similarly has discretion to contract or not contract with any entity.

3. Since benefits for partial dual members are not "coordinated or paid for" by the State Medicaid agency, will CMS allow plans to offer a D-SNP serving only partial duals as a non-demonstration plan? If so, what is the obligation of the State Medicaid Agency to contract with D-SNPs that cover partial duals?

Yes, CMS would allow plans to offer a D-SNP that serves only partial duals, although a plan cannot do so within the demonstration, which is limited to full duals. The State has discretion to select the health plans with which it will contract pursuant to MIPPA, and all plans would be required to have a contract that complies with D-SNP requirements in order to operate in 2013.

General Financial Alignment Demonstration Process

1. Is there a hard date that States need to submit their proposal?

   CMS expects that States will submit their proposals on a rolling basis throughout the late February to late May 2012 timeframe, and no later than May 31, 2012.

2. For well-established SNP programs participating in the demonstration that want to continue the same arrangements indefinitely, what happens after the end of the demonstration?

   All demonstration plans s will be rigorously evaluated as to their ability to improve quality and reduce costs. Under section 1115A(c), the Secretary of Health and Human Services (HHS) may, through rulemaking, expand the duration and scope of a model being tested under section 1115A(b) if certain findings are made regarding the effect of the expansion on program spending and the quality of patient care.

3. After the demonstration is completed, will CMS transition to a new program entirely and then phase out current SNP model?

   CMS hopes the evaluation and monitoring of the demonstrations will result in improved quality and cost outcomes, allowing the Secretary of HHS to expand the duration and scope of this model in accordance with section 1115A(c). Whether and when any such expansion might occur, however, is unknown at this time. Also unknown is whether Congress will reauthorize SNPs beyond 2013. If regular program authority for SNPs were not extended after 2013, the demonstrations could continue under section 1115A authority for the remainder of the period for which the demonstration project was approved. We will consider all options and provide sufficient notice to plans and enrollees if either the demonstration or SNP program were to change in any substantive way.

4. Since the target date for demonstration plan selection is after the June 4th bid submission deadline, plans may need to submit 2 bids (one demonstration bid and one non-demonstration bid) even if their intention is to ultimately have only one offering in 2013. Will CMS allow a plan to withdraw the non-demonstration bid, for example, if they are selected for the demonstration?

   CMS is working to develop guidance for organizations interested in participating in the financial alignment demonstration on the issues regarding application and bid withdrawal processes and timelines. It is our expectation that guidance on this issue will be released by the Center for Medicare along with all general bid guidance for non-demonstration plans in the early to mid-April timeframe.

Demonstration Effective Dates

1. Will CMS consider options for effective dates off-cycle from CMS' traditional contract timeline? In other words, if a State is not ready to 'go live' for January 1, 2013, but proposes enrollments starting during the year such as April of 2013, would CMS consider that? Or, would that State need to wait until the 2014 contract year to participate in this demonstration?

   Our guidance is geared to January 1, 2013 demonstration start dates. States may request different start dates and we will consider those on a State-by-State basis. In the event we are able to approve later start dates, we will issue additional guidance about timelines for the plan selection process.

2. It is our understanding that our State has requested an implementation date of January 1, 2014, rather than January 1, 2013. Assuming that our State's Medicaid Agency is granted the 2014 implementation date, how when we need to submit a notice of intent to apply (NOIA)?

   We expect the NOIA deadline for interested organizations in States moving forward with 2014 implementation dates to be in the fall of 2012. We will issue guidance regarding timelines and processes for interested organizations in States that are approved to implement their demonstration in 2014.

Payment

1. Will the Medicare A and B components of the integrated rate under the demonstration be risk adjusted?

   Yes, the Medicare A and B components of the rate will be risk adjusted in the demonstrations.

2. Rates are calculated based on baseline spending on both programs; how will this be calculated on Medicare side?

   CMS will work with the Office of the Actuary and an external actuarial firm, as well as States, on the process and methodology for establishing a baseline spending figure for purposes of the demonstration.

3. The goals for this demonstration sound very similar to the goals for the D-SNP program, down to the financial assistance from and contracting with the States. Can you differentiate the two?

   The difference is that, under the demonstration, CMS – together with the States – will establish a joint/blended (and prospectively determined) capitated rate for plans to provide a seamless and integrated package of services across Medicare and Medicaid. The payment rates will be set to increase the quality of services through better integration of services and care coordination while providing upfront savings to both CMS and States. One of the principal goals of the demonstration is to provide a platform for a simplified and unified set of rules and procedures around supplemental benefits, enrollment, appeals, auditing, and marketing.

4. Is CMS providing guidance to States on savings estimates?

   CMS is working with each individual State on the development of State-specific savings estimates.

5. How will savings be shared between CMS and the States under this demonstration?

   In developing the rates, CMS will work with the State to establish saving targets across the three years of the demonstration and determine the savings expectations at the outset. The identified savings target will be applied to both the State and Medicare A/B components of the rate.

Quality Incentives

1. Will demonstration plans be eligible for star bonuses or other quality bonus payments?

   Demonstration plans will not be eligible for star bonuses. Plans will be subject to an increasing quality withhold and will be able to earn back the withheld capitation revenue if they meet quality incentives.

2. Will withholds under the demonstration take into account similar quality or performance withholds that States may already have in place on the Medicaid side?

   Demonstration withholds will be taken from across the full blended capitated rate and will be based on metrics that have relevance across the integrated benefit. CMS will work with States to better understand what types of quality or performance levers they may be using on the Medicaid side to determine whether/how these could be incorporated into the demonstration.

Systems Issues

1. Are changes being made to the HPMS system that allow for integrated products? If so, is that functionality available outside the demonstration process?

   CMS is working to make changes to the existing HPMS system in order to support the submission and review of materials specific to the demonstration to the extent possible.

Qualified Entities under the Demonstration

1. What type of entities are eligible to participate in the capitated financial alignment demonstration?

   The Medicare-Medicaid Coordination Office and States expect to work in partnership with a variety of health plans or other qualified entities under this initiative. CMS and States are interested in working with interested organizations that have experience coordinating and delivering care to Medicare-Medicaid enrollees, provided they meet both CMS' and the States' qualifications. This is irrespective of whether they are currently considered health plans or contract with the State or with Medicare today. In other words, it is not a CMS requirement that interested organizations currently be operating as Medicare or Medicare health plans, but it is essential that they meet all the CMS and State plan selection requirements.

2. Does a potential demonstration plan first need to be approved as a Medicare Advantage (MA) plan or SNP prior to applying for the demonstration project?

An organization interested in participating as a demonstration plan does not first need to become an MA plan or MA SNP. Participating plans will, however, need to meet both the State-specified requirements and the Medicare components of the plan selection process consistent with the demonstration specific timelines provided in the January 25th and March 29th guidance documents, as well as the Capitated Financial Alignment Demonstration application..

Readiness Assessment

1. What is the timeline for the readiness review?

   Plans need to demonstrate readiness by the time contracts are signed in mid-September and should be fully ready to provide the full array of services to beneficiaries when enrollment begins on January 1st. We anticipate that the readiness reviews will be conducted between early August and mid-September 2012.

Notice of Intent to Apply (NOIA) Process and Timelines

1. Will organizations currently offering Medicare Advantage plans (including those offering special needs plans) need to be issued a separate contract number for any demonstration plans they intend to offer, or can they continue to use the same contract number for the demonstration and non-demonstration plans?

   Organizations that submitted a NOIA to offer plans in 2013 under the capitated financial alignment demonstration have been issued a new contract number specific to their demonstration plan(s), regardless of whether they are currently operating plans under a current Medicare Advantage contract.

2. What is the latest date an organization can submit a NOIA to be considered as a demonstration plan for 2013?

   If an interested organization did not submit a NOIA by April 2, 2012, it will not be eligible to offer a demonstration plan in 2013.

Plan Selection Process: General

1. Will satisfaction of all of Medicare's requirements for demonstration plans guarantee interested organizations a three-way contract?

   No. Demonstration plans will be selected through a joint CMS-State process that utilizes State-based plan selection vehicles. Satisfaction of Medicare requirements is a necessary step in the joint plan selection process, but interested organizations will also have to qualify for participation through the specific plan selection process established for each State.

2. Will interested organizations need to follow the standard Medicare Advantage or Part D application deadlines in order to offer demonstration plans?

Organizations interested in offering demonstration plans must follow the Medicare plan selection processes and timelines outlined in our January 25, 2012 and March 29, 2012 guidance memoranda, the Capitated Financial Alignment Demonstration application, and any subsequent demonstration guidance we release. For 2013, The CMS/State joint plan selection process will proceed on a separate track from the standard Medicare Advantage and Prescription Drug Plan application cycle. In addition, interested organizations will need to meet State-specific plan selection processes and requirements.

3. If an organization currently operates a Dual Eligible Special Needs Plan (D-SNP) and also submits an application for a demonstration plan, at what point can it withdraw a submitted bid for its current D-SNP? Similarly, if an organization applies to offer either a new D-SNP or to expand its current D-SNP offering, and also submits an application for a demonstration plan, at what point may it withdraw its application for the new or expanded D-SNP?

   States are in different phases with respect to their demonstration approval and plan selection processes. For that reason, organizations that currently contract with Medicare and wish to retain the option of continuing to do so pending the conclusion of demonstration approval and plan selection processes should separately proceed with demonstration and non-demonstration plan application and contracting processes. It is our expectation that guidance on this issue will be released by the Center for Medicare along with all general bid guidance for non-demonstration plans in the early to mid-April 2012 timeframe.

Plan Selection Process: Network Adequacy

1. How will network adequacy be evaluated under the demonstration?

   CMS' preferred requirement standard for demonstrating network adequacy under the capitated financial alignment demonstration is to use Medicare standards for medical services and prescription drugs. For long-term supports and services (LTSS) and other Medicaid-only services, demonstration plans will use State Medicaid network adequacy standards. For areas of overlap where services are covered under both Medicaid and Medicare (e.g., home health), the appropriate network adequacy standard will be determined via the CMS-State MOU negotiation and memorialized in the three-way contract with health plans, so long as such requirements result in a network of providers that is sufficient in number, mix, and geographic distribution to meet the diverse and complex needs of the anticipated number of enrollees in the service area.

   Demonstration plans will be able to utilize an exceptions process in areas where Medicare's medical service network adequacy standards may not reflect the number or needs of dual eligible beneficiaries. As part of the joint selection process for demonstration plans, we will establish a joint State/CMS exceptions review team to evaluate exceptions requests for portions of demonstration plan service areas where an alternate standard has been negotiated in the MOU. The State/CMS exceptions review team will review all submitted exceptions requests and make determinations about the adequacy of plans' network in areas where exceptions have been requested. Ultimately, all plans must demonstrate that the network they offer is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. CMS will provide additional guidance on the timelines and processes for the Medicare medical and pharmacy network adequacy determinations.

2. Will CMS use a similar process for determining network adequacy for Medicare-covered medical services as it uses for the Medicare Advantage program (e.g., submission of current Health Services Delivery (HSD) table templates)? Does CMS anticipate making changes to the current HSD templates due to the inclusion of State standards for long-term supports and services (LTSS) or to accommodate negotiated standards for overlap areas of service?

   CMS issued additional guidance providing additional information on the timelines and processes for Medicare network adequacy determinations in the Capitated Financial Alignment Demonstration Application. The current Medicare standards will be changed. Either States or the CMS/State joint exceptions review team will make network adequacy determinations for overlap services, depending on the negotiated standard.

3. How will CMS contract with interested organizations to provide Part D coverage under the demonstration? Will interested organizations need to follow the standard Medicare Advantage or Part D application deadlines in order to offer demonstration plans?

   CMS and States will contract with demonstration plans to offer Part D benefits as part of the integrated package of benefits offered under the demonstration to Medicare-Medicaid enrollees. Organizations interested in offering demonstration plans must follow the Medicare plan selection processes and timelines outlined in our January 25, 2012 and March 29, 2012 guidance memoranda, the Capitated Financial Alignment Demonstration application, and any subsequent demonstration guidance we release.

4. Will interested organizations be required to have a pre-existing Part D contract as a prerequisite for participation?

   No. Organizations interested in offering demonstration plans will need to satisfy the Medicare Part D requirements as part of the CMS portion of the demonstration plan selection process. Offering Part D under a current contract is not a prerequisite for plan selection under the demonstration.

5. Will there be flexibility under the demonstration to offer a prescription drug benefit that is not based on the Medicare Part D benefit? Will the 15 States that received contracts to design person-centered models to coordinate primary, acute, behavioral, and long-term services and supports for Medicare-Medicaid enrollees have any additional flexibility with respect to the prescription drug benefit?

   The Medicare-Medicaid Coordination Office is working with States interested in pursuing a capitated approach to integration on the model articulated in the July 8, 2011 State Medicaid Director letter and in our January 25, 2012 guidance memorandum. Under this model, prescription drug benefits must be consistent with Medicare Part D requirements. While the 15 States that were awarded the $1 million design contracts could seek approval for a different approach, there is no guarantee that any approach would be approved, or that there would be additional flexibility with respect to the pharmacy benefit requirements.

Formulary Submissions

1. Must interested organizations submit two separate formularies – one for drugs covered under Medicare and one for drugs covered under Medicaid?

It is our expectation that formulary submission will be integrated under the demonstration to include all drugs covered under demonstration plans, regardless of payer. Interested organizations must either: (1) submit a Part D formulary to CMS by April 30, 2012 if they are submitting a new formulary; or (2) submit a crosswalk to CMS by May 14, 2012 if they intend to use the same formulary as they have already submitted for a non-demonstration Medicare Advantage or prescription drug plan. Interested organizations will also be required to submit supplemental formulary files on June 8 and 15, 2012, as outlined in our March 29, 2012 guidance memorandum. These supplemental files will capture Medicaid-covered drugs.

Quality

1. Will demonstration plans receive star-based plan ratings like Medicare Advantage and Prescription Drug Plans?

   In Attachment 1 of our January 25, 2012 guidance memorandum, we explained that our "preferred requirement standard" represents CMS' starting point for the framework to be utilized under the State demonstrations and that will be discussed in more detail with States as part of their demonstration and MOU development and approval processes. It is our preferred requirement standard that demonstration plans be subject to strong, consistent quality oversight and monitoring requirements. Quality requirements will be integrated and will include some measures currently collected by Medicare and Medicaid. Our ultimate goal is to require a core set of measures that will allow quality to be evaluated for an integrated program. We will provide additional guidance regarding this core set of measures.

   Prescription drug quality reporting measures for demonstration plans will be consistent with those currently required for Medicare Advantage-Prescription Drug Plans and stand-alone Prescription Drug Plans.

2. To the extent that there is an overlap between State and Medicare reporting requirement on HEDIS and CAHPS, would there be an opportunity to negotiate one set of metrics?

   In Attachment 1 of our January 25, 2012 guidance memorandum, we explained that our "preferred requirement standard" represents CMS' starting point for the framework to be utilized under the State demonstrations and that will be discussed in more detail with States as part of their demonstration and MOU development and approval processes. Under the demonstration, it is our preferred requirement standard to advance an integrated quality and performance improvement program for plans in order to reduce administrative burden and duplication. We intend to require reporting of a core set of quality measures that will allow for evaluation and comparison across demonstration plans. However, because each State is different and has different reporting requirements for its Medicaid managed care organizations, there is an opportunity to discuss integration of quality reporting beyond the core set of measures on a State-by-State basis during the Memorandum of Understanding negotiation process.

Model of Care

1. What are the model of care requirements for demonstration plans?

As outlined in our March 29, 2012 guidance memorandum, interested organizations must develop a model of care (MOC) for their enrollees that incorporates both CMS and State requirements. Organizations interested in operating a demonstration plan in 2013 will be required to submit to CMS as part of their Capitated Financial Alignment Demonstration Application by May 24, 2012. Our expectation is that the MOC narrative will be a unified document that accounts both for CMS' requirements and any additional requirements the State wishes to include.

As detailed in our March 29, 2012 guidance memorandum, CMS will review and approve MOC submissions based on the same eleven elements and scoring standards CMS has established for approval of Medicare Advantage Special Needs Plan MOCs. States may wish to require interested organizations to include additional elements in their MOCs beyond the 11 elements required by CMS or to address certain topics or State-specific requirements within the 11 elements required by CMS. We emphasize that CMS will score the MOCs strictly based on its current scoring criteria for the 11 required elements. However, it is our expectation that interested organizations' MOC submissions will be structured to satisfy both CMS and any additional State requirements. CMS will coordinate review of the MOC with the State, and both the State and CMS will need to approve the MOC prior to the target date for joint plan selection (July 30, 2012) for a 2013 demonstration implementation.

2. If an interested organization operates a Dual Eligible Specials Needs Plan (D-SNP) and has received a multi-year approval of its model of care, will it be required to resubmit a model of care for any demonstration plan it intends to offer?

   <u>All</u> interested organizations must submit a MOC specific to the demonstration's targeted population and benefits, regardless of whether the organization has an approved MOC for any non-demonstration Medicare Advantage (MA) special needs plan (SNP) it may also operate.