

## TRANSCRIPT

### Day 1 07b: Status of the Capitated Financial Alignment Demonstrations

*Duran, Rothhouse*

Thank you so much, Abe. As Abe mentioned, Marla and I both hail from the Medicare/Medicaid Coordination Office. And there's some basic information on the slide about our office and its mandate, but I think the bottom line for us is that the mandate reflects the huge priority that it is at CMS to improve the healthcare experience for people who are dually eligible for Medicare and Medicaid since these individuals are currently navigating multiple sets of rules and benefits and providers at a total cost of more than \$300 billion each year across both programs. And at the Medicare/Medicaid Coordination Office we spend time working not just with states but also with folks throughout CMS and a variety of external stakeholders on a number of initiatives that are aimed at improving the frequently fragmented healthcare experience for this population.

One of these initiatives, of course, is the Capitated Financial Alignment Initiative, and more generally, the Financial Alignment Initiative. Our office, in partnership with the Center for Medicare and Medicaid Innovation, launched this initiative last July as a new demonstration opportunity for states to better coordinate care for this population. The goal of this initiative is to better serve the Medicare and Medicaid population by testing a person-centered integrative care model that provides more easily navigable and a more seamless path to both Medicare and Medicaid benefits.

Under the financial alignment initiative we will be testing the effectiveness of two different care models. One is a managed fee-for-service model, and the second is a capitated approach. And under this approach, the capitated approach, we will be using health plans or other qualified entities as the vehicle for providing healthcare across medical, drug, behavioral, and long-term services and supports. And these organizations, of course, will enter into a three-way contract with CMS and a state, following both a joint CMS and state plan selection process, as well as the execution of a memorandum of understanding with each state.

Other goals of the demonstration include improved beneficiary experience of care, and so that would be things like fewer avoidable hospitalizations and ER visits, and, of course, greater independence both at home and in community both for disabled folks and seniors. We also want to test administrative benefits and enrollment flexibilities that will foster a more simplified and unified set of rules wherever that's possible, and also to flesh out further our vision of a seamless experience of care for these enrollees. So that would include, as just a couple of examples, integrated grievance and appeals processes and also integrated marketing and beneficiary communication materials, so, for example, a single ID card for access to all benefits.

Also critically important for us is to put the beneficiary first by taking the best of both Medicare and Medicaid world in terms of beneficiary protections, and also following a person-centered model of

care so that Medicare and Medicaid enrollees have the ability to shape and direct the healthcare that they receive. And, finally, another critical priority, sort of thinking long-term of course, is rigorously measuring, monitoring, and evaluating the overall impact of the demonstration. So we will be looking at things across various dimensions, including access to care, beneficiary outcomes and experiences, and of course healthcare outcomes.

This slide includes other examples of beneficiary enhancements, and I think rather than read through these bulleted items I would prefer to spend some time during this presentation just talking about how we're going to implement our vision for beneficiary enhancements under this model.

In my portion of the presentation I just am going to provide a bit of a general overview of the state demonstration planning and implementation process, as well as a general status update on all the demonstrations that we currently have in the pipeline and give you some information on various policy and operational areas of particular interest to you, including things like payment rates, quality, enrollment and marketing, as well as a very specific and technical issue on Part D cost sharing. And then Marla will shift into the portion of the presentation where we'll provide more specific state updates, and she's going to be focusing as well on readiness reviews and implementation monitoring, and also on evaluation.

So, first, some context regarding the various steps involved in state's demonstration planning and implementation processes. As many of you know, last October we required the submission of the letter of intent by states who were interested in participating either in the capitated or the managed fee-for-service models. And then states had submitted these letters of intent and determined they continued to be interested in implementing a demonstration, initiated a comprehensive planning and design process.

I think an important side note for additional context, because it's a question I get asked a lot, separate from this initiative and of course launched prior to the Financial Alignment Initiative was the initiative where 15 states received design contracts through our office's state demonstrations to integrate care for dual eligible individuals. So for these states the demonstration planning process was nearly a continuation of efforts they had already received funding for. Actually, I should go back and say that the stakeholder engagement process is really important to the demonstration development. And states were required to post a demonstration proposal for public comment for 30 days before submitting it to CMS, and once submitted to CMS it was posted for an additional 30 days of public comment on our Integrated Care Resource Center website. And the next slide actually has a link to where all the 26 proposals we've received -- actually a few slides from now. So we have all the 26 proposals posted on our website. We also have all the public comments received on the proposal to the extent that you're looking for those.

Once we determine that a proposal has met certain terms and conditions, then we proceed to the process of developing a state-specific memorandum of understanding with a state. And once that process is complete, and also once health plans are selected jointly by CMS and the state, we sign the three-way contracts with selected health plans. So I mentioned stakeholder engagement, and I just want to emphasize that it's a real key piece of the demonstrations. Input from the public is also required part of the demonstration development and planning process because states are required

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to work with various stakeholders including beneficiaries and their families and caregivers, consumer organizations, beneficiary advocates, providers, and plans, and it's not just during the design of the demonstration, but it's also, in a meaningful way, to continue during the implementation of the demonstration.

Participating plans will also be required to establish meaningful beneficiary input processes, and that includes things like beneficiary participation and plan governing boards and quality review bodies, and also the establishment of beneficiary advisory boards. So I mentioned earlier we have received 26 proposals, 18 of those proposals are for capitated approach. And of those 18 states, we're working to implement demonstrations at some point in 2013 in 6 states.

Marla will spend a portion of her presentation really more in the weeds on each specific state's approach, so I'm not going to spend time doing that here. But at a high level, I will just let you know that four of these states, California, Illinois, Massachusetts, and Ohio are pursuing the capitated financial alignment pathway, and two other states, Wisconsin and Minnesota, are pursuing capitated approach but not necessarily the financial alignment approach, and these two states are part of the cadre of 15 states and they have a little bit more flexibility in this regard. Again, all the proposals and all the comments we received can be accessed on our website.

So payment rates, very important topic. I'll give you a high level overview of how the payment rates were to be set. And I know that we have some folks here from Sherry Rice's [PH] group who will help us field questions and answers to the extent that you have more detailed questions. But at a high level, participating plans do not submit plans as Medicare Advantage plans and prescription drug plans do today. Instead, both we and the state develop a blended capitation rate that encompasses all the Medicare and Medicaid services including Part D drug benefits. So rates for the participating organizations are developed based on baseline spending in both programs, as well as anticipated savings under the demonstration. Now these rates are risk adjusted for each enrollee, but they don't otherwise vary from plan to plan. And both we and the state will work to determine the portion of the payment that will be paid by CMS for Medicare services, as well as the portion that will be paid by the state for Medicaid services.

So how do we establish that baseline? On the Medicaid side states have discretion subject to CMS approval to develop rates on a county, a regional, or a statewide basis. The Medicaid baseline is developed based on historical state data, Medicaid state data. And the trend rates are developed by state actuaries with oversight by CMS and our contractors and staff. The Medicaid baseline includes a combination of spending both by Medicaid Managed Care plan payment levels, as well as fee-for-service costs, and it's based on expected enrollment under the demonstration, so where are these beneficiaries coming from.

On the Medicare side we develop payment rates for the Medicare parts A and B portion using baseline estimates of what Medicare would have spent in the absence of the demonstration. So each county baseline will be a weighted average of the fee-for-service and the MA county costs based on the expected proportion of enrollments that we would expect from fee-for-service and from Medicare Advantage.

The Part D portion and the capitation rate will be based on the standardized national average monthly bid amount, and that amount will be risk-adjusted in accordance with the same rules that apply to Part D with adjustment to today. And, in addition, so I should mention also that that amount was released last month and it is \$79.64 for 2013. In addition to that “NAMBA” [PH] amount the low income cost sharing subsidy and reinsurance subsidies of course are estimated and paid out prospectively and are subject to cost reconciliation the same way that it happens under the Part D program today.

We expect the savings under the demonstration to come from integration, improved care management, and also administration efficiencies. And the savings opportunities will vary from state to state, so it will not necessarily be the same percentages that applied in each state. And they will depend on a number of factors. So the sorts of things that will impact the savings opportunities include historical utilization rates, it also includes the current managed care penetration both on the Medicare and the Medicaid sides, as well as the ratio in each particular state of institutional community-based services. That aggregate savings target is applied to both the Medicare parts A and B portion of the rate, as well as the Medicaid portion, and so that means that CMS and states share proportionately in the savings achieved regardless of whether the utilization is on the Medicare side or the Medicaid side.

The Medicaid component of the rate will be risk-adjusted, and that risk adjustment methodology will be according to a methodology that is proposed by the state and agreed to by CMS. On the Medicare side we will be adjusting the Medicare and be in the Part D direct subsidy components of the rate consistent with the risk profile of each individual beneficiary. And so, of course, for the Medicare A and B services we will use the current CMS hierarchical conditions and categories model, and on the Part D side we’ll use the RxHCC Risk Adjustment Model.

In each year of the demonstration a percentage of plans capitation will be withheld and will be repaid the extent that plans establish quality thresholds. This withheld amount will increase after the first year of the demonstration in years two and three. The quality withhold measures that we will use for that withhold are a subset of the overall quality reporting requirements, and so they include both CMS determined core quality measures that will be the same across all plans and all demonstrations, and they also include state-specific measures. Because of the amount of time that it takes to develop baseline data the first year quality withholds will focus on CMS and state-defined process measures, and this will include things like measuring timely enrollee health risk assessments, developing individualized care plans for enrollees, submission of encountered data, and the establishment of a consumer advisory board.

In the second and third years of the demonstration, though, we will be shifting to more outcome-based measures, and that will put things like hospital readmissions, care chronic disease, and medication adherence. If you want to get an idea of what these measures are I would refer you to the Massachusetts MOU, and I know Marla will talk a little bit more about that. It’s our first published MOU. It was released a couple of weeks ago, and it includes extensive information about the quality withholds as well as the core quality metrics for the demonstration.

So, as I mentioned, the quality withhold measures are just a subset of a core set of quality metrics that will be applicable across all demonstrations. And we’ll be focusing on a variety of names

including access and availability of services, care coordination and transitions, health and wellbeing, mental and behavioral health, long-term services and support, and also enrollee and caregiver experiences. We focused on national consensus-based measurement sets that are commonly used in both Medicare and Medicaid programs, and many of these core measures, in fact, build on existing Medicare Advantage quality reporting requirements under HEDIS, CAPS, and HOS. In addition, it's important to note that all of the Part D metrics that are collected today will continue to be collected.

Our emphasis in selecting these measures, again, was on broad relevance to this population. We acknowledge and we agree with the feedback that we have received that there are a number of gaps in measures for this population. So we continue to work. Our office works with the National Quality Forum, National Committee for Quality Assurance, and other entities to develop consensus-based measures, identify the ones that exist today, but also try to develop the ones that are relevant for this population. The core set, of course, is also supplemented with additional measures that reflect state-specific goals and as well long-term services & supports, as well as behavioral health measures.

Enrollment is another hot topic. We will approve, subject to certain robust beneficiary protections, on the use of a single, seamless, passive enrollment process. And, again, the process has to provide the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from a plan. Again, the goal here is to assign beneficiaries based on their particular needs, and subject to advanced notice, and so that would be advanced notice of at least 60 days. So beneficiaries are afforded the opportunity to opt out. It also includes the opportunity to disenroll from a plan or to transfer from one demonstration plan to another on a month-to-month basis any time during the entire duration of the initiative. And, finally, we expect there to be strong options counseling and enrollment assistance for each state that undertakes the passive enrollment approach. If we agree to it mutually in a memorandum of understanding states can also use an independent third-party to facilitate this passive enrollment, and typically that was something like an enrollment broker.

State proposals, of course, vary as to their target population, but across all demonstrations there are certain populations that are not eligible to be picked up in the passive enrollment algorithm, and that would include individuals who are enrolled in PACE, also individuals who are enrolled in an employer-sponsored insurance option or those whose former employee receive a retiree drug subsidy. We also, of course, respecting beneficiary choice, will not passively enroll individuals who have already opted out participation in a demonstration plan. And another important note is that we will be coordinating with the states the passive enrollment transactions with CMS's annual Part D reassignment process because we want to make sure that beneficiaries are only assigned to one plan a year. And this means that in states that are implementing demonstration in 2013 for individuals who will be reassigned to a below benchmark prescription drug plan effective January 1<sup>st</sup> of 2013 those folks would be left in that plan and that PDP through the end of the calendar year and cannot be picked up in a passive enrollment assignment until 2014.

As part of the passive enrollment process we are implementing a number of safeguards that will ensure the demonstrations protect and enhance beneficiaries' access to high-quality care. Examples of that include CMS and the state working together to ensure that there are multiple communication plans at multiple times and in an understandable format for beneficiaries. So

beneficiaries would be provided clear notices. These notices will be jointly developed by CMS and the state and tested for readability in terms of a – basically we'll be developing a model notification and it will be from state to state. The states will provide this written notification to beneficiaries no fewer than 60 days prior to the passive enrollment assignment. And, again, this notice will convey a number of things including sort of we want to make sure the beneficiaries are aware of the benefits that they'll received, their rights and their choices, and the opportunity that they have to either stay where they are or to be assigned to the new plan.

Following the notice by the state, CMS will send a second letter, and that will be approximately one month before the passive enrollment takes effect. The state is also required to provide choice counselors or enrollment brokers to support beneficiary inquiries. And we expect to leverage existing resources for educating beneficiaries, and this would include entities like state health insurance programs and aging and disability resource centers.

Another thing that I would bring to your attention is that on August 23<sup>rd</sup> CMS announced a new funding opportunity together with the HHS Administration for Community Living. And that funding opportunity is for SHIPs and ADRCs to provide option counseling for dual eligible in demonstration states specifically.

As part of each proposal, of course, we'll be reviewing enrollment timing frequency, and it is our expectation that states will be phasing in enrollment over a period of time at program startup, which we consider to be the first year of the demonstration. Examples of potential phasing could include phasing by geography or certain population groups. This phasing will allow both CMS and the state to make sure that plans have everything they need to enroll folks and that would be provider capacity, community support & systems of infrastructure, and they need to just really be in a position where they can deliver this person-centered care before beneficiaries are enrolled. States will not be able to phase in entirely new service areas or populations following the first year of the demonstration startup.

And not to steal Marla's thunder because I know she's going to be reviewing the writing of this review and implementation monitoring processes we expect to undertake, but I think it's really important for you to know that we will be actively monitoring each plan's capacity and performance, and that is part of that CMS and/or the state halting or limiting plan enrollment if a plan fails to meet established requirements, and that could be before implementation and certainly after implementation as well.

We expect CMS and the states to develop a flexible marketing approach and also a flexible approach to marketing and beneficiary communication review processes as part of not just their MOU development, but also their demonstration implementation. In general, and you will see this if you look at the Massachusetts MOU that we made public a couple of weeks ago, you can expect that the Medicare requirements as articulated in regulation and statute and Medicare marketing guidelines will serve as the starting point. And, of course, the standards can defer, as we said previously, to whichever standard, whether it's the Medicare or the Medicaid standard in a particular state, to whatever the standard is that's more beneficiary-friendly. So certainly there may be some variation from the Medicare marketing requirements.

In June of this year we implemented modifications to the health plan management system marketing module, and those changes allowed for the intake of marketing materials and sort of a dual review track by CMS and by state reviewers. We, of course, will work with the states to determine which categories and materials must be prospectively reviewed. And we intend to leverage the processes that exist today in terms of Medicare review and also importantly the file in use process.

Marla will discuss this further in her presentation, but we are anticipating mid-2013 implementation dates for the four states that are pursuing the capitated financial alignment model. So plan marketing activity will, in no case, begin any earlier than January 1<sup>st</sup> of 2013; that is 90 days before any enrollment would take effect. We're developing a number of demonstrations specific integrated plan model materials and working with a variety of internal and external stakeholders to get input on those models. We're targeting the models that are needed immediately for enrollment, and those would include the evidence of coverage or member handbook, a summary of benefits, which will be demonstration-specific, it will not be the summary of methods that we use today in Medicare Advantage; also, a comprehensive integrative formulary, a combined provider and pharmacy directory, a single ID card for all services, and also integrated enrollment forms. We'll of course we'll be developing additional materials, but these are the first wave of materials that we intend to develop.

And before I hand things over to Marla, I have a fairly technical point that I wanted to make, and it is a question we've gotten so – this is an issue we've gotten so many questions on, we thought it was really important to address today, and that is on Part D cost sharing. Unless specified otherwise by a state or absent any further reduction at a plan's election, Part D cost sharing will be subject to the standard low-income subsidy copayment amount that are applicable to whatever specific category of full/dual eligible we're talking about. So, of course, those are zero to \$6.60 for brands, and zero to \$2.65 for generics for 2013.

States and plans have, of course, been interested in whatever flexibility there is to allow plans to lower Part D cost sharing. And I would point you again to Massachusetts because in their MOU, as well as in their RFR, they are requiring plans to assess the lesser of the Part D cost-sharing amount or the state's Medicaid cost sharing amount, which at \$1 and \$3.65 in many cases is lower than the Part D cost sharing amount. So plans have been really concerned that because of the way that the Part D payment rules apply; that, basically, they require the plan pay supplemental benefits paid before the low income cost-sharing subsidy. The plans that do this would be forfeiting their low income cost sharing subsidy. So we have essentially used our demonstration waiver authority, and as described in the Massachusetts MOU, we intend to test whether reduced cost sharing will improve medication adherence and lead to improved health outcomes and also reductions in overall healthcare expenditures.

So what this means practically is that demonstration plans have the option of using administrative dollars, the administrative portion of their payment rate, to reduce Part D cost-sharing amounts, and what that means is not the part – so the income cost-sharing subsidy will not be picking up the difference, but neither will plans be forfeiting that payment amount. So we know that you all need more technical guidance on that, and we are working on that technical guidance. But because it's a flexibility that plans outside Massachusetts could benefit from we wanted to make sure that you

were aware of that today. We know that this doesn't just impact the submission of prescription event information, but it also impacts your plan benefit packages. And so we just wanted to let you all know that we do intend to allow one additional opportunity for plans to submit their plan benefit packages to after – so basically to account for supplemental benefits once rate information is made available a little bit later this fall. So that will be the opportunity to make any changes to Part D cost sharing in addition. And now Ms. Marla Rothhouse.

Thank you, Vanessa. All right. So off from that very technical Part D cost-sharing issue to let's talk about the states with some specificity of where we are today. So at a high level, because all of their proposals are on the web and they're very detailed and long, I'm keeping this high level for you all, on what the states are proposing for 2013. I'm going to start off with the states that are following the capitated financial alignment model, in no particular – well in alphabetical order, so I'm not picking favorites by going with California first.

They are looking at implementing their demonstration in June of 2013 in eight counties. They're looking at covering full benefit duals that are 18 and over, and they would be excluding PACE altogether. They will be covering Medicare parts A, B and D services, all of their Medical, which is their Medicaid managed care services, and in addition they're going to include in-home supportive services, community-based adult services, and nursing facility services. Their whole approach is looking at the medical home with interdisciplinary teams that work towards focusing care to the specific beneficiary.

In Illinois they will be starting their demonstration in April of 2013. They are looking to include full benefit duals that are actually 21 or older. They are not going to be including individuals that are enrolled in PACE or individuals that have intellectual disabilities or other developmental disabilities. In Illinois they are going to build off the new integrated care program that they began through Medicaid. It is a care delivery system anchored in the medical home that will include support by care teams to meet those individual care needs. I'm going to skip Massachusetts because I'm going to go into a little bit more detail with them in the MOU in a couple of slides. So let me just jump to Ohio.

They are also seeking to begin their demonstration in April of 2013. Like Illinois, they will be covering full benefit duals that are 18 or older, excluding beneficiaries that are enrolled in PACE or individuals with intellectual disabilities or other developmental disabilities. At the same time that they are seeking to implement the demonstration, they will be working towards implementing a mandatory managed care for Medicaid. They are looking to do, in addition, a comprehensive set of home and community-based services through another newly-developed waiver that they have.

So as we move towards the high level, skipping Massachusetts for right now, of where the states are with their proposals we had to go through a plan selection process. For 2013 it was really the states had a plan selection process and then there were requirements that had to be met with CMS. It included plans submitting an application, their formularies, the plan benefit package, their medication therapy management program, and models of care. So this slide just kind of highlights for you where we are in approving all of those different plan selection processes. The applications we actually completed in the end of July, and every individual plan got a application status letter. Where there were deficiencies still remaining with those applications, those will be validated

during the readiness review that they have been corrected. Formularies, the base formularies have all been reviewed, but we're still in the process of reviewing supplemental formulary files with the states. As Vanessa mentioned, because we'll be opening the gates again to adjust plan benefit packages, that won't finish until later in the fall. Everyone's medication therapy management programs have been completed. And think we're just about done models of care. So then we have the state selection process.

In California they actually selected their plans well before we started our selection process at CMS. They based it on their existing network of Medical Managed Care plans. And the plans that were selected have existing Medical-only populations and have experience operating a dual special need plan within the specific county in at least one of the last three years. So here's the list of selected plans. You'll see that in two of the counties. There's only one plan that was selected, and that's based on the state law in California.

Ohio, my slide is out of date with Ohio because Ohio announced its selected plans on August 27<sup>th</sup>. So I'm not going to go through the time of reading those selected plans, but I can certainly let you know what they are. The way Ohio has designed its program is broken out into seven regions in the state. Three plans will be in the northeast region, two plans in all of the other regions, and no one plan is allowed to be in more than three regions, if you can follow that. But they did release those final plans on August 27<sup>th</sup>.

So that leaves me Massachusetts and Illinois. Massachusetts we expect to select their final plans by the end of the month. And Illinois, I'm very hopeful that we'll hear who their selected plans are in the next week or two. So that brings me to Massachusetts. As Vanessa alluded, actually CMS and the state entered into a memorandum of understanding with them on August 22<sup>nd</sup>. And here we have the links for you for where the actual MOU is and some question and answers that are targeted towards Massachusetts but provide some background information on the MOU's in general. In addition, and I have this link on a later slide, the addendum to the original Massachusetts State proposal has also been posted on our website. And I just want to take a minute to explain what that addendum is.

For each state that submits the proposals to CMS, during its review process we submit back to the state a series of questions where we are looking to get more clarity and more information on a part or many parts of their proposal, and then the state responds back with formal answers to those questions. Rather than amend their entire proposal and rewrite their entire proposal, that question & answer will become an addendum to the proposal once the memorandum of understanding is completed. So for additional states you can look to see those as we proceed with more MOUs.

So the Massachusetts demonstration, it will cover approximately 111,000 eligible beneficiaries between the ages of 21 and 64. Massachusetts is targeted to start their enrollment on April 1<sup>st</sup>. It will cover services parts A, B, and D under Medicare, and all of their existing Medicaid Mass Health Services. In addition, some of those Medicaid services will be expanded in terms of like dental and vision. They will also be adding additional new services, such as long-term community support services and new behavioral health services.

I just want to mention why the state targeted ages 21 to 64 for a minute. The state already has an integrated Medicare/Medicaid program that's called "Senior Care Options." That's been in existence for a while, and that focuses on the dual eligible population of age 65 and over. So beneficiaries age 21 to 64 obviously aren't eligible for that program and that's why Massachusetts is seeking this targeted population.

So the Massachusetts MOU, in case you all haven't been as excited as we have been about its release and have read through it a bunch of times, is broken down into multiple sections; three main sections, which are the statement of the initiative, the purpose, and, really, the program design section. That program design section is broken out into 12 other sections, and then the actual signatures. But those 12 sections are things like the enrollment, the eligibility, the benefit design, the network, the credentialing— those big topic areas. And then those 12 sections are further flushed out in a series of appendices that are attached to the MOU. So I just want to highlight a couple of those appendices for you.

When and if you choose to look through that Massachusetts MOU you'll see that there's one appendix that really highlights any of the Medicaid regulations we needed to waive using our demonstration waiver authority to implement the Massachusetts demonstration. There's a similar appendix that highlights any of the Medicare regulatory sections we needed to waive to implement the demonstration. There is another appendix that is totally dedicated to the payment rate structure that will be used for Massachusetts, very detailed, much more in the weeds than even Vanessa got into in her slides. Lastly, there is another appendix, appendix seven, it is the program parameters, and that's really where the MOU gets into the weeds of how the demonstration will work in Massachusetts. It goes into much more detail on things like credentialing, health risk assessments, care coordination, all of the provider networks, behavioral, medical, pharmacy, all of them. So all of that detail is provided in appendix seven of the Massachusetts MOU, and it's wonderful reading. We're proud.

So that's the four states moving forward with the capitated financial alignment model. Vanessa alluded to our two other states, Minnesota and Wisconsin, that are following more of under the design contract approach that we announced prior to the financial alignment model, and just did a high level. Let me go over what they're proposing to do.

Minnesota currently has a very integrated program today, and it's Medicare/Medicaid through its dual-eligible SNP plans. What the state is seeking to do is to further test integration using administrative functions, marketing, and enrollment to further test efficiencies in their dual SNP plans that they have today. So that's how Minnesota is proceeding. Wisconsin is taking a completely different approach and looking at a completely different targeted population. They are solely focusing on beneficiaries that are currently residing in the institutional setting. They want to use interdisciplinary teams to help manage care for the beneficiary in the institutional setting and when that beneficiary transitions out into the community, so a very different approach from what we're seeing in some of the other demonstrations. I just want to say all of those proposals are still under review with CMS, and we haven't actually approved any of those other than Massachusetts yet.

So moving away from state-specific information, I wanted to go over some things related to oversight. I spend a lot of my time getting a lot of questions on this next topic, so hopefully this will help answer some things for all of you. When I think of oversight for the demonstrations I think of it as a phased-in approach. There will be the readiness reviews, what we're referring to as implementation monitoring, and then ongoing monitoring.

The readiness reviews: So we are actively working on technical guidance that will be much more detailed. Let me say that, because we are trying to get that out to you all as soon as possible. That being said, those application status letters that many of you may have received refer to a two-step process that CMS and the state will jointly use to conduct the readiness reviews. Depending on a selected plan's Medicare Advantage and Medicaid Managed Care experience will dictate whether they get both the on-site review and the desk review, or just the desk review. It will be determined between CMS and the state based on the plan.

The readiness review itself will cover a wide breadth of topics that will include health risk assessments, care coordination, testing your systems, claims process, enrollment systems, how to handle transition policies on the pharmacy and the medical side, because there will be transition policies on the medical side, how you're handling hiring new staff for call centers, for care coordination, for risk assessment, and looking at validating networks.

CMS has been actively working, and soon you will hopefully see, a general readiness review plan. It's what I like to think of what we would use if a selected plan had never participated in Medicare or Medicaid today. Anything and everything under the sun that we would want to make sure a plan is ready to have to be up and running to implement the demonstration. That being said, CMS and each state will take that general review plan and tailor it to the specific needs of their demonstration. So what would work for a readiness review plan in California will not be what works for a readiness review plan in Ohio, Illinois, or Massachusetts. They will all be tailored to meet the needs of that demonstration, and that's so we can make sure that the criteria we're looking at really address the targeted population the state is looking to cover.

And my favorite question I get is, "When will the readiness reviews occur?" I'll be honest with you, we can't start a readiness review until we have a signed MOU between CMS and the state, and the state has actually picked the plans. We need that appendix seven really to make that state-specific readiness review plan. So it's very contingent on the MOU. That being said, once the state and CMS have the MOU and the state has selected the plans, those selected plans will receive a letter from us and have -- and I know it's a tight timeframe -- about two weeks to prepare the materials for the desk review portion of the review. If the selected plan is chosen for an on-site review they'll get a second letter with another couple of weeks to prepare for that review. As the readiness review comes to a conclusion, the plan will receive a report, and they will have an opportunity to address any outstanding issues that are raised in the report.

Let me just say a couple more things about the timing on the readiness review. I know that the provider network validation is a big question that I'm getting from a lot of plans. You all can't execute contracts with your providers if you don't know the payment rates. We totally appreciate that. We are aware of that. And that desk review may have to occur in phases depending on when the payment rates are released for your particular state. We are totally going to work with the

plans and the state to make sure that there is time for you all to execute those contracts with your provider networks. In addition, we will be coordinating the timing of the three-way contracts between CMS, the state, and the plan based on that final determination of readiness. So don't be concerned that the readiness review has to be done by X date in order for CMS and the state and you to enter the contract. We are working out the timing of all of those issues so everything will happen relatively smoothly.

Once the readiness reviews are done, we're moving towards implementation monitoring. Vanessa did allude to this a little bit with her enrollment discussion. We are going to use the readiness review, take criteria from that, and jointly develop with the state milestones on key areas that we feel are essential to monitor once implementation begins in the demonstration. This can be happening right when we're starting to – right before enrollments are starting and as enrollments progress, depending on how the state is phasing in enrollments. An example of something that might be looked at in a readiness review is a hiring plan. We're not expecting you during the readiness review to have hired all of the care coordinators you may need based on the enrollment you're projected to receive. But during implementation monitoring, we're going to want to see that you actually hired care coordinators and that they are actually trained and have the background to adequately do the job of care coordination for the beneficiaries, so just an example of something that will go from readiness review to implementation monitoring. And as Vanessa did allude, depending on how you are meeting those milestone criteria, CMS and/or the state may delay future enrollments until the plan is showing that it's meeting these critical criteria.

Building off of the implementation monitoring is the ongoing monitoring. Again, I believe we'll take elements out of that readiness review that will continue to be looked at throughout the life of the demonstration, but that doesn't preclude ongoing monitoring to incorporate what state Medicaid agencies look at today in their oversight and what Part C under Medicare Advantage and Part D look at in terms of reporting requirements and their data-driven monitoring protocols.

Our oversight on a day-to-day basis is going to look slightly different than what you may be accustomed to in Medicare Advantage. Rather than having an account manager, there will be a coordinated team of individuals between the state and CMS, both in the regional office and out of central office; that will make up a contract management review team. But we were also intending to leverage existing things like the health plan management system, complaints tracking modules. So we will be leveraging existing processes as we develop this contract management review team.

Lastly, just a quick mention about evaluation, as Vanessa also alluded to. We have contracted with an independent evaluator, RTI, to do the evaluation of the demonstrations for us. They will be creating state-specific evaluation plans, as well as a meta-analysis that will look at the demonstration overall. The contractor will look at qualitative and quantitative analysis to focus on a number of things like the beneficiary health status, beneficiary satisfaction, system changes & efficiencies throughout the demonstration, and overall cost or our overall savings for both Medicare and the Medicaid program.

So moving forward, as we are actively working on the 2013, states we are still actively working on the 2014 states. So here is the list of the 12 states that will be moving forward in 2014 with the capitated financial alignment demonstration. Their proposals are still being currently reviewed by

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CMS, but they are, again, available on our website, along with the comments received during that CMS public comment period.

Different from how we handled 2013 was the timing for 2014's process for the demonstrations. This next slide kind of gives you, at a high level, the same timeline that will be used for Medicare Advantage and Part D for 2014. So just some key dates for you to look at, some of them actually aren't very specific yet. We don't have the actual date nailed down. But it's just to let you know that for the demonstration plans next year, we will be following the same cycle as Medicare Advantage and Part D. So with that being said, the last two slides really are links that are useful for you to have. And when in doubt, if you have any questions, please send them there. Vanessa and I monitor that mailbox on a regular basis, and we'll try to get back to you really quickly.

Thank you Vanessa and Marla.