Medicare-Medicaid Accountable Care Organization Model
Webinar #1: Model Overview and State Application Process
Transcript

Leslie: Welcome, everyone. Thanks so much for joining us. I'd like to welcome you to today's webinar entitled Model Overview and State Application Process. My name is Leslie Vasquez and I'll be moderating today's event.

Before we get started, I'd just like to cover a few tips so that we could have a successful webinar. First, we are recording this event and will make it available on the CMMI webpage. Second, we'll have a formal Q&A answer period at the end of the event. So we encourage you to submit any questions you have in the chat window, which is located in the upper right hand corner of the screen. Just type those in at any time and we'll make sure that we address them at the end of the event, in the order in which they're received.

If you have any technical questions, please just type them into the chat window directly. We have our producer, Colleen, on the line, who can help you with any technical challenges you may be having. And finally, we are making the slides available for download today. You can see that there is a slide download pod in the lower right hand corner of the screen. You can just click on the file name under name and click the download files button and you can access those.

And with that, I would like to welcome our presenter, Maria Alexander from the model team. Maria, take it away.

Maria: Great. Thanks, Leslie, and thanks everyone for joining us today. Before we begin, I'd like to take a moment to inform today's learning event participants that all comments made on this call are offered only for general informational and educational purposes. As always, the agency positions on matters may be subject to change. CMS's comments are not offered as and do not constitute legal advice or legal opinions, and no statement made on this call will preclude the agency and/or its law enforcement partners from enforcing any and all applicable laws, rules, and regulations. Participants are responsible for ensuring that their actions fully comply with applicable laws, rules, and regulations. And we encourage you to consult with your own legal counsel to ensure such compliance. Furthermore, to the extent that we may seek together facts and information from you during this call, we intend to gather your individual opinion only. CMS is not seeking group advice.

So, thanks again for joining us. My name is Maria Alexander and I'm the team lead for the Medicare Medicaid ACO Model. Today's webinar will cover several topics related to the Medicare Medicaid ACO or MMACO Model. And we'll start with an overview of the model, an overview of the Medicare shared savings program, and then we'll briefly discuss the quality payment program before moving on to a bit more details regarding the MMACO model design. Finally, we'll walk through the state-specific development and application process and we'll make sure to have time for questions at the end.

So begin with the model overview. The MMACO model is a new accountable care opportunity authorized under Section 1115A of the Social Security Act, which created the CMS Innovation Center. This fee-for-service model is focused on beneficiaries enrolled in Medicare and Medicaid, which you may hear me refer to as dual eligible individuals or Medicare-Medicaid enrollees. We'll also talk more later in this presentation about the option for states to include additional populations, beyond dual eligible, in this model. And this model seeks to test whether a three-way partnership between CMS states and ACOs can improve quality of care and result in Medicare and Medicaid savings.

I'm on slide seven now, which lists the principles under which we developed the MMACO model. They include protecting beneficiary choice and assuring representation in governance, aligning financial incentives across Medicare and Medicaid, offering a range of financial options to ACOs, and engaging safety-net providers and efforts to improve quality and reduce costs.

Next, I'd like to highlight a few key aspects of the model design. The Medicare Medicaid ACO model's built on the Medicare shared savings program and we'll talk more about the shared savings program in the next section of this presentation. All Medicare Medicaid ACOs or MMACOs are required to be shared savings program ACOs, but this model is not limited to existing shared savings program ACOs. We hope to encourage the formation of new ACOs through this model. CMS and interested states will jointly develop the Medicaid structure and methodologies under this model. And throughout this presentation today, you may hear about aspects of the model that are already set and defined, those are primarily on the Medicare side, as well as areas that we've left open to meet the unique needs of participating states. So, those areas of flexibility are primarily on the Medicaid side.

Through this model, CMS will provide significant operational support to participating states and ACOs. Some examples of this include running financial calculations, producing data files and reports, and collecting quality data. This model also includes the opportunity for certain ACOs that qualify as safety-net ACOs to be eligible for pre-payment of Medicare shared savings. The specific definition of a safety-net ACO has not yet been finalized, but we will release more information on that in the future. In addition to the opportunity for states to reduce Medicaid expenditures through this model, states may be eligible to share with CMS in Medicare savings. We will hold a webinar next month to discuss the methodology for calculating those savings for which a state may be eligible.

Now, moving to slide nine. So, through the MMACO model, CMS will partner with up to six states and we currently have two options available for when the model would begin. January 1 of 2019 or January 1 of 2020. You'll note the January 1 date for the performance period is set that way to align with the Medicare shared savings program performance period. The agreement with a state will be for three performance years, with the potential option to extend for a fourth and/or fifth year.

Next, I'll provide a brief overview of the Medicare shared savings program because of this model's close ties to that program, we are providing this overview for context. But we note that there are many more details of the shared savings program that we will not have time to cover today.

The Medicare shared savings program was established under section 1899 of the Social Security Act. It is a fee-for-service program in which ACOs voluntarily participate. And I'll provide a bit more detail on how ACOs defined under that program shortly. There are currently 480 ACOs participating in the program. And the shared savings program does have two tracks that qualify as advanced alternative payment models under the quality payment program, as well as a new track one plus model and we will talk more about that when we get to the quality payment program piece of this presentation.

Under the shared savings program, an ACO is a legal entity that is recognized under state or tribal law. It is identified by a taxpayer identification number and it comprises eligible providers or groups of providers that work together to manage and coordinate care for Medicare fee-for-service beneficiaries.

ACOs can earn savings under the Medicare shared savings program if the Medicare part A and B expenditures for their assigned patient population is below the established benchmark and meets or exceeds a minimum savings rate. Within the Medicare shared savings program, ACOs have a choice of financial track which are listed here. Track 1 is shared savings only. We refer to that as a one-sided track. Tracks 2 and 3, ACOs have the potential for shared savings or shared losses, depending on how they perform in relation to that established benchmark that I mentioned earlier. We refer to those as two-sided tracks. And then, third, there's a new innovation center model called the track 1+ ACO model. That is a two-sided model as well, but it has less risk than tracks 2 or 3.

The ACOs that participate in the MMACO model would be able to participate in any of those tracks of the shared savings program, subject to the rules of the shared savings program. The shared savings program uses quality measures to factor into the shared savings or shared loss rate that the ACO is eligible for. And as I mentioned before, this is just a high level overview of the shared savings program. There is a link on the bottom of this slide that takes you to the CMS website and I would strongly encourage you to look at that website for more detailed information on the shared savings program.

Generally speaking, ACOs participating in the MMACO model will be required to follow all the rules and regulations of the shared savings program. There are, however, a few exceptions in which CMS will waive shared savings program regulations. Those are listed on this slide, slide 14.

So, first regulation under the shared savings program that we will waive is in order to allow simultaneous participation by ACOs, ACO participants, and ACO providers and suppliers in the shared savings program, the MMACO model, and for ACOs that are

participating in the track 1+ model that I mentioned. That would allow them to participate in all of those simultaneously.

Secondly, currently under the shared savings program, ACOs in track 1 or 2 have retrospective beneficiary assignment. Track 3 has a prospective beneficiary assignment. For MMACOs, the beneficiary assignment methodology will follow that user under track 3 regardless of the financial track that the ACO selects under the shared savings program. Related to this second waiver, we will also ensure that the data sharing policies for MMACOs follow those under track 3, which means that data will only be shared on prospectively assigned beneficiaries.

I'll now briefly speak about the MMACO model and the quality payment program. The quality payment program has options for providers to earn qualified participant, or QP status, through participation in advanced APMs, alternative payment models, under Medicare and through arrangements with other payers. For the Medicare calculation, whether the model is a QPP advanced APM depends on the financial track that the ACO selects under the shared savings program. Track 1 of the shared savings program is not considered an advanced APM. However, tracks 2, 3, and the track 1+ model are considered advanced APM.

Under the all payer combination option within the quality payment program, certain Medicaid arrangements can qualify as other payer advanced alternative payment models. CMS will assess the Medicaid financial tracks that states and CMS develop together to determine if they qualify as other advanced APMs.

Now, we'll move on to describe more of the model design elements in more detail. I'll begin with beneficiary assignment, or the way that we attribute beneficiaries to ACO. As mentioned earlier, this model is built on the Medicare shared savings program. In this diagram on slide 18, you'll see that there are two boxes on the left, the gray box and the light blue box. These two leftmost boxes represent the beneficiaries population assigned to the ACO using the shared savings program methodology. Note that this population may include both beneficiaries that have only Medicare coverage, as well as dual eligible beneficiaries. Both of these populations are included in the ACOs Medicare benchmark under the Medicare shared savings program.

The middle light blue box on this slide represents dual eligible beneficiaries assigned through the shared savings program for which the ACO would have accountability for both Medicare and Medicaid costs. States will have the flexibility to choose the target population they wish to include in the model. This could include all dual eligible beneficiaries or a subset. Additionally, on the far right, there is a dark blue box. This represents additional flexibility we have built into the model design to allow states to extend this model beyond just those dual eligible beneficiaries assigned through the shared savings program. This could include beneficiaries who are dually-eligible but not assigned through the shared savings program, beneficiaries with only Medicaid coverage, or both. If states choose to include additional beneficiaries in the target population, their Medicaid costs would be included in the ACOs Medicaid

benchmarks, along with the Medicaid expenditures for those dual eligible beneficiaries in the target population assigned for the shared savings program.

I know that that can be a lot to take in. This is a really important piece of this model and I do want to note that an upcoming webinar that we have scheduled for about a month from now, in June, will cover beneficiary assignment and the target population in more detail. Additionally the requests for letters of intent from [inaudible 00:13:44] have this information as well.

And slide 19 covers some of the information that I just described in relation to the previous slide as well. So you can refer back to that if you have additional questions.

I'm on slide 20 now. At a high level, the Medicaid financial methodology measures expenditures for the assigned population and will include all Medicaid covered services. The methodology will compare the ACO's assigned population's expenditures to a benchmark and determine the amount of savings and losses and share of savings and losses that the ACO would be accountable for under Medicaid. CMS and states will work together to design the specific methodology for that state. I'll note that this is just a very high level overview of the Medicaid financial methodology, but that webinar that I previously mentioned will go into more detail about how that methodology would be developed by CMS and the states.

The MMACO model will include multiple quality measure steps. First, ACOs will be assessed on the quality measures used in the shared savings program. Performance on these measures will factor into the ACOs Medicare shared savings and losses, consistent with the rules under the shared savings program. The links that we had earlier in this slide deck to more information about the shared savings program does include information on the measures that used and additional information about how quality measures are used in the shared savings program.

The second set of measures is measures that the state will have the flexibility to select. And under this state-specific measure set, we will use the performance of ACOs to affect the Medicaid shared savings. Or in the case of losses, to affect those. And then finally, CMS will conduct a quality of life survey for the dual eligible population in the model. Initially, this information will only be used for informational purposes. But we may choose to incorporate it into ... it may be phased in in later years to affect the Medicaid shared savings or losses under the model.

Now, moving on to slide 22 and discussing data and reports. As mentioned earlier, this is a key area where CMS intends to provide significant operational support to states. CMS will share Medicare and Medicaid data for assigned beneficiaries with each ACO. The Medicaid data will come from T-MSIS, the transformed Medicaid statistical information system and it is important that states are up to date on T-MSIS reporting in order for the model to be implemented. Because the ACOs participating in this model will be shared savings program ACOs, they will continue to receive the standard files and reports, including Medicare data, provided by the shared savings

program. And CMS also intends to link the Medicare and Medicaid data to share with ACOs.

Consistent with CMS's other ACO models, CMS will offer a learning system for participants. In this case, both states and ACOs. This learning system will be used to share best practices between states, ACOs, and participants in other CMS initiatives, both to improve participant performance and help improve the model.

On slide 24, you can see some examples of the types of activities that may be offered to participants through the MMACO learning system.

As with all innovation center initiatives, CMS will evaluate the MMACO model. The evaluator will attempt to answer a series of questions, including assessing the model's impact to cost, quality, and utilization. And how model participants went about implementing changes as a result of the model.

The evaluation will use both qualitative analyses such as focus groups, interviews, and surveys, and quantitative analyses using utilization, cost, and quality data.

I'm not going to move away from the model design details to discuss the application process. Slide 28 shows the overall process from letter of intent submission by the state to the performance period beginning for the ACOs. We think of this process in two phases. The first phase, represented in the blue boxes in this slide, represents the state's specific development and application process. Once CMS and the state reach agreement, ACOs may apply to participate in the model. That's not to say, however, that providers are not involved in the state-specific development process, simply that the official ACO application process does not begin until later. The yellow boxes represent the ACO application process and beginning of the performance year for ACOs. We'll walk through this process in more detail on the next few slides.

Slide 29 shows a more in-depth view of the state application and development process. It begins with a state submitting an LOI, a letter of intent, but I should note here that states are welcome and encouraged to begin engaging with CMS prior to submitting a letter of intent. So this development process may in fact begin before the official letter of intent is submitted. And we encourage states to begin the process of working with CMS and discussing the model with CMS as early as possible.

CMS, the state, and potential ACO partners, which are essentially providers or groups of providers in the state, will develop pieces of the state application, which includes things like the Medicaid financial methodology, selecting the measure set, identifying any additional ACO eligibility criteria. Once the application is complete, the state application will go through a clearance process at CMS, where it will be reviewed by various components within CMS, the department of health and human services, and the office of management and budget.

Additionally, states are required to secure the necessary Medicaid approval. This could be through a state plan amendment and/or through Medicaid waiver request.

That state plan amendment or waiver request would need to be reviewed by CMS and approved by CMS consistent with existing policies and regulations. I should note here that the process for the state application to be reviewed, as well as the process for the state plan amendment or the Medicaid waiver to be reviewed, are shown in this slide as occurring in parallel, but they may take varying amounts of time. So, they may be overlapping, but one of the processes may take longer than the other. Once both of these processes are complete, CMS and the state would enter into a participation agreement.

On slide 30, we focus in on the ACO application process. So once that CMS and state participation agreement have been executed, a request for applications would be released to ACOs and ACOs would then apply to the MMACO model and to the shared savings program. As I mentioned before, this model is not limited to existing shared savings program ACOs. So, it could either be an ACO that has not previously participated in the shared savings program applying to participate for the first time, and they would apply both to the shared savings program and to the MMACO model, or it could be an existing shared savings program ACO that is in the process of applying to renew their participation agreement for an additional three years with the shared savings program going through this same process.

Once the ACOs have gone through the application process, CMS, the state, and the ACO would execute participation agreements with those approved ACOs. There will be an MMACO participation agreement, and additionally, ACOs will enter into the shared savings program participation agreement. I want to note here that we intend to align the timing and the process for applying to the shared savings program and the MMACO model as closely as possible.

Now I'll talk a bit about state eligibility. The MMACO model is open to all states and the District of Columbia. This is a fee-for-service model. So a state with all of its beneficiaries in Medicaid managed care would not be eligible for this model. However, if you have questions about this eligibility requirement and the specifics of your state's Medicaid arrangement, we're more than happy to discuss that with you. So please don't hesitate to reach out to the MMACO team. We'll have the email address up at the end if you do have questions about how that might apply to your state.

Additionally, we will give preference to states that have low Medicare ACO saturation. So, states that do not have many existing SFP ACOs should consider this model as we would hope to encourage new participation from ACOs through it.

As I mentioned previously, CMS intends to use T-MSIS data for calculating Medicaid savings and providing files and reports to ACOs. Additionally, we will need Medicaid data through T-MSIS to run financial modeling during the state-specific development and application process. States may also need to pass state-level legislation, and as mentioned previously, we'll need to secure appropriate Medicaid approval. The process for securing those Medicaid approvals can really vary by state, and so we

strongly encourage you to start that process as early as possible and to engage with CMS as early as possible if you are considering this model.

Speak a bit more about the Medicaid authority. In addition to the state's application going through the CMS, health and human services, and OMB application process, the state must secure the necessary Medicaid approval. Because of the flexibility available to states in designing the Medicaid portions of the model, the appropriate Medicaid authority may vary by state. As you may know, the amount of time needed for a state plan amendment or a waiver may vary depending on how significant the changes the state is making are. Innovation center staff, regional office staff, and the center for Medicaid and chip services will work closely together with states to make this process as smooth as possible. But again, we strongly encourage states to start engaging with CMS on this as early as possible, given the variation in amount of time it may take to get the appropriate approval. Additionally, depending on the changes that the state is making, there may be requirements around public notice periods.

Ultimately, the state's application will need to include a description of the state's target population, the ACO eligibility criteria, a description of any legislative action the state will need to take in order to implement the MMACO model, the Medicaid financial methodology and quality measures, and a description of provider and beneficiary engagement efforts that have been conducted. CMS does not expect states to come to us with these items fully developed, but rather anticipates working closely with states and stakeholders in those states to design the model in a manner that meets the state's, provider's and CMS's goals.

I'm going to talk through some of the deadlines and also the process for submitting a letter of intent, for which these deadlines apply. You can see that there are a separate set of deadlines for 2019 versus the 2020 start. Again those are January 1st start dates. So the deadline for 2019 is August 4th of 2017. And then we additionally have a deadline for when the CMS state participation agreement would need to be executed, which is at the end of March of the prior calendar year. The reason for this March deadline is so that we can align the application cycle for ACOs between the shared savings program and the MMACO model and additionally to make sure the ACOs have sufficient time to prepare for the start of the performance period.

As noted on the next slide, those deadlines are the states must submit their letter of intent prior to the deadline for the state to be considered for a possible start, but it is not a guarantee of approval for that date and we really strongly encourage you to initiate the process sooner than that, especially given the variable timelines that may be required either to develop the Medicaid financial methodology, elect quality measures, secure the necessary Medicaid approvals, and various other aspects of state-specific development.

The letter of intent is non-binding and it must be submitted by email to mmaco@cms.hhs.gov. That's also the email address where you can contact us if you have any questions. Appendix A of the request for letters of intent include the template that will show you all the questions that need to be included in the letter of

intent submission. And the letter of intent must be accompanied by at least one non-binding letter of interest from a potential ACO partner. A potential ACO partner is not required to be an existing ACO. It can be any provider or group of providers in your state that wish to engage with CMS and the state during the state specific development process. Submitting a letter of interest does not hold the ACO to participate in the model nor will participation in the model be limited to those providers that submit letter of interest. But we do want to engage those providers during state specific development process as well and this is a required part of the letter of intent.

Additionally, the letter of intent must include brief descriptions of the state's vision for testing the model, the state's current approach to payment and care for dual eligible beneficiaries, a beneficiary and caregiver and provider engagement plan, and an update on the status of the state's submission of T-MSIS data.

This slide includes links to several important documents that can help you better understand the MMACO model. The request for letters of intent, which includes Appendix A, which has the letter of intent template, is on the CMS website. Additionally, there are FAQs, and also another link to that email inbox that I mentioned previously. Again, I want to note that you can also download these slides through the download files box to the right of the webinar, if you want to be able to access these links after this webinar.

And so, with that, I will turn it back over to Leslie and we will open it up for questions.

Leslie: Thanks, Maria. I'd just like to remind everyone that we've got the chat window along the right hand side of the screen. If you have any questions, please go ahead and type them into the chat window. We'll answer all questions in the order in which we receive them.

All right, I see we've got our first question from the audience. The question is around MSSP. Will MSSP track 1 AIM funded ACOs be eligible to participate in this program if offered in their state?

Maria: Just to make sure I understood the question correctly, that was will MSSP track 1 ACO investment model funded ACOs be eligible to participate in this program if offered in the state? There is no restriction on AIM SSP ACOs participating in this model. They would not be eligible for the safety-net prepayment of funding that I mentioned, because that's similar to the funding that you receive under AIM. But the model's not restricted to exclude AIM ACOs as long as you meet the other eligibility criteria.

Leslie: Thanks, Maria. Are there any other questions from the audience? We've got some additional audience members typing in questions, so we'll just await those in the chat window. Go ahead and type away your questions in the chat. If we don't get to them today, we'll make sure that we pass them along accordingly to the multiple-

Maria: Great and while folks are writing in questions, this is Maria, I'll just add that we did this webinar for a broad group of states and other folks who are interested. But, really getting into the details of the model is obviously a state specific discussion, and so we really do welcome states that want to discuss their specific situation, we're happy to have one-on-one conversations following this as well.

Leslie: Thanks, Maria. Looks like we've got a few additional questions in the chat window. So the next question is, can you speak to the level of integration you expect from the MMACOs compared to FIVESMPs and MMPs under the financial alignment demonstrations?

Maria: Sure. I can talk a little bit about this model in relation to the financial alignment initiative, which is run out of the Medicare Medicaid coordination office that we worked closely with them. So, under the financial alignment initiative, there are two options for states. Most states are in the capitated arrangement, under which CMS and states partner with MMPs, those are the Medicare Medicaid plans. And that's a managed care approach. It has similarities with our model in that both models intend to improve care and better align financial incentives across Medicare and Medicaid for the dual eligible population. But a key difference is that this model, from the capitated models, is that this model is a fee-for-service model.

And then additionally, the financial alignment initiative has a managed fee-for-service model. That has a bit more similarities to this model because it is a fee-for-service model. The primary difference in the structure of that model is that that's primarily a relationship between CMS and the state. States may choose to partner with ... to change the way that they work with providers downstream from that. Where this model, up front, is a three way partnership between ACOs, CMS, and the state. To get more to the specific question around the level of integration that we expect to see, generally with our ACO models, [inaudible 00:33:04] is not prescriptive about the specific care intervention that an ACO uses to address the needs of its population. But I would say that generally, there is a lot of consistency across model and the financial alignment initiative in terms of the types of things that we would want to see, which would be better coordination of care across all the providers that a beneficiary sees.

If you have specific additional questions around differences between this and the financial alignment initiative or other models targeting duals, do feel free to follow up with us via email. We're happy to discuss that further.

Leslie: Thank you. Our next question in the chat window. Are FQHCs a good fit for becoming an ACO?

Carrie: Hi, this is [Carrie Vandergrift 00:33:53] with the shared savings program and we have specific rules in the shared savings program to allow for FQHCs and even RHCs to form their own ACOs, so yes. There are rules in place to allow you to form an ACO made of exclusively with FQHCs, RHCs. We do caution that it can sometimes be harder to reach the 5,000 beneficiary threshold. So you may want to partner with a

few other entities, but we definitely welcome and encourage FQHCs and RHCs to join ACOs.

Leslie: Thanks so much. I can see that we've got multiple attendees adding additional questions into the chat window. Please keep them coming. We've got plenty of time to address your questions.

All right, we've got our next question in the chat. Under this model, are there any flexibilities for ACOs to offer additional benefits that wouldn't be ordinarily covered by FFS?

Maria: Great, thanks for that question. So, on the Medicare side, the rules around benefits that ACOs can offer to ACOs will follow the rules under the shared savings program. And there is included for certain tracks of the shared savings program a waiver of the Smith three day rule, so that would be available to any ACOs that meet the requirements under the shared savings program for that. To speak more broadly, though, to the extent that it's allowed under existing laws, ACOs can certainly ... I wouldn't consider this a benefit in the way that we define benefits that are covered by Medicare, but things like care coordination services or we have examples of Medicare ACOs that do home visit programs and things like that that aren't necessarily reimbursed under fee-for-service Medicare, but the ACO feels is an effective way to better manage care and improve quality and reduce cost. As long as those things are allowable under existing laws, ACOs can certainly engage in those activities.

Sorry, I should clarify that we don't then pay for those services through the model, but ACOs can choose to engage in those types of activities.

And then on the Medicaid side, we would work with states to determine whether any changes needed to be made to what they're covering and how they're covering services under Medicaid but there aren't existing plans to add additional benefits through this model.

Leslie: Thanks, Maria. And it looks like we've got a Medicaid related question next in the chat window. Someone's looking for some expertise on the Medicaid side to speak to the 1115 or the FPA process.

Maria: Sure. So, I think depending on what your specific question is, there may be different folks in the center for Medicaid and CHIP services or in the regional offices of CMS that handle a lot of the FPA questions. So, if you don't mind emailing us, you can email mmaco@cms.hhs.gov with more specifics on your question or if you just want to talk through the process more, we're happy to get on the phone with you and folks from the center for Medicaid and CHIP services or from the regional office to make sure we can talk you through what the ... either the 1115 waiver or demonstration process, or the FPA process is in relation to your state specific situation.

Leslie: Thanks, Maria. And I just typed that email address in the chat window just for easy reference. Our next question. As an existing ACO, who should you contact to express interest in this program? Is there a list of states who have expressed interest in submitting an LOI?

Maria: Thanks for that question. So, the right person to contact is probably going to depend on your state and how your state's Medicaid program is structured. But if you have an existing contact in your state Medicaid office that you typically send questions to, that's probably a good place to start. As I described before, this is sort of a two phase process for this model. The first phase is working to develop the state specific aspects of the model and certainly want ACOs to engage in that, but that process can't really get fully underway without a state having interest. So I would, if you have an existing contact at your state, I would contact them. And if you are having trouble identifying who that might be or whether your state might be interested, you're welcome to email that same inbox and if we have a contact at the state, we're happy to put you in touch or we have, with some states, had joint calls between the state, providers in the state, and CMS. So, feel free to reach out to us, but I would also encourage you to talk to your usual contact in the state Medicaid office.

Leslie: Excellent. Are there any additional questions from the audience? All right, I see we've got some additional audience members typing questions. We'll just wait while they populate.

All right. Our next question. What is the biggest difference between the current model and the new?

Maria: So I'm not sure I'm totally understanding your question, but you may be asking what the biggest difference between the existing shared savings program and this new model? Though if I'm misinterpreting that, feel free to speak up or write your question to the chat more. But, if that is your question I think that the big difference is that the Medicare shared savings program ... okay, great. It looks like that is what you are asking. So, the Medicare shared savings program is an ACO program that exclusively has Medicare accountability. What this model does is introduces Medicaid accountability into that program. Well, not really into that program, but through, by adding on to that program.

There are obviously some other smaller differences, but I think that's sort of the fundamental difference is that right now, an ACO that participates in the shared savings program takes on accountability for part A and B expenditures and quality of care for a patient population and then can earn savings or in some cases may be accountable for losses based on how the expenditures for their population compared to a benchmark. But, for the dual eligible beneficiaries that would be assigned to an ACO under the shared savings program, even though they have Medicaid costs, the ACO would not be accountable for those Medicaid costs.

But through this model, we would partner with states to then offer ACOs the opportunity to take on accountability for a fuller picture of the dual eligible

beneficiary's total cost of care for that population. But certainly, if you have more questions about that, we're happy to talk through it more. As I said, there are some other differences, but that's the main fundamental change that this model introduces.

Leslie: Thanks for clarifying that. Are there any further questions from the audience? We've got time for quite a few more questions, so please go ahead and type them in the chat window.

All right, I can see that we've got another question underway.

All right, our next question. Is the learning system already set up and running so that MMACO states may join immediately, or is that still being set up?

Maria: So TMS, the TMS innovation center has learning systems set up for our existing models, so for example the next generation ACL model has a learning system. The comprehensive primary care plus initiative has a learning system. There's a learning system for shared savings program, ACOs, and those are just a few examples. Those are up and running. We don't have an existing MMACO model learning system up and running because we'll wait until we have states and ultimately ... we'll wait until we have states onboard for the model and then later we'll integrate ACOs as well. We typically design those learning systems with input from the model participants. So, there's some design that's happening now, but we would also get feedback from states and ACOs that are participating about topics that they were interested in and various aspects of the model that they wanted to explore more with each other or with CMS. We would expect for the learning system to start at the beginning of the performance period, if not with some potential options for earlier information to be shared between states prior to when performance period starts.

Leslie: Thanks, Maria. Are there any other simple questions? All right, I can see that we've got one additional question. Would states have the opportunity to participate in shared savings?

Maria: So, a state's eligibility to participate, to earn Medicare shared savings, will be dependent on the performance of the ACOs in their state. So, it's not that we would decide up front this state is eligible for Medicare shared savings and this state is not. There's a fairly complex methodology for determining whether a state is eligible and how much savings they're eligible for based on the performance of ACOs in the state. And we will have a webinar in June to go into more depth on that. You can also look at the request for letters of intent had a high level summary of what that methodology looked like.

Leslie: Thanks so much, Maria. I can see that we've got some additional questions underway in the chat, so we'll just wait for those to populate.

All right. Our next question. Will the MMACOs be able to use integrated marketing materials including member materials such as a summary of benefits, provider directories, etc., and integrated appeals and grievances processes?

Emily: So, I'm not sure that this is something that we have considered. I think, just thinking off the top of my head, this is Emily Kerr, by the way, I'm also on the model team. Our usual approach to beneficiary outreach would be similar to other ACO models where there's a notification letter for beneficiaries. You're describing a different type of outreach effort that I think we think about more with MA plans, for example. But I couldn't give you a final answer on that. I think if it's a thing of interest, if you can reach out to us with some examples, we'd be happy to talk through it. It might be the kind of decision that would be made later on in the process of working with the states.

Leslie: Thanks for clarifying that. It looks like we have another question being typed into the chat as we speak.

All right. Our next question. Would ACOs and states be able to move towards a capitation payment on either the Medicare or Medicaid side?

Maria: So, this model is built off of the Medicare shared savings program which does not have an option for a capitated payment to ACOs that as payments continue as fee-for-service Medicare payments. And then there's a reconciliation after the end of the year where we compare performance to the benchmark and shared savings or losses are paid. So, at this time we don't, because of the tie to the shared savings program we wouldn't depart from that in terms of the Medicare payment.

On the Medicaid side, our expectation is that the financial methodology on the Medicaid side would roughly near the financial methodology on the Medicare side. Obviously, there will need to be changes to account for the fact that we're talking about Medicaid and not Medicare but at a high level, we expect them to be similar methodologies. But certainly, if you have a specific approach in mind on the Medicaid side that you'd like to talk through with us more and see whether that might fit within the model, we'd be happy to discuss that further. But it hasn't really been contemplated, given that we expect the Medicaid side to mirror the Medicare side in most ways.

Leslie: All right, thanks for clarifying that. Are there any additional questions for our experts? I think we have a few additional moments where again, we can answer a couple of additional questions then we will post a short confidential survey at the end for you to provide feedback. But we have time to address a few more questions if you'd like to go ahead and submit them in the chat window.

I see we've got one more question underway. All right. Our next question. Would it be possible to include MLTSS Medicaid enrollees in an ACO model if they receive acute and primary services via fee-for-service?

Maria: So, I think the question might be coming from someone who's in a state where the long-term services and supports under Medicaid are carved out or sort of paid for in a different way than you're paying for the rest of Medicaid services. So, I think, for the most part, we should discuss that with more contacts in your state, so we'd be happy to discuss that with you further. But I'll give a more general answer as well which is that we generally expect that all Medicaid services would need to be included in the ACOs Medicaid benchmark. So that would include LTSS services. If they're currently being paid for in a different way, we could talk to you about options for ways to either move them into the ACO benchmark possibly starting in the second year or something like that. But I would say, generally, we think this model would be most effective in states where all services for the beneficiaries are covered under Medicaid fee-for-service.

Emily: I would add just one other thing. One of the core elements of these models is sharing utilization data with participating providers on an ongoing basis. So regardless of the specific payment arrangement for these LTSS patients, I think we would probably need to have a scenario where they were generating some kind of claim or similar thing that could be shared with the ACOs participating providers. Otherwise, that would be very challenging.

Maria: But I will just reiterate that please don't hesitate to reach out to us. We're happy to get more of the details of how your state currently handles that and figure out how best to work within the context of this model.

Leslie: Thank you both. It looks like we've got another question on the chat. Does CMS anticipate releasing additional Medicare Medicaid integrated model opportunities in the future? I.e. not based on the shared savings model. And I think they're trying to clarify that that relates to ACOs.

Maria: So, I can't speak to any models that are not currently publicly announced. You can go to the innovation center website and look at the existing models. We do have other models that target the dual eligible population and we have several different types of ACO models. So, do feel free to check out that website. But, certainly can't speak to anything that is or is not in development at this stage. But you can find our existing models on the CMS website and you're always welcome to submit suggestions and ideas for other models as well.

Leslie: All right. Thanks so much. At this point, we'd like to go ahead and wrap up the Q&A. We appreciate all of our speakers in answering the questions that came across the chat window today. And just thanks everyone so much for participating in today's event.

Before closing the event, we would like to invite you to provide feedback. Our producer will shortly move some questions on the screen for your response. Your responses are confidential and we really appreciate it if you can just take a moment or two to provide us with your feedback on each item. We will use this information to improve how we deliver future events with this model team.

Our next learning event is scheduled for June 8th at 1:00 PM Eastern. I'm going to post a link to that in the chat shortly that you can use to register for that event. We encourage you to reach out to the model team using the email just provided or visit the model webpage online as well.

Thanks everyone. Have a great afternoon.