

MEMORANDUM

TO: State Executives, CPAC, Finance Committee, Medicare-Medicaid Work Group, Legal Committee, Medicaid Advisory Group

FROM: Mike Check, Vice President for Medicaid and Long Term Care Policy

SUBJECT: CMS Approval of Washington State Medicare-Medicaid Integration Proposal

DATE: November 2, 2012

On Thursday, October 25, the Centers for Medicare and Medicaid Services (CMS) and Washington State signed a Memorandum of Understanding (MOU) marking the next key federal-state step in launching the Washington State Medicare-Medicaid Financial Alignment Initiative entitled, [HealthPathWashington](#). The Washington State is the second state to enter into an MOU with the CMS Medicare-Medicaid Coordination Office (MMCO) but the first managed fee-for-service (MFSS) approval. On August 22, the Commonwealth of Massachusetts and CMS signed the first Financial Alignment MOU.

On the same day as the Washington State approval, the Kaiser Family Foundation released an analysis of research on previous efforts (capitated and managed fee-for-service) aimed at reducing costs associated with full duals. ***The analysis indicates that virtually none of the earlier efforts produced projected savings and raises notable concern about the likelihood of the existing Financial Alignment Initiative to produce projected savings.***¹ The analysis goes on to highlight specific action steps likely necessary to make such savings achievable.

In the following document, AHCA offers key points gleaned from a review of the Washington State MOU, discussions with MMCO staff, the Washington State Affiliate, as well as a comparison of the Washington State and Massachusetts MOUs (where appropriate). The document also provides an overview of MFSS as well as the Washington State MOU.

¹ Brown, R. and Mann, David. [Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence](#). Mathematica Policy Research. October 2012.

Key Findings

The Washington State MOU marks the first managed fee-for-service financial (MFFS) alignment agreement. In general, MFFS refers to contracting arrangements between states and other entities which coordinate and oversee service delivery and organization of local or regional provider networks for a fixed fee, typically a per member per month (PMPM) payment. Providers participating in a MFFS network are paid using fee-for-service (FFS) rates and may be eligible for some shared savings.

- ***Taken together, the Commonwealth of Massachusetts MOU and the Washington State MOU are strategic MMCO action steps.*** Regarding the Medicare-Medicaid Financial Alignment Initiative, considerable concern has been expressed about the lack of state and plan experience, state proposals to enroll their entire full Medicare-Medicaid eligible population rather than using pilot programs, passive enrollment, and concern about payment rates. By signing MOUs with Massachusetts and Washington State, MMCO has somewhat avoided heightening these concerns while still demonstrating forward momentum (see below). For example, Massachusetts has extensive prior Medicare-Medicaid integration experience while Washington State has operated a number of pilot programs.
- ***CMS and the state agreed to a less aggressive integration initiative than originally proposed.*** The initial Washington State Financial Alignment proposal included two strategies, MFFS and capitated, risk-based or managed care, and three stages culminating in moving from a proposed initial MFFS approach to a statewide integrated capitated, risk-based managed care network. In the MOU, Washington State and MMCO agree to pursue a modified version of stage one. Specifically, Washington will launch a statewide network of health home (or medical home) lead entities which, in turn will deliver health home care coordination via a health home care coordination organizations. Direct care and support services will be delivered by health home networks; each network has a health home lead entity and health home coordination organizations. Direct services will be delivered by a broad representation of community-based organizations including primary, acute, mental health, substance abuse disorder, and long-term services and supports (LTSS) providers. Medicare-Medicaid financial alignment using capitated, risk-based managed care only will be used in three counties (King, Snohomish, and Whatcom). No provision for expansion of managed care is made in the MOU. A new proposal would be needed for such action.
- ***Use of the Section 2703 of the Affordable Care Act (ACA) offers enhanced Medicaid matching but raises a number of questions about net costs to the state.***² The ACA added a new Section 1945 to the Social Security Act, “State Option to Provide Health Homes for Enrollees with Chronic Conditions.” Functions and CMS requirements for health homes are described in a detailed State Medicaid Directors Letter ([SMDL 10-024](#)) released in 2010 and an accompanying, as well as equally detailed, state plan option pre-print

² States have a variety of policy vehicles with which to implement MFFS. In July 2012, CMS announced the availability a new state plan option for MFFS and described how the new vehicle and other existing authorities could be used for payment and service delivery reform. For more information, see [State Medicaid Directors’ Letter 12-002, Policy Considerations for Integrated Care Models](#).

template. In the MOU, CMS stipulates that implementation of the demonstration is contingent upon the state receiving CMS approval for its health home state plan amendment (SPA) and that the new health home program must comply with all health home SPA requirements. The state has targeted January 1, 2013 for approval. The core functions of a health home are matched at a 90 percent federal medical assistance percentage (FMAP). Enhanced health home matching funds only are available for the first eight fiscal quarters for which the SPA is in effect, not health home operation. It is unclear whether the enhanced matching and any savings from care coordination activities will offset ongoing rigorous CMS reporting and quality monitoring costs for health homes. Such administrative activities are matched at 50 percent FMAP.³ Furthermore, through a retrospective calculation for potential performance payments (see below), any Medicare savings will be reduced by Medicaid expenditure increases above specified levels.

- ***Health Homes will be paid using a methodology set forth in the SPA while providers will be paid using Medicare and Medicaid fee-for-service rates.*** Health homes will be paid using a per member per month (PMPM) methodology which will be described in the SPA. As noted above, for the first eight months from SPA approval, certain health home operations will be matched at a 90 percent FMAP. Providers participating in the health home networks will continue to bill Medicare and Medicaid and be paid using fee-for-service rates as they do now. No enhanced federal matching is available for health home network LTSS providers except for those delivering home and community-based services (HCBS) following beneficiary enrollment in the state's Money Follows the Person program.
- ***Other costs associated with program implementation may be offset by any savings from the demonstration should certain financial performance and quality standards be met.*** Washington State may accrue savings on Medicare and Medicaid services. [Section 1899](#) of the Social Security Act authorizes the Secretary to established shared savings arrangements. These provisions are waived under the demonstration. The MOU lays out specific calculations for how the state may achieve savings from Medicare. And, the MOU describes steps the state must take to ensure that Medicare savings are not double counted. CMS also has laid out "[Principles for Beneficiary Enrollment in Medicare Fee-for-Service Models](#)" that discuss attribution; attribution also is specified in the MOU. Any savings will be shared between the state and federal government; the MOU makes no provision for savings to be shared with health homes or providers participating in health home networks. However, there appears to be no barrier to the state sharing savings with health homes and related networks as long as the principles, noted above, are not violated. Finally, as noted above, a recent review of Medicare-Medicaid eligible care coordination research raises questions about whether such arrangements will produce savings at the projected levels.
- ***The MOU indicates that the "State will automatically enroll eligible beneficiaries ... to a qualified Health Home Network;" but, as in the Massachusetts MOU, the state must transmit CMS-approved materials on the demonstration to potential participants prior to "auto-enrollment."*** However, the MOU does not specify the number of days prior to auto-enrollment such information must be transmitted. The Massachusetts MOU stipulated that the initial notice of auto-enrollment (or passive

³ The Washington State CY 2012 and CY 2013 "regular" FMAP is/will be 50 percent federal.

enrollment) must be transmitted 60 days before such enrollment. Additionally, the Washington State MOU notes only one pre-enrollment notification; in the Massachusetts MOU, three pre-passive enrollment notifications are described.

- ***Enrollment will be lower than initially proposed.*** Washington State’s initial proposal implied enrollment of the entire full dual population. The MOU indicates enrollment will be in the 20,000-30,000 range depending upon assessment scores and health home eligibility.
- ***CMS will conduct a readiness review of the state prior to implementation.*** CMS had indicated that it would only conduct readiness reviews of plans in capitated, risk-based financial alignment initiatives, not the states. In the Washington State MOU, the first MFFS effort, CMS indicates that will it conduct a readiness review of the state to ensure the state, health home lead entities and related networks are prepared. In prior discussions, CMS had indicated the plan readiness review tool would be released for public comment. To date, the document has not been shared.
- ***Some detail is offered on Health Home Network infrastructure requirements.*** Health Home Networks must establish subcontracts and/or signed memoranda of understanding (MOA) among network participants “to ensure referrals and ongoing coordination, addressing issues such as roles and responsibilities of different parties.” Standardized training and technical assistance must be provided to network providers and a web-based Health Information Technology (HIT) platform. The Predictive Risk Intelligence System (PRISM) will be used to identify potential demonstration participants, develop their Health Action Plan (e.g., plan of care), and serve as interoperable HIT platform for care coordination and communication among providers.
- ***Both MOUs contain beneficiary protections but with several differences.*** First, regarding choice of providers, the Washington State MOU indicates that participants may change Health Home providers on a monthly basis and may select providers and change providers following existing Medicare FFS rules and Washington State Medicaid rules. The MOU indicates that continuity of care will be augmented by health home care coordination and by ongoing FFS provider choice provisions. In Massachusetts, beneficiaries may opt out or change plans on a monthly basis, also. In terms of continuity of care, changing provider is limited to the array of providers in the plan(s) network. Additionally, the Massachusetts MOU notes that plans must ensure access to all medically necessary services. The Washington State MOU is silent on medical necessity while it is likely that the federal Medicare definition will be followed for Medicare-financed services and the state Medicaid definition will be used for Medicaid-financed services. Third, the Massachusetts MOU contains a protection targeted to “enrollment assistance and options counseling.” While the Washington State MOU discusses how information will be conveyed to participants as well as assistance, no specific beneficiary protection is stipulated. Fourth, both discuss the Americans with Disabilities Act and the Civil Rights Act. However, the Washington State MOU is silent on U.S. Supreme Court’s decision in *Olmstead*. This likely is related to ongoing *Olmstead* litigation in Washington State. Finally, the Massachusetts MOU contains an “enrollee communications” specific protection. However, maximizing use of

home and community-based services (HCBS) remains a key component of the effort. The Washington State MOU contains a description of enrollee communication but not a specific requirement.

In conclusion, the Washington State MOU is the second in a five step implementation process. First, the state submitted its proposal to CMS and, second, the state and CMS entered into an MOU framing the demonstration. Third, the state must secure approval of its health home SPA. And, fourth, all indications are that far more detail regarding how Washington State demonstration will become available when the approved SPA is released. Finally, the state and CMS will enter into a “final demonstration agreement.” CMS will not enter into the final agreement until the SPA has been approved and the state has successfully completed its readiness review.

Potential Long Term Care Profession Considerations

For the long term care profession, the following areas merit additional exploration:

1. *Provider participation in Health Home Networks* – Based on the information, the Memoranda of Agreement (MOAs) primarily are targeted to LTSS providers.⁴ The expectation is that the health home networks will contain key LTSS providers and will have relationships for care coordination purposes with non-network LTSS providers. Going forward, understanding the structure and specifics of the MOAs will be key as well as the criteria used by health home networks for identifying LTSS network providers.
2. *State use of savings* – As noted above, any savings will be shared between the state and the federal government. The provider community might explore whether such savings could be pushed out to providers via quality or performance incentive payments.
3. *Participation in a Network as a Health Home Care Coordination Organizations* – The proposal and MOU both are vague on precisely what sorts of entities may serve as care coordination entities. Likely candidates are Area Agencies on Aging and Centers for Independent Living. However, nursing home providers might explore the possibility of delivering care coordination services or serving as one of the care coordination organizations within health home networks.
4. *Access to PRISM* – PRISM could be an important step toward interoperable health information technology for health home network participating providers. It will be important to understand the level of access granted to network providers and non-network providers as well as whether any financial assistance will be available to support PRISM use.
5. *Quality will be critical* – The state only will be eligible for shared savings with the federal government from reduced Medicare expenditures if it meets both fiscal *and* quality targets. The provider community should carefully define its value proposition with the state in terms of aiding the state meeting quality requirements such as preventable rehospitalizations.

⁴ The single Memorandum of Understanding (MOU) is between the state and CMS framing the entire demonstration. The Memoranda of Agreement (MOA) will be individual agreements between health homes and health home network providers.

6. *Support with Behavioral Health* – Health Homes are required to ensure behavioral health is embedded in their supports. The Washington State proposal includes a discussion of such services. Assistance with securing behavioral supports or delivering behavioral support might also be a point of discussion with the state and Health Home Lead Entities.

The items, above, are not intended to be an exhaustive list. When the SPA is approved, the results of the readiness review, and the final agreement are released additional opportunities and challenges will emerge. If you have questions, suggestions or concerns, please feel free to contact me at mcheek@ahca.org or 202-454-1294.

MFFS and WA State MOU Overview

The Washington State MOU is the first Financial Alignment example of a MFFS arrangement to-date. However, states and federal government have long experimented with MFFS as a method to better coordinate care for persons who are Medicare-Medicaid eligible. While considerably less attention has been paid to MFFS, core elements for maximizing the potential for success have been defined. Two key elements are:

- **Accountable Entity** – In Washington State, the Health Home Lead entity is accountable for care coordination and overall delivery of services; and
- **Identification of High-Need, High-Cost Beneficiaries** – Likelihood that MFFS will achieve savings is dependent upon identifying beneficiaries who are at risk of becoming high cost. PRISM is intended to address this function in Washington State.

Other MFFS components are: a) multidisciplinary care team use; b) comprehensive assessments conducted; c) person-centered care planning; d) comprehensive care management intervention implementation; and d) real-time information exchange.⁵

Some key barriers to MFFS achieving Financial Alignment Initiative goals are that no completely replicable models that have focused on Medicare-Medicaid enrollees exist. And, time and resources will have to be expended to create managed FFS programs that reflect a state's unique environment. Additionally, if there is no single accountable entity that is responsible for coordinating care for Medicare-Medicaid enrollees, states may have to develop work-around solutions to obtain information on care provided outside of the accountable care system. Washington State appears to have addressed this issue, in concept, with PRISM and its Health Home Lead Entity proposal components.

While obtaining real-time information on hospital admissions and discharges and emergency room use is crucial to maximizing the success of managed FFS programs for Medicare-Medicaid enrollees, states have very little leverage over hospital behavior in these programs, since Medicare-Medicaid

⁵ Integrating Care for Medicare-Medicaid Enrollees Using a Managed Fee-for-Service Model. Integrated Care Resource Center. Technical Assistance Brief. February 2012.

enrollees' hospital care is paid for primarily by Medicare. Hospitals generally do not benefit financially from reducing avoidable hospital and emergency room visits, since these services are major revenue sources for hospitals, so hospitals have little financial incentive to cooperate with states in these situations.

Previous work on the use of MFFS includes the Robert Wood Johnson Foundation (RWJF) Medicare/Medicaid Integration program (MMIP) in which Washington State participated. The RWJF effort was launched in response to increasing state concern in the early 2000s about the volatility and costs associated with the managed care marketplace.⁶ And, early research on approaches similar to MMIP concluded that “enhanced [primary care case management] PCCM programs may equal or exceed capitated MCO programs on measures of access, cost, and quality, but only if states devote substantial resources to designing, implementing, managing, and funding the enhancements.”⁷ However, as noted above, more recent research raises questions about the savings potential for both capitated, risk-based models as well as MFFS.

Washington State Approach. In Washington State, the MFFS demonstration will integrate service delivery across primary, acute, prescription drugs, behavioral health and LTSS. The effort, entitled HealthPathWashington will operate from April 1, 2013 to December 31, 2016 unless terminated or extended.

Services will be coordinated by state contracted Health Home Lead Entities and their Health Home Care Coordination Organizations. The yet-to-be-approved health home SPA will frame how these relationships will function, the payment methodology, and how health homes are to establish and coordinate health home networks of providers.

Health Homes are not physical entities; rather, they will be a network of administrative entities closely tied to care coordination organizations whose services will cover a geographic region. “Health home services will include: comprehensive care management; care coordination and health promotion; comprehensive transitional care; individual and family supports; referral to community and social support services; and the use of a web-based clinical decision support tool (PRISM) and other health information technology to improve communication and coordination of services.” Health homes will be paid using a per member per month (PMPM) methodology which will be described in the SPA. Payments to providers will be rendered using the current Medicare and Medicaid FFS arrangements.

Washington will be eligible to receive a retrospective performance payment based on its performance on beneficiary experience, quality and benchmarked savings criteria. In terms of achieving performance based savings, a CMS contractor will conduct a pre/post analysis of Medicare expenditures. Payments will be calculated using the following principles and calculations:

- Retrospective performance payments will be made unless the state achieves Medicare Minimum Savings Rates (MSR). If the Medicare savings calculated are less than the MSR, the state will not qualify for a payment.

⁶ Applying Managed Fee-for-Service Delivery Models to Improve Care for Dually Eligible Beneficiaries. University of Maryland Center on Aging Medicare/Medicaid Integration Project. May 2002.

⁷ Verdier, J. et. Al. [Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States](#). Center for Health Care Strategies. September 2009.

- Qualification for the retrospective performance payment is contingent on achieving overall Federal savings. Therefore, in determining the retrospective performance payment, any Medicare savings may be offset by any increases in federal Medicaid expenditures. To calculate any Medicaid-related subtractions, CMS will develop a Medicaid Significance Factor (MSF). If increases in Medicaid exceed the projected MSF, then the federal share of the Medicaid increase (including costs below the MSF) will be deducted from the amount of Medicare savings to establish the net federal savings
- State savings potential only is available if net federal savings are produced. If Medicare savings calculated exceed the MSR, the state will qualify to earn up to 50 percent of the net federal savings (e.g., 50 percent of the total Medicare savings after deducting the federal Medicaid increase, if the federal Medicaid increase exceeds the MSF).
- The same Medicare savings cannot be shared more than once. Therefore, CMS will apply attribution (alignment) rules to ensure that the experiences of specific beneficiaries are not simultaneously attributed to this demonstration and to other Medicare shared savings initiatives.
- The State of Washington is primarily responsible for the new investments and operating costs associated with the demonstration, with costs eligible for federal matching funds based on applicable Medicaid rules. Therefore, the State assumes financial risk associated with those new investments. If the demonstration is failing to meet cost or performance objectives, CMS will pursue corrective action or termination as described in Final Demonstration Agreement.

Finally, the savings calculation will be based on the difference in changes over time in both Medicare and Federal Medicaid expenditures found between the demonstration group and the comparison group. The savings determination will compare actual spending for the demonstration group to the spending that would have been expected in the absence of the demonstration. However, even if financial targets are achieved, the state still must hit quality targets outlined in the MOU in order to be eligible for retrospective performance payments.

Approximately 20,000-30,000 Medicare-Medicaid enrollees are estimated to participate in the demonstration. Supporting health home care coordination entities and health home network providers as they service these individuals is the Predictive Risk Intelligence System (PRISM). PRISM will identify potential program participants, along with the health home SPA eligibility criteria, inform the development of a Health Action Plan (e.g., plan of care), and provide real time health information exchange among participants in the health home network.

Finally, CMS will contract with a Washington State specific independent evaluator for the demonstration. The evaluator will assess the demonstration's impact on person-centered outcomes, service utilization and program costs. CMS will measure quality including the beneficiary overall experience of care, care coordination, beneficiary care transitions, and support of community living in Washington. The evaluation will use a comparison group to identify any changes in quality and cost.