MEMORADUM

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

FROM: Mike Cheek

SUBJECT: CMS Approval of Massachusetts Medicare-Medicaid Integration Initiative

DATE: September 13, 2012

On Thursday, August 22, the Centers for Medicare and Medicaid Services (CMS) and the Commonwealth of Massachusetts signed a Memorandum of Understanding (MOU) clearing the path to integrate care for Medicare-Medicaid eligible under CMS' Financial Alignment Initiative While Massachusetts has a long history with Medicare-Medicaid Integration, the Commonwealth is the first state to receive approval from the federal government to begin implementing a new system of integrated care for Medicare-Medicaid eligibles under the Affordable Care Act (ACA) authorized effort.

Executive Summary

In brief, the MOU and subsequent AHCA dialogue with the CMS Medicare Medicaid Coordination Office (MMCO) offers the following insights into CMS' review and approval process and possible action steps for state affiliate consideration. However, it is important to note that considerable detail still must be elaborated upon in the three-way contract arrangement among the Commonwealth, CMS, and the plans.

- ***The Commonwealth of Massachusetts approval likely is not a good indication of future approvals with a few exceptions which are discussed below*** – Massachusetts has operated a Medicare-Medicaid integration effort for close to twenty years. Initially, the state was a demonstration site for CMS' Social Health Maintenance Organization (SHMO) demonstration. During the demonstration, the state made blended Medicare-Medicaid capitation payments to health plans using a Medicaid Section 1115 waiver and a Medicare 222 waiver. Under the latter, states receive Medicare payments from the federal government and, acting as a Medicare administrative entity, make Medicare payments for services to Medicare providers. Later, following enactment of the Medicare Modernization Act (MMA), the Commonwealth was one of a handful of states to utilize a CMS-designed three-way contracting mechanism among the state, CMS, and Medicare Advantage Special Needs Plans. The three-way contracting arrangement also is being used in MMCO's current financial alignment initiative. Strategically, MMCO's approval of Massachusetts' demonstration was an extremely conservative first step while demonstrating some forward momentum. Additionally, MMCO's approval of Massachusetts, first, also likely was strategic

in that the Commonwealth's proposal and implementation environment address some of the health care community's demonstration concerns: a) the demonstration only includes a portion of the total Medicare-Medicaid eligible population; b) the Commonwealth has experience with such efforts; and c) unlike many other states, the Commonwealth has been reasonably transparent about its plans.

- ***Passive enrollment will be included but with some protections –*** Despite considerable opposition from the advocacy community and Congressional concern, the Massachusetts proposal includes passive enrollment. During AHCA's follow-up meeting with MMCO, federal officials indicated that subsequent approvals will include passive enrollment. However, CMS staff indicated that the 60 day prior notice period included in the Massachusetts MOU will be the minimum allowed for any state. Additionally, the states and CMS will send three letters at different points during the 60 prior notice period – one from the state, the second from CMS, and a third and final notice from the state. CMS currently is testing the letters with beneficiaries; all states will be required to use the CMS designed and approved letters. Finally, CMS and the federal Administration on Aging are making small grants available to the Financial Alignment states aimed at increasing Aging and Disability Resource Centers (ADRCs) and State Health Insurance Program (SHIP) capacity to support individuals making decisions about whether to participate or opt out of a Medicare-Medicaid Integration program.

- ***The definitions of "medically necessary" will remain program specific*** – CMS indicated that it has attempted to eliminate as many conflicting or duplicative Medicare and Medicaid provisions as possible. However, MMCO noted that some were too challenging to blend or collapse including development of a single definition of medical necessity. Medicare includes a federal definition of medical necessity; the federal Medicaid statute only includes a high level framework and states develop their own definitions of medical necessity. In the Massachusetts MOU and all future MOUs, Medicare-financed services will follow the federal Medicare definition and Medicaid-financed services will follow the states' definitions of medical necessity. MMCO also indicated that in instances where Medicare and Medicaid both cover a service, the demonstration will follow the more generous definition.

- ***The MOU contains little protective language regarding "any willing provider***" – Plans still will have the authority to design provider participation requirements but they also must meet federal Medicare and state Medicaid network adequacy requirements. Further detail on these points will be included in the state, CMS and Plan, or "three-way" contract arrangements which has yet to be released. The MOU does require the plans to allow enrollees to maintain their current providers for 90 days, or until the plan to complete a service assessment, whichever is longer. Additionally, on an ongoing basis, plans must contact providers not currently participating provider network members with information on becoming "credentialed as in-network providers." Furthermore, in urgent or emergency situations, the plan must reimburse an out-of-network provider at the Medicare or Medicaid FFS rate applicable for the service. Beyond the 90 day transition period, under certain defined circumstances, plans will be required to offer an out-of-network agreement to providers who are currently serving the enrollee and are willing to continue serving them.

- ***Medicare and Medicaid supplemental payments will follow existing Medicare Advantage rules and Medicaid clarifications*** – Earlier in the year, CMS informed AHCA that Medicaid supplemental payments, such as provider tax based payments, could not be paid by plans. Rather, CMS Central Office took the position that such payments had to be part of the plan capitation payments based on state set rates or provider rates negotiated with the plans. Regarding Medicare, MMCO indicated that Bad Debt may not be paid in managed care arrangements on behalf of managed care participants. Federal officials noted that the Medicare-Medicaid Financial Alignment demonstrations would follow the Medicare Advantage rules on Bad Debt. In general, officials indicated that, in their opinion, Medicare Bad Debt is included in regional Medicare Advantage rates and providers should negotiate rates which likely will cover historical Bad Debt levels. CMS officials agreed that this area is a serious concern for the long term care industry. Supplemental payment guidance will be issued as part of the Financial Alignment array of state guidance; no formal guidance, such as a State Medicaid Directors' Letter, will be released. See below for AHCA action steps on this and other issues.

- ***At AHCA's request, MMCO will explore how ACA Administrative Simplification provisions could be included in future approvals*** – Section 1173(g) of the Affordable Care Act (ACA), the administrative simplification provisions, directs states to build into managed care plan contracts standardized processes for eligibility verification as well as claim status verification. See below for AHCA action steps on this and other issues.

- ***CMS will be releasing for public review its plan readiness review tool used by its contractor but the Agency will not be reviewing state readiness*** – AHCA and other organizations have urged CMS to release more information on how the Agency is assessing state and plan readiness for Medicare-Medicaid integration effort implementation or expansion. During AHCA's follow up meeting with MMCO, officials indicated that the Agency would not be conducting state readiness reviews but would be releasing its standardized plan readiness review tool for public comment in the coming weeks. For state readines, the agency will continue to rely on state submission of materials documenting compliance with MMCO's standards and conditions for participation. In terms of the plan readiness review tool, it is unclear whether the tool will be released for comment before other demonstration proposal approvals.

- ***In terms of capitation rate setting, states will follow Medicaid requirements with the expectation that they accurately account for Medicare expenditures*** – In Massachusetts, under the three-way contracting arrangement, plans will receive Medicare capitation payments from the federal government and Medicaid capitation payments from the Commonwealth for each Medicare-Medicaid eligible. Plans, in turn, will negotiate blended Medicare-Medicaid rates with providers. In AHCA's follow-up meeting, CMS indicated that it expects all states to calculate actuarially sound Medicaid capitation rates including accounting for Medicare payment for certain services. However, MMCO officials were unaware of a recent Massachusetts Office of the Inspector General (OIG) report highlighting Medicaid managed care plan challenges with achieving cost savings. In fact, for certain services and populations, the Massachusetts OIG found that Medicaid managed care costs were substantially higher than fee-for-service costs raising more questions about Medicaid managed care's capacity to achieve cost savings.

- ***At AHCA's request, MMCO will coordinate with the CMS Center for Survey and Certification as proposals are approved*** – Some of the demonstration proposals include delivery of increased levels of skilled care in nursing facilities in an attempt to avoid hospital admissions and to reduce costs. AHCA expressed concern that CMS Regional and state survey and certification staff might be unprepared to assess such activities depending on the state. At AHCA's request, MMCO and the CMS Center for Survey and Certification have agreed to work with CMS Regional Office and State Survey and Certification staff as demonstration proposals are approved to ensure regulatory officials are prepared for new models of skilled care delivery.

- ***Quality monitoring detailed in the Massachusetts MOU may prove challenging for states with little experience*** – Quality measurement and monitoring in managed long term care arrangements is comprised of limited body of work and knowledge. The framework detailed in the Massachusetts MOU may prove achievable for the Commonwealth but likely will be extremely difficult for states with little to no existing infrastructure and experience.

- ***MOU contains Olmstead language*** – The Massachusetts MOU stipulates that the Commonwealth and CMS will ensure that plans deliver long term care services in compliance with the ***Olmstead*** decision. It is likely this language will appear in all MOUs.

- ***The MOU pre-supposes savings and highlights cost savings as a key objective*** – The MOU includes savings targets for each year of the demonstration. MMCO officials indicated that all MOUs will include such targets with language on state and CMS action steps if such targets are not met as calculated by the CMS Office of the Actuary.

Action Steps

For now, the Agency appears to be moving forward with proposal approval although at a slower pace than anticipated. State government association staff have expressed frustration with the pace as well as the lack of information and action from MMCO. In the coming weeks, AHCA will take the following steps:

- Conduct research on what is working and not working in existing Medicare-Medicaid integration programs and schedule time for state affiliates in those states to share their experiences and advice with MMCO officials;

- AHCA is scheduling an additional meeting with MMCO and the Center for Medicaid and CHIP to discuss in detail supplemental payments approaches once the research, above, is conducted;

- AHCA will continue educational efforts with Congressional delegations on state affiliate concerns as directed by state affiliates; and

- Regarding managed care, AHCA transmitted a letter to CMS on the administrative simplification provisions and is in the process of scheduling a meeting with the Center for Medicaid and CHIP and MMCO officials on how these provisions should be implemented and broadened as states implement managed long term care programs and Medicare-Medicaid integration initiatives which also include long term care.

In light of what can be gleaned from the Massachusetts approval, state affiliates might consider the following steps:

- Advocate for as long a prior notification period as possible and ensure the state applies for additional ADRC and SHIP funding intended to provide additional assistance for potential Medicare-Medicaid integration program enrollees. Request sample copies of the letters which will be transmitted to potential enrollees;

- Explore the availability of reports on the actuarial soundness of the state's Medicaid managed care rates to determine whether the state currently has challenges;

- Ensure the state Medicaid agency is aware of the administrative simplification requirements and explore how the agency plans to implement such efforts in any managed long term care or capitated, risk-based Medicare-Medicaid integration effort;[1]

- In terms of Medicare-Medicaid program implementation, determine whether the state will be submitting a new Medicaid Section 1115 waiver or amending an existing waiver. If the state is submitting a new Section 1115 waiver, the waiver is subject to CMS' new transparency requirements.[2] However, if the state is amending an existing Section 1115, state affiliates should be prepared to argue that the amendment make substantive changes so CMS will apply additional rigor in its review;

- Establish an understanding of the implementing contract language. In terms of ramping up state integration initiatives, finalization of the MOU is third among four key steps: a) state submission of the proposal; b) CMS approval of the proposal; c) finalization of the CMS and state MOU; and d) finalization of the State, CMS and health plan three-way contract agreement. CMS likely will build its model three-way contract on a long-standing contract model currently used in Massachusetts. o view the current Massachusetts three-way contract click here;

- Message that nursing facilities may be a more cost effective service setting for certain populations in terms of avoidable hospitalizations and generating Medicare savings. First, in a study published by ***Health Affairs***, researchers found that while Medicaid's coverage of home and community-based services has increased over recent years, many of these beneficiaries were particularly vulnerable to avoidable hospital admissions compared to other

[1] Administrative Simplification Interim Final Rule Overview
[2] CMS Transparency Requirements and the CMS Section 1115 Waiver Transparency Website to submit comments

Medicaid beneficiaries and the general population.[3] A second study, commissioned by the Centers for Medicare and Medicaid Services (CMS), found that when considering a wide array of health care conditions, dually eligible individuals using home and community-based services had higher avoidable hospital admission rates than nursing facility residents;[4] and

- If the state has included the provision of additional skilled care in nursing facilities to avoid hospitalization or re-hospitalization, ensure that CMS and the state have engaged survey and certification staff in a dialogue once the demonstration has been approved.

Finally, state affiliates may find it helpful to review the Dual Advocacy Center website maintained by the National Senior Citizens Law Center. The website includes an advocacy tool kit and links to letters transmitted to CMS by advocacy groups as well as members of Congress.

We hope the information, above, is helpful. If you have questions, suggestions or concerns, please feel free to contact me at mcheek@ahca.org or 202 454 1294.

[3] Konesta, R.T., et. Al., Users of Medicaid Home and Community-Based Services Are Especially Vulnerable to Costly Avoidable Hospital Admissions. Health Affairs 31, No. 6 (2012): 1167-1175.

[4] Walsh, E.D., PhD. Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community-Based Services Waiver Programs. Prepared for the Centers for Medicare and Medicaid Services. August 2010.

Background

Massachusetts has long operated a Massachusetts has operated a Medicare-Medicaid integration effort for close to twenty years. Initially, the state was a demonstration site for CMS' Social Health Maintenance Organization (SHMO) demonstration. During the demonstration, the state made blended Medicare-Medicaid capitation payments to health plans using a Medicaid Section 1115 waiver and a Medicare 222 waiver. Under the latter, states receive Medicare payments from the federal government and, acting as a Medicare administrative entity, make Medicare payments for services to Medicare providers. Later, following enactment of the Medicare Modernization Act (MMA), the Commonwealth was one of a handful of states to utilize a CMS-designed three-way contracting mechanism among the state, CMS, and Medicare Advantage Special Needs Plans.

Called Senior Care Options (SCO), the current program is targeted to older adults, only, and notably differs from the new Medicare-Medicaid Financial Alignment Demonstration (see ***table***, below).

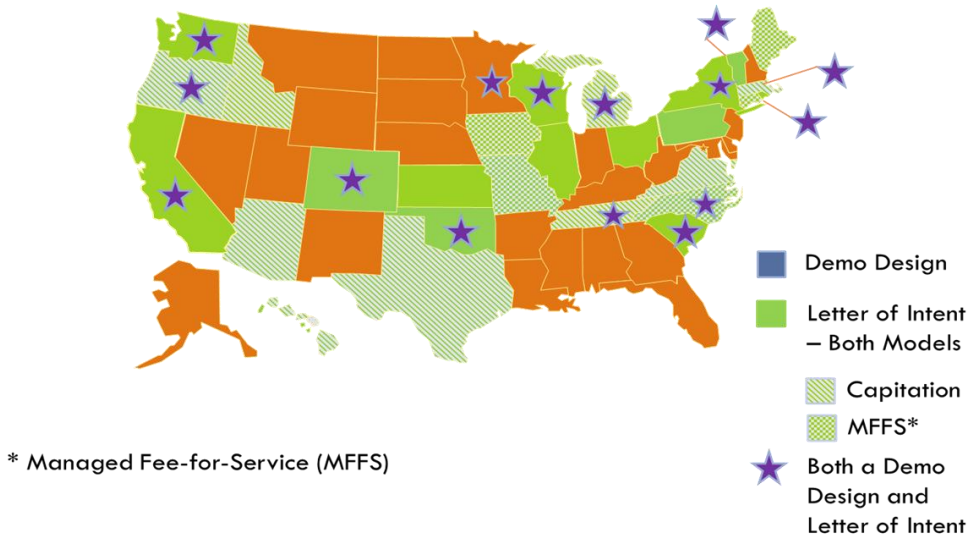
	SCO	**ICO**
Design Feature		
Target Population	Older Adults	Young Adults with Disabilities
Enrollment	Voluntary	Passive Enrollment
Benefits Emphasis	Geriatric Care	Behavioral Health
Rates	Published	Not Available
Programmatic Savings Requirements	None	Yes – savings target by demonstration year

Additionally, young adults enrolled in the new Medicare-Medicaid Alignment ICOs will be allowed to age in those plans. Thus, SCO essentially may be subsumed by the ICO model. Also, reimbursement under SCO has been less problematic than other currently operating integration initiatives. However, the adequacy of reimbursement may become a question under the new initiative because of the programmatic savings requirements which could erode rates.

Financial Alignment Initiative and MOU Overview

Massachusetts was one of 26 states to submit to MMCO at CMS a proposal to participate in CMS' Dual Eligible Financial Alignment Demonstration (see ***chart***, below). A draft of the proposal was first released in December 2011 for a state-level public comment period. In February, Massachusetts formally submitted the proposal to CMS for a 30 day federal comment period.

States Engaged In Medicare-Medicaid Financial Alignment Efforts



Note: Since March 2012, 12 states have withdrawn from the Financial Alignment Initiative. Those states are AK, DE, DC, FL, IN, KY, MD, MN, MT, NE, NM, and NV.

To learn more about CMS' Medicare-Medicaid Financial Alignment Initiative and state activity, visit the Integrated Care Resource Center.

Over the spring and summer, Massachusetts and CMS negotiated the terms of the contract for the demonstration. The agreement between the state and federal government was finalized in the MOU, released in late August. The MOU has significant state and offers some insights on national approval elements. For Massachusetts consumers and their advocates, the MOU provides more detail than was previously available on the new delivery system, and stakeholders can begin preparing for the April 1, 2013 implementation date.

For other states, the MOU provides an idea of the guidance and principles CMS will require for those states seeking to participate in the demonstration. However, much detail still is needed and likely will appear in the three-way contracting documents. To-date it is unclear how much of that information will be made public. While more analysis and additional approvals will offer a clearer picture of what MMCO is likely to approve in states with little or no Medicare-Medicaid integration experience, the information below provides a general overview of the Massachusetts MOU and some sense of what may appear in subsequent approvals.

The Basics. Under the MOU, Massachusetts and CMS will contract with managed care plans to provide all Medicare and Medicaid services to Medicare-Medicaid eligibles aged 21-64. There are 109,000 of these individuals in Massachusetts. The managed care plans, referred to as Integrated Care Organizations (ICOs), will be paid on a capitated basis. The demonstration will last from April 1, 2013 to December 31, 2016.

ICOs may begin accepting enrollment from full dual eligible individuals aged 21-64 after January 1, 2013 for coverage beginning April 1, 2013. For individuals who do not elect to enroll in a plan, MassHealth will conduct passive enrollment in two periods: July 1, 2013 and October 2, 2013.

Enrollment. Individuals will have the ability to opt out of the demonstration prior to the passive enrollment taking effect. They will also retain the right to disenroll or switch plans on a monthly basis at any time during the year. CMS and Massachusetts Medicaid will utilize an independent third party to facilitate all enrollment into the participating plans. And, CMS and Massachusetts Medicaid are developing uniform enrollment and disenrollment forms. As noted in MMCO comments, Massachusetts will be using an "intelligent assignment" algorithm for passive enrollment. Details on the intelligent assignment process will appear in the contracts.

Continuity of Care. CMS and the Commonwealth will require ICOs to ensure that individuals continue to have access to medically necessary items, services, and medical and long term services and supports providers. Specifically, ICOs must allow enrollees to maintain their current providers for 90 days, or until the ICO completes a service assessment, whichever is longer. Additionally, on an ongoing basis, plans must contact providers not currently participating provider network members with information on becoming "credentialed as in-network providers." Furthermore, in urgent or emergency situations, the ICO must reimburse an out-of-network provider at the Medicare or Medicaid FFS rate applicable for the service. Beyond the 90 day transition period, under certain defined circumstances, plans will be required to offer an out-of-network agreement to providers who are currently serving the enrollee and are willing to continue serving them.

Americans with Disabilities Act (ADA) and Civil Rights Act of 1964. The MOU also stipulates that plans and providers must comply with the ADA and the Civil Rights Act of 1964. This language, in part, is intended to ensure that providers and plans provide accessible and disability sensitive services including accommodation for people who are Deaf and for people with cognitive limitations. The MOU also states, "CMS and [Massachusetts Medicaid] are committed to compliance with the ADA, including application of the Supreme Court's Olmstead decision and [the two parties] agree to ensure that ICOs provide for demonstration enrollees long-term services and supports in care settings appropriate to [participants] needs." Additionally, the three-way contract will include reporting requirements on plan capacity to "rebalance from institutional to HCBS settings."

Limited Cost Sharing. The MOU prohibits plans from charging Medicare Parts C and D premiums as well as assessing any cost sharing for Medicare Parts A and B services. Additionally, provider balance billing is prohibited for all enrollees and for all services.

Care coordination. The ICOs will offer care coordination to all enrollees through a care coordinator or clinical care manager for medical and behavioral health services. Care coordination will also be offered through an Independent Living and LTSS coordinator contracted from a community based organization for LTSS. Specific details on care coordinator roles and qualifications will be included in the three way contract.

Network Adequacy and Out of Network Requirements. When evaluating the network for long-term supports and services, Medicaid standards will be utilized. If Medicare and Medicaid standards overlap, such as in home health and durable medical equipment (DME) requirements, the state will use the Medicaid standard, or the standard that is more stringent and beneficiary-friendly. In addition to the requirement that they provide all Medicare and Medicaid services, ICOS must also cover supplemental benefits including day services, home care services, respite care, peer support/navigation, care transitions assistance, home modifications, community health workers, and medication management.

Grievances and Appeals. All initial appeals must be filed within 60 days directly with the ICO. Plan appeals must be resolved within 30 days of submission for standard appeals, and within 72 hours for expedited appeals. Appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE). If the appeal relates to a Medicaid benefit, the appeal may go to the Massachusetts Medicaid Board of Hearings. Aid paid pending will be provided for both Medicaid and Medicare A and B services during the internal appeal, but only for Medicaid services during the external appeal process. Existing appeal mechanisms for Medicare Part D will be unchanged.

Payment Rates. Payment rates for Medicaid, Medicare Parts A and B and Medicare Part D will be developed using a two-step process. First, CMS and the Commonwealth will establish baseline costs. Second, payment rates then will be determined by applying savings percentages to these baseline spending amounts. Medicaid rates will be developed by the Commonwealth and its actuaries and validated by a CMS contracted actuary. For Medicare, the baseline rate for A and B will be a blend of the Medicare Advantage projected payment rates and the Medicare fee-for-service standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the demonstration.

Risk Adjustment. Medicare Parts A and B county rate will be risk adjusted based on the risk profile of each beneficiary using the existing CMS Hierarchal Condition Categories (HCC) risk adjustment methodology.[5] The Commonwealth will use its existing process for Medicaid risk adjustment.

Risk Mitigation Strategies. In addition to reserve requirements, the MOU lays out two key strategies for mitigating risk. First, the Commonwealth will establish High Cost Risk Pools (HCRP) to account for enrollment of high cost members, defined based on spending for select Medicaid long term care services above a defined threshold within Medicaid rating categories across ICOs. For each rating category with a HCRP, a portion of the base Medicaid capitation rate will be withheld from all ICOs into a risk pool. The risk pool will be divided across ICOs based on their percent of total costs above the threshold amount associated with high cost members. Second, risk corridors will be established for the first year of the demonstration but will not be used in years two and three. Further detail on risk mitigation will be provided in the contracts.

Quality Oversight and Quality Withhold. The Commonwealth and CMS will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to plans' performance consistent with quality thresholds. A high level overview of the

[5] To learn more about CMS-HCC, click here.

quality withhold measures by demonstration years is provided in the MOU. However, CMS notes that more detail will be provided in the contracts.