kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

April 2012

An Update on CMS's Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees

Executive Summary

Beginning in January, 2013, the Centers for Medicare and Medicaid Services (CMS) will implement a three year multi-state demonstration to test new service delivery and payment models for people dually eligible for Medicare and Medicaid. The planned demonstrations, authorized by the Affordable Care Act, will enroll people who receive Medicare and full Medicaid benefits in managed fee-for-service or capitated managed care plans that seek to integrate benefits and align financial incentives between the two programs. On January 25, 2012, CMS issued a memorandum providing additional guidance for organizations interested in offering health plans in the capitated financial alignment demonstration. This policy brief describes significant characteristics of CMS's capitated financial alignment model, including information provided in the new guidance, and summarizes key dates in the state demonstration approval and plan selection processes. An appendix describes the standards and conditions that CMS will use to evaluate and approve state proposals.

Financing: The January, 2012 guidance requires that the prospective blended capitation rate for participating plans provide upfront savings to both CMS and the state; absent savings for both payers, the demonstration will not go forward. The guidance does not clarify whether the savings for CMS will be attributable to just the Medicare program or also will include the federal share of Medicaid spending. CMS also explains that plans will be subject to an increasing quality withhold from the capitation rate during the three year demonstration that plans can earn back if they meet quality objectives.

Enrollment: Under the proposed capitated financial alignment model, CMS will allow states to passively enroll participants with an opt-out available on a month-to-month basis. The enrollment process will coincide with the open enrollment period for Medicare Advantage and Part D plans.

Provider Network Adequacy: Participating plans must meet Medicare provider network adequacy standards for medical services and prescription drugs and Medicaid provider network adequacy standards for long-term services and supports.

Medical Necessity Determinations: Medical necessity determinations for covered services will be based on Medicare standards for acute services and prescription drugs and on Medicaid standards for long-term services and supports.

Appeals: The capitated financial alignment model will use a single integrated appeals process for internal plan appeals and external appeals.

Quality and Oversight: States participating in the capitated financial alignment model will report individual-level quality, cost, enrollment, and utilization data, and participating plans will report encounter data and must meet "certain quality indicators" still to be determined.

CMS expects most state demonstration proposals to be made public by early April, 2012. The guidance issued to date leaves a number of important policy issues unresolved, including how standards for plans will vary from existing Medicaid managed care and Medicare Advantage requirements and across states; how rates will be calculated and risk-adjusted; the amount and source of savings and how savings will be shared between CMS and the state; what new benefits will be provided; how the enrollment and disenrollment processes will function; the specific quality standards plans must meet; and how the demonstrations will be overseen and evaluated.

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Introduction

Beginning in January, 2013, the Centers for Medicare and Medicaid Services (CMS) will implement a three year multi-state demonstration, authorized under the Affordable Care Act, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid. The dually eligible population includes nearly nine million low-income seniors and people with disabilities.[1] Of this group, seven million are known as "full duals" because they receive Medicare and full Medicaid benefits: Medicare is their primary source of health insurance, and Medicaid provides assistance with Medicare cost-sharing and services that are not covered by Medicare, such as long-term services and supports.

The planned demonstrations will enroll full duals in managed fee-for-service or capitated managed care plans that seek to integrate benefits and align financial incentives between both programs. Implementation of a state's proposal will involve a memorandum of understanding (MOU) between CMS and the state, and in the capitated model, a three-way contract between CMS, the state, and the participating health plan. CMS's approval of state demonstration proposals and the joint CMS-state selection of health plans for the capitated model will occur on parallel tracks this year.

CMS's Medicare-Medicaid Coordination office is working with the Center for Medicare and Medicaid Innovation, which awarded contracts in April, 2011 to 15 states to design proposals for the demonstration.[2] Subsequently, CMS invited any interested state to submit a letter of intent to potentially test its proposed capitated and/or managed fee-for-service financial alignment models.[3] Thirty-eight states and the District of Columbia responded, and as of January, 2012, CMS estimated that approximately 26 states remain interested in testing the capitated model.[4] As of mid-April, 2012, three states (MA, IL, OH) have submitted proposals to CMS, and seventeen states (CA, CO, CT, ID, MI, MN, NC, NY, OK, OR, SC, TN, TX, VA, VT, WA, WI) have proposals posted for the required state-level public comment period prior to CMS submission.[5] Additional proposals may be released in the coming weeks by other states that submitted letters of intent.[6]

On January 25, 2012, CMS issued a memorandum providing additional guidance for organizations interested in offering health plans in the capitated financial alignment demonstration.[7] The guidance details the state demonstration approval and plan selection processes, compares existing Medicare and Medicaid managed care plan requirements, and sets out CMS's preferred standards for the capitated financial alignment demonstration model; it does not address the managed fee-for-service financial alignment model. The January, 2012 guidance contains many technical elements and provides insight into CMS's expectations and framework for evaluating state proposals.

This policy brief describes significant characteristics of CMS's capitated financial alignment model, including information provided in the new guidance concerning financing, enrollment, provider network adequacy, medical necessity determinations, appeals, and quality and oversight. It also summarizes key dates in the state demonstration approval and plan selection processes. An appendix describes the standards and conditions against which CMS will evaluate the state proposals.

CMS's January 25, 2012 Guidance for the Capitated Financial Alignment Model

CMS's January, 2012 guidance supplies new information in several key areas for states and plans seeking to participate in the capitated financial alignment model demonstration. Regarding financing, CMS asserts that demonstrations will not go forward unless the prospective blended capitated rate provides upfront savings for both CMS and the state. However, the guidance does not clarify whether the savings for CMS will be attributable to just the Medicare program or also will include the federal share of Medicaid spending. CMS also explains that

plans will be subject to an increasing quality withhold (of 1, 2, and 3 percent in years 1, 2, and 3 of the demonstration, respectively) from the capitation rate during the three-year demonstration which plans can earn back if they meet quality objectives. Unlike the Medicare Advantage program, demonstration plans will not be subject to a minimum medical loss ratio. If states elect passive enrollment of duals in the demonstrations (explained below), the enrollment process will coincide with the open enrollment period for Medicare Advantage and Part D plans.

The January, 2012 guidance explains that plans participating in the capitated financial alignment model must meet a combination of Medicare, Medicaid and integrated requirements. CMS clarifies that Medicare Part D requirements, including those regarding specific benefits and cost-sharing, network adequacy, formularies, and submission of prescription drug event data, will apply to demonstration plans. However, the January, 2012 guidance does not require participating plans to qualify as Medicare Advantage (Part C) or Medicaid managed care plans. Instead, CMS proposes holding plans to Medicare standards in some areas, to Medicaid standards in some areas, and to hybrid integrated standards in other areas.

The January, 2012 guidance incorporates policies for the demonstrations that previously were announced in CMS's July 8, 2011 State Medicaid Director Letter (which CMS calls "pre-established parameters") and also includes new policies (which CMS calls "preferred standards"). CMS explains that the "preferred standards" will be the agency's starting point for reviewing and approving the state proposals. These elements will be further defined, and possibly modified, in memorandum of understanding negotiations with the states whose proposals are selected by CMS for implementation and in the three-way contract between CMS, the state, and the health plan.

In addition to the requirements described in the January, 2012 guidance, plans must qualify for participation in the demonstration based on each state's specific plan selection process. CMS states that its guidance should not be seen as conflicting with or undermining state-specific requirements for plans. Finally, to the extent that the duals integration demonstrations will involve Medicaid § 1115 waiver authority, CMS has stated that the public notice and comment provisions of its recently finalized § 1115 waiver transparency rules will apply to these demonstrations.[8]

While the existing guidance provides some new information, it lacks details in key areas (described below). Moreover, the timeframe within which the state proposals will be evaluated and implemented is moving quickly, with state proposals being submitted to CMS this spring for implementation by January 1, 2013. Consequently, CMS's selection of the state proposals that will be implemented is occurring concurrently with the selection of plans for the capitated model. As a result, plans that are interested in participating in the demonstration must submit information, such as their model of care, network adequacy and prescription drug formulary, by deadlines that likely will precede CMS's approval of a state's proposal and the finalization of the terms of the demonstration. Table 1 on the following page summarizes key dates in the remainder of 2012 as CMS selects state proposals for implementation, and CMS and the states jointly select participating plans for the capitated model.

Table 1:
Key Dates in CMS Capitated Financial Alignment Model State Demonstration Approval and Plan Selection Processes

Date	State Demonstration Approval Process	Plan Selection Process
October 1, 2011	State letters of intent (LOI) to participate in financial alignment model demonstration were due to CMS. 38 states and D.C. submitted LOIs. CMS estimates that approximately 26 states are still exploring a capitated demonstration as of January 25, 2012.	
October 1, 2011-ongoing	State planning and design process.	
After January 25, 2012		CMS begins accepting non-binding Notice of Intent to Apply to operate demonstration plan from interested organizations.
February 17, 2012		CMS released for public comment the CY 2013 Draft Call Letter.
March-July 2012		Health plans or other qualified entities are selected through CMS-state joint selection process and submit required information on licensure, network adequacy and plan model of care.
Spring-Summer 2012	State proposals submitted to CMS after 2 public hearings and 30 day state level public comment period; CMS to evaluate whether proposal meets established standards and conditions and post proposals for 30 day federal level public comment period. CMS expects most demonstration proposals to be made public by early April, 2012.	
April 2, 2012		CMS released CY 2013 Final Call Letter; additional information on demonstration requirements and timelines provided to interested plans; final deadline for submission of non-binding Notice of Intent to Apply to operate demonstration plan.
April 30, 2012		Part D formulary submissions due to CMS for plans submitting a new formulary (those that have not submitted formulary for CY 2013 non-demonstration plan).
May 7, 2012		Medication Therapy Management Program submission due to CMS.
May 14, 2012		Part D formulary submissions due to CMS for plans that have already submitted a non-demonstration plan formulary for CY 2013 and intend to use that formulary for their demonstration plan.
Summer-Fall 2012	CMS to work with state to develop state-specific MOU based on State Medicaid Director Letter template.	
June 4, 2012		Plan submission of proposed benefit packages due.
July 30, 2012 (target date)		Demonstration plan selection completed.
Late July-September 2012		CMS and state conduct readiness reviews for selected plans.
Mid-September 2012	CMS and states select qualified health plans for 3-way contracts.	September 20, 2012 is target date for 3-way contracts to be finalized and signed.
October 1, 2012		Selected plans receiving passive enrollment of beneficiaries must send notification of enrollment and information about opt-out procedures to affected beneficiaries.
January 1, 2013		Effective enrollment date.

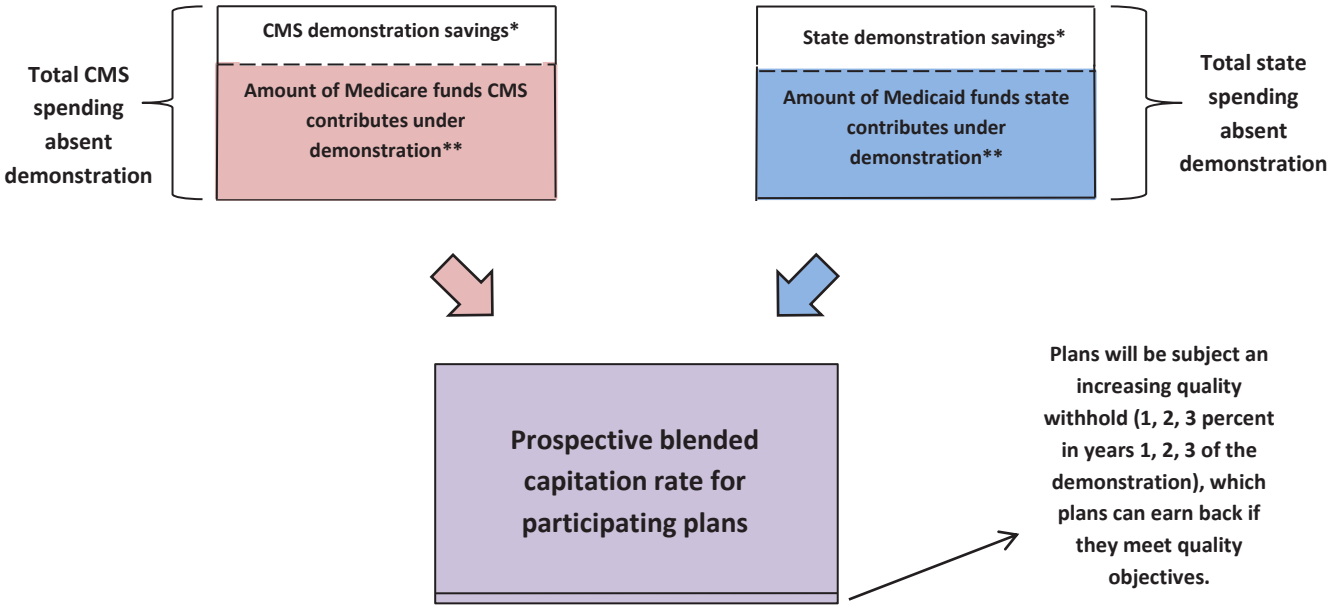
SOURCE: CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans, Jan. 25, 2012, available at https://www.cms.gov/medicare-medicaid-coordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

Significant Characteristics of CMS' Proposed Capitated Financial Alignment Model

Financing: **The January, 2012 guidance requires that the capitation rate for participating plans provide upfront savings to both CMS and the state; absent savings for both payers, the demonstration will not go forward.** In the capitated financial alignment model, plans will receive a prospective blended capitated rate from CMS for the Medicare portion of services and from the state for the Medicaid portion of services. CMS and the state will share savings, as compared to lower of expected fee-for-service or managed care spending for Medicare and Medicaid, respectively, for each service area. The guidance does not clarify whether CMS's savings will include the federal share of Medicaid spending as well as Medicare spending.

Capitation rates will be developed by CMS in partnership with each state based on baseline spending in Medicare and Medicaid and anticipated savings from integration and improved care management. The January, 2012 guidance does not indicate which year will be used for Medicare baseline spending, which is significant because both Medicare fee-for-service and Medicare Advantage spending varied between 2006 and 2012. The Part D portion of the capitation rate will be based on the standardized national average bid amount, risk adjusted according to Part D rules. This is important because it implies that Part D low-income subsidy payments, which comprise a large amount of Part D spending for many dual eligibles, will be excluded. Plans will not be eligible for Medicare quality-based bonuses. However, plans will be subject to an increasing quality withhold from the capitation rate, of 1, 2, and 3 percent in years 1, 2, and 3 of the demonstration, respectively, which plans can earn back if they meet quality objectives. The financing arrangements for the capitated financial alignment model are illustrated in Figure 1.

Figure 1:
Capitated Financial Alignment Model Financing Arrangements



*Proportions depicting demonstration savings are not to scale. It is unclear whether CMS's savings will include only the Medicare program or also the federal portion of Medicaid spending.

**Contributions to be determined by CMS in partnership with each state based on baseline spending in both programs and anticipated savings from integration and improved care management. The Part D portion of the capitation rate will be based on the standardized national average bid amount, risk adjusted according to Part D rules. CMS and state to share savings, as compared to lower of expected fee-for-service or managed care spending for Medicare and Medicaid, respectively, for each service area. Absent upfront savings for both parties, demonstration will not go forward.

Enrollment: **Under the proposed capitated financial alignment model, CMS will allow states to passively enroll participants with an opt-out available on a month-to-month basis.** Passive enrollment means that beneficiaries will be automatically placed into the demonstration, and they will have to affirmatively express their desire to disenroll. CMS proposes that plans receiving passive enrollment of beneficiaries must notify them of their enrollment and provide information about opt-out procedures by October 1, 2012, three months before the effective enrollment date of January 1, 2013, and consistent with the existing open enrollment period for Medicare Advantage plans. CMS indicates that duals already participating in a Medicare Advantage, Medicaid managed care or PACE program can choose to disenroll from their current program and participate in the demonstration. CMS also proposes using whichever standard (Medicare or Medicaid) is more beneficiary friendly for the readability and translation of plan materials.

Provider Network Adequacy: **Participating plans must meet Medicare provider network adequacy standards for medical services[9] and prescription drugs[10] and Medicaid provider network adequacy standards for long-term services and supports.[11]** Plans can utilize an exceptions process in areas where Medicare's medical service network adequacy standards may not reflect the number of dual eligible beneficiaries. For areas of overlap where services are covered by both Medicare and Medicaid, such as home health, an appropriate network adequacy standard will be determined in the MOU negotiation between CMS and the state and memorialized in the 3-way contract between CMS, the state, and the plan, so long as the provider network is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Medical Necessity Determinations: **Medical necessity determinations for covered services will be based on Medicare standards for acute services and prescription drugs and on Medicaid standards for long-term services and supports.** Areas of coverage overlap will be address in the 3-way contract.

Appeals: **The capitated financial alignment model will use a single integrated appeals process for internal plan appeals and external appeals**, which are currently resolved separately through independent Medicare contractors and the state Medicaid fair hearing system.[12] Issues subject to appeal include, but are not limited to, plan decisions to deny, terminate, reduce, or suspend medically necessary services.

Notices: CMS proposes a hybrid standard for notices, with a single document that explains the integrated appeals process.

Timeframes for filing appeals: CMS proposes affording beneficiaries 60 days to file appeals related to benefits, based on the current Medicare standard. The existing Medicaid standard allows states to establish a timeframe within 20 to 90 days for beneficiaries to file appeals.

Access to state level/external review: Appeals would "ideally" go through the internal plan process first, and then external appeals would be heard by a Medicare qualified independent contractor, based on the current Medicare standard. The existing Medicaid standard allows states to opt to provide beneficiaries with direct access to the external appeals system, without having to first exhaust the internal plan process.

Continuation of benefits pending appeal: CMS proposes a hybrid Medicare-Medicaid standard for continued benefits while appeals are pending: during an internal plan appeal, benefits would continue according to the current Medicaid standard; however, once appeals reach the external review, benefits would not continue according to the current Medicare standard, except for Medicaid-only benefits, which would continue during the pendency of the external appeal according to the current Medicaid standard.

Timeframes for resolving appeals: CMS proposes using the Medicare standard for timeframes to resolve appeals related to benefits, with 30 days for standard appeals and 72 hours for expedited appeals. The existing Medicaid standard requires plans to take final action on appeals within 45 days for standard appeals and 3 working days for expedited appeals.

Quality and Oversight: **States participating in the capitated financial alignment model will report individual-level quality, cost, enrollment, and utilization data, and participating plans will report encounter data and must meet "certain quality indicators."** Quality requirements will be integrated and will include some measures currently used by Medicare and Medicaid. CMS's January, 2012 guidance states that plans will be subject to Medicare Part D quality reporting requirements for prescription drugs. CMS will use a core set of measures to allow comparisons with other plans in the model as well as with non-model plans. A "single entity" will review the integrated report on quality measures. States may fulfill the auditing function and monitor plans for compliance with demonstration standards if states establish to CMS's satisfaction that state standards meet or exceed Medicare's standards.

Significant characteristics of CMS's proposed capitated financial alignment model, as described in CMS's July, 2011 State Medicaid Director Letter and further elaborated in the January, 2012 guidance, are summarized in Table 2 below.

Table 2:
Summary of CMS Standards for Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees Based on July 8, 2011 State Medicaid Director Letter and January 25, 2012 Guidance

Parties	*Three-way contract between CMS, state, and participating health plans.* CMS and states expect to work with interested organizations that have experience coordinating and delivering care to Medicare-Medicaid enrollees, including current Medicare contractors offering Special Needs Plans, state Medicaid managed care contractors, and other qualified organizations.
Entity responsible for benefits delivery and care coordination	*Health plan, either directly or by subcontracting with other qualified entities*. Medicaid standard will govern plan solvency requirements, as Medicare requirements already defer to state licensure and solvency requirements. Medicaid standards apply to plan credentialing.
Benefits package	*All primary, acute, behavioral health, and long-term services and supports covered by Medicare and Medicaid.* Medical necessity based on Medicare standards for acute services and prescription drugs and Medicaid standards for long-term services and supports. To be determined by contract where coverage overlaps.
Provider network adequacy	*CMS, state, and plans to ensure beneficiary access to adequate network of medical and supportive services providers that are appropriate and competent for the population's needs*. Medicare standards apply for medical services and prescription drugs. Medicaid standards apply for long-term services and supports. For areas of overlap where services are covered by both Medicare and Medicaid (e.g., home health), appropriate network adequacy standard will be determined in the CMS-state MOU negotiation and memorialized in the 3-way contract, so long as provider network is sufficient in number, mix, and geographic distribution to meet the needs of anticipated number of enrollees in service area. Plans can utilize exceptions process in areas where Medicare's medical service network adequacy standards may not reflect the number of dual eligible beneficiaries.

Table 2: (continued)
Summary of CMS Standards for Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees
Based on July 8, 2011 State Medicaid Director Letter and January 25, 2012 Guidance

Payment rates to plans	*Health plans to receive prospective blended capitated rate from CMS for Medicare portion of services and from state for Medicaid portion of services.* Rates for participating organizations will be developed by CMS in partnership with each state based on baseline spending in both programs and anticipated savings that will result from integration and improved care management. The Part D portion of the capitation rate will be based on the standardized national average bid amount, risk adjusted according to Part D rules.
Shared savings arrangements between CMS and state	*The prospective blended capitated rate will provide upfront savings to both CMS and the state.* Absent savings for both payers, the demonstration will not go forward. CMS and state will share savings, as compared to lower of expected fee-for-service or managed care spending for Medicare and Medicaid, respectively, for each service area.
Shared savings arrangements with plans	*Plans will be subject an increasing quality withhold (1, 2, 3 percent in years 1, 2, 3 of the demonstration).* Plans will be able to earn back the withheld capitation revenue if they meet quality objectives. Plans will not be eligible for Medicare quality-based (star) bonuses.
Enrollment	*Full duals. Passive enrollment permitted with opt-out available on month-to-month basis.* Passive enrollment process will coincide with Medicare Advantage/Part C/D open enrollment timeframe. Flexible approach to both minimum marketing requirements and review processes. Consistent set of required beneficiary information. For readability and translation standards, defer to whichever standard is more beneficiary friendly.
Data reporting requirements	*State to report individual-level quality, cost, enrollment and utilization data; health plans to report encounter data and certain quality indicators.* Uniform encounter reporting. Part D requirements apply.
Quality evaluation	*CMS and state to jointly select and monitor plans; plans required to meet established quality thresholds.* Joint selection process will take into account previous performance in Medicare and Medicaid. There will not be a minimum MLR requirement in the demonstration. Require strong, consistent quality oversight and monitoring requirements. Quality requirements will be integrated but will include some measures currently used by Medicare and Medicaid. Core set of measures will allow quality to be evaluated and compared with other plans in the model as well as other non-model plans. Prescription drug quality reporting measures will be at least consistent with Part D. Advance an integrated quality/performance improvement program for plans and have a single entity receive and review this integrated report and other quality measures.
Enforcement	*Coordinated oversight as negotiated and determined in MOU or contract.* States may conduct auditing function and monitor plans for compliance with demonstration standards if states establish to CMS' satisfaction that state standards meet or exceed Medicare's. Part D requirements continue to apply.
Beneficiary input	*Plans required to establish meaningful beneficiary input processes, which may include beneficiary participation on plan governing boards or beneficiary advisory boards*; however this is not addressed in the January, 2012 guidance.
Appeals system	*CMS and state will develop unified set of requirements for plan complaints and internal appeals processes that incorporate relevant Medicare Advantage, Medicare Part D and Medicaid managed care requirements*. CMS and state will develop a single external appeals process using both Medicare and Medicaid requirements. *Beneficiary notice of appeal rights:* Hybrid standard – one document that explains integrated appeals process. *Timeframes for filing appeals related to benefits:* Medicare standard – 60 days. *Access to state level or external review:* Medicare standard – internal appeals should ideally go through the plan first, and then external appeals should go through Medicare qualified independent contractor. *Continuation of benefits pending appeal:* Hybrid standard – during internal plan review, benefits should be continued per Medicaid standard; however, once appeals reach external Medicare level, benefits are not continued per Medicare standard. Medicaid-only benefits would continue per current Medicaid standard. *Timeframes for resolution of appeals related to benefits:* Medicare standard – 30 days for standard appeal and 72 hours for expedited appeals.
Target implementation	*End of 2012, with effective enrollment January 1, 2013.*

SOURCE: Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf and CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans, Jan. 25, 2012, available at https://www.cms.gov/medicare-medicaid-coordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

Looking Ahead

CMS expects most state demonstration proposals to be made public by early April, 2012. Because portions of the plan selection process will occur concurrently with the state demonstration approval process, interested organizations will need to submit a non-binding Notice of Intent to Apply and develop and submit a formulary, Medication Therapy Management Program, and plan benefit package before all state demonstration proposals are approved and MOU negotiations between CMS and the state are complete (see Table 1). On March 29, 2012, CMS issued additional guidance on the Medicare plan selection process for organizations interested in offering capitated financial alignment demonstration plans.[13]

The guidance to date leaves a number of important policy issues unresolved, including:

- The exact standards that a plan must meet to participate in a state's demonstration, how those standards will vary from existing Medicaid managed care and Medicare Advantage plan requirements, and the extent to which demonstration standards for plans will vary by state;

- How Medicare and Medicaid payments on behalf of dual eligibles will be calculated, risk-adjusted and adjusted annually over time;

- The source and amount of Medicare and Medicaid savings from the demonstrations, given that plans will not be subject to a minimum medical loss ratio, especially in states that already have low Medicaid fee-for-service payment rates – will demonstration savings be derived from lower network provider payments, tighter utilization controls, reductions in hospital readmissions and emergency room visits, or other means?

- How Medicare and Medicaid savings from the demonstration model will be shared among CMS and the state and whether CMS's portion of savings will include only Medicare spending or also the federal portion of Medicaid spending;

- What new benefits and services will be provided to improve the quality of care for beneficiaries;

- How the enrollment and disenrollment processes will function and how continuity of care will be ensured for beneficiaries with existing provider relationships who will be passively enrolled in plans;

- The specific quality standards that plans will be required to meet and how the oversight process will be administered by CMS and the state;

- The methodology for determining whether the demonstrations achieve intended outcomes.

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Appendix:
CMS Standards and Conditions for State Demonstrations

CMS's process for approving state demonstrations is summarized in Table 1 (p. 4) and further described in Kaiser Commission on Medicaid and the Uninsured, *Financial Alignment Models for Dual Eligibles: An Update* (November, 2011).[14] CMS will determine which states' proposals will be implemented, pending CMS's approval of the design, and for the states receiving design contracts, the availability of funds. The Standards and Conditions against which CMS will evaluate the states' proposals include the following elements:[15]

1. Integration of Benefits: The state's proposal must ensure the provision and coordination of all necessary Medicare and Medicaid covered services, including primary, acute, prescription drug, behavioral health, and long-term services and supports.

2. Care Model: The state's proposal must offer mechanisms for person-centered coordination of care and include robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.

3. Stakeholder Engagement: The state's proposal must provide evidence of ongoing and meaningful stakeholder engagement during the planning phase, including dates and descriptions of all meetings, workgroups, advisory committees, focus groups, etc., and incorporate input into the proposal. The proposal also must establish a plan for continuing to gather and incorporate stakeholder feedback for the duration of demonstration, including the process for informing beneficiaries of changes.

4. Beneficiary Protections: The state's proposal must identify protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care) that would be established, modified or maintained, at minimum including:
    - Meaningful beneficiary input processes, such as participation on plan governing boards or beneficiary advisory boards
    - Uniform/integrated enrollee materials that are accessible and understandable to people with disabilities and people with Limited English Proficiency
    - Privacy of and enrollee access to health records
    - Care that meets beneficiary needs, allows for caregiver involvement and is in appropriate setting, including home or community
    - Access to services in manner that is sensitive to beneficiary language and culture, including customer service representatives that can answer enrollee questions and respond to complaints and concerns appropriately
    - Adequate and appropriate provider network
    - Meaningfully inform beneficiaries about care options
    - Access to grievance and appeals rights

5. State Capacity: The state's proposal must demonstrate the necessary infrastructure to implement and oversee the model, including staffing resources, appropriate use of contractors and capacity to receive and/or analyze Medicare data.

6. Network Adequacy: The state's proposal must provide adequate access to medical and supportive services providers that are appropriate for and proficient in addressing needs of target population.

7. Measurement/Reporting: The state's proposal must have necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including the ability to collect and track data on key metrics related to quality and cost outcomes, such as beneficiary experience, access to and quality of all covered services, including behavioral health and long-term services and supports, utilization, etc.

8. Data: The state's proposal must collect and/or provide data to CMS to inform program management, rate development and evaluation, including beneficiary level expenditure data and covered benefits for the most recently available three years, including available encounter data in the capitated model. The proposal also must describe any state plan changes that would affect enrollees during the demonstration period, such as payment rate changes, benefit design addition or expiration of waivers, and state supplemental payments to providers (DSH, UPL).

9. Enrollment: The state's proposal must identify enrollment targets based on an analysis of the current target population and have strategies for conducting beneficiary education and outreach so that enrollment is sufficient to support the model to ensure a stable, viable and evaluable program.

10. Expected Savings: The state's proposal must achieve meaningful savings while maintaining or improving quality.

11. Public Notice: The state's proposal must have been subject to at least a 30 day public notice and comment period, at least 2 public meetings prior to proposal submission, and appropriate tribal consultation.

12. Implementation: The state's proposal must demonstrate the reasonable ability by end of 2012 to conduct meaningful stakeholder engagement, seek approval of any necessary Medicaid waivers or state plan amendments, receive any necessary state legislative or budget authority, complete the joint procurement process for capitated model, and conduct beneficiary outreach and notification of enrollment processes.

Endnotes

[1] For background on the dually eligible population, see Kaiser Family Foundation, *Medicare's Role for Dual Eligible Beneficiaries* (April, 2012), available at http://www.kff.org/medicare/upload/8138-02.pdf and Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for Dual Eligible Beneficiaries* (April, 2012), available at http://www.kff.org/medicaid/upload/7846-03.pdf.

[2] Kaiser Commission on Medicaid and the Uninsured, "Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS," Aug., 2011, available at http://www.kff.org/Medicaid/8215.cfm.

[3] Kaiser Commission on Medicaid and the Uninsured, "Financial Alignment Models for Dual Eligibles: An Update," Nov., 2011, available at http://www.kff.org/medicaid/8260.cfm.

[4] CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans, Jan. 25, 2012, available at https://www.cms.gov/medicare-medicaid-coordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

[5] Information about the status of state proposals is available from the National Senior Citizens Law Center at http://dualsdemoadvocacy.org/state-profiles.

[6] The 15 states that received design contracts (CA, CO, CT, MA, MI, MN, NC, NY, OK, OR, SC, TN, VT, WA, WI) are required to submit proposals to CMS. Other states, which did not receive design contracts but did submit letters of intent to test one or both of the financial alignment models, also may submit proposals (AK, AZ, DE, DC, FL, HI, ID, IL, IN, IA, KS, KY, ME, MD, MO, MT, NE, NV, NM, OH, PA, RI, TX, VA).

[7] CMS Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans, Jan. 25, 2012, available at https://www.cms.gov/medicare-medicaid-coordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

[8] CMS Fact Sheet, *Improved Review and Approval Process for Section 1115 Medicaid Demonstration Projects* (Feb. 22, 2012), available at http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4284; see also 77 Fed. Reg. 11678 (Feb. 27, 2012), available at http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/html/2012-4354.htm. For more information about the new § 1115 waiver transparency regulations, see Kaiser Commission on Medicaid and the Uninsured, *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers* (March, 2012), available at http://www.kff.org/medicaid/upload/8292.pdf.

[9] The Medicare Advantage program requires plans to maintain and monitor a network of appropriate providers, including primary care, specialists, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers. The network must be supported by written agreements and sufficient to provide adequate access to Medicare covered services to meet the needs of the population served. Plans must provide or arrange for necessary specialty care out-of-network when network providers are unavailable or inadequate to meet an enrollee's medical needs.

[10] Medicare Part D plans must have a contracted pharmacy network that assures convenient access to network pharmacies, including retail, home infusion, long-term care, and I/T/U pharmacies.

[11] Medicaid managed care plan contracts must require plans to give assurances to the state and provide supporting documentation that demonstrates they have the capacity to serve the expected enrollment in their service area in accordance with the state's standards for access to care. Plans must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

[12] For more information about Medicaid appeals, see Kaiser Commission on Medicaid and the Uninsured, *A Guide to the Medicaid Appeals Process* (March 2012), available at http://www.kff.org/medicaid/upload/8287.pdf.

[13] CMS Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013 (March 29, 2012), available at https://www.cms.gov/medicare-medicaid-coordination/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemonstrationPlans032912.pdf.

[14] Available at http://www.kff.org/medicaid/8260.cfm.

[15] Demonstration Proposal Instructions and Standards and Conditions, available at https://www.cms.gov/medicare-medicaid-coordination/Downloads/FADemonstrationsStandardsandConditionswithCoverPage.pdf.

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