kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

October 2012

Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries

Executive Summary

Massachusetts is the first state to finalize a memorandum of understanding (MOU) with the Centers for Medicare and Medicaid Services (CMS) to test CMS's capitated financial alignment model for beneficiaries who are dually eligible for Medicare and Medicaid, beginning on April 1, 2013. Massachusetts' demonstration is unique among the state proposals for its focus on full dual eligible beneficiaries ages 21 to 64 and its required Independent Living-Long Term Services and Support (LTSS) Coordinators from community-based organizations independent of the demonstration health plans. This policy brief summarizes the MOU terms in the following key areas:

Enrollment: Massachusetts' demonstration will focus on full benefit dual eligible beneficiaries ages 21 to 64 statewide. Beneficiaries will be passively enrolled in managed care plans unless they take affirmative action to opt out, which may be done prior to enrollment or any time thereafter. The state will provide independent enrollment assistance and options counseling to beneficiaries.

Care Delivery Model: Massachusetts' demonstration is organized around managed care entities called Integrated Care Organizations (ICOs). ICOs will provide patient-centered medical homes, care coordination, and clinical care management. LTSS needs will be overseen by Independent Living-LTSS Coordinators employed by community-based organizations.

Benefits: ICOs will provide nearly all medical, behavioral health, prescription drug, and LTSS that are presently covered by Medicare and Medicaid as well as some supplemental benefits. Subject to CMS and state oversight, ICOs will have flexibility to provide community-based services as an alternative to other high-cost services, based on enrollee needs and wishes.

Financing: CMS and the state will use combined Medicare and Medicaid funds to provide a risk-adjusted blended capitated payment to ICOs and share in savings. The demonstration will include high-cost risk pools based on ICO spending for select Medicaid LTSS above a defined threshold for certain populations. The demonstration also will include ICO-level risk corridors in the first year only. ICOs will be subject to an increasing quality withhold which they can earn back if quality measures are met.

Beneficiary Protections: Upon enrollment in an ICO, beneficiaries must have continued access to their existing providers and service authorizations during a 90 day transition period. The demonstration will have a unified grievance and appeals system. ICOs and their network providers are expected to comply with the Americans with Disabilities Act. ICOs must establish at least one consumer advisory committee and a process for that committee to provide input to the ICO governing board.

Monitoring and Evaluation: Daily oversight of ICOs will be coordinated among CMS and the state. CMS will fund an independent evaluation of the overall demonstration, including a state-specific component.

Massachusetts' MOU is significant both for the additional information provided about its demonstration and the insight into policy decisions that CMS may make in other states' MOUs. Important details remain to be determined in the 3-way contracts among CMS, the state, and ICOs.

Introduction

Just over half the states have submitted proposals to the Centers for Medicare and Medicaid Services (CMS) to integrate care and align financing for people who are dually eligible for Medicare and Medicaid.[1] The initiative began in April, 2011 when CMS awarded design contracts to 15 states to design new service delivery and payment models for this population.[2] Subsequently, CMS issued a July, 2011 State Medicaid Director letter inviting any interested state to submit a letter of intent to test its proposed capitated and/or managed fee-for-service (FFS) financial alignment models for dual eligible beneficiaries.[3] Massachusetts, one of the 15 states that received a design contract, is the first state to finalize a memorandum of understanding (MOU) with CMS to implement its demonstration of the capitated financial alignment model.[4] Massachusetts' demonstration is unique among the state proposals for its focus on full dual eligible beneficiaries ages 21 to 64 and its required Independent Living-Long Term Services and Support Coordinators from community-based organizations independent of the demonstration health plans. The goals of Massachusetts' demonstration, as articulated in its MOU with CMS, are summarized in Text Box 1, and key features of Massachusetts' demonstration are summarized in Text Box 2.

This policy brief summarizes key aspects of Massachusetts' demonstration, including the target population, enrollment, care delivery model, benefits package, continuity of care provisions, financing, grievances and appeals system, disability accommodations, stakeholder engagement, oversight, reporting and quality measures, evaluation, governing authority and waivers, and implementation plans.

Text Box 1:
Massachusetts' Demonstration Goals

- Alleviate fragmentation and improve service coordination and transitions among care settings
- Improve care quality and reduce health disparities
- Eliminate cost-shifting between Medicare and Medicaid and reduce federal and state costs through improvements in care coordination
- Improve beneficiary experience in accessing care, deliver person-centered care, and meet beneficiaries' health and functional needs
- Promote independent community living and self-direction of care

Text Box 2:
Key Features of Massachusetts' Demonstration

- Targets full benefit dual eligible beneficiaries ages 21 to 64 statewide
- Provides for passive enrollment with an opt out available at any time
- Delivers care through Integrated Care Organizations (ICOs) that will provide patient-centered medical homes, care coordination and clinical care management
- Requires Independent Living-Long Terms Services and Supports (LTSS) coordinators from community-based organizations independent of ICOs
- Includes nearly all Medicare and Medicaid services and supplemental benefits
- Uses capitated financing with risk corridors in first year and high-cost risk pools for certain Medicaid LTSS

Target Population

The vast majority of dual eligible beneficiaries in Massachusetts currently do not participate in managed care. Of the over 242,000 dual eligible beneficiaries in Massachusetts in 2010, over 93 percent received their Medicaid benefits on a FFS basis. Nearly six percent received their Medicaid benefits through a Medicaid managed care organization, over five percent received their Medicare benefits through Medicare Advantage Duals Special Needs Plans (SNPs), and just under one percent received both Medicare and Medicaid benefits through the Program of All-Inclusive Care for the Elderly (PACE).[5] The proportion of dual eligible beneficiaries enrolled in Duals SNPs and PACE who are under vs. over age 65, and the number of dual eligible beneficiaries who are enrolled in Medicare Advantage plans that are not Duals SNPs are unknown.

Massachusetts' demonstration will focus on the estimated 115,000 full benefit dual eligible beneficiaries ages 21 to 64 statewide.[6] While this population, unless institutionalized or participating in PACE, is presently enrolled in Massachusetts' § 1115 Medicaid demonstration waiver, they are excluded from the managed care features of the waiver and are ineligible for the additional behavioral health diversionary services offered through the waiver. Instead, they receive Medicaid benefits on a FFS basis, without funding for care management. Dual eligible beneficiaries with other comprehensive public or private insurance, residents of ICF/DD facilities, and § 1915 home and community-based services (HCBS) waiver participants are excluded from Massachusetts' demonstration target population. Beneficiaries who are currently enrolled in a Medicare Advantage plan or PACE may choose to participate in the demonstration if they disenroll from their existing plan.

Enrollment

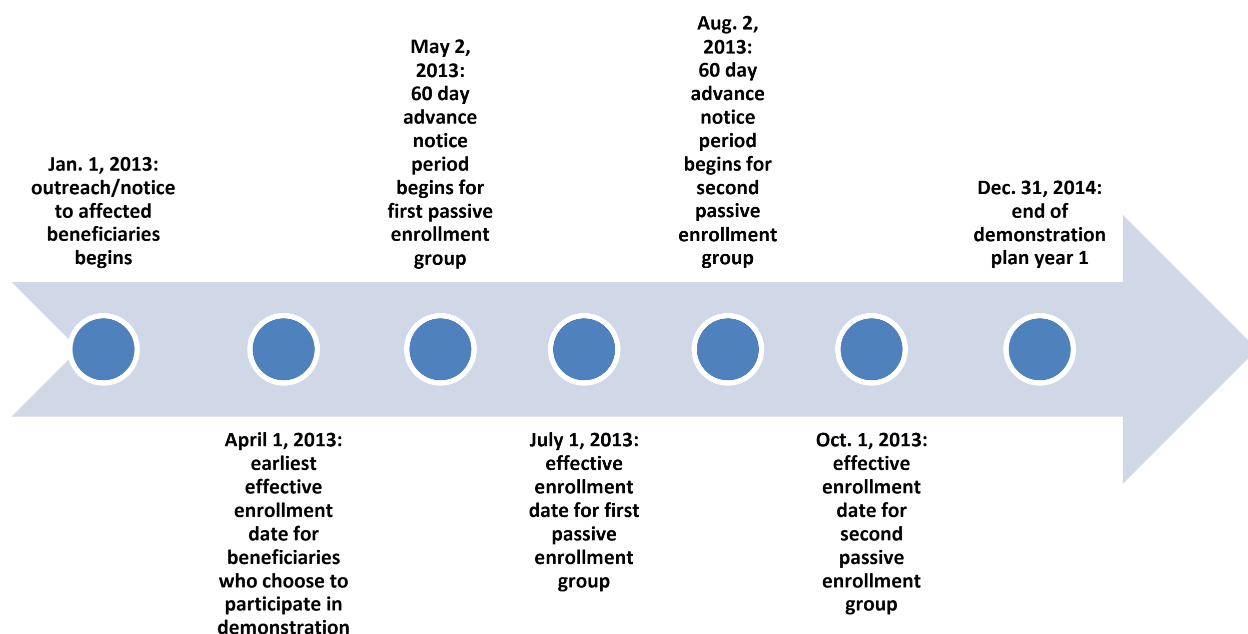
Massachusetts will passively enroll beneficiaries in demonstration managed care plans unless beneficiaries take affirmative action to opt out. Plan marketing and notice of the demonstration to affected beneficiaries will begin no sooner than January 1, 2013. The earliest effective coverage date is April 1, 2013. Initial enrollment will encompass beneficiaries who choose to participate in the demonstration by selecting a plan. Subsequently, there will be two passive enrollment periods in the first year of the demonstration with effective coverage dates of July 1, 2013 and October 1, 2013. The MOU does not specify which beneficiaries will be included in each passive enrollment group nor does it provide detail about the infrastructure in place for beneficiaries who opt out of the demonstration.

Prior to their effective passive enrollment date, beneficiaries will receive a minimum of 60 days' advance notice that they will be enrolled in a demonstration managed care plan unless they indicate their choice to remain in their current FFS arrangements. During the 60 day advance notice period, beneficiaries also have the opportunity to select a demonstration managed care plan of their choice.[7] If they do not take action to opt out of the demonstration or select a plan during the advance notice period, they will be passively enrolled in a demonstration plan. Massachusetts will develop an "intelligent assignment" algorithm that is to prioritize continuity of providers and/or services for beneficiaries who are passively enrolled into demonstration plans, the details of which will be specified in the three-way contract between CMS, the state, and the plan. After enrollment, beneficiaries may disenroll from the demonstration at any time, effective on the first day of the following month.

Massachusetts will use an independent entity to facilitate demonstration plan enrollment and will provide independent enrollment assistance and options counseling to beneficiaries.[8] In addition, ICOs must meet Medicare Advantage customer assistance requirements, have a toll-free number available at least 12 hours per day, seven days per week, and provide oral interpretation services free of charge in all non-English languages spoken by enrollees and TTY or comparable access for people who are deaf. Upon request, ICO customer service staff must provide written materials in the "prevalent" languages spoken by enrollees and in alternate formats that are accessible to people with cognitive limitations.

The enrollment timeline for the first year of Massachusetts' demonstration is illustrated in Figure 2.[9]

Figure 2:
Enrollment Timeline for Massachusetts Demonstration, Year 1



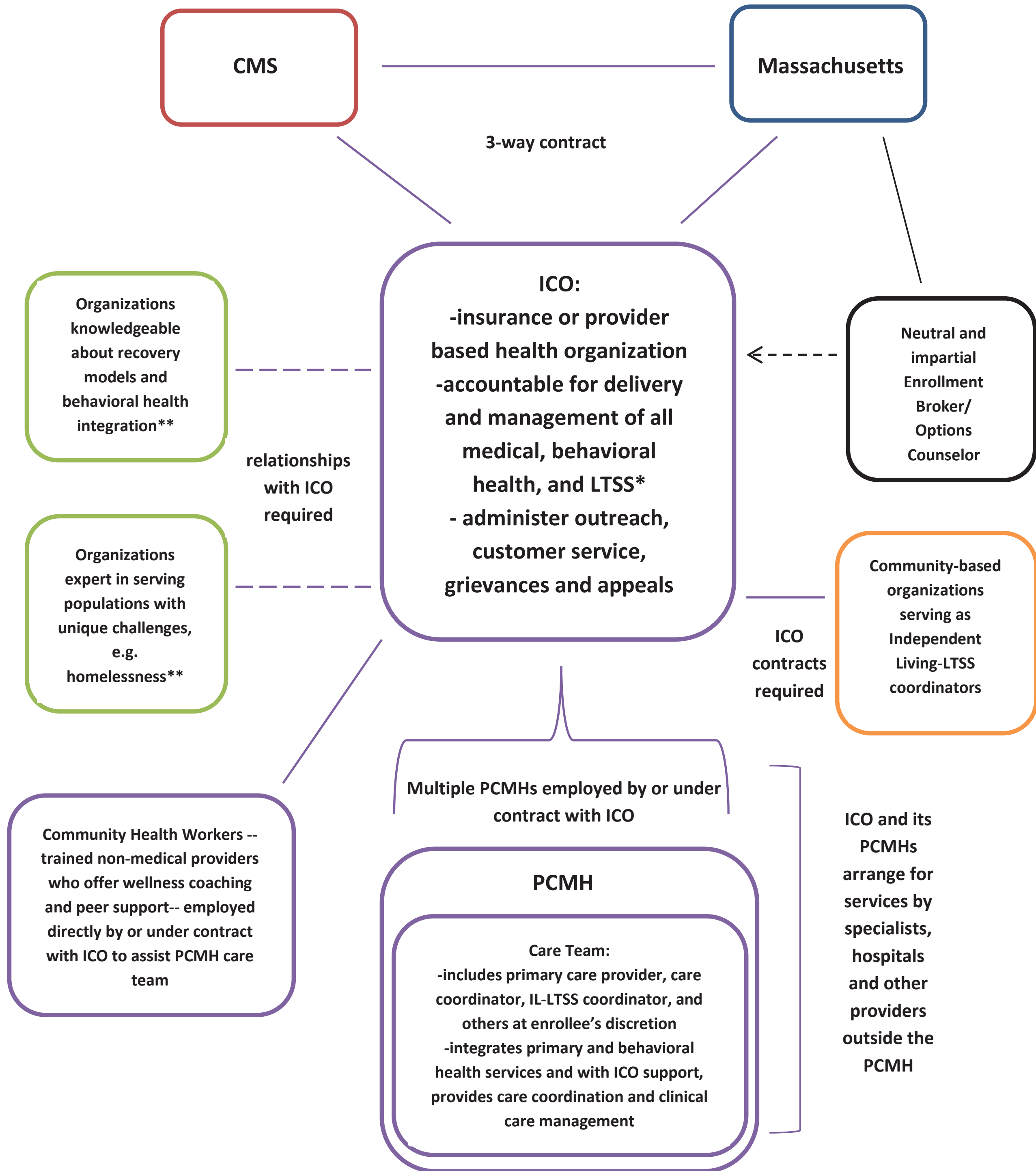
Care Delivery Model

Massachusetts' demonstration is organized around capitated managed care entities called Integrated Care Organizations (ICOs). ICOs will be either insurance-based or provider-based health organizations that offer care coordination to all enrollees. ICOs will employ or contract with providers functioning as patient-centered medical homes (PCMHs) that will deliver team-based integrated primary and behavioral health care to enrollees and coordinate care across all providers within and outside the PCMH. The PCMH, with support from the ICO, will provide clinical care management for enrollees with complex medical needs.[10]

The PCMH will provide a care team that shares responsibility for delivering care that meets the enrollee's needs and in which the enrollee will play a central role. The care team will include the primary care provider, care coordinator, Independent Living-LTSS coordinator (described below), and others at the enrollee's discretion. ICOs also are expected to offer community health workers, trained non-medical providers who will provide culturally competent peer support and wellness coaching, to assist the PCMH care team.

A key revision to Massachusetts' proposal, based on stakeholder comments, is the requirement for ICOs to contract with community-based organizations to provide Independent Living-Long Term Services and Supports (IL-LTSS) Coordinators. IL-LTSS Coordinators will be independent of ICOs and full members of the care team, serving at the enrollee's discretion and overseeing the evaluation, assessment and plan of care to ensure that LTSS services are delivered to meet the enrollee's needs. The care delivery model for Massachusetts' demonstration is illustrated in Figure 3.

Figure 3:
Massachusetts' Demonstration to Integrate Care for Dual Eligible Beneficiaries:
Care Delivery Model



*ICO benefits package excludes DD and mental health targeted case management services, mental health rehabilitation option services, and Medicare-covered hospice services. Because HCBS waiver participants are excluded from the demonstration, the ICO benefits package does not include HCBS waiver services and state plan LTSS for waiver enrollees (people with DD or TBI and frail elders ages 61 to 64).

** Mentioned in state proposal to CMS but not MOU.

Benefits Package

ICOs in Massachusetts' demonstration will provide nearly all medical, behavioral health, prescription drug, and long-term care services that are presently covered by Medicare and Medicaid. Plans will offer an integrated formulary, including all drugs covered by Medicare Parts A, B, and D and Medicaid, although details about plan formulary requirements are not specified, including whether plans could require enrollees to change medication regimens or require prior authorization. The ICO benefits package excludes Medicaid-covered developmental disabilities (DD) and mental health targeted case management services, Medicaid-covered mental health rehabilitation option services, and Medicare-covered hospice services. Because HCBS waiver participants are excluded from Massachusetts' demonstration, the ICO benefits package does not include HCBS waiver services and Medicaid state plan LTSS for waiver enrollees. Medical necessity will be determined based upon the Medicare definition for Medicare-covered services and the Medicaid state plan definition for Medicaid-covered services. In areas of overlap, such as home health services and durable medical equipment, rules will be set out in the three-way contract between CMS, the state and the ICO.

ICOs also must provide supplemental benefits to demonstration enrollees. Supplemental benefits include the diversionary behavioral health services that are encompassed in Massachusetts' § 1115 Medicaid demonstration waiver, additional community support services not presently available through Massachusetts' Medicaid state plan benefits package, and expanded services that are broader than those currently offered through Massachusetts' state plan benefits package. The specific supplemental benefits to be offered by ICOs are itemized in Text Box 3.

Subject to CMS and state oversight, plans will have "significant flexibility" to provide community-based services as an alternative to or means to avoid high-cost services, as indicated by the enrollee's needs and wishes. CMS, the state and ICOs will ensure that beneficiary self-direction of LTSS is supported, and ICOs shall ensure that care is provided in the least restrictive community setting.

Text Box 3:
Supplemental Benefits in Massachusetts' Demonstration

Diversionary Behavioral Health Services:
- community crisis stabilization
- community support program
- partial hospitalization
- acute treatment services for substance abuse
- clinical support services for substance abuse
- psychiatric day treatment
- intensive outpatient program
- structured outpatient addiction program
- program of assertive community treatment
- emergency services program

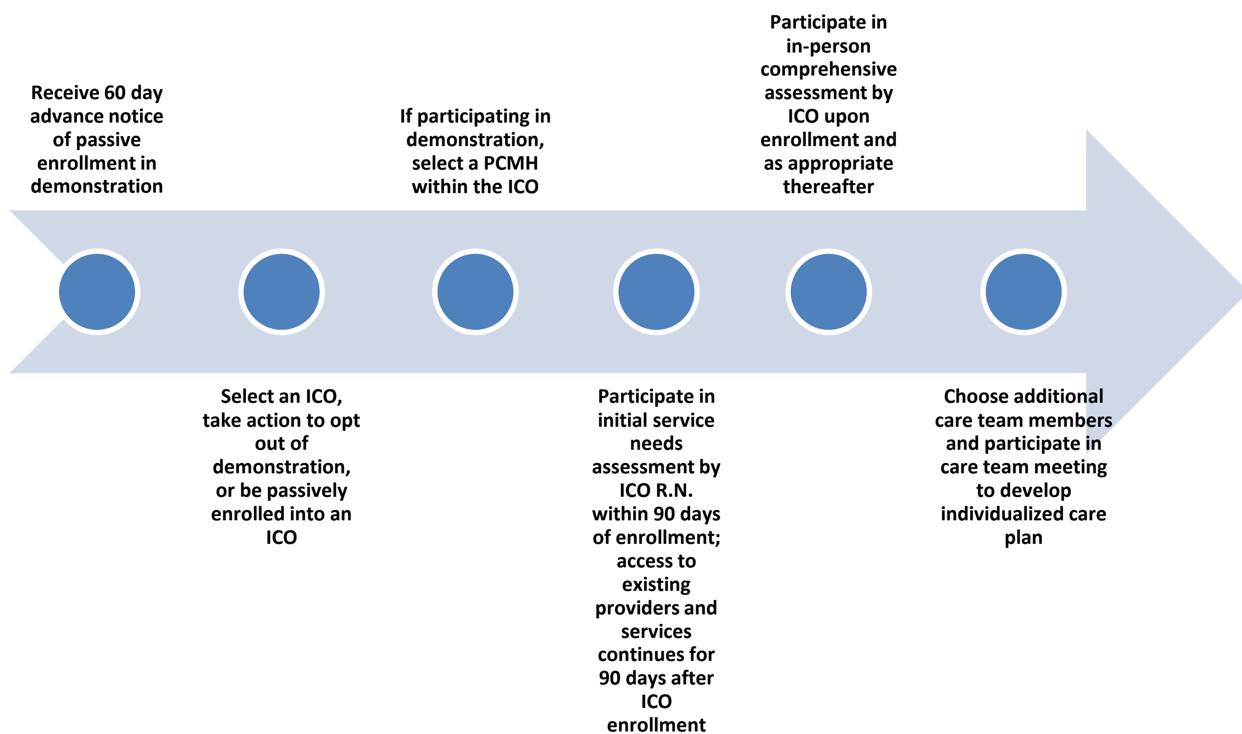
Community Support Services:
- day services
- home care services
- respite care
- peer support/counseling
- care transitions assistance
- home modifications (including installation)
- community health workers
- medication management
- non-medical transportation

Expanded State Plan Services:
- restorative dental services
- personal care assistance--including cueing and supervision
- improved access to durable medical equipment

Continuity of Care

Upon enrollment in an ICO, beneficiaries must have continued access to their existing providers and service authorizations during a 90 day transition period. Within the first 90 days of ICO enrollment, a registered nurse must conduct an "initial assessment" of the beneficiary's medical, behavioral health and LTSS needs to establish the appropriate rating category for the ICO's capitated payment (described below). In addition, upon enrollment and as appropriate thereafter, the ICO will perform an in-person "comprehensive assessment" of the beneficiary's needs in social, functional, medical, behavioral, wellness, and prevention domains; beneficiary strengths and goals; the need for any specialists; and the plan for care management and care coordination. The comprehensive assessment will become the starting point for creating the enrollee's individualized care plan. If the ICO proposes any changes to the beneficiary's existing service authorizations as a result of the initial assessment, the beneficiary must receive 10 days' advance written notice, the opportunity to appeal, and continued services while the appeal is pending if applicable. After the 90 day transition period, ICOs must offer single case out-of-network agreements "under certain circumstances" to providers who currently serve enrollees and are willing to accept the ICO network rate but not willing to join the ICO network or accept new patients. Key events in the care transition process are illustrated in Figure 4.

Figure 4:
Key Events for Dual Eligible Beneficiaries Affected by Massachusetts' Demonstration



Financing

Massachusetts' demonstration will test CMS's capitated financial alignment model, in which the state and CMS will use combined Medicaid and Medicare funds to provide a blended capitated payment to ICOs and share in savings. CMS will make separate contributions to the ICO blended rate for Medicare Parts A and B services and for Medicare Part D services. The state will contribute to the ICO blended rate for Medicaid services.[11]

Savings from the demonstration for CMS and the state will be derived by applying the same percentage (1% in year 1, 2% in year 2, 4% in year 3) to CMS's baseline contribution for Medicare Parts A and B (but not Part D) services and the state's baseline contribution for Medicaid services. 2013 baseline spending for CMS's Medicare Parts A and B contribution will be calculated from a blend of Medicare Advantage projected payment rates and Medicare FFS standardized county rates weighted by where beneficiaries who meet demonstration criteria and are expected to enroll are served in the prior year.[12] Baseline spending for CMS's Medicare Part D contribution will be based on the national average monthly bid amount. Baseline spending for the state's Medicaid contribution will be calculated from historical state spending data through at least CY2010. The savings percentage applied to the state's Medicaid contribution may vary by rating category (described below) but will equal the Medicare Parts A and B savings percentage in the aggregate for the applicable demonstration year, unless or until the Medicare Parts A and B savings percentage is adjusted to recoup materially higher or lower savings attributable to changes in Part D spending as determined by the state and CMS.

CMS and the state's contributions to the blended capitated rate will be risk-adjusted. Medicare risk adjustment will be based on the Medicare Advantage model for Parts A and B and the Medicare Part D model for prescription drugs. Medicaid risk adjustment will be based on rating categories and high cost risk pools (described below). Beneficiaries will be assigned to one of four rating categories as detailed in Text Box 4.

Text Box 4:
Massachusetts Demonstration Enrollee Rating Categories

-Facility-based care*: long-term stay of more than 90 days

-Community tier 3*: skilled need to be met by ICO seven days/week; or two or more ADL limitations and skilled nursing need to be met by ICO three or more days/week; or four or more ADL limitations

-Community tier 2: one or more behavioral health diagnoses reflecting ongoing chronic condition

-Community tier 1: all other enrollees

*Category subject to high cost risk pool

The demonstration will include high cost risk pools based on spending for select Medicaid LTSS above a defined threshold within certain Medicaid rating categories across ICOs. For each rating category with a risk pool (facility-based care and community tier 3), a portion of the state's Medicaid contribution to the ICO base capitation rate (to be determined in the three-way contract) will be withheld from all ICOs in the risk pool. The risk pool funds will then be divided among all ICOs based on their percentage of total enrollee costs above the threshold amount.

The demonstration will include ICO-level risk corridors to share risk among CMS and the state and ICOs in the first year only. CMS and state shares of risk corridor payments or recoupments will be in proportion to their respective contributions to the ICO capitation rate, including Medicare Parts A and B and Medicaid but not Medicare Part D, with the maximum Medicare payment or recoupment equaling one percent of the risk-adjusted Medicare baseline contribution. All remaining payments once CMS has reached its maximum Medicare obligation will be treated as Medicaid expenditures eligible for federal Medicaid matching funds. Risk corridors will consider both service and care management costs and are detailed in Text Box 5.

Text Box 5:
Massachusetts Demonstration Risk Corridors (Year 1 Only)

> 10% gain or loss: plans bear 100%

5-10% gain or loss: plans bear 50%, CMS and state share in 50%

0-5% gain or loss: plans bear 100%

ICOs will be subject to an increasing quality withhold (of 1% in year 1, 2% in year 2, and 3% in year 3) from the capitated rate, which ICOs can earn back if certain quality measures are met. Whether an ICO has met the applicable quality measures in a given year, and the relevant results in demonstration years 2 and 3, will be made public. ICOs also will be subject to certain financial solvency requirements specified in the MOU. The quality withhold measures are listed in Text Box 6.

Text Box 6:
Massachusetts Demonstration Quality Withhold Measures

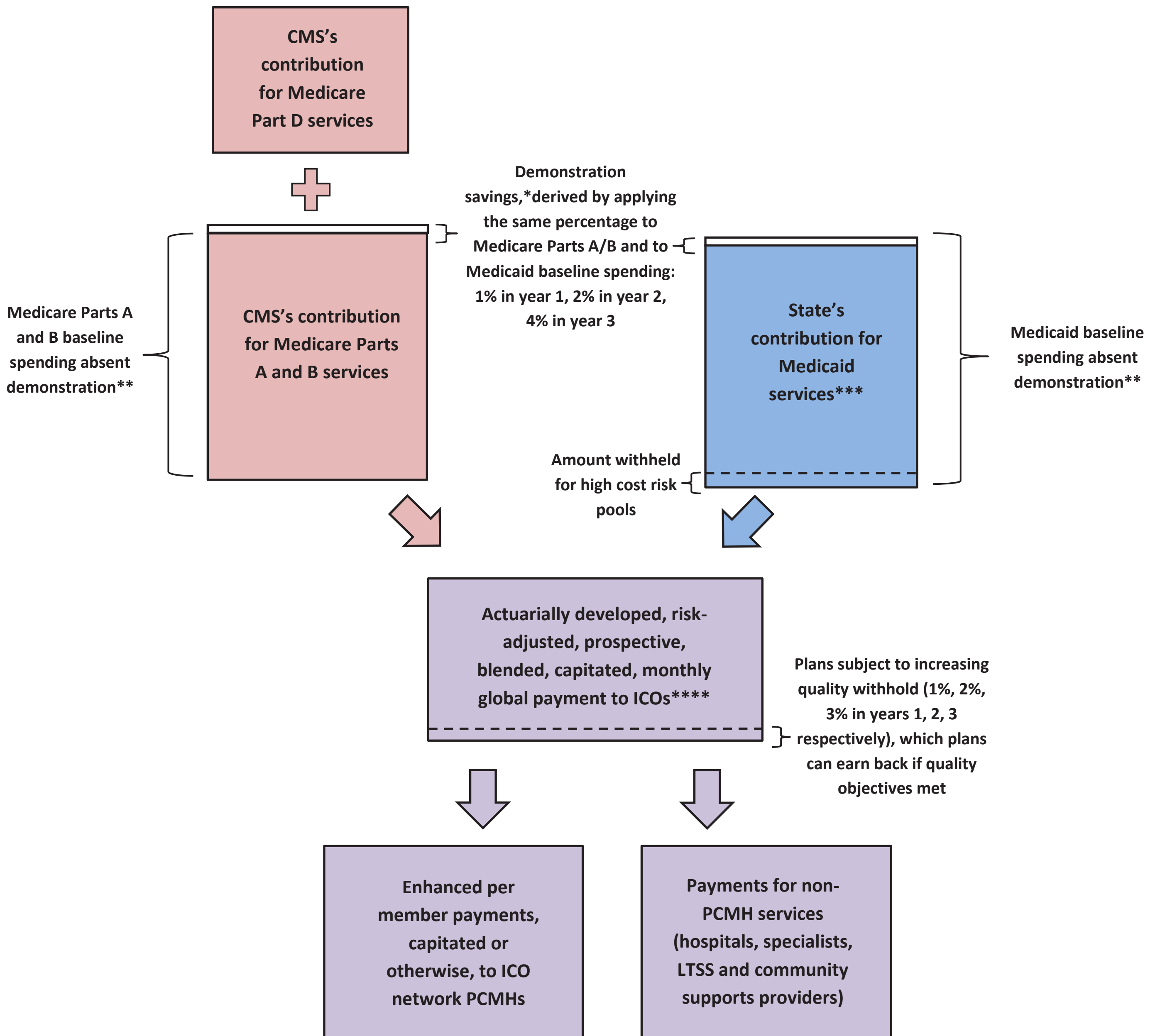
Year 1:
-encounter data submitted accurately and completely
-% enrollees with initial assessments completed within 90 days
-% enrollees for whom specific demographic data is collected and maintained in centralized record
-% enrollees with documented discussions of care goals
-% enrollees with LTSS needs who have IL-LTSS coordinator
-established consumer advisory board or inclusion of enrollees on governance board
-established workplan and identified individual responsible for ADA compliance
-% respondents who always or usually were able to access care quickly when needed
-% of best possible score ICO earned on how easy it was for enrollees to get information and help when needed

Years 2 and 3: % of enrollees who
- were discharged from hospital stay and readmitted in 30 days
-got flu shot prior to flu season
-had mental health outpatient follow-up care after mental health hospitalization
-were screened for clinical depression and follow-up plan documented
-discussed problem falling, walking or balancing with doctor and got treatment
-had hypertension adequately controlled
-had oral diabetes medication filled 80% or more of the time
-received treatment within 14 days of new alcohol/drug dependence diagnosis and 2 or more additional services within 30 days of initial visit
-had transition record transmitted to designated follow-up provider within 24 hours of inpatient discharge
-met quality of life measures to be determined in three-way contract

Upon receiving the blended capitated payment, ICOs in turn will make enhanced per member payments, through capitated or alternative methods, to their network PCMHs. A detailed description of the ICO's risk sharing arrangements with providers will be available to enrollees upon request. ICOs may not charge Medicare Parts C or D premiums or cost-sharing for Medicare Parts A or B services. ICOs may charge co-pays for Medicare Part D and Medicaid-covered prescription drugs to enrollees to whom co-pays currently apply. Drug co-pays will be the lesser of the applicable amounts established by CMS under the Part D low-income subsidy or the Medicaid co-pay and will enable CMS to test whether reducing enrollee cost-sharing for drugs improves health outcomes and reduces overall health expenditures through improved medication adherence.

The financing arrangements for Massachusetts' demonstration are illustrated in Figure 5.

Figure 5:
Massachusetts Demonstration to Integrate Care for Dual Eligible Beneficiaries: Financing Arrangements



*Medicaid savings percentages may vary by rating category but will equal the Medicare Parts A/B savings percentage for the respective demonstration year in the aggregate, unless and until the Medicare Parts A/B savings percentage is adjusted to recoup materially higher or lower savings from changes in Part D spending.
**Medicare Parts A/B baseline calculated from blend of Medicare Advantage projected payment rates and Medicare FFS standardized county rates weighted by where beneficiaries who meet demonstration criteria and are expected to enroll are served in prior year. Medicare Part D baseline based on national average monthly bid amount. Details not specified as to whether Part D payments include federal payments for Part D low-income drug subsidies. Medicaid baseline established from historical state data through at least CY2010.
***State's Medicaid contribution is subject to federal matching dollars based on the state's FMAP.
****Risk adjustment for base capitation rates based on Medicare Advantage methods for Medicare Parts A/B, Medicare Part D model for prescription drugs, and rating categories and high cost risk pools for Medicaid. High cost risk pools based on spending across ICOs for select Medicaid LTSS above a defined threshold within the rating categories for facility-based care and high community needs. ICO level tiered risk corridors based on combined Medicare Parts A/B and Medicaid costs in year 1 only.

Grievances and Appeals

The demonstration will have a unified grievance and appeals process.[13] Beneficiaries will receive a single notice and may file appeals regarding coverage decisions within 60 days, with the initial appeal heard by the ICO. Further appeals will be automatically forwarded to the Medicare independent review entity for Medicare Parts A and B services, and appeals regarding Medicaid services may be appealed to the state board of hearings. Areas of overlap will be addressed in the 3-way contract, but if a decision is issued by both the Medicare independent review entity and the state board of hearings, the ICO will be bound by the ruling most favorable to the enrollee. All appeals at each level must be resolved within 30 days for standard appeals and 72 hours for expedited appeals. The ICO must provide continuing benefits while an internal ICO appeal is pending for all prior authorized services that the ICO proposes to terminate or modify, other than Part D services. Enrollees may request continuing benefits that were prior authorized while Medicaid service appeals are pending with the state board of hearings. The Part D appeals process continues to apply. Beneficiaries also may file internal grievances directly with the ICO.

Disability Accommodations

ICOs and their network providers are expected to comply with the Americans with Disabilities Act (ADA), with monitoring and quality measures to be further developed. The ADA prohibits disability-based discrimination by state and local governmental entities and places of public accommodation. Specific areas mentioned in the MOU include ensuring physical access to buildings, services and equipment; providing flexibility in scheduling and processes; ensuring effective communication including interpreters for people who are deaf;[14] and offering accommodations for people with cognitive limitations. ICO and PCMH staff will be trained in the areas of accessibility and accommodations, independent living and recovery models, and wellness philosophies, and ICOs shall ensure that no credentialed provider engages in unlawful disability-based discrimination.[15] The MOU also indicates that CMS and the state are committed to complying with the Supreme Court's *Olmstead* decision[16] and ensuring that ICOs provide LTSS in settings appropriate to enrollee needs. Where Medicare and Medicaid rules for written materials differ, the standard providing the greatest access to people with disabilities will apply.

Stakeholder Engagement

ICOs must establish at least one consumer advisory committee and a process for that committee to provide input to the ICO governing board. ICOs may include enrollees on their governing board and/or quality review entity. ICOs must demonstrate that people with disabilities, including enrollees, participate in the ICO governance structure.

ICO Oversight, Reporting, and Quality Measures

Daily oversight of ICOs will be coordinated between CMS and the state with each retaining their current program responsibilities. The demonstration-specific monitoring process and frequency of ICO reporting will be specified in the three-way contract. In addition to demonstration-specific

oversight by a joint CMS-state contract management team, CMS will continue to apply "many" Medicare Advantage requirements and all Medicare Part D requirements through its centralized program-wide monitoring. ICOs will be required to report and quality will be evaluated based upon selected measures including the Healthcare Effectiveness Data and Information Set (HEDIS), rebalancing from institutional to community-based settings, utilization, encounters, enrollee satisfaction including the Consumer Assessment of Healthcare Providers and Systems (CAHPS), complaints and appeals, enrollment and disenrollment rates, and "applicable" Medicare Parts C and D requirements as negotiated with ICOs. The MOU contains a "preliminary" set of quality measures, with final measures to be specified in the 3-way contract. A subset of these quality measures will be used to evaluate whether ICOs have earned back the quality withhold from their capitated payment (described above).

Demonstration Evaluation

CMS will fund an independent evaluation of the overall demonstration which will include a state-specific component. The evaluation will include a comparison group, the methodology for which will be determined in the state-specific evaluation plan. The evaluation will assess issues such as beneficiary health status and outcomes by sub-population, care quality across settings, beneficiary access to and utilization of care across settings including any changes in patterns between medical and non-medical services, beneficiary satisfaction and experience, administrative and systems changes and efficiencies, and overall costs or savings for Medicare and Medicaid. Rapid cycle evaluation will be available through quarterly reports on enrollment, implementation, service utilization, and costs, depending on data availability. The state will track beneficiaries eligible for the demonstration, including those who choose to enroll, disenroll, or opt out.

Governing Authority and Waivers

All Medicare Parts C and D and Medicaid managed care statutes, regulations, and sub-regulatory guidance continue to apply to the demonstration except as specified in the MOU, and for sub-regulatory guidance, as waived in the three-way contract.[17] CMS will use its § 1115A demonstration authority to waive Medicare requirements to limit ICO enrollment to beneficiaries ages 21 to 64 and to implement the demonstration components regarding passive enrollment, payment methodology and enrollee liability, approval of marketing materials, grievances and appeals, and Part D cost-sharing. CMS will use its § 1115A demonstration authority to waive Medicaid requirements regarding statewideness and contract requirement rules regarding the methods for prior approval and the demonstration methodology. The Medicaid actuarial soundness requirement is not waived.

Demonstration Implementation

Massachusetts' demonstration will last from April 1, 2013 through December 31, 2016, unless terminated or continued. CMS and the state either directly or through a contractor will conduct ICO readiness reviews prior to plan enrollment. The reviews at minimum will be desk reviews and may include a site visit to ICO headquarters. Readiness reviews will evaluate whether the ICO has a network adequate to address the full range of beneficiary needs and the capacity to uphold all beneficiary protections. Network adequacy will be determined based on Medicare standards for prescription drugs

and services where Medicare is the primary source of coverage and Medicaid standards for LTSS and other services where Medicaid is the primary source of coverage. In areas of coverage overlap, the Medicaid standard will apply as long as it is more generous than the Medicare standard. A stakeholder engagement process is required for material modifications to the MOU, and a 30 day state-level public notice and comment period is required before the state submits a demonstration phase-out plan to CMS.

Looking Ahead

The MOU for Massachusetts' demonstration provides additional information that was previously unavailable about how CMS and the state envision the demonstration working. The Massachusetts MOU also provides insight into the framework and policy decisions that CMS may apply when developing MOUs to implement financial alignment demonstrations for dual eligible beneficiaries in other states that submitted proposals. Nevertheless, important details remain to be specified in the three-way contract between CMS, the state, and the participating managed care plans. As the demonstrations to integrate care and align financing for dual eligible beneficiaries move forward, continued attention to their implementation remains important to ensure that the needs of this vulnerable population are met.

This policy brief was prepared by MaryBeth Musumeci of the
Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

Endnotes

[1] For an overview of these demonstrations, *see* Kaiser Commission on Medicaid and the Uninsured, *Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries* (Oct. 2012), available at http://www.kff.org/Medicaid/8368.cfm. For a summary of the 26 states' proposals to CMS, *see* Kaiser Commission on Medicaid and the Uninsured, *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS* (Oct. 2012), available at http://www.kff.org/Medicaid/8369.cfm. For background on the dual eligible population, *see* Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for Dual Eligible Beneficiaries* (April 2012), available at http://www.kff.org/medicaid/7846.cfm; Kaiser Family Foundation, *Medicare's Role for Dual Eligible Beneficiaries* (April 2012), available at http://www.kff.org/medicare/8138.cfm.

[2] For background on the state design contract proposals, *see* 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] For background on the states' letters of intent, *see* 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. For a summary of CMS's guidance on the capitated financial alignment model, *see* Kaiser Commission on Medicaid and the Uninsured, *An Update on CMS's Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees* (April 2012), available at http://www.kff.org/medicaid/8290.cfm.

[4] MOU between CMS and the Commonwealth of Massachusetts Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees, Demonstration to Integrate Care for Dual Eligible Beneficiaries (Aug. 22, 2012), available at http://www.cms.gov/Medicare-Medicaid-

Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf. For a summary of Massachusetts' proposal as submitted to CMS, *see* Kaiser Commission on Medicaid and the Uninsured, *Massachusetts' Proposed Demonstration to Integrate Care for Dual Eligibles* (April 2012), available at http://www.kff.org/medicaid/8291.cfm.

[5] Kaiser Commission on Medicaid and the Uninsured, *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS* (Oct. 2011), Table 4, available at http://www.kff.org/Medicaid/8369.cfm.

[6] Beneficiaries may continue to participate in the demonstration after turning age 65 provided that they continue to meet other eligibility requirements.

[7] The number of ICOs per service area may be limited to a certain number but will be no less than two, provided that there are two qualified bids.

[8] While the details of Massachusetts' enrollment assistance and options counseling are not specified in the MOU, in August, 2012, CMS and the Administration for Community Living announced a new funding opportunity for State Health Insurance Programs and/or Aging and Disability Resource Centers to provide options counseling to dual eligible beneficiaries in states that have finalized MOUs to implement financial alignment demonstrations, available at http://www.aoa.gov/aoaroot/grants/funding/docs/2012/SHIP_ADRC_Duals_FOA_FINAL8_22_2012.pdf.

[9] The first year of Massachusetts' demonstration will last more than 12 months, beginning on April 1, 2013 and ending on December 31, 2014.

[10] Clinical care management includes the assessment of clinical risks and needs, medication review and reconciliation, medication adjustment by protocol, enhanced self-management training and support including family and caregiver coaching, and frequent enrollee contact as appropriate.

[11] State Medicaid spending qualifies for federal matching funds based upon the state's Federal Medical Assistance Percentage (FMAP). For more information about the FMAP, *see* Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)* (Sept. 2012), available at http://www.kff.org/medicaid/8352.cfm.

[12] In 2013, payments for Medicare Advantage plans will exceed Medicare FFS rates in all counties in Massachusetts. The difference in payment rates may incentivize plans to encourage dual eligible beneficiaries who were previously enrolled in Medicare Advantage plans to remain in the demonstration, rather than disenrolling back into their former Medicare Advantage plan, particularly in some counties.

[13] For more information about the Medicaid appeals process, including state fair hearings and the procedures for Medicaid managed care 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/8287.cfm.

[14] The MOU also mentions the provision of interpreters for non-English speakers.

[15] Discrimination is also prohibited based upon relevant federal laws regarding race, color, national origin, and age.

[16] In *Olmstead v. L.C.,* the U.S. Supreme Court held that people with disabilities have the right to live at home or in the community if they are able and do not oppose doing so, rather than be institutionalized. 527 U.S. 581 (1999), available at http://www.law.cornell.edu/supct/html/98-536-ZS.html.

[17] For a summary of CMS's § 1115A demonstration authority, *see* Kaiser Commission on Medicaid and the Uninsured, *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS,* Appendix A (Oct. 2012), available at http://www.kff.org/Medicaid/8369.cfm.

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