Highlights of Texas's Memorandum of Understanding with CMS
For the "Texas Dual Eligibles Integrated Care Demonstration Project"

Scope

- Individuals eligible for the demonstration include full benefit Medicare-Medicaid enrollees aged 21 or older who are required to receive their Medicaid benefits trough the State's STAR+PLUS program. Approximately 168,000 dual eligible beneficiaries will be eligible to participate in the demonstration.
- Excluded populations include dually eligible individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions, individuals receiving Section 1915(c) waiver services via the Community Living Assistance and Support Services, Deaf Blind with Multiple Disabilities Program, Home and Community-based Services, and Texas Home Living Program waivers.
- Populations who may elect to enroll, who will be excluded from passive enrollment in the demonstration, but who may disenroll from their existing coverage to participate include: individuals enrolled in a Medicare Advantage plan not operated by the same parent organization that operates a STAR+PLUS Medicare-Medicaid demonstration plan (MMP); individuals enrolled in the Program for All-inclusive Care for the Elderly (PACE), and; individuals participating in the CMS Independence at Home demonstration.
- The demonstration will be implemented in six counties of the State – Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant – and will begin no sooner than March 1, 2015 and continue until December 31, 2018.

Contracting and Rates

- CMS and the State will enter into a joint rate-setting process as described in Appendix 6 of the MOU.
- CMS will develop baseline spending (costs absent the demonstration) and payment rates for Medicare Parts A and B services using estimates of what Medicare would have spent on behalf of the participants using a blend of Medicare Advantage projected payment rates and Medicare Fee-for-Service (FFS) standardized county rates. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year.
- Subject to CMS approval, the State and its actuaries will determine the baseline spending for Medicaid services under the demonstration using the actuarially sound Medicaid capitation rates for the State's existing Texas Health Care Transformation and Quality Improvement Program (THTQIP) Section 1115(a) demonstration that would otherwise apply for beneficiaries in the target population who are enrolled in the integration demonstration. These rates will also be adjusted for historical costs and Medicare cost sharing that are currently not in the underlying Medicaid capitation rates.
- The proposed rating categories for the Medicaid component of the rates in the demonstration are described on pages 38-41 of the MOU. The demonstration's rating categories will be consistent with those in the State's STAR+PLUS program, although the STAR+PLUS capitation structure is still subject to future review and approval by CMS.
- Rates for each demonstration year will incorporate projected savings: Year 1a, 1.25% (March 1 to December 31, 2015; Year 1b, 2.75% (January 1 to December 31, 2016; Year 2, 3.75% (January 1 to December 31, 2017, and; Year 3, 5.5% (January 1 to December 31, 2018).
- CMS-HCC risk adjustment methodology will be applied to the Medicare Part A/B portion of the rate and Part D RxHCC will be applied to the Part D portion. The Medicaid portion of the blended rate paid to health plans will include a tiered rate cell structure risk adjustment based on the level of care, further described on page 40 of the MOU.
- Because most enrollees will come from Medicare FFS, in calendar year 2015, CMS will apply an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis. In CY 2016, CMS will apply an appropriate coding intensity adjustment reflective of all demonstration enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportionate to the anticipated percent of enrollees in CY 2016 with prior Medicare Advantage experience and/or experience in the demonstration, depending on the demonstration's enrollment phase-in as of September 30, 2015. After calendar year 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all STAR+PLUS MMP enrollees.
- Beginning in the second year of the demonstration, the demonstration will utilize a one-sided Experience Rebate, similar to that used in Texas's STAR+PLUS program. The Experience Rebate is designed to limit the profits received by STAR+PLUS MMPs to a reasonable percentage of total revenue and to encourage use of revenues for services rather than administrative expenses. The Experience Rebate will include all Medicare A/B and Medicaid eligible costs. The STAR+PLUS MMP must pay to the State an Experience Rebate if the STAR+PLUS MMP's net income

before taxes is greater than the percentage target of total revenue established for the period. The rebate amount will be graduated based on excess revenue above a target profit margin of 3%. Further details will be included in the three-way contracts.

Enrollment

- Enrollment is scheduled to begin on March 1, 2015 with one month of opt-in only enrollment. The State will conduct a phased-in passive enrollment period over six months starting on April 1, 2015. Passive enrollment is effective no sooner than 60 days after beneficiary notification of the right to select a participating MMP. A limit of 5,000 and 3,000 beneficiaries per month, depending on the county, will be the maximum allowable number of beneficiaries to be passively enrolled. No enrollments will be accepted within 6 months from the end of the demonstration.
- Requests to disenroll from a STAR+PLUS MMP or opt-out of the Demonstration will be accepted at any point after an individual's initial enrollment occurs and are effective on the first day of the month following receipt of the request.
- The State will develop an "intelligent assignment" algorithm for passive enrollment that prioritizes continuity of providers and/or services. The algorithm will consider beneficiaries' previous managed care enrollment and historic provider utilization.

Model of Care & Assessments

- All STAR+PLUS MMPs (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC) having explicit components consistent with the Special Needs Plan (SNP) MOC.
- STAR+PLUS MMPs will ensure the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services (LTSS). CMS, the State, and MMPs shall ensure that care is person-centered, outcome-based, and consistent with CMS MOC and Medicare and Medicaid requirements and guidance.
- STAR+PLUS MMPs will develop a person-centered plan of care with the enrollee, his or her caregiver and/or family supports, primary care providers, and other members of the Service Coordination Team, which will be led by a Service Coordinator, and will direct and ensure the integration of service and care – medical, behavioral, substance use, LTSS, and social needs – for each enrollee.
- Each enrollee's plan of care must also include, as applicable and consistent with enrollee preferences, coordination with the enrollee's family and community support systems, including Independent Living Centers, Area Agencies on Aging (AAAs), and Local Authorities, as applicable. For all enrollees, the STAR+PLUS MMP must ensure that the plan of care is in place within 90 days of enrollment, or upon receipt of all necessary eligibility information from the State, whichever is later.
- If an enrollee is found to be eligible for HCBS waiver services as a result of the HCBS assessment, the Service Coordinator will work with the enrollee to develop an Individual Service Plan (ISP). HCBS waiver service planning includes: 1) determining the individual's needs, goals, and preferences; 2) determining service levels; 3) maintaining costs and cost ceilings; 4) reviewing services; and 5) obtaining approval for planned services. The ISP will be incorporated into the enrollee's overall plan of care.

Consumer Protections

- CMS, the State, and the STAR+PLUS MMPs shall ensure that all medically necessary covered benefits are provided to participants and are provided in a manner that is sensitive to the participant's functional and cognitive needs, language and culture, allows for involvement of the participant and caregivers, and is in a care setting appropriate to the participant's needs, with a preference for the home and the community.
- The State and CMS will require STAR+PLUS MMPs and their providers to communicate with their enrollees in a manner that accommodates their individual needs, including providing interpreters for those who are deaf or hard of hearing, accommodations for enrollees with cognitive limitations, and interpreters for those who do not speak English.
- The State will provide Medicare-Medicaid beneficiaries with enrollment options counseling and assistance, independent of the STAR+PLUS MMPs, to help them make an enrollment decision that best meets their needs. The Texas Department of Aging and Disability Services will work with the Texas Health and Human Service Commission (HHSC), the Texas State Health Insurance Assistance Program, Aging and Disability Resource Centers, the State's

Medicaid enrollment broker, and other local partners to ensure ongoing outreach, education, and support to beneficiaries eligible for the Demonstration.

- The HHSC Ombudsman will support individual advocacy and provide the State and CMS with feedback on MMP performance issues encountered during their individual advocacy work, with a focus on compliance with principles of community integration, independent living, and person-centered care in the HCBS context. The Ombudsman will be responsible for gathering and reporting data to the State and CMS via the Contract Management Team described in Appendix 7 of the MOU.
- CMS and the State agree to utilize a unified set of requirements for grievances and internal appeals processes that incorporate relevant Medicare Advantage and Medicaid managed care requirements, to create a more beneficiary-friendly and easily navigable system, which is discussed in further detail in Appendix 7 and will be specified in the three-way contract. All STAR+PLUS MMP grievances and internal appeals procedures shall be subject to the review and prior approval of CMS and the State. Medicare Part D appeals and grievances will continue to be managed under existing Part D rules, and Medicaid non-Part D pharmacy appeals will be managed by the State. CMS and the State will work to continue to coordinate grievances and appeals for all services.
- Quality withhold measures will be applied to the demonstration for Medicare Parts A and B and Medicaid. The percentage withhold will be 1%, 2%, and 3% in each of the three demonstration years, respectively.

Continuity of Care

- STAR+PLUS MMPs must allow enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to 90 days, with further details to be outlined in the three-way contract.
- The STAR+PLUS MMP must perform an initial comprehensive health risk assessment within 90 days of an individual's enrollment in the STAR+PLUS MMP. A reassessment will be completed at least once every 12 months after the initial assessment completion date.
- STAR+PLUS MMPs are required to provide or arrange for all medically necessary covered services, whether by sub-contract or by single-case agreement, in order to meet the needs of the enrollee. STAR+PLUS MMPs must reimburse an out-of-network provider of emergent or urgent care at the prevailing Medicare or Medicaid FFS rate applicable for that service. The STAR+PLUS MMP must comply with out-of-network provider reimbursement rules as adopted by the State for services for which Medicaid is the primary payor.
- On an ongoing basis, and as appropriate, STAR+PLUS MMPs must also contact providers not already members of their network with information on becoming credentialed as in-network providers.

Evaluation

- CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the financial alignment models, including the demonstration, on beneficiary experience of care, quality, utilization, and cost. The evaluator will also explore how the Texas initiative operates, how it transforms and evolves over time, and enrollees' perspectives and experiences.
- The evaluator will design a Texas-specific evaluation plan for the demonstration, and will also conduct a meta-analysis that will look at the state demonstrations overall. A mixed methods approach will be used to capture quantitative and qualitative information.
- Texas is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. Texas and STAR+PLUS MMPs must submit all required data for the monitoring and evaluation of the demonstration, according to the data and timeframe requirements to be listed in the three-way contract.