Highlights of Washington State's Memorandum of Understanding with CMS

For Washington State's "*HealthPath Washington*" Federal-State Partnership
To Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees

Scope

- Individuals eligible for this demonstration include persons aged 21 and older entitled to benefits under Medicare Part A, enrolled in Medicare Parts B and D, receiving full Medicaid benefits, and residing in King County or Snohomish County. The target population is estimated to number approximately 27,000 individuals.
- Eligible subgroups include persons currently participating in the Aging and Long-Term Support Administration (ALTSA) and Community Options Program Entry System (COPES) home and community-based services (HCBS) Medicaid 1915(c) waiver; individuals receiving Medicaid personal care services, including individuals with developmental disabilities; individuals with End Stage Renal Disease (ESRD); individuals enrolled in Medicare Advantage plans operated by the same organization sponsoring a Medicare Medicaid Integration Plans (MMIP) in the demonstration; and American Indians/Alaska Natives, though they will not be passively enrolled in the demonstration.
- Excluded individuals include persons with developmental disabilities receiving institutional services in Residential Habilitation Centers or Community Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD), individuals who participate in the Developmental Disabilities Administration (DDA) HCBS waiver for Adults and Children with Developmental Disabilities; individuals in the Money Follows the Person program; individuals enrolled in the Program for All-inclusive Care for the Elderly (PACE); individuals enrolled in a hospice program; individuals enrolled in a stand-alone Medicare Advantage (MA) plan; those individuals in the Medicaid spend-down population who meet criteria for Specified Low Income Medicare Beneficiary (SLMB) plans; individuals with comprehensive third party insurance, and; individuals residing outside of the demonstration counties.
- The demonstration will begin no sooner than July 1, 2014 and will continue until December 31, 2017.

Contracting and Rates

- CMS and the State's Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) 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 A and B services using estimates of what Medicare would have spent on behalf of the enrollees absent the demonstration and payments rates for Medicare Parts A and B services 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.
- The data sources for development of the Medicaid component of the rate for Demonstration Year 1 are based on Washington fee-for-service and encounter data for State Fiscal Years 2010 through 2012. The Medicaid component of the rate for Demonstration Years 2 and 3 will use updated Washington fee-for-service and encounter data, as available at the point of rate setting for each demonstration year. Medicaid actuarial soundness principles will apply to payments to health plans.
- Rates for each demonstration year will incorporate the following projected savings: Year 1, 1%; Year 2, 2%; and Year 3, 3%.
- The Medicaid component will employ rating categories (Appendix 6, Section IV) with the capitated rate paid to each MMIP in the demonstration representing a composite of three separate components: medical and chemical dependency; mental health; and long-term services and supports (LTSS). Rates paid in the period July 2014 to August 2014 will be based on an average mix of acuity for medical, chemical dependency, mental health and LTSS found in the eligible population, with geographic and age/gender adjustment factors. The composite payment rate to each MMIP will reflect the membership mix at the beginning of the demonstration year. CMS-HCC risk adjustment methodology will be applied to the Medicare Part A/B portion of the rate and Part D RxHCC risk adjustment will be applied to the Part D portion.
- The majority of new demonstration enrollees will come from Medicare FFS, and 2014 health plan risk scores for those individuals will be based solely on prior FFS claims. In calendar year 2014, CMS will apply an appropriate coding intensity adjustment based on the proportion of the target population with prior MA experience on a county-specific basis. In CY 2015, CMS will apply an appropriate coding intensity adjustment reflective of all demonstration enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of demonstration enrollees in CY 2015 with prior MA experience and/or demonstration experience based on the demonstration's enrollment phase-in as of September 30, 2014. After calendar year 2015, CMS will apply the prevailing MA coding intensity adjustment to all enrollees.
- Each MMIP will be required each year to meet a minimum Medical Loss Ratio (MLR) threshold of 85%. The three-way contracts will include additional specifications on the MLR. If a MMIP has an MLR below 85% of the joint Medicare and Medicaid payment to the MMIPs, the MMIP must remit the amount by which the 85% threshold exceeds the MMIP's actual MLR multiplied by the total applicable revenue of the contract. If a MMIP has an MLR between 85% and 90% of the joint Medicare and Medicaid payment to the MMIPs, such MMIP must remit 50% of the amount by which the 90% threshold exceeds the MMIP's actual MLR multiplied by the total applicable revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicare and Medicaid programs on a percent of premium basis.

Enrollment

- Passive enrollment for eligible beneficiaries is effective no sooner than 60 days after participant notification of the right to select a MMIP plan and the option to not participate in the demonstration. A voluntary opt-in enrollment period is scheduled to begin June 1, 2014, prior to the initial effective enrollment date of July 1, 2014.

- The passive enrollment process for those beneficiaries who have not made a plan selection will begin no earlier than July 1, 2014, with enrollment effective no earlier than September 1, 2014. Passive enrollment will be conducted in three phases, with enrollment for Phase One, Phase Two and Phase Three beginning September 1, 2014, November 1, 2014, and January 1, 2015, respectively. Enrollee assignment to each phase of passive enrollment will be based on random assignment within each county's eligible population. Such assignment will take into consideration the number of opt-in enrollments prior to Phase Two and Phase Three and the disenrollment rate for each MMIP. Starting February 2015, passive enrollment of newly eligible beneficiaries will be done monthly.
- Disenrollment from MMIPs and enrollment from one MMIP to a different MMIP shall be allowed on a month-to-month basis any time during the year. All disenrollments will be effective the first day of the month after the choice is made.
- Medicare-Medicaid Enrollees will maintain their choice of plans and providers for which they are eligible and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose a different MMIP, a Medicare Advantage Plan, a PACE plan (where applicable), to receive care through Medicare Fee-For-Service (FFS) and a Prescription Drug Plan, and to receive Medicaid services in accordance with the State's approved State Plan services and any approved waiver programs.
- MMIP outreach and marketing materials will be subject to a single set of rules developed jointly by CMS and the State as outlined in Appendix 7.
- Enrollees may access independent enrollment assistance and options counseling offered by the State's Area Agencies on Aging (AAA) to help them make an enrollment decision that best meets their needs.

Consumer Protections

- CMS, the State, and MMIPs shall ensure that all medically necessary, covered benefits are provided to enrollees in a manner that is sensitive to their individual functional and cognitive needs, language, and culture, and that allows for the involvement of the enrollee and caregivers (as permitted by the enrollee) in a care setting appropriate to the enrollee's needs, with a preference for the home and the community. CMS, the State, and MMIPs shall ensure that care is person-centered and can accommodate and support self-direction. MMIPs shall also ensure that enrollees have the option to receive LTSS in the least restrictive setting when appropriate, with a preference for the home and the community, and in accordance with the enrollee's wishes and Individualized Care Plan (ICP).
- The State and CMS will require MMIPs to provide access to contracted providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their enrollees. The State and CMS will require MMIPs 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 with limited English proficiency.
- Performance will be monitored throughout the operation of the demonstration and measured according to certain quality metrics. Other monitoring activities will include the Project Governance Team, MMIP Enrollee advisory committees, and stakeholder meetings held by the State. The State will use the established Ombudsman through the Washington State Office of the Insurance Commissioner to assist in monitoring.
- Enrollees will have access to an integrated Appeals and Grievance process. CMS and the State agree to develop a unified set of requirements for MMIP grievances and internal appeals processes that incorporate relevant Medicare Advantage and Medicaid managed care/appeals requirements to create a more Enrollee friendly and easily navigable system. All MMIP 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 by CMS under existing Part D rules, and Medicaid non-Part D pharmacy appeals will be managed by the State.
- 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.

Care Model and Assessments

- MMIPs (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC). Participating MMIPs must meet all CMS MOC standards for Special Needs Plans as well as additional requirements established by the State. MMIPs 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. CMS, the State, and MMIPs shall ensure that care is person-centered and can accommodate and support self-direction.
- Each enrollee shall receive, and be an active participant in, initial screenings and ongoing health risk assessments of medical, behavioral health and LTSS needs, which will be used as the starting point for creating an Individual Care Plan,(ICP). An ICP for a course of treatment or care monitoring will be developed for all enrollees within 90 days of enrollment. The ICP is an integrated, individualized, person-centered care plan jointly created and managed by the enrollee, his or her selected support system, his or her MMIP care management team, and his or her interdisciplinary team of care providers.

- Enrollees will then be stratified into one of three tier levels (Supported Self-Intervention, Disease/Episodic Care Management, and Intensive Care Management for Enrollees with Special Health Care Needs) using information from their initial and secondary screening, health risk assessment, and/or other utilization data for enrollees.
- MMIPs at a minimum will offer Care Management services to all enrollees based on their tier level, needs, and preferences to ensure effective linkages and coordination between the medical, behavioral health, LTSS, and other community providers to coordinate the full range of supports, as needed, both within and outside the MMIP. All enrollees will be assigned a Care Manager or Intensive Care Coordinator and will have access to an Interdisciplinary Care Team (ICT).
- Every enrollee must have access to an ICT to ensure the integration of the enrollee's medical, mental health, chemical dependency ,, LTSS, and social needs. The ICT will consist of clinical and non-clinical disciplines, inclusive of the enrollee and individuals of his or her choice, whose interactions are guided by specific team functions and processes to achieve positive outcome for enrollees.
- The intensity of Care Management services will depend on the beneficiary's tier level.
- MMIPs will administer a State-approved Initial Health Screen within 30 days of a beneficiary's enrollment.

Continuity of Care

- CMS and the State will require MMIPs to ensure that enrollees continue to have access to medically necessary items, services, prescription drugs, and medical, behavioral health, and LTSS providers for the transition period as specified in Appendix 7.
- During the transition period, MMIPs will advise in writing enrollees and providers that the enrollees have received care that would not otherwise be covered at an in-network level. On an ongoing basis, MMIPs must also contact providers not already members of their network with information on becoming credentialed as in-network providers.
- MMIPs will be required to offer a 180-day transition period in which enrollees may maintain a current course of treatment with a provider not part of the MMIP's network. For ESRD services, Nursing Facilities, Adult Family Homes and Assisted Living Facilities, MMIPs will be required to offer a continuity of care period of 180-days at minimum or until an ICP is completed, whichever is later.

Evaluation

- CMS will fund an external evaluation, and has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the State Demonstrations to Integrate Care for Dual Eligible Enrollees and the Financial Alignment Demonstrations, on enrollee experience of care, quality, utilization, and cost. The evaluator will also assess how the Washington State demonstration operates, how it transforms and evolves over time, and enrollees' perspectives and experiences.
- The State is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. The State and MMIPs must submit all required data for the monitoring and evaluation of this demonstration according to the data and timeframe requirements to be listed in the three-way contract.