DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

August 9, 2013

Dear Dr. Sulick (et al):

Thank you for your letter detailing recommendations for the Financial Alignment Initiative. We appreciate your feedback and interest in ensuring the demonstrations created under this initiative effectively improve the care available to Medicare-Medicaid enrollees.

Through the Financial Alignment Initiative, we are continuing to work with states to develop demonstrations to improve the care experience of Medicare-Medicaid enrollees. As you are aware, the Centers for Medicare & Medicaid Services (CMS) has signed Memoranda of Understanding (MOUs) with six states to proceed with these demonstrations, under both a capitated model and a managed fee for service models.

Input from stakeholders has been a critical part of the development process for each of these demonstrations. As you mentioned in your letter, we have made adjustments to all of these demonstrations to reflect valuable input we have received from you and others, including adjusting start dates, establishing enrollment periods and utilizing independent ombudsman programs.

We appreciate the opportunity to comment on your most recent round of recommendations. Please see our responses below:

**Transparency**

Both your letter of June 19th and a subsequent letter sent August 6th by many of the same organizations have raised questions about transparency as it relates to development of the three-way contracts among CMS, states, and plans participating in the capitated model.

CMS is committed to making stakeholder input a critical part of each demonstration, both in their development and implementation. The original proposals submitted by each state were posted for public comment on the CMS website, and each state conducted extensive outreach to gain stakeholder input on demonstration design. The MOUs signed between CMS and states are a reflection of this process. The three-way contracts between CMS, states, and plans participating in these demonstrations are meant to execute the principles detailed in the MOU, and they will be made available on the CMS website when finalized. The Massachusetts contract is available on the CMS website at:
http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf

CMS and states will continue regular meetings with beneficiary stakeholders and offer opportunities for feedback on demonstration structure and operations. To date, we have given stakeholders an opportunity to comment on key guidance documents, including enrollment guidance, marketing guidance, and reporting requirements for plans participating in capitated demonstrations. These guidance documents inform the development of the three-way contracts. In many cases, the three-way contract explicitly references these documents. We appreciate that under Medicare Advantage stakeholders are provided with opportunities to provide feedback on manuals and other sub-regulatory guidance. For that reason, we are providing the same opportunity under the demonstration to comment on areas—such as enrollment or marketing—where the demonstration deviates from Medicare Advantage requirements. We are committed to soliciting this input on similar documents and updates to these documents throughout the life of the demonstration.

**Ombudsman Programs**

CMS shares your interest in developing ombudsman programs in every state participating in the Financial Alignment initiative. CMS also believes that additional funding streams can be instrumental in supporting states in developing these programs.

To that end, as you know, CMS recently announced a new Funding Opportunity Announcement (FOA) for states participating in the Financial Alignment initiative. Funding from this FOA will support the development of independent Ombudsman Programs, which will provide beneficiaries access to new resources and person-centered assistance in answering questions and resolving issues related to the demonstration. They will also carefully monitor the beneficiary experience and offer recommendations to CMS, the states, and participating plans on possible improvements to the initiative. We appreciate the input that your organization and other stakeholders provided to us regarding the concept of an ombudsman program, and we believe that this FOA is responsive to several points raised in your letter.

**Financing Structure**

CMS projects that each approved demonstration can achieve overall savings through improved care coordination and administrative efficiency. There will be different savings opportunities across states and within both the capitated and managed fee-for-service demonstration models. We believe the savings targets established by each demonstration reflect what can be achieved through providing Medicare-Medicaid enrollees with more person-centered, coordinated care. In coming weeks, we will update the documentation on our website describing the financing framework for the capitated demonstrations. The updates should provide additional clarity on the financing structure.

**Quality Measures**

The MOUs released thus far provide examples of what will be measured in all demonstrations, including beneficiary experience of care, care transitions, support of community living, access to services, and shifts in service utilization patterns, and many others. Additional quality measures, as well as qualitative evaluation components such as beneficiary focus groups and key informant interviews, will be included in the state-specific evaluation plans that will be made public as they are finalized.

CMS is also working closely with the National Quality Forum (NQF) and the National Committee for Quality Assurance (NCQA) to ensure that the demonstrations effectively track the quality of care provided to beneficiaries in the demonstration, without creating duplicative reporting requirements that create an unnecessary administrative burden. We believe that this work will be critical to developing an effective strategy for quality measurement over the duration of the demonstrations.

NQF's recent work on Medicare-Medicaid quality measurement reinforces the absence of nationally validated measures for long-term services and supports. NQF has identified "structural measures as they apply to providers and health plans integrating with community organizations or other providers of long-term supports and services (LTSS)" as a measure gap area[1] In the absence of nationally validated measures, we are working with states to apply LTSS measures that reflect the care needs of demonstration enrollees, match existing Medicaid measures or respond to state-specific stakeholder input. We are also helping to fund NQF's ongoing work on this issue.

**Passive Enrollment**

The states participating in the Financial Alignment initiative have different enrollment strategies that reflect their different marketplaces and unique landscapes. In some states, enrollment strategies also vary by county or region.

We agree that phased-in approaches to beneficiary enrollment are critical to ensuring a person-centered focus to the demonstration. Each demonstration approaches this phase-in differently, but with a similar objective of staggering the enrollment process over time. For example, the enrollment phase-in in California is different from other states, as enrollment is phased in over a longer period of time and is county-specific. For most of the participating California counties, enrollment is spread over a 12 month period, and the majority of eligible beneficiaries will have an opt-in period that is much longer than those in other states. During this phase-in, CMS and the state will monitor participating plans to ensure they have the necessary provider capacity, community supports, systems, and infrastructure to deliver person-centered care.

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[1] http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=72738

We believe that following a state-specific method of determining enrollment policies is an important way that CMS can ensure that beneficiaries have access to high quality care through these demonstrations. By taking into account local factors, such as the number of participating plans, the concentration of beneficiaries in a given locality, and level of current managed care enrollees, CMS and the states can establish an enrollment method that best reflects the interests of beneficiaries.

**Size and Speed**

In most states participating in the Financial Alignment initiative, CMS and the states have chosen to reduce the total number of beneficiaries included in the demonstrations. These decisions were, in part, a product of extensive stakeholder input. In California alone, the total size of the demonstration was reduced from an original proposal of more than 800,000 Medicare-Medicaid enrollees to 456,000. Additional recent changes in California regarding beneficiaries in Medicare Advantage and in Dual Special Needs Plans (D-SNPs) will further reduce the number of beneficiaries eligible for passive enrollment.

With respect to speed, we are proceeding at a measured, considered pace for each state and implementing safeguards that will ensure the demonstrations protect and enhance beneficiaries' access to high quality care. CMS issued the original notice to State Medicaid Directors in July 2011 and has worked closely with states to develop and implement demonstrations in a thoughtful manner over the past two years. In many of the states with a signed MOU to participate in the capitated model, CMS and the state have adjusted the start date of the demonstration, to reflect stakeholder input and to ensure demonstrations move forward only when ready.

**State and Plan Readiness**

Every plan selected to participate in a capitated demonstration must pass a comprehensive joint CMS/state readiness review. The readiness review process includes desk reviews, site visits, validations of the provider and pharmacy networks, review of key subcontracted entities and validation of systems and capacity to ensure that each plan has the ability to offer high-quality, coordinated care while adhering to all federal and state requirements. Importantly, there will be a specific focus on those areas and processes, which directly impact beneficiary care including assessment processes, care coordination, provider network development and maintenance, and the plan's staffing and staff training. For each demonstration, CMS works with the state to establish a state-specific readiness review tool, based on the MOU signed with CMS, applicable Medicare and Medicaid regulations and stakeholder feedback. The readiness review protocols for approved states are available on our website.

With respect to State readiness, CMS is working with each state to determine readiness to implement the demonstration. State readiness is and will continue to be a requirement for each demonstration. CMS implementation funding helps to support many states with their readiness. CMS funding of SHIPs, ADRCs and Ombudsman resources will help provide information and support that will both help further state readiness and provide CMS with important information to assess ways the demonstrations can be strengthened, as well as assisting beneficiaries with questions or issues they have with the demonstration.

**Continuity of care and transitions**

In the capitated financial alignment model, CMS is applying network adequacy standards to ensure that all health plans have sufficient number of providers and continuity of care provisions to ensure that beneficiaries can continue to see current providers (including those at community health centers) during any transitions into the demonstration health plan. These provisions will ensure beneficiaries have access to their existing doctors and other providers for at least a specified period of time while they transition into demonstration plans, and ensure demonstration enrollees will retain all Medicare Part D beneficiary protections.

In the development of any beneficiary-outreach materials, CMS and the states will make an effort to gain stakeholder input to ensure that materials accurately and thoughtfully provide beneficiaries with accessible information about their options under the demonstrations. CMS and states will continue this outreach throughout implementation of the demonstration.

**Enrollment Broker**

Under the capitated model, CMS and States will use different approaches to verify and ensure that enrollment broker organizations are independent and conflict free. Recently-released enrollment guidance provides additional information on the role of state enrollment brokers. That guidance is available on the MMCO website.

**Supplemental Services**

We believe that all of the Financial Alignment demonstrations have the potential to offer beneficiaries higher quality care than they currently receive. Through a unique person-centered approach that blends Medicare and Medicaid benefits in a manner more accessible to beneficiaries, this initiative will help many beneficiaries access new providers and services that may not have been available before.

Some demonstrations will offer additional benefits ranging from dental and vision to behavioral health. However, each demonstration is the product of a separate discussion with a state under different circumstances, and CMS cannot guarantee that every state will offer the same types of additional services.

Non-Medicare/Medicaid services that are specifically included in either the demonstration benefit package or offered by particular plans to all enrollees in their plan benefit packages and marketing materials are called "supplemental benefits." For these benefits, plans must provide all medically necessary services, and beneficiaries may appeal denial of these benefits in the same manner as any Medicare or Medicaid benefits. We also encourage all plans to offer additional benefits—typically called "flexible benefits"—that are in the individual's care plan, as appropriate, to address the enrollee's needs.

We thank you again for your thoughtful input, and for your commitment to Medicare-Medicaid enrollees across the country. We look forward to continuing to work with you to address these concerns, and to make improvements to the demonstrations under development and being implemented across the country.

Sincerely,

Melanie Bella

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