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On July 8, 2011, CMS released a State Medicaid Director (SMD) letter providing preliminary guidance on two new demonstration models for States pursuing integration of primary, acute, behavioral health and long-term supports and services for their full benefit Medicare-Medicaid enrollees. The SMD letter explained that under one model, the managed fee-for-service (MFFS) model, CMS and a participating State will enter into an agreement whereby the State would be eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicaid and Medicare. The SMD letter can be found at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

Interested States were required to submit letters of intent by October 1, 2011. Since that time, the Medicare-Medicaid Coordination Office (MMCO) has been working with those States interested in pursuing the MFFS model. The purpose of this letter is to provide general guidance to those States on a number of demonstration-related elements.

The purpose of the MFFS model is to encourage and support State investment in models to better align service delivery and financing for Medicare-Medicaid enrollees across the two programs, integrating primary, acute, behavioral health, and long term supports and services. In the MFFS model, CMS will make a retrospective performance payment to a State if that State qualifies by meeting certain quality and savings criteria. The following are key principles that govern the MFFS model.

- **State opportunity to benefit from Medicare savings**. Currently, if a State makes an investment in Medicaid that reduces expenditures for Medicare-Medicaid enrollees, it does not receive any financial benefit from any resulting Medicare savings. The MFFS model allows States to receive Medicare performance payments based on reductions in Medicare spending among Medicare-Medicaid enrollees, contingent on States meeting certain quality thresholds.
- **Achieving performance goals**. States that participate in the MFFS model will be evaluated on a carefully selected set of quality measures. States that fail to meet minimum criteria will not be eligible to receive performance payments. A State that meets minimum criteria will be eligible to receive 60% of a maximum potential performance payment. The remaining 40% will be scaled based on State performance.

- **Statistically significant savings.** CMS is requiring that any Medicare savings be shown to be statistically significant before a performance payment would be made to a State. Each demonstration will include a minimum savings rate against which savings will be measured. This will protect against performance payments being made where savings are simply the result of chance or random variation.
- **Use of well-crafted comparison groups**. Numerous factors may cause changes in Medicare or Medicaid spending. These include national changes in payment policy or utilization patterns. In order to control for these outside factors, CMS intends to use carefully chosen comparison groups to identify the extent to which changes in expenditures are actually due to the State's MFFS demonstration.
- **Limited risk for participating States**. States that participate in the MFFS model are expected to make up-front investments to improve coordination for Medicare-Medicaid enrollees. By making these investments, States assume the risk that their investment may not result in savings sufficient to achieve a performance payment. However, CMS will not require States to also be responsible for covering Medicare cost increases if they occur in the demonstration.
- **Consideration of all Federal spending**. In order to receive a performance payment, States must demonstrate a reduction in *overall* Federal spending on Medicare-Medicaid enrollees. Accordingly, increases in Federal Medicaid spending will be deducted before States receive a performance payment based on Medicare savings. Each demonstration will include a Medicaid significance factor against which Medicaid increases will be measured to reduce the likelihood of attributing cost increases to the demonstration that are simply the result of or chance or random variation.

The MFFS Memorandum of Understanding

Each demonstration will be established through a memorandum of understanding (MOU) with CMS. The MOU describes the principles under which CMS and the State plan to implement and operate the demonstration, the methodologies for calculating Medicare savings and the retrospective performance payment, the quality framework for the demonstration, readiness activities CMS and the State plan to conduct in preparation for implementation, and the appropriate Medicare and Medicaid authorities applicable for the demonstration.

The MOU development process is iterative in that it involves extensive exchange between the State and CMS. During this process, both parties have the opportunity to build on the base of the State's demonstration proposal and more fully establish the parameters of the demonstration. It is also during this time that CMS will work with the State to assess whether there is a reasonable expectation of savings in the demonstration. Throughout the MOU development process, we encourage States to continue to engage with stakeholders on any critical design elements that may evolve or reach a greater level of detail in the MOU than in the original State proposal. Changes made to the proposal will be captured in a proposal addendum that will be posted online in conjunction with the MOU.

The Readiness Review

A State with a signed MOU will undergo a comprehensive readiness review tailored to its demonstration prior to implementation. The purpose of the readiness review is to determine the extent to which the State is prepared to implement its demonstration as outlined in its MOU. CMS has contracted with an external entity to develop a general readiness review for the model, tailor the general readiness review to appropriately assess each State's individual demonstration, and perform the readiness review for each demonstration. The contractor will provide its findings in a report to both the State and CMS. CMS will use the report to assess and verify the State's general preparedness for moving forward and to identify any areas to be addressed in the model as conditions of implementation. Every effort will be made to build on existing work done with the State and avoid duplicative processes. For instance, in States where the demonstration is based on Medicaid health home authority, the contractor will look to any site visits or existing reports performed by CMS to inform this readiness review.

The MFFS readiness review will include at least the following steps:

1. CMS will establish criteria relevant to the context of the demonstration and the State-specific MOU.

2. The contractor will begin with a desk review of information already obtained from the State or other sources to assess whether any criteria can be recorded as "met" based on the contents of the existing documentation. Sources may include approved Medicaid State plan amendments, State laws and regulations, and relevant reports or surveys otherwise completed by the contractor or other entities external to CMS.

   To minimize the burden on the State, requests for additional documentation from the State will be limited to criteria not otherwise met based on this initial review.

3. For criteria not met during the initial review, the contractor will notify the State of potential evidence for each criterion both to serve as examples for the State about the type of evidence that could be submitted and to help guide reviewers' assessment of submitted materials to determine whether the State has met a given criterion.

4. The contractor will review documentation supplied by the State and determine whether the materials meet the defined readiness review criteria. The contractor's review of documentation will be guided by the following:

   - For those functional and operational areas for which the State developed content, that content may serve as documentation of evidence. For most of the criteria, the following types of documents may contain content evidence:

     - Contract language with the providers
     - Policy guidance related to the MFFS financial alignment demonstration and/or underlying delivery system reforms
     - Training curricula

- State monitoring activities for participating providers
- Reporting requirements for participating providers
- State audit approach and program integrity processes

- For the functional and operational areas for which the State has delegated development of content to providers, the contractor will review the State's oversight approach and approval of materials (e.g., if the provider has developed training materials, the contractor will review the State's plan to review the provider's training approach).

A site visit may be warranted based on the outcome of the document review. Reviews may be conducted on-site or, in some cases, by phone and will involve interviews with key state staff or other stakeholders to review evidence in support of selected criteria and tests of selected systems, as necessary.

MFFS Final Demonstration Agreement

Following the signing of the MOU and the completion of the readiness review, but prior to implementation of the demonstration, CMS and the State will enter into a final demonstration agreement. The final demonstration agreement will outline the terms and conditions of the demonstration, including the specific conditions under which CMS will make retrospective performance payments under the demonstration.

All provisions of the MOU will be incorporated by reference into the final demonstration agreement unless explicitly stated. The agreement will also include additional legal, operational, and technical requirements pertinent to the implementation of the demonstration.

The Savings Calculation

The State will be eligible to receive a retrospective performance payment if actual savings are generated by its intervention and quality standards are met.

Savings will be calculated by comparing the experience of the demonstration group to a target amount determined by trending the expenditures of the demonstration group (from a base period before the demonstration) by the change in costs of the comparison group. The demonstration group will include all Medicare-Medicaid beneficiaries eligible for the demonstration, regardless of their level of engagement in the associated interventions. The evaluator will draw a comparison group of Medicare-Medicaid enrollees from statistically similar regions where there is no financial alignment model underway. The comparison group will include Medicare-Medicaid enrollees with similar utilization and cost characteristics as the demonstration population. Where possible, the comparison group will be drawn from within the demonstration State. In cases where comparison groups have to be drawn from other States, the evaluator will conduct a cluster analysis to identify potential comparison States based on factors such as Medicare and Medicaid expenditures for Medicare-Medicaid enrollees, long-term care service users by type of provider, and managed care penetration rates, among other factors. Then, within

the comparison State(s), the evaluator would identify a comparison group with similar utilization and cost characteristics as the demonstration population.

The savings calculation results that will be used in retrospective performance payment calculations will include the difference in changes over time in both Medicare A/B and Federal Medicaid expenditures found between the demonstration group and the comparison group (Part D costs will not factor into the analysis). To determine demonstration savings, the contractor will:

1. Calculate a pre-demonstration baseline for Medicare Parts A/B per capita spending and Medicaid per capita spending for the demonstration group and comparison group. The baseline spending will be based on actual Medicare and Medicaid costs during a two-year period prior to the start of the demonstration for those beneficiaries eligible for the demonstration.
2. Calculate a Medicare A/B growth percentage and a Medicaid growth percentage by measuring the actual rate of increase in Medicare A/B and Medicaid per capita spending in the comparison group between the baseline and performance years.
3. Apply the growth percentages to the demonstration group Medicare A/B and Medicaid baselines to determine per capita expected cost for the demonstration group.
4. Calculate savings as the difference between the expected costs and actual costs for the Demonstration group.

As part of the savings calculation, the contractor will make necessary adjustments to the data to account for cost outliers and will adjust for changes in Federal and State policies or related factors that could affect the calculations, as appropriate.

Subject to minimum savings rates (MSR) and Medicaid significance factor (MSF) as described later in this document, Medicare A/B savings will be offset by the Federal share of Medicaid cost increases to determine the total amount available for the retrospective performance payment. The Federal Medicaid increase will be assessed based on all Medicaid costs. The Medicaid increase calculation will follow the comparison group and adjustment approaches used for the Medicare savings calculation.

The Retrospective Performance Payment

If Medicare savings are demonstrated according to the savings calculation for the model, the State will have the opportunity to earn a retrospective performance payment. The methodology for determining the amount of the retrospective performance payment will consider both the Medicare and Medicaid cost experiences within the State, as described below.

Consistent with other CMS programs and demonstrations, calculated savings will be compared to a MSR. The purpose of the MSR is to minimize the chance of attributing savings to the demonstration that were actually due to measurement variability, or chance. The CMS Office of the Actuary (OACT) has calculated an MSR range for the model, using a 90% confidence

interval, capping spending at the 99th percentile, and trending baseline data using a percent growth approach.

The MSR for the State's demonstration will be based on the number of Medicare-Medicaid enrollees eligible for participation in the demonstration. Medicare A/B savings will be compared to the MSR for the State's demonstration. If the Medicare A/B savings calculated are less than the MSR, the State will not qualify for a retrospective performance payment.

The minimum MSR will be 2%. The table below shows examples of the MSR for various levels of potential enrollment for this model. Points not shown on the table will be interpolated based on the underlying curve. The MSR decreases as the enrollment increases because variability in underlying program and cost components decrease with size.

Medicare MSR for MFFS Model	
Number of Eligible Beneficiaries	**MSR**
5,000	4.50%
10,000	3.20%
20,000	2.45%
50,000+	2.00%

If Medicare savings calculated exceed the MSR, the State will qualify to earn up to 50% of the net Federal savings (i.e., 50% of the total Medicare savings after deducting the Federal Medicaid increase, if the Federal Medicaid increase exceeds the MSF).

CMS has also established a maximum performance payment amount of 6% of total Medicare A/B expenditures. That is, the retrospective performance payment to the State shall be no greater than 6% of total Medicare expenditures for the demonstration population.

The State will be primarily responsible for the investment necessary for the intervention proposed in each demonstration. CMS has established a MSF for the demonstration. The purpose of the MSF, like the MSR above, is to minimize the chance of attributing costs to the demonstration that were actually due to measurement variability. The MSF is set at the same percentage as the Medicare MSR for the State's demonstration.

If increases in Medicaid costs exceed the MSF, then the Federal share of the Medicaid increase (including costs below the MSF) will be deducted from the amount of Medicare savings to establish the net Federal savings for the purposes of calculating a retrospective performance payment. If increases in Medicaid costs are less than the MSF, CMS will not deduct the increases in Federal Medicaid costs from the Medicare savings.

CMS will calculate retrospective performance payments for each demonstration year. Each annual calculation will be independent of the prior year's findings. The timing of performance payments is dependent on data availability, including the timeliness of State submission of

Medicaid data to CMS. To account for claims run-out and the time necessary for analysis and review, the earliest a State would be able to receive a performance payment would be 9 months after the end of each demonstration year.

Retrospective performance payments made to States under this demonstration are Federal funds and may not be used as the non-Federal share of Medicaid payments for matching purposes.

Quality Requirements under the MFFS Model

Approval of a MFFS demonstration is contingent on developing person-centered models of care that better integrate the delivery of services and help improve beneficiary outcomes and experiences. Quality measurement is a critical part of managing the demonstration and calculating the retrospective performance payment. The core quality measures under the MFFS model are based on recommendations from the multi-stakeholder panel convened by the National Quality Forum (NQF), including the starter measure set outlined in its June 2012 report *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population.* Measures are also incorporated consistent with the U.S. Department of Health and Human Service's National Quality Strategy and the CMS Quality Framework, including measures that support the domain priorities identified in both.

Medicare and some State Medicaid programs have already established FFS measurement frameworks. This existing work provides a platform for the MMCO overall quality strategy and for determining individual measures for the MFFS model. Still, challenges exist in identifying the appropriate and meaningful measures for this population, creating a consistently reported group of measures, and ensuring that States have the capability, systems, and data to capture and report State-level measures to CMS. As part of the demonstration, States will begin reporting a core set of measures, as well as process and demonstration measures. The measurement framework is designed to encourage State work with Medicare data and to promote quality improvement for the Medicare-Medicaid population.

Under the model, the State qualification for retrospective performance payments will be based on complete and accurate reporting and State performance on the individual quality measures. CMS intends to release additional quality measurement and scoring guidance.

Quality Measures Framework

Measures for each demonstration will be broken into three measurement groupings, as specified in each State's MOU:

- Model Core Measures (transitioning from 4-8 over the life of each demonstration)
- State-specific Process Measures (2 mandatory measures and at least one additional State-selected measure from a list of designated measures)
- State-specific Demonstration Measures (3-5 State-selected measures)

We will maximize consistency with other measurement efforts, including the CMS health home measures, but application of specific measures may depend on the particular context of each demonstration. Because the measurement requires use of Medicare claims data and some measures are new, we focus on reporting in the first year and phase in performance and other measures over time.

MFFS Measure Table (By Demonstration Year)

Model Core Measures	**Year 1**	**Year 2**	**Year 3**
All Cause Hospital Readmission *(Plan All Cause Readmission #1768)*	Reporting	Benchmark	Benchmark
Ambulatory Care-Sensitive Condition Hospital Admission *(PQI Composite #90)*	Reporting	Benchmark	Benchmark
ED Visits for Ambulatory Care-Sensitive Conditions *(Rosenthal)*	Reporting	Benchmark	Benchmark
Follow-Up after Hospitalization for Mental Illness *(NQF #0576)*	Reporting	Benchmark	Benchmark
Depression screening and follow-up care *(#0418)*		Reporting	Benchmark
Care transition record transmitted to health care professional *(NQF #648)*		Reporting	Reporting
Screening for fall risk *(#0101)*			Reporting
Initiation and engagement of alcohol and other drug dependent treatment: (a) initiation, (b) engagement *(NQF #0004)*			Reporting
State-Specific Process Measures: State must select the Care Plan and Training Process Measures, and select at least one other process measure	**Year 1**	**Year 2**	**Year 3**
Care Plan Measure: To be proposed by State (Required)	Reporting	Benchmark	Benchmark

Training Measure: To be proposed by State (Required)	Benchmark	Benchmark	Benchmark
Discharge Follow-up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit	Benchmark	Benchmark	Benchmark
Real Time Hospital Admission Notifications: Percentage of hospital admission notifications occurring within specified timeframe	Reporting	Benchmark	Benchmark
Percentage of providers with an agreement to receive data from beneficiaries' Medicare Part D Plans	Reporting	Benchmark	Benchmark
State-Specific Demonstration Measures- State must select at least 3, but no more than 5	Year 1	Year 2	Year 3
State-Specific Demonstration measures – Must include at least one LTSS and/or community integration measure	Reporting	Benchmark	Benchmark

States will report claim-based measures using Medicare claims data provided to the State through a data use agreement with CMS. The data will be assessed for the full target population for the demonstration, including those individuals who meet the eligibility criteria but choose not to engage in the intervention. States may report the partially claim-based and non-claim-based measures using sampling approaches among those individuals who were actively engaged in the intervention.

In addition, CMS will sponsor the implementation of a CAHPS survey for this demonstration. States, as part of the requirements of the demonstration, will assist CMS and its designated contractor in administering the survey by helping to identify appropriate beneficiaries and providing necessary data.

The Evaluation Process

The Demonstration will be evaluated in accordance with section 1115A(b)(4) of the Social Security Act. CMS or its contractor will measure, monitor, and evaluate the overall impact of the demonstrations, including the impacts on person-level health outcomes and beneficiary experience of care; changes in patterns of primary, acute, and long-term supports and services use and expenditures; and any shifting of services between medical and non-medical expenses. We will use principles of rapid-cycle evaluation and feedback to inform the implementation of the demonstrations and to guide midcourse corrections and improvements as needed. Key features of the demonstrations will also be examined per qualitative and descriptive methods.

The evaluation will assess the overall impact of the demonstration on quality, utilization, and cost measures using a difference-in-differences methodology with a comparison group. Under

this approach, pre- and post-intervention changes for beneficiaries eligible for the demonstration will be compared with the pre- and post-experience of a comparison group. As discussed earlier in this document, the evaluation will use cluster analysis to identify in-State comparison regions or potential comparison States. It is critical for the evaluator to be able to identify a comparison group that closely resembles the demonstration group. Therefore, States must ensure that their demonstration eligibility criteria can be replicated using claims or other data available for Medicare-Medicaid enrollees in potential comparison States.

The evaluator will develop aggregate and State-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final State-specific evaluation report at the end of the Demonstration. CMS will post the State-specific annual reports and final evaluation reports online.

State Data Submission Requirements for the Evaluation

Each MOU will require that the State cooperate with CMS and the evaluator in all monitoring and evaluation activities. States must submit all required data for the monitoring and evaluation of this demonstration, including but not limited to:

- All Medicaid Statistical Information System (MSIS) data in a timely manner throughout the demonstration and for the two-year pre-demonstration baseline period.
- Monthly data to the CMS Master Data Management (MDM) system for the purposes of identifying beneficiaries aligned with the demonstration to prevent duplication with other Medicare shared savings initiatives programs and other Innovation Center models.
- Beneficiary-level data, submitted each quarter, that identifies individuals eligible for the demonstration by month, whether the beneficiary was identified as eligible using administrative data or – as applicable – non-administrative information (e.g., BMI, smoking status), and beneficiaries enrolled in the demonstration.
- Coordination of and participation in at least two site visits during the demonstration period, the first of which will occur within the first 4 months of the demonstration start date.

The evaluator is developing a State Data Reporting System (SDRS) to collect and store information needed for the evaluation, and for generating tables for quarterly reporting to States and CMS. Where possible, the evaluator will pull States' performance data from claims and administrative data quarterly, and enter the data into the SDRS. States will be required to make quarterly entries for a set of elements related to demonstration implementation status and progress, including aggregated counts of the number of beneficiaries eligible for the demonstration, the number enrolled in the demonstration (if different than the number eligible), numbers of beneficiaries who opt out (if applicable) or disenroll, and questions on implementation progress.

Medicaid Authorities

Each MOU will have a Medicaid Authorities Appendix that will overlay existing State plan, waiver, and/or 1115(a) demonstration authorities. To the extent that 1115(a) demonstrations,

1915(b), or 1915(c) waivers include Medicare-Medicaid enrollees that are also included in the State financial alignment demonstration, CMS will consider all provisions of the existing State plan and waiver programs to apply unless explicitly waived in the demonstration MOU.

There will be instances where new Medicaid authorities are necessary. In these cases, States will need to work with CMS to have those authorities approved. If a State is seeking new authority to implement aspects of its financial alignment demonstration, it must submit and receive approval for the appropriate authorities prior to implementation of the financial alignment model.

In some cases, States may need to amend existing waiver programs terms and conditions, budget neutrality calculations, cost effectiveness, and/or cost neutrality calculations to accommodate the MFFS model. In these instances, the State would need to include any necessary conforming amendments for the MFFS model at the next renewal or amendment of the existing 1915(b) or 1915(c) program.

When States are making multiple changes to authorities across Medicaid programs, CMS will work with States in assuring the appropriate authorities and amendments for each program.

Alignment with Medicare Shared Savings Programs and other Federal Initiatives

To address instances where new initiatives involving Medicare shared savings may be operating within a State that is also implementing a MFFS demonstration, CMS has previously provided guidance on how beneficiaries will be aligned with Medicare shared savings programs. The guidance states that to avoid potential redundancy of payments between the MFFS model and other initiatives involving shared Medicare savings; CMS will allow beneficiaries to be aligned with only one initiative involving shared Medicare savings. It also states that beneficiaries enrolled in any form of Medicare Advantage or PACE programs are not eligible for alignment to MFFS model.

In order to facilitate this process, States must submit monthly data for the purposes of identifying beneficiaries attributed to the demonstration to prevent duplication with other Medicare shared savings programs and other Innovation Center Models. This guidance can be found at: http://innovation.cms.gov/Files/x/external_guidance.pdf

While it is critical for CMS to guard against attributing Medicare savings for the same beneficiaries to multiple demonstrations or interventions, we strongly encourage States to identify synergies between MFFS models and other Federal initiatives, including Million Hearts, Partnership for Patients, and the National Partnership to End Health Disparities.

Additional Information

If you need additional information please contact your State lead directly, or send an e-mail to MedicareMedicaidCoordination@cms.hhs.gov.