
EXHIBIT D: MEDICARE REQUIREMENTS TO COORDINATE CARE FOR DUAL ELIGIBLE ACUTE INDIVIDUALS

Section 1: Background Information

Medicaid members who are also enrolled in Medicare are referred to as dual eligible members. In an effort to improve care coordination for AHCCCS dual eligible members, the State will require all Acute Care Contractors to be organizations that manage and provide Medicare benefits to dual eligible members in all GSAs in which they hold a contract.

The State is currently working with CMS to implement a three-year Demonstration beginning January 1, 2014 which will integrate Medicare and Medicaid for dual eligible AHCCCS members. The State submitted a Demonstration proposal to CMS on May 31, 2012 which is available at <http://www.azahcccs.gov/reporting/legislation/Integration/Duals.aspx>. This Demonstration presents a novel and unique opportunity for Contractors to improve quality and reduce costs for dual eligible members in Arizona. Under the CMS Capitated Financial Alignment Demonstration "Demonstration," CMS, AHCCCS, and an AHCCCS Contractor enter into a Contract/Memorandum of Understanding (MOU) in which the Contractor receives payments from both AHCCCS and CMS to provide comprehensive, coordinated care for the integrated Medicare and Medicaid benefits. This Contract/MOU may modify some or all aspects of the clinical and non-clinical performance measures, the performance improvement projects and the quality management requirements that are specified in this RFP as well as other requirements or provisions in this RFP. The State is proposing the automatic enrollment of all dual eligible members into their AHCCCS plan for Medicare benefits on January 1, 2014. Under the Demonstration, individuals will have the ongoing option to opt-out so that they may receive their Medicare benefits on a fee-for-service basis through Original Medicare or through a Medicare Advantage plan, as negotiated with CMS.

It is important for Offerors to note that this Demonstration is not final and is currently undergoing Federal review. The State will continue to work with CMS, and AHCCCS intends to have a finalized Contract/MOU with CMS in early 2013. AHCCCS anticipates that the Contract/MOU will outline State-specific details associated with the terms and conditions of the Demonstration including, but not limited to: Program Authority, Contracting Process, Readiness Review, Enrollment, Beneficiary Protections, Administration and Reporting, Quality Management, Financing and Payment, Evaluation, and Oversight Responsibilities. Additional information and MOU templates can be found in the July 8 State Medicaid Director Letter *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*. The Demonstration approach is subject to change until the Contract/MOU is finalized and approved by CMS.

July 8 State Medicaid Director Letter: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf
AHCCCS Dual Demonstration Website: <http://www.azahcccs.gov/reporting/legislation/Integration/Duals.aspx>

Section 2: Medicare Structure

As required by A.R.S. §36-2906.01, the awarded Contractor must establish a separate corporation whose only authorized business is to provide services under this contract to AHCCCS eligible persons enrolled with the Contractor. This separate corporation must be established within 120 days of contract award. In addition, the Contractor must by January 1, 2014 operate either a Medicare Demonstration plan or a D-SNP serving beneficiaries eligible for both Medicare and Medicaid. The Contractor must have, and assure AHCCCS it has, the legal and actual authority to direct, manage, and control the operations of both the corporation established under this contract and the Medicare product to the extent necessary to ensure integration of AHCCCS and Medicare services for persons enrolled with the Contractor for both programs. The Contractor must ensure the integration of Medicare and Medicaid services within the following key functional areas of the organization or when utilizing administrative services subcontracts:

- Network Management/Provider Relations;
- Member Services;
- Quality Management;
- Medical Management;
- Corporate Compliance; and
- Grievance System.

In addition, the Contractor must establish or assure AHCCCS that it intends to establish branding for the Medicare product that ensures it is easily identifiable to members and providers as an integrated plan for both Medicare and Medicaid.

Section 3: Medicare State Certification

Medicare Advantage plans are required to be licensed under State law. As outlined in A.R.S 36-2903(B)(2) AHCCCS has the authority to certify its Contractors for Medicare purposes. Contractors are able to apply for certification through AHCCCS or apply and receive licensure through the Arizona Department of Insurance. The AHCCCS certification process is detailed in ACOM Policy 313.

Section 4: Participation in the Demonstration

In addition to all requirements of this RFP, the Contractor must meet all Medicare Demonstration participation requirements as dictated by CMS and the State. This may include, but is not limited to, approval of a Medicare Demonstration specific application, approval of a formulary consistent with Part D requirements, approval of a medication therapy management program (MTMP), and approval of a unified model of care. Additional information can be found in the March 29 CMS Memo found here: http://www.azahcccs.gov/reporting/Downloads/Integration/Duals_CMSMemo_MarchGuidanceDocumentforFinancialAlignmentDemonstrationPlans032912.pdf

With regard to the Demonstration's emphasis on coordination of Medicare and Medicaid benefits for dual eligible members, Medicare-Medicaid Demonstration Plans will be rigorously evaluated by CMS and the State as to their ability to improve quality and reduce costs for dual eligible individuals. After evaluation and selection by CMS and the State of the Acute plans to become Medicare-Medicaid Demonstration plans, a contract will be signed between CMS, the State, and the Offerors awarded the Acute Care contracts. To comply with the statute outlined in Section 2, this contract will be signed with the Medicare entity, not the AHCCCS entity. This contract will outline the health plan responsibilities for dual eligible members enrolled in the Demonstration plan. Additional details will be made available as determined by CMS and AHCCCS.

Finally, Contractors must pass a rigorous Readiness Review completed prior to enrollment of any beneficiary for Medicare benefits. Plans will be subject to a Readiness Review by CMS and the State across all areas, including but not limited to, network adequacy, stakeholder involvement, and consumer protections.

AHCCCS requires that Offerors submit a Notice of Intent to Apply (NOIA) with CMS as a Medicare-Medicaid Demonstration Plan (MMP) by November 14, 2012. Information can be found here: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NOIA_Memo.pdf. To comply with ARS 36-2906.01, the NOIA must be submitted under the Medicare entity name. Separate NOIAs must be submitted for all AHCCCS lines of business in which the Offeror wishes to participate (Acute, ALTCS-EPD, and the Maricopa RBHA). The NOIA must be submitted specifically for the State of Arizona. The specific service area will be defined during the application process. This is a non-binding submission, but is required for Offerors to participate as a Demonstration plan. In addition, all Offerors must submit Demonstration specific applications to CMS by February 21, 2013 unless AHCCCS has notified Offerors otherwise. If the State does not move forward with the Demonstration or if an Offeror is not awarded a contract in a specific GSA, there is no penalty for an Offeror to withdraw an Application.

Section 5: Demonstration Requirements

While past Medicare performance is not required for the Offeror to be awarded a contract or for participation as a Medicare Demonstration plan, CMS and the State will consider this performance, if applicable. Organizations that are either an outlier in CMS' past performance analysis for CY 2014 or have a "consistently low performing" icon on the Medicare Plan Finder website may qualify to offer a Demonstration plan, after meeting other requirements, but will not be eligible to receive any new passive enrollments.

If the Contractor does not meet all CMS Demonstration requirements and is not approved by CMS and the State to participate as a Demonstration plan or is not eligible to receive new passive enrollments, the State reserves the right to take whatever action it deems is in the best interest of the State and may re-evaluate the Medicaid contract.

Section 6: Rates under the Medicare-Medicaid Demonstration

If the State and CMS successfully reach an agreement to implement the Demonstration, capitation rates shall be adjusted for dual members participating in the Demonstration. The awarded Acute Care capitation rates will be replaced with capitation rates computed by AHCCCS and CMS for the Medicaid and Medicare expenses, respectively, of the dual members projected under the Demonstration. AHCCCS intends to work with CMS to develop actuarially sound rates ensuring sufficient reimbursement for the Demonstration. AHCCCS proposes to use its current rate-setting methods for the Medicaid component of the Demonstration, including the potential for reconciliation of excess profits or losses.

Section 7: Participation as a Medicare Advantage Special Needs Plan

If the State and CMS are unable to reach an agreement to implement the Demonstration, all Acute Care Contractors will be required to provide Medicare benefits to dual eligible members as a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) in all awarded GSAs. Contractors will be required to implement Medicare business on January 1, 2014 and thus all Offerors are required to submit a non-binding Notice of Intent to Apply (NOIA) as D-SNPs to CMS no later than November 14, 2012 if applicable. Additional information found here: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NOIA_Memo.pdf. Offerors should note that this submission is **in addition** to the submission of the Notice of Intent to Apply as a Medicare-Medicaid Demonstration plan (see Section 3). To comply with the statute outlined in Section 2, the NOIA must be submitted under the Medicare entity name. D-SNPs must have a contract with AHCCCS to enroll Acute full benefit dual eligible members and must have a D-SNP subset that matches this contract. All respondents must also submit D-SNP applications to CMS by February 21, 2013. Additional information on D-SNPs can be found at: <http://www.cms.gov/SpecialNeedsPlans/>.

Section 8: State Contracting with D-SNPs

AHCCCS will not contract with any D-SNP to serve the Acute Care Medicaid population outside of awarded Acute Care contracts. If the State and CMS successfully reach an agreement to implement the Demonstration, Medicare-Medicaid Plans under the Demonstration will replace D-SNPs as a method for aligning Medicare and AHCCCS enrollment for dual eligible members.

Section 9: D-SNP Responsibilities

This section outlines requirements which are designed to improve care coordination and timely information sharing for dual eligible members enrolled in Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) consistent with 42 CFR 422.107, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Affordable Care Act.

- 9.1 **Care Coordination:** If the dual eligible member is eligible for AHCCCS acute care benefits, then the D-SNP is responsible for coordination of both Medicare and Medicaid services regardless of whether the individual is enrolled with the D-SNP for Medicaid.

- A. If the dual eligible member is enrolled with a D-SNP for both Medicare and Medicaid services, the D-SNP is responsible for coordinating all benefits covered by both the D-SNP and AHCCCS.
- B. If the dual eligible member is not enrolled with the D-SNP for Medicaid, the D-SNP is responsible for coordinating AHCCCS only benefits with the member's AHCCCS Contractor. Coordination of Medicaid benefits is not the beneficiary's responsibility.
- C. AHCCCS will ensure that the D-SNP has access to the dual eligible member's AHCCCS enrollment through AHCCCS Online.
- D. The D-SNP will establish a contact within each AHCCCS Contractor that will be responsible to share, at minimum, timely inpatient hospital, emergency room, and chronic illness information to assist the AHCCCS Contractor with coordinating care when benefit coverage switches from Medicare to Medicaid.
- E. The D-SNP will provide AHCCCS with the name of the contact person at the D-SNP who will be responsible for the coordination of care for dual eligible members.
- F. The D-SNP will participate in any AHCCCS meetings (telephonic or in person) relating to care for dual eligible members and timely provide any necessary information and data.

9.2 **Medicaid Eligibility:** D-SNPs are responsible for coordinating care for full benefit dual eligible AHCCCS Acute Care members. These members are eligible for receiving full AHCCCS benefits and do not meet criteria for long term care services through the Arizona Long Term Care System. These members are defined as:

- Qualified Medicaid Beneficiary with AHCCCS Benefits (QMB+)
- Specified Low Income Beneficiary with AHCCCS Benefits (SLMB+)
- Other Full Benefit Dual Eligible Beneficiary (FBDE)

9.3 **Benefits Covered by D-SNP:** The D-SNP is not responsible for the provision or reimbursement of any Medicaid benefits. The D-SNP is responsible to maintain current knowledge and familiarity with AHCCCS acute covered services through ongoing review of AHCCCS laws, rules, policies, contracts, and guidance, as well as through information posted on AHCCCS' website. The D-SNP shall timely coordinate provision of AHCCCS covered services for persons enrolled in the D-SNP who are also enrolled with an Acute Care Contractor.

9.4 **Medicaid cost-sharing protections covered under the D-SNP:** The D-SNP providers shall not impose Medicare cost sharing on dual eligible members for services covered by both Medicare and Medicaid. The D-SNP providers agree to accept the D-SNP payment as payment in full for services covered by both Medicare and Medicaid, or bill the appropriate AHCCCS Contractor for additional payments that may be reimbursed under Medicaid. Dual eligible members shall be responsible for any applicable AHCCCS copayment.

Section 1902(n)(3)(B) of the Social Security Act prohibits Medicare providers from balance billing QMB members for Medicare cost-sharing, including deductibles, coinsurance, and copayments. QMB members have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. The D-SNP shall include a provision in all provider agreements specifying that the provider agrees to accept the D-SNP payment as payment in full, or bill the appropriate AHCCCS Contractor for additional payments that may be reimbursed under Medicaid.

9.5 **Identification and Sharing of Information on Medicaid Providers:** The D-SNP shall develop a network of providers which includes an overlap of providers in the D-SNP network who are also contracted with AHCCCS Acute Care Contractors. AHCCCS Contractor networks can be accessed online through individual websites from <https://azweb.statemedicaid.us/HealthPlanLinksNet/HPLinks.aspx>.

9.6 **Verification of Eligibility for both Medicare and Medicaid:** The D-SNP is responsible for accurately verifying both Medicare and Medicaid eligibility of potential and enrolled members.

The D-SNP will have access to AHCCCS Online to verify member real-time Medicaid eligibility. Members who have Medicare eligibility can be clearly identified.

9.7 **D-SNP Service Area:** The D-SNP service area shall match the Acute Care Medicaid contract service area.

Section 10: Medicare Data

For purposes of care coordination and future analysis, AHCCCS will be reviewing mechanisms for receiving all data on dual eligible members. AHCCCS may require D-SNPs to submit Medicare encounters to AHCCCS in addition to CMS.

Section 11: Transition of Dual Eligible Members

If AHCCCS does not move forward with the Demonstration, where possible and in the best interest of members, in instances where dual eligible members are enrolled with an Unsuccessful Incumbent Contractor, AHCCCS may assign the dual eligible members to Contractors they are currently enrolled with for Medicare services in order to align members and maximize care coordination opportunities.

Section 12: Other Options for Improving Alignment

If AHCCCS does not move forward with the Demonstration, AHCCCS will explore and identify other methods for improving care for dual eligible members with D-SNPs. AHCCCS may implement ways to encourage alignment of Medicare and Medicaid plan including, but not limited to:

- On an ongoing basis, aligning Medicaid enrollment with Medicare;
- Working with community stakeholders for outreach and education;
- Conducting state sponsored outreach and education;
- Requiring plan outreach and education; and
- Data and information submission from D-SNPs.