

APPENDIX E – Dual Eligibles Questionnaire

This Appendix consists of the following sections:

- Section 1:** Background Information
- Section 2:** Participation in the Demonstration (Pending CMS approvals)
- Section 3:** Proposed Scope of Work

Section 1 - Background Information – Inclusion of Dually Eligible Individuals in CCOs

HB 3650 indicates that “Subject to the Oregon Health Authority obtaining any necessary authorization from the Centers for Medicare and Medicaid Services... coordinated care organizations that meet the criteria [for CCOs]...are responsible for providing covered Medicare and Medicaid services, other than Medicaid-funded long term care services, to members who are dually eligible for Medicare and Medicaid in addition to medical assistance recipients.”²

The OHA is preparing a formal proposal to CMS for a demonstration to integrate care for individuals dually eligible for Medicare and Medicaid. CMS has offered all states the previously unavailable opportunity to pursue three-way contracts between health plans, the state, and CMS for blended Medicare and Medicaid payments to plans, set at a level to target savings that can be shared. CCOs will be required to participate in the three-way contracts, contingent on OHA and CMS reaching mutually agreeable terms, after OHA consultation with Oregon health plans.

Oregon’s proposal to CMS will be released for a 30-day public comment period in early March 2012 and will be submitted to CMS following that public comment period, with a current target date of mid-April. Following the submission of the proposal to CMS, CMS will have their own 30 day public comment period. During and following the CMS public comment period, CMS and Oregon will negotiate the requirements and payment rates for plans participating in the demonstration and will sign a memorandum of understanding (MOU), with a current target date of mid- to late-June. The timeline of the CMS process means that plans will be initially certified to become CCOs by OHA, and then the certification of plans to participate in the CMS demonstration/three-way contracts will take place later. The target date for CCOs to begin providing Medicare services to dually eligible individuals is January 1, 2013.

OHA has been working closely with CMS throughout the development of the CCO proposal to ensure that the general CCO structure will be acceptable for the demonstration and three-way contracts. However, since the final details of the demonstration requirements have not been finalized at this time, in order to participate in the three-way contracts and offer Medicare benefits as required by HB 3650, plans will be asked to provide additional information as part of the CMS certification process and will need to meet additional requirements. CMS recently released guidance with key information related to the demonstration for organizations that may wish to participate. The guidance is available on the CMS website at: <https://www.cms.gov/medicare-medicaid-coordination/downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf>

The CMS guidance linked above outlines some of the key areas of plan requirements that will be negotiated between CMS and the state. In particular, areas where there are likely to be additional requirements for CCOs related to the inclusion of dually eligible individuals for Medicare include:

- An integrated Medicare and Medicaid benefit package
- Integrated Medicare and Medicaid appeals process for dually eligible individuals
- Integrated beneficiary materials

² HB 3650, Section 7.

- Integrated quality assurance/performance improvement requirements incorporating Medicare priorities and standards
- Model of care requirements
- Quality reporting and incentive program

Section 2 - Participation in the Demonstration (Pending CMS approvals)

The CMS guidance also provides an overview of key CMS deadlines that plans **must meet** in order to participate in the demonstration/three-way contracts and offer Medicare benefits, as required by HB 3650. The CMS guidance also includes instructions and links related to the first two deadlines below. While the CMS certification process will follow after the OHA process, many of these deadlines will occur prior to that CMS certification:

- April 2, 2012 – Final date for submission to CMS of Notice of Intent to Apply to offer demonstration plans
- April 9, 2012 – Final date for submission of CMS User ID connectivity form
- April 30, 2012 – Part D formulary submissions due to CMS for organizations that have not submitted a formulary for CY 2013 for a non-demonstration plan
- May 7, 2012 – Part D Medication Therapy Management Program submission due to CMS
- May 14, 2012 – Part D formulary submissions due to CMS for organizations that have already submitted a non-demonstration plan formulary for CY 2013 to CMS and intend to use that previously submitted formulary for their demonstration plans
- June 4, 2012 - Proposed plan benefit package submissions (including all Medicare and Medicaid benefits) due to CMS
- June 8, 2012 – Additional required Part D information submissions due to CMS

E.2.1. Has the applicant submitted the required CMS Notice of Intent to Apply prior to the April 2nd deadline? Provide a copy.

E.2.2. Has the Applicant submitted the required CMS User ID connectivity form? Provide a copy.

Formulary development is an extensive body of work, particularly for plans which have not previously offered a Part D plan. CMS has encouraged plans to start the work of developing their formulary and meeting other Part D requirements as soon as possible in order to meet the deadlines above. CMS has indicated that they will provide training to interested organizations on the Medicare Part D requirements and has provided an email address for any questions: CMSMMCOcapsmodel@cms.hhs.gov.

E.2.3. How does the applicant intend to meet the CMS Part D requirements, including the formulary requirement? Has the applicant previously offered a Part D benefit? If Applicant has not previously been offered a Part D benefit, does the Applicant intend to contract with a Pharmacy Benefits Manager or will they develop their own formulary and meet other Part D requirements without this type of assistance?

Applicants are not required to have prior experience as a Medicare Advantage (MA) plan (or as a Special Needs Plan in particular) in order to participate in the CMS demonstration.

E.2.4. Does Applicant or any Affiliate of Applicant currently have a contract with CMS to serve Medicare beneficiaries? If so, describe if it is:

- PACE program
- Special Needs Plan, including what type (dual eligible, chronic condition, institutional)
- Other Medicare Advantage

- E.2.5.** Describe the length of time and contract history with CMS or its intermediaries for any Medicare line of business for Applicant or any Affiliate of Applicant.
- E.2.6.** Is the Applicant or any Affiliate of Applicant a MA plan or applying to become one for 2013? If yes, the Applicant will submit with its CCO Application a copy of the entire MA application of Applicant or the Affiliate for 2013.

Section 3 – Proposed Scope of Work

Applicant is invited and encouraged to submit a proposed scope of work to address the part of the Contract governing the health services transformation strategies and model of care described within the scope of this questionnaire.

Please submit a proposed scope of work to serve as the foundation for the part of the Contract governing Work within the scope of this questionnaire. See RFA Section 3.2 for further information about Applicant's proposed scope of work.