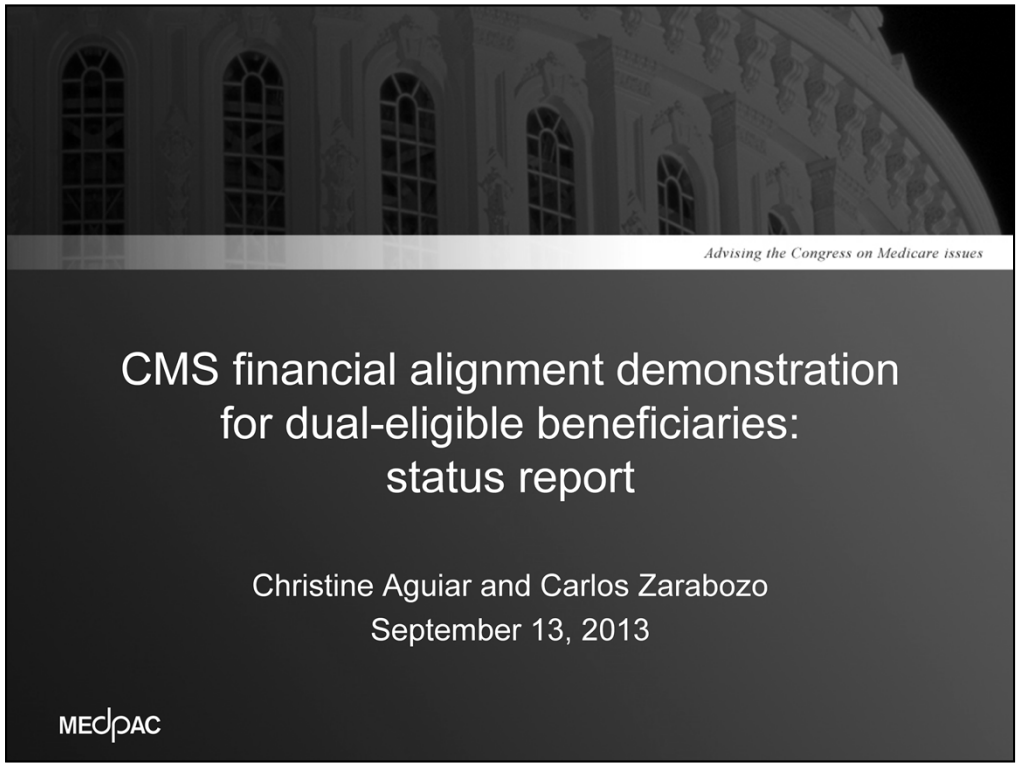

Good morning, today Carlos and I will update you on CMS' financial alignment demonstration for dual-eligible beneficiaries. As a reminder, the Commission last discussed the demonstration in April 2012 and submitted a comment letter to CMS regarding the demonstration in July 2012.

Presentation outline

- Background on the financial alignment demonstration
- Overview of states implementing the demonstration
- Comparison between demonstration parameters and Commission's comment letter
- Reasons some states are no longer participating in the demonstration
- Renewed interest among some states in dual-eligible special needs plans (D-SNPs)
- Key differences between the demonstration and the Medicare Advantage (MA) program

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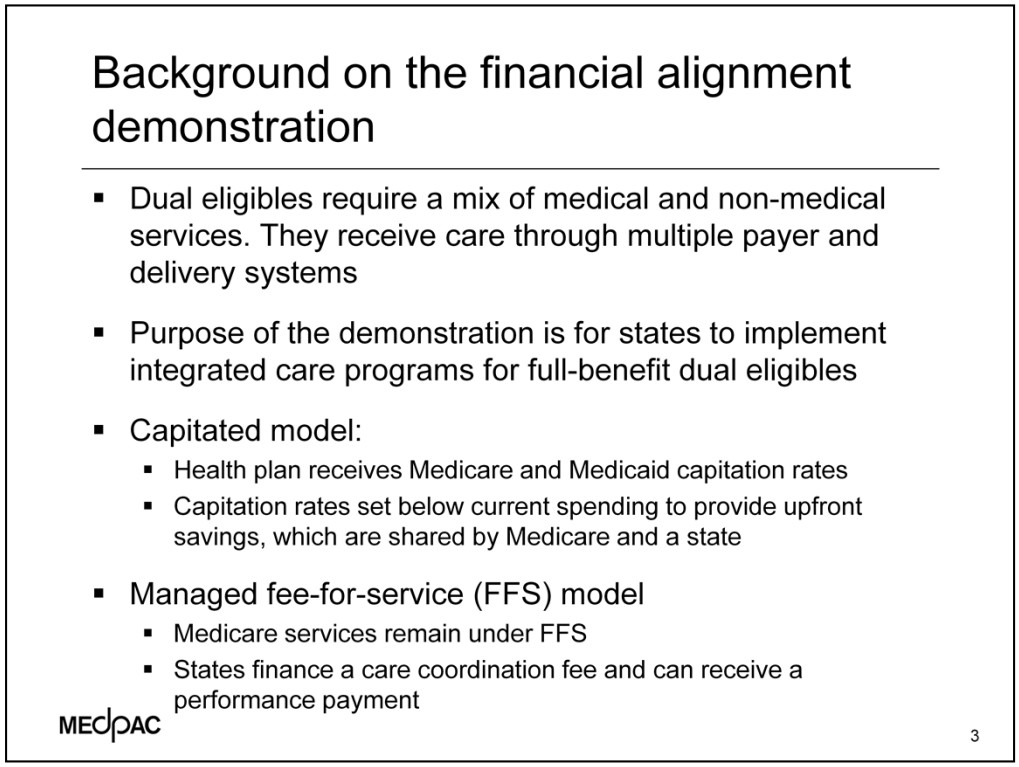
Today's presentation will start with background on the demonstration, followed by an overview of the states that are progressing towards implementation. Next I will discuss how elements of the demonstration align with the Commission's comment letter. Then I'll go over the main reasons why some states have decided to no longer participate in the demonstration and why there is a renewed interest among states in dual-eligible special needs plans, or D-SNPs. Finally, Carlos will discuss the main similarities and differences between the demonstration and the Medicare Advantage program.



Let's begin with some background information. As you know, dual eligibles are a diverse population and require a mix of medical care, long-term care services and supports, and behavioral health services. This is a population that can benefit from coordination of care and the Commission has been assessing ways to improve care coordination for these beneficiaries over the past few years.

From the perspective of improving care coordination for dual eligibles, the Medicare–Medicaid Coordination Office at CMS announced the financial alignment demonstration in 2011. The purpose is for states to develop integrated care programs for full-benefit dual eligibles. States can implement a capitated model, a managed fee-for-service model, or both. Under the capitated model, a health plan receives Medicare and Medicaid capitation payments. The plan payment rates will be set below expected Medicare and Medicaid spending in order to provide for upfront savings that will be shared between CMS and the state. The managed FFS model maintains Medicare FFS. States finance a care coordination program and can receive a retrospective payment if the program meets quality thresholds and results in Medicare savings.

States implementing the financial alignment demonstration

State	Model	Estimated implementation date*
California	Capitated	• April 2014: opt-in and phase-in of passive enrollment
Illinois	Capitated	• January 1, 2014: opt-in enrollment • April 1, 2014: passive enrollment
Massachusetts	Capitated	• October 1, 2013: opt-in enrollment • January 1, 2014: passive enrollment
New York	Capitated	• July 1, 2014 and September 1, 2014: opt-in and passive enrollment for community-based beneficiaries • October 1, 2014 and January 1, 2015: opt-in and passive enrollment for beneficiaries in nursing homes
Ohio	Capitated	• March 1, 2014: opt-in enrollment • April 1, 2013: phase-in of passive enrollment begins
Virginia	Capitated	• March 1, 2014: opt-in enrollment • July 1, 2014: passive enrollment
Washington	Managed FFS	• Implemented on July 1, 2013

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Source: MOUs and conversations with CMS. Note: this information is preliminary and subject to change. *CMS and the states are currently planning for enrollment to begin no sooner than these dates. These dates may be delayed pending state, CMS, and plan readiness.

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This slide describes the states that are implementing the demonstration. I apologize for small font on this slide, but this is important information we wanted to share with you all. In order to participate in the demonstration, states first had to submit a proposal to CMS. 26 states submitted proposals. The next stage is for CMS and the state to sign a memorandum of understanding, or MOU. The states on this slide are the seven states that, to date, have signed an MOU with CMS. As you can see in the second column on the table, six of these states are implementing the capitated model, while Washington is the only state with an MOU for the managed FFS model.

As you see on the last column on the slide, Washington's program began on July 1, 2013. The other demonstrations are expected to begin in fall 2013 or 2014. Most demonstrations will begin with a three-month opt-in enrollment period that is followed by a period of passive enrollment. During opt-in enrollment, eligible beneficiaries can choose to enroll in the demonstration. During passive enrollment, eligible beneficiaries that have not yet enrolled will be automatically enrolled in the demonstration and assigned to a plan. The start dates for some of the demonstrations have been delayed. For example, California's MOU stated an October 1, 2013 start date, but the demonstration is delayed until April 2014.

Main points raised in the Commission's July 2012 comment letter

- Scope of the demonstration
- Passive enrollment
- Plan requirements
- Monitoring and evaluation
- Program costs and savings

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In the July 2012 comment letter to CMS, the Commission commented on the five aspects of the demonstration that are listed on this slide. Over the next few slides, I will describe how the MOUs align with the Commission's comments on these aspects.

Scope of the demonstration

- *MedPAC comment letter: the scope of the demonstration is too broad if most or entire subgroups of dual eligibles are enrolled in every state*

States with a signed MOU	Number of beneficiaries eligible to enroll	Percent of full-benefit dual eligibles in the state
California	456,000	41%
Illinois	135,000	54%
Massachusetts	90,000	33%
New York	170,000	23%
Ohio	115,000	63%
Virginia	78,600	71%
Washington	20,000	17%
Total estimated enrollment	**1,064,600**	
Number of beneficiaries eligible to enroll in 12 states with active proposals*	888,771	

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Source: MOUs and conversations with CMS. Note: this information is preliminary and subject to change. *The states are Colorado, Connecticut, Idaho, Iowa, Michigan, Missouri, North Carolina, Oklahoma, Rhode Island, South Carolina, Texas, Vermont

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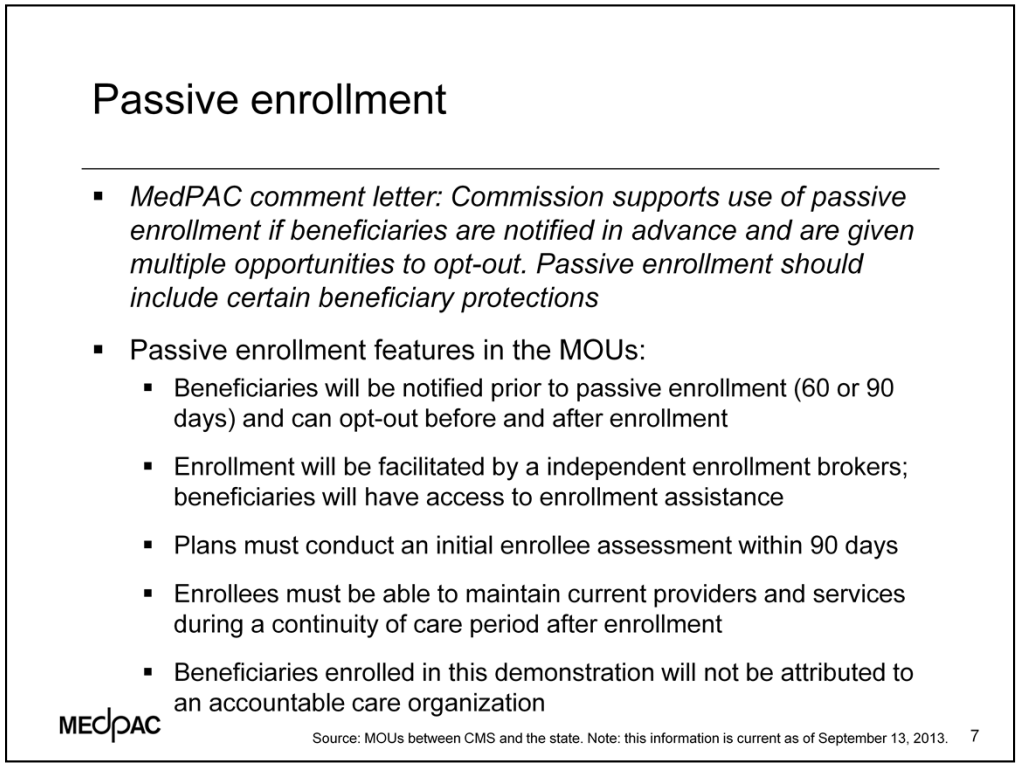
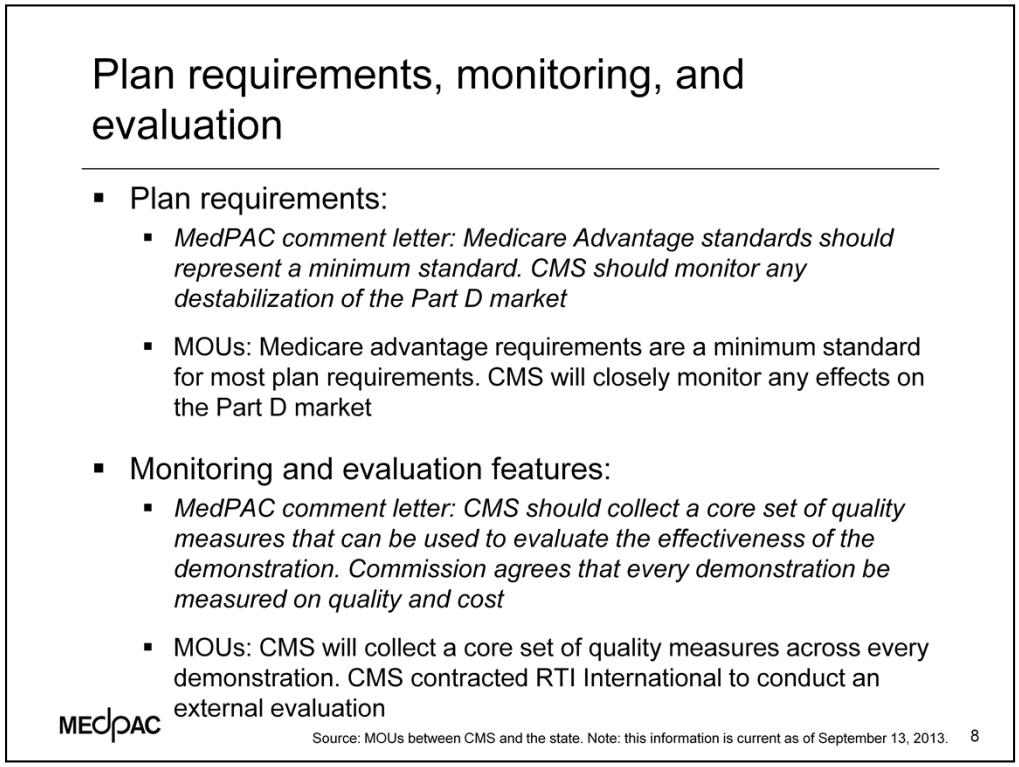
We'll start with the scope of the demonstration. Most of the 26 state proposals included enrollment of the majority, or entire subgroups of dual eligibles in the state into the demonstration. The Commission commented that the scope of the demonstration was too broad and represented a program change because approximately 3 million dual eligibles would be enrolled in the demonstration if CMS approved every state's proposal. The Commission encouraged CMS to reduce the scope. As you can see on this slide, estimated enrollment across the seven states could reach over 1 million. California was the only state that largely reduced the scope between the proposal and the MOU. California had initially proposed to enroll up to 1 million dual eligbiles, but reduced the scope to about 456,000.

There are still 12 active state proposals that have not yet progressed to a signed MOU. As you see in the last row on the table, close to one million beneficiaries are eligible to enroll across these 12 states. If every state with an active proposal proceeds to implementation without reducing its scope, total enrollment in the demonstration could reach close to 2 million.



With respect to enrollment, CMS' proposed design for the capitated model included a passive enrollment strategy with opt-out. The Commission expressed support for the use of passive enrollment as long as certain beneficiary protections were included. There is precedence for passive enrollment in the Medicare program because it is already used for the low-income subsidy population under Part D.

The passive enrollment features, which are listed on this slide, are consistent across all MOUs and align well with the Commission's comments. For example, beneficiaries will be notified of the demonstration 60 or 90 days prior to passive enrollment and can opt-out both before and after enrollment.



Moving on now to plan requirements, the Commission suggested that MA requirements represent the minimum standard in order to provide a baseline standard of requirements for the demonstration plans. Consistent with the Commission's suggestion, the MOUs indicate that MA requirements do represent a minimum standard for most plan requirements. The Commission also raised concerns about the potential destabilization of the Part D market given that large number of dual eligibles will be enrolled in the demonstration and demonstration plans will not submit Part D bids. CMS indicated that it does not expect the treatment of Part D under the demonstration to have a major effect on beneficiaries, but that it will closely monitor any effects.

For monitoring and evaluation, the Commission emphasized the importance of collecting consistent quality measures across all demonstrations in order to evaluate and monitor the demonstration. The MOUs were largely in agreement with these comments. CMS will collect a core set of quality measures across all demonstrations, and will fund an external evaluation of the demonstration.

Program costs and savings – methodology for estimating savings

- *MedPAC comment letter: CMS should estimate savings separately for Medicare and Medicaid and adjust each programs' capitation rates based on these estimates. CMS should develop realistic savings estimates*
- MOUs: CMS will develop a combined Medicare and Medicaid savings estimate. Medicare and Medicaid capitation rates will be reduced each year by the same savings estimate as indicated below:

State	Demonstration Year One	Demonstration Year Two	Demonstration Year Three
California	1 percent	2 percent	4 percent
Illinois	1 percent	3 percent	5 percent
Massachusetts	0 percent first 6 months; 1 percent remainder of year	1.5 percent	At least 4 percent
New York	1 percent	1.5 percent	3 percent
Ohio	1 percent	2 percent	4 percent
Virginia	1 percent	2 percent	4 percent

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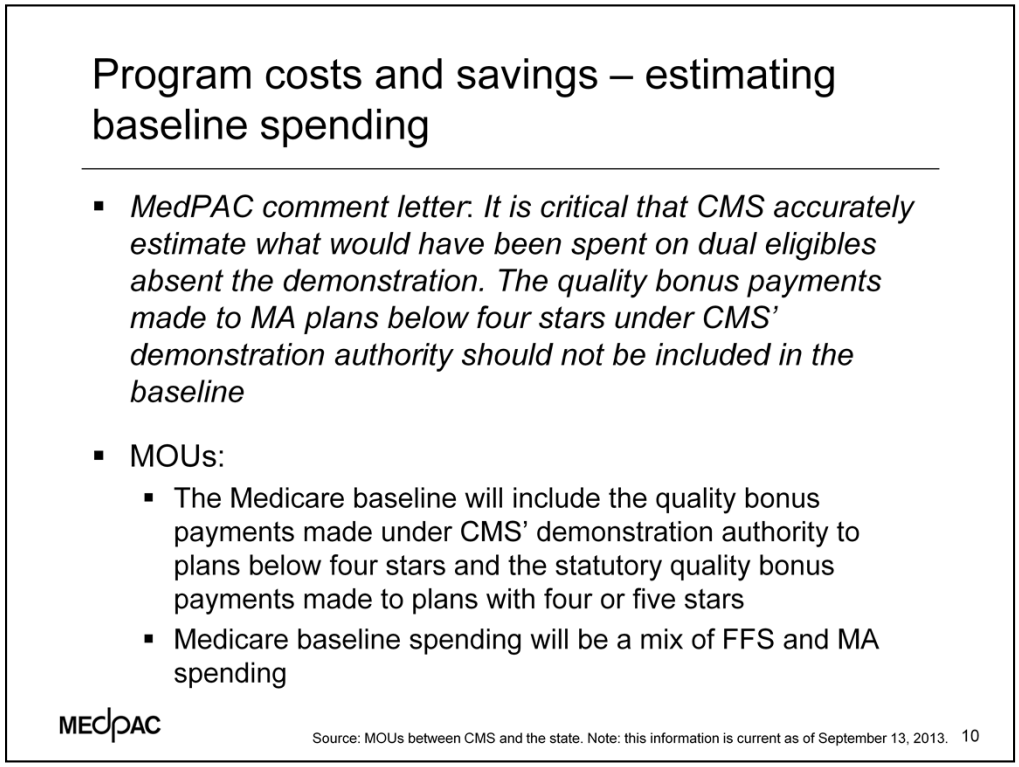
Source: MOUs between CMS and the state. Note: this information is preliminary and subject to change. 9

Turning now to program costs and savings. There is more detail on this topic in your mailing materials. In the interest of time, I will focus on the methodology for estimating savings on this slide and the methodology for developing baseline spending on the next slide. With respect to estimating savings, the Commission stated that CMS should estimate savings separately for Medicare and Medicaid and then adjust each programs' capitation rates based on these estimates. This would be an equitable way to allocate savings since savings are more likely to come from one program or the other. The Commission also encouraged CMS to develop realistic savings estimates so that plan capitation rates neither exceed nor are below the cost of care. The methodology for estimating savings in the MOUs is largely unchanged from CMS original proposal. CMS will develop a combined Medicare and Medicaid savings estimate and both Medicare and Medicaid capitation rates will be reduced by this same savings estimate. The savings estimates for each state are listed on the slide. Note that the savings estimates are generally 1 percent for the first year of the demonstration and increase each year.



With respect to estimating Medicare and Medicaid spending absent the demonstration, the Medicare baseline will be a mix of FFS and MA spending, based on CMS' assumptions of whether beneficiaries would have been enrolled in FFS or MA absent the demonstration.

The Commission commented that the quality bonus payments made to MA plans below four stars under CMS' demonstration authority should not be included in the baseline. The Commission has strongly objected to CMS' use of its demonstration authority to make unilateral changes in payment rates, and including the bonus payments in the baseline would institutionalize these payments. However, as we understand, these bonus payments will be included in the baseline, in addition to the statutory bonus payments made for four and five star plans.

States no longer participating in the financial alignment demonstration

Category	State
Formally withdrew	Arizona, New Mexico, Tennessee
Working with CMS through other demonstrations/initiatives	Minnesota, Wisconsin, and Oregon
No longer participating; may reconsider in the future	Hawaii

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Source: Discussions with CMS staff. Note this information is current as of September 13, 2013.

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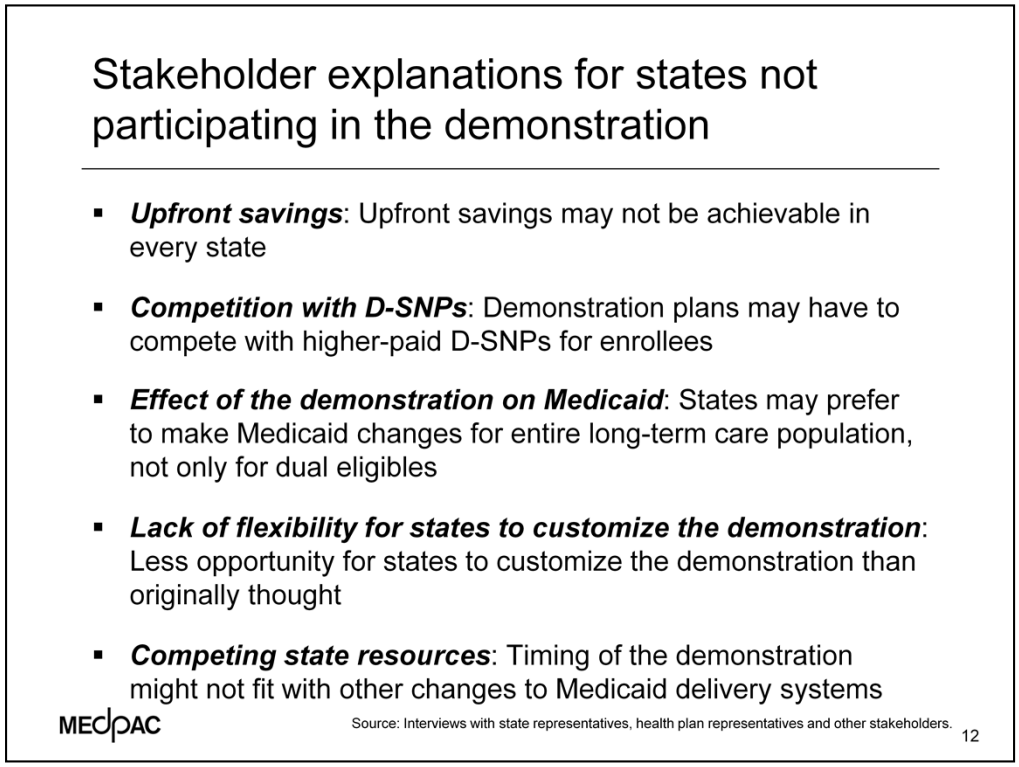
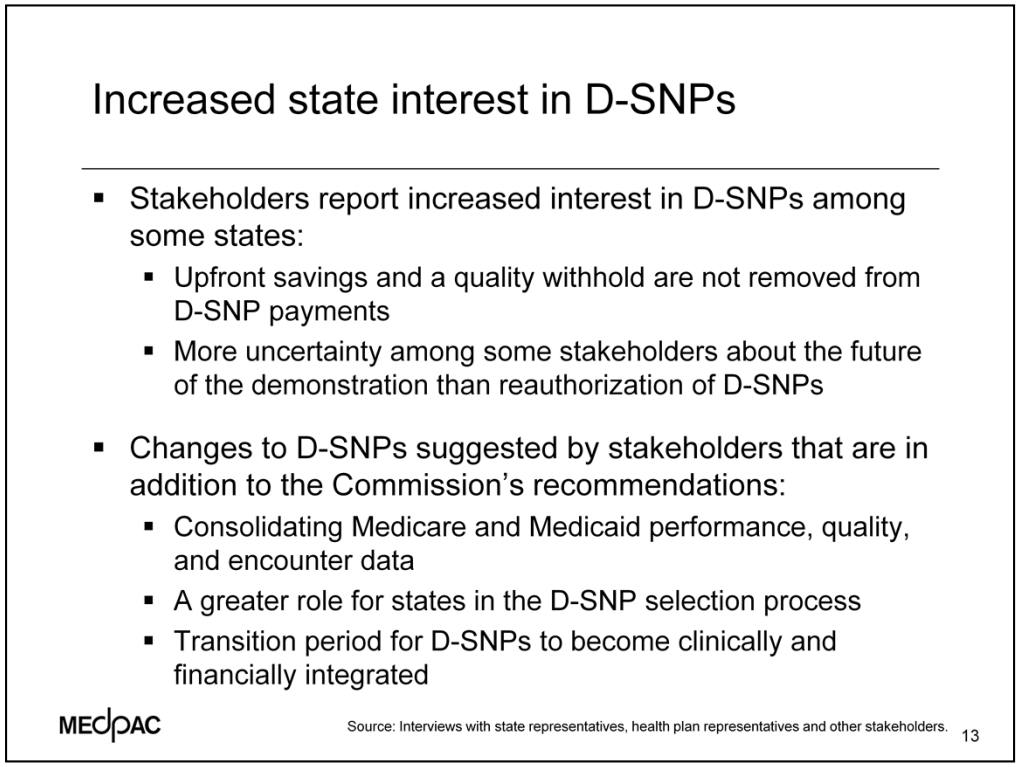
Moving on now, a number of states are no longer participating in the demonstration. Three states – Arizona, New Mexico, and Tennessee – formally withdrew. Three other states, Minnesota, Wisconsin, and Oregon are still working with CMS on programs for dual eligibles, but under different demonstration authority. Hawaii is no longer working on the demonstration, but may do so after 2014. All of these states had submitted proposals to implement the capitated model.



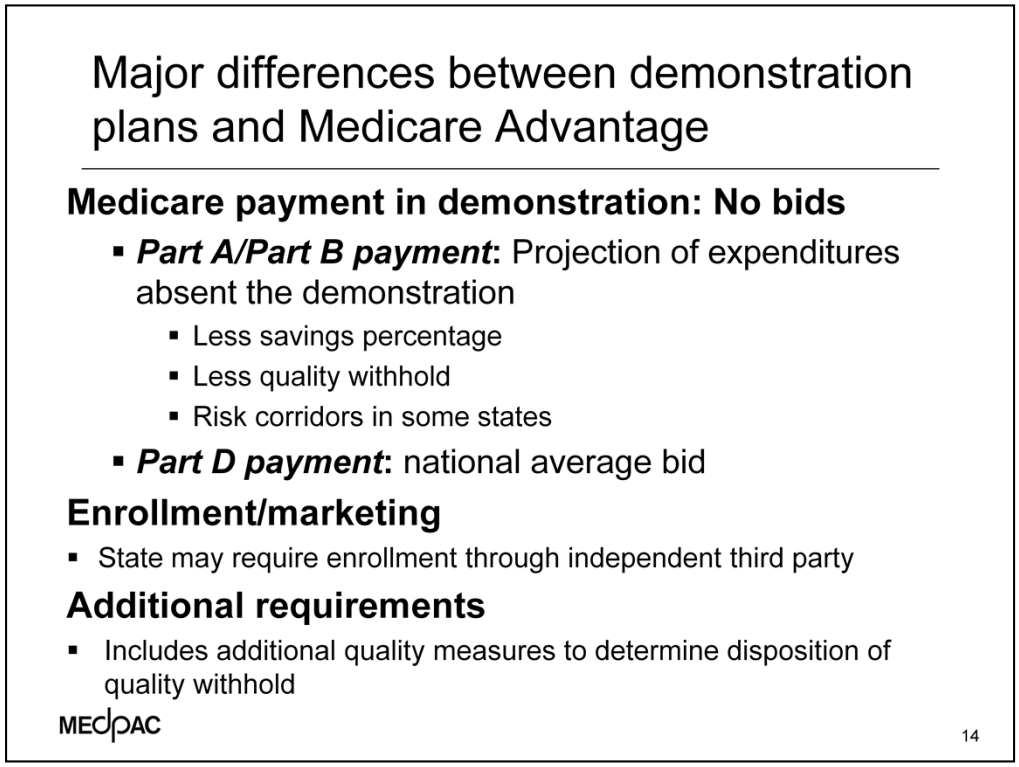
We interviewed state representatives, health plan representatives, and other stakeholders to better understand why some states decided not to participate. The main reasons the stakeholders cited are listed on this slide. For one, upfront savings may not be achievable in every state and the removal of upfront savings and the quality withhold may not leave plans with enough funding to address unmet need. Second, if D-SNPs are paid higher than demonstration plans because upfront savings and quality withholds are not removed from their rates, they could compete with demonstration plans for enrollees by offering more attractive supplemental benefits. Third, the demonstration focuses solely on dual eligibles and states may prefer to make delivery system changes for the entire long-term care population. Fourth, there has been less flexibility than originally thought for states to customize the demonstration to align with their individual Medicaid programs. Finally, the timing of the demonstration conflicts with other state priorities and changes to their Medicaid programs.



Recently, momentum has developed among some states to pursue integration through D-SNPs. The stakeholders we interviewed stated that the D-SNP program may be preferable to states because, unlike the financial alignment demonstration, upfront savings and quality withholds are not removed from D-SNP payment rates. They also reported that there is more uncertainty among some stakeholders over the future of the demonstration than over the reauthorization of D-SNPs.

The stakeholders we interviewed generally agreed with the Commission's 2013 recommendations to Congress on D-SNPs. Changes that extend beyond the Commission recommendations include consolidating Medicare and Medicaid reporting requirements, giving states a greater role in the D-SNP selection process, and implementing a transition period to enable states to work with D-SNPs to incrementally become more integrated. The National Association of Medicaid Directors is currently working with states to identify legislative and regulatory changes to D-SNPs that would improve Medicare and Medicaid integration.

Carlos will now compare the requirements for the demonstration and the MA program.



In the next 2 slides, we will review the major differences and similarities between the demonstration plans and contracts under the Medicare Advantage, or MA, program. The major differences are in the area of plan payments, how enrollment generally occurs, and what additional requirements are being imposed.

With regard to payment, the demonstration plans will not submit bids for the Medicare Part A and Part B benefits. In MA, plans bid against an area benchmark, and the bids determine how much a plan will be paid, any premium the plan would charge, and the extra benefits plans are able to offer.

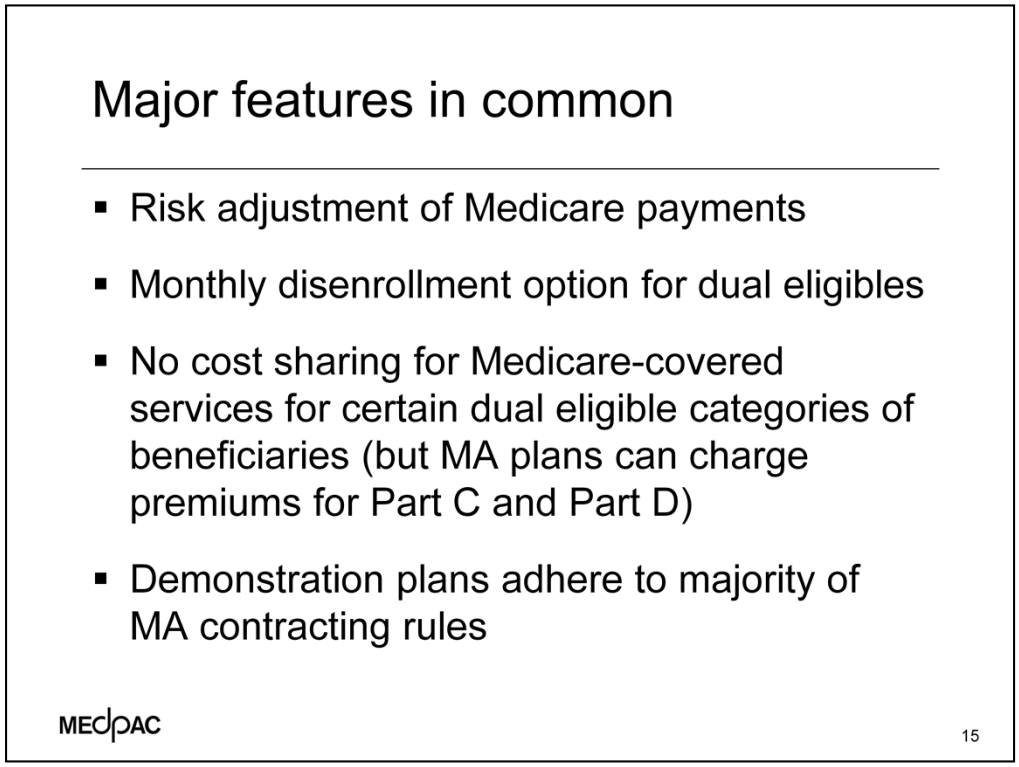
In the demonstrations, plans will receive a capitated per member per month payment based on the costs that CMS projects the Medicare program would have incurred absent the demonstration. So it would be a combination of projected FFS expenditures and all projected MA payments, as Christine discussed. Once the basic capitation rate is set, the savings percentage is then deducted "up-front," and there is an additional withhold of payments that can be returned to plans if they meet quality targets. Some states are also including risk corridor arrangements whereby Medicare and Medicaid will share in the losses and gains of plans.

The demonstration plans will not have Part D bids, but will be paid the national average bid amount plus a monthly estimated payment for the low-

income cost-sharing and reinsurance subsidy amounts. As Christine discussed, the Commission expressed concern over the effect on the Part D market of having large numbers of low-income beneficiaries and plans serving them outside the Part D bidding process.

In addition to the Medicare capitation payments, Medicaid will be making capitation payments to the plans, which will cover the costs of Medicaid services as well as providing revenue for cost sharing associated with Medicare-covered services, which is revenue that is not included in the Medicare FFS base rates or MA benchmarks. Some states will also require plans to offer additional benefits not currently covered by Medicaid.

The two other major aspects of the demonstration that differ from MA are enrollment rules and reporting requirements. Although it is common for MA plans to obtain enrollment through insurance agents and brokers who receive commissions, some states will require that all enrollment be through an independent third party. Another difference is that the demonstration plans will be meeting some additional requirements, including the need to report additional quality data that will determine whether or not they are entitled to receive the quality withhold amounts. The measures that must be reported will vary from state to state.



There are a number of features that are common to both the demonstration plans and Medicare Advantage, though some of the features are common only up to a point.

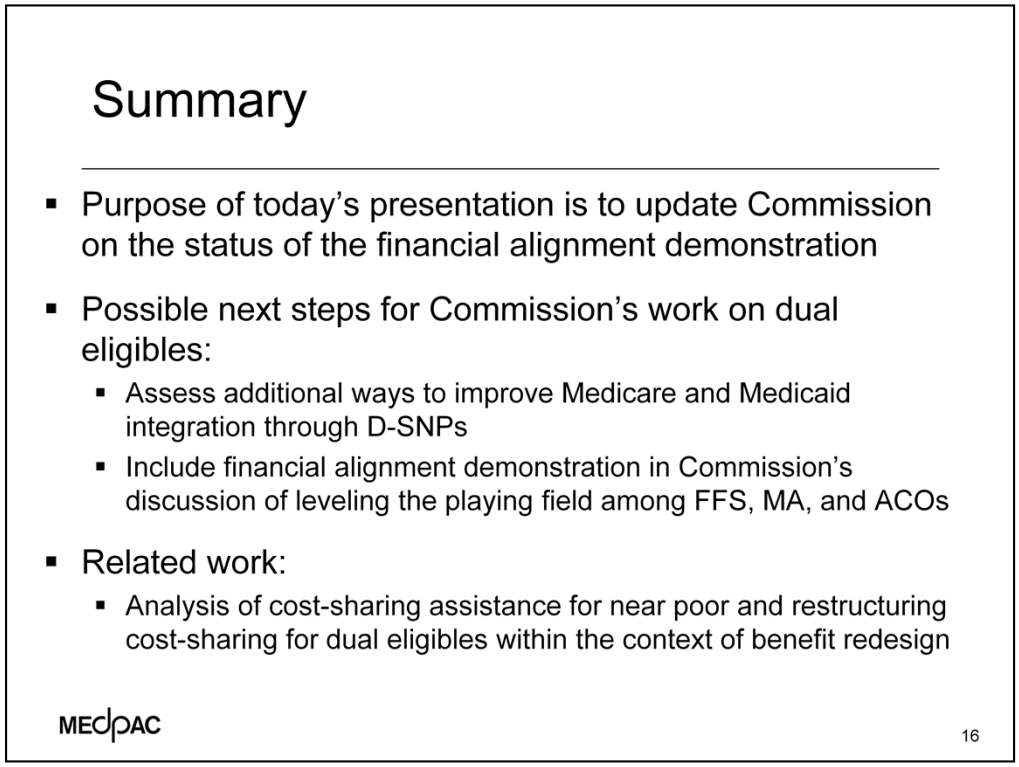
Plan payments will be risk-adjusted based on the risk scores of individual enrollees as in MA and in Part D.

It is currently the case that in MA, low-income beneficiaries can enroll in, or drop out of plans on a monthly basis. This is also the case for demonstration plans.

In any Medicare Advantage plan, the plan is prohibited from charging cost sharing for Medicare-covered services to dually eligible beneficiaries who are qualified Medicare beneficiaries or who otherwise have Medicare cost sharing covered under Medicaid. MA plans can have premiums which beneficiaries would be expected to pay. The demonstration plans are not permitted to charge any premium for the Medicare Part A and Part B benefit package or for Part D. In MA, beneficiaries pay Part D premiums that vary depending on where the plan's bid is in relation to the national average bid and whether the beneficiary can receive the low-income premium subsidy. We should also note that in 2013, the vast majority of Medicare beneficiaries

have access to an MA plan with no premium that includes Part D drug coverage because plans are using Part A and B rebate dollars to reduce the Part D premium.

As Christine mentioned, demonstration plans will generally be required to comply with all MA contract rules, which includes the reporting of encounter data and compliance with the new minimum medical loss ratio requirements.



In summary the purpose of today's presentation was to update you on the status of the financial alignment demonstration. In terms of next steps and additional work on the subject of dual eligibles, possible work would include exploring additional ways of improving the care for dual eligible beneficiaries through dual eligible special needs plans, or D-SNPs, and adding the financial alignment model to the range of structures or options that the Commission is discussing with respect to having a level playing field among options. As we have explained, the financial alignment model is a capitated model with payment benchmarks and payment rules that differ from the existing Medicare Advantage capitated model.

Also related to this work is an issue that arises in connection with the Commission's discussions of redesigning the Medicare benefit package. One of the possible benefit packages includes an out-of-pocket maximum for

beneficiary cost sharing but with a higher initial deductible. Such a design raises a concern as to whether there should be additional financial support for low-income individuals beyond what currently exists in the Medicare Savings Program.

Thank you and we look forward to your discussion.