Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The Commonwealth of Massachusetts

Regarding A Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees

Demonstration to Integrate Care for Dual Eligible Beneficiaries

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I. STATEMENT OF INITIATIVE

To establish a Federal-State partnership between the Centers for Medicare & Medicaid Services (CMS) and the Commonwealth of Massachusetts (Commonwealth/State/MassHealth) to implement the Demonstration to Integrate Care for Dual Eligible Individuals (Demonstration) to better serve individuals eligible for both Medicare and Medicaid ("Medicare-Medicaid Enrollees" or "dual eligibles"). The Federal-State partnership will include a three-way contract with Participating Plans and other qualified entities ("Participating Plans") that will provide integrated benefits to Medicare-Medicaid Enrollees in the targeted geographic area(s). The Demonstration will begin on April 1, 2013 and continue until December 31, 2016, unless terminated pursuant to section L or continued pursuant to section K of this Memorandum of Understanding (MOU). The initiative is intended to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care and reduce costs for both the Commonwealth and the Federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

Individuals ages 21 through 64 at the time of enrollment who are enrolled in Medicare Parts A and B and eligible for Medicare Part D and MassHealth Standard or CommonHealth and who have no other comprehensive private or public health insurance will be eligible for enrollment in this initiative, as discussed in more detail in section C.1 below.

Under this initiative, Participating Plans will be required to provide for, either directly or through subcontracts, Medicare and Medicaid-covered services, as well as supplemental items and services, under a capitated model of financing. CMS, the Commonwealth, and the Participating Plans will ensure that beneficiaries have access to an adequate network of medical and supportive services.

CMS and the Commonwealth shall jointly select and monitor the Participating Plans. CMS will implement this initiative under Demonstration authority for Medicare and Demonstration or

State Plan authority or waiver for Medicaid as described in section IIIA and detailed in Appendices 4 and 5.

Key objectives of the initiative are to improve the beneficiary experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid and achieve cost savings for the Commonwealth and Federal government through improvements in care and coordination. CMS and the Commonwealth expect this model of integrated care and financing to, among other things, improve quality of care and reduce health disparities, meet both health and functional needs, and improve transitions among care settings. Meeting beneficiary needs, including the ability to self-direct care, be involved in one's care, and live independently in the community, are central goals of this initiative. CMS and the Commonwealth expect Integrated Care Organization (ICO) and provider implementation of the independent living and recovery philosophy, wellness principles, and cultural competence to contribute to achieving these goals.

The initiative will test the effect of an integrated care and payment model on serving both community and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency and oversight standards. Contract management will focus on performance measurement and continuous quality improvement. Except as otherwise specified in this MOU or the Massachusetts Section 1115 Demonstration, Participating Plans will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as program specific and evaluation requirements, as will be further specified in a three-way contract to be executed among the Participating Plans, the Commonwealth, and CMS.

As part of this initiative, CMS and the Commonwealth will test a new Medicare and Medicaid payment methodology designed to support Participating Plans in serving Medicare-Medicaid Enrollees in the Demonstration. This financing approach will minimize cost-shifting, align incentives between Medicare and Medicaid, and support the best possible health and functional outcomes for Enrollees.

CMS and the Commonwealth will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid Enrollees, utilizing a simplified and unified set of rules, as detailed in the sections below. Flexibilities will be coupled with specific beneficiary safeguards and will be included in this MOU and the three-way contract. Participating Plans will have full accountability for managing the integrated blended capitated payment to best meet the needs of Enrollees according to Individualized Care Plans developed using a person-centered planning process. CMS and the Commonwealth expect Participating Plans to achieve savings through better integrated and coordinated care. Subject to CMS and Commonwealth oversight, Participating Plans will have significant flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to or means to avoid high-cost traditional services if indicated by the Enrollees' wishes, needs and Individualized Care Plan.

Preceding the signing of this MOU, the Commonwealth has undergone necessary planning activities consistent with the CMS standards and conditions for participation, as detailed through supporting documentation provided in Appendix 2. This includes a robust beneficiary- and stakeholder- engagement process.

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document details the agreement between CMS and the Commonwealth regarding the principles under which the initiative will be implemented and operated. It also outlines the activities which CMS and the Commonwealth agree to conduct in preparation for planned implementation of the initiative. Further detail about Participating Plan responsibilities will be included in and appended to the three-way contract.

The Commonwealth has released a Participating Plans Procurement Document, known as a Request for Responses (RFR). The Commonwealth and CMS will ultimately enter into three-way contracts with selected Plans, which will have also met the Medicare components of the

plan selection process, including submission of a successful Medicare Part C and Part D application to CMS, and adherence to any annual contract renewal requirements and guidance updates, as specified in Appendix 7.

III. PROGRAM DESIGN / OPERATIONAL PLAN

A. PROGRAM AUTHORITY

1. **Medicare Authority:** The Medicare elements of the initiative shall operate according to existing Medicare Parts C and D laws and regulations, as amended or modified, except to the extent these requirements are waived or modified as provided for in Appendix 4. As a term and condition of the initiative, Participating Plans will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act, and 42 C.F.R. Parts 422 and 423, and applicable sub-regulatory guidance, as amended from time to time, except to the extent specified in this MOU, including Appendix 4 and, for waivers of sub-regulatory guidance, the three-way contract.

2. **Medicaid Authority:** The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the initiative, Participating Plans will be required to comply with Medicaid managed care requirements under Title XIX and 42 C.F.R. §438 et. seq., and applicable sub-regulatory guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5 and, for waivers of sub-regulatory guidance, the three-way contract.

B. CONTRACTING PROCESS

1. **Participating Plan Procurement Document:** The Commonwealth has issued an RFR that, consistent with applicable State law and regulations, includes purchasing specifications that reflect the integration of Medicare and Medicaid payment and benefits. As articulated in January 25, 2012 and March 29, 2012 guidance from CMS, Participating Plans are also required to submit a Capitated Financial Alignment Demonstration application to CMS and meet all of the Medicare components of the plan selection process. The Commonwealth procurement and CMS plan selection process will be utilized to select entities that will be eligible to contract with CMS and the Commonwealth.

   All applicable Medicare Advantage/ Part D requirements and Medicaid managed care requirements are cited in the RFR.

2. **Participating Plan Selection:** CMS and the Commonwealth shall contract with qualified Participating Plans on a selective basis. See Appendix 7 for more information on the plan selection process.

3. **Medicare Waiver Approval:** CMS approval of Medicare waivers is reflected in Appendix 4. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XVIII. CMS will promptly notify the Commonwealth in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Act, afford the Commonwealth a reasonable opportunity to request reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.

4. **Medicaid Waiver and/or Medicaid State Plan Approval:** CMS approval of any new Medicaid waivers pursuant to Sections 1115, 1115A, or 1915 of the Social Security Act authority and processes is reflected in Appendix 5. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities for the purpose of this Demonstration would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the Commonwealth in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Act, afford the Commonwealth an opportunity to request a hearing to appeal CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.

5. **Readiness Review:** CMS and the Commonwealth, either directly or with contractor support, shall conduct a readiness review of each selected Participating Plan. Following the signing of the three-way contract, CMS and the Commonwealth must agree that a Participating Plan has passed readiness prior to that Plan accepting any enrollment. CMS and the Commonwealth will collaborate in the design and implementation of the readiness review process and requirements. This readiness review shall include an evaluation of the capacity of each potential Participating Plan and its ability to meet all program requirements, including having an adequate network that addresses the full range of beneficiary needs, and the capacity to uphold all beneficiary safeguards and protections.

6. **Three-way Contract:** CMS and the Commonwealth shall develop a single three-way contract and contract negotiation process that both parties agree is administratively effective and ensures coordinated and comprehensive program operation, enforcement, monitoring, and oversight.

C. ENROLLMENT

1. Eligible Populations:

- Individuals in the Commonwealth ages 21 through 64 at the time of enrollment who are enrolled in Medicare Parts A and B and eligible for Medicare Part D and MassHealth Standard and who have no other comprehensive private or public health insurance will be eligible for enrollment in this initiative. This includes individuals receiving MassHealth Standard benefits under the Commonwealth's Section 1115(a) Demonstration, and individuals with End Stage Renal Disease (ESRD) at the time of enrollment.
- Individuals in the Commonwealth ages 21 through 64 who are enrolled in Medicare Parts A and B and eligible for Medicare Part D and MassHealth CommonHealth who have no other private or public health insurance will also be eligible for enrollment. This includes individuals receiving MassHealth CommonHealth benefits under the Commonwealth's Section 1115(a) Demonstration, and individuals with ESRD at the time of enrollment.
- Individuals who turn 65 while enrolled in the Demonstration may remain enrolled as long as they continue to be enrolled in Medicare Parts A and B and eligible for Medicare Part D and MassHealth Standard, and have no other comprehensive private or public health insurance.
- Beneficiaries enrolled in a Medicare Advantage plan, Program of All-inclusive Care for the Elderly (PACE), Employer Group Waiver Plans (EGWP) or other Employer-Sponsored Plans, or plans receiving a Retiree Drug Subsidy (RDS), and who meet the eligibility criteria for this Demonstration, may participate in this initiative if they choose to disenroll from their existing programs.
- Individuals participating in the CMS Independence at Home (IAH) demonstration who meet the eligibility criteria for this Demonstration may enroll or be enrolled in this Demonstration if they choose to disenroll from IAH.

- Individuals residing in an ICF/MR facility may not enroll or be enrolled in this Demonstration. Individuals enrolled in a 1915(c) waiver may not enroll or be enrolled in this Demonstration. 1915(c) waiver participants are an important population that CMS and the Commonwealth may seek to bring into this Demonstration in the future, through an amendment of this MOU and the three-way contract.
- To best ensure continuity of beneficiary care and provider relationships, CMS will work with the Commonwealth to address beneficiary or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). A beneficiary enrolled in the Demonstration will not be attributed to an ACO or any other shared savings initiative for the purposes of calculating shared Medicare savings under those initiatives. Additional State-specific eligibility criteria are provided in Appendix 7.

2. **Enrollment and Disenrollment Processes:** Enrollment into a Participating Plan may be conducted using a seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the Participating Plan at any time. Prior to the effective date of their enrollment, individuals who would be passively enrolled will have the opportunity to opt-out and will receive sufficient notice and information with which to do so, as further detailed in Appendix 7. Disenrollment from Participating Plans and transfers between Participating Plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month. CMS and the Commonwealth will monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing laws, for the purposes of identifying any inappropriate or illegal marketing practices. Any illegal marketing practices will be referred to appropriate agencies for investigation. As mutually agreed upon, and as discussed further in Appendix 7 and the three-way contract, CMS and the Commonwealth will utilize an independent third party entity to facilitate all enrollment into the Participating Plans. Participating Plan enrollments and disenrollments shall become effective on the same day for both Medicare and Medicaid (the first of the

month). For those who lose Medicaid eligibility during the month, coverage and Federal financial participation will continue through the end of that month.

3. **Uniform Enrollment/Disenrollment Documents:** CMS and the Commonwealth shall develop uniform enrollment and disenrollment forms and other documents.

4. **Outreach and Education:** Participating Plan outreach and marketing materials will be subject to a single set of marketing rules by CMS and the Commonwealth, as further detailed in Appendix 7.

5. **Single Identification Card:** CMS and the Commonwealth shall work with Participating Plans to develop a single identification card that can be used to access all care needs, as further detailed in Appendix 7.

D. DELIVERY SYSTEMS AND BENEFITS

1. **Participating Plan Service Capacity:** CMS and the Commonwealth shall contract with Participating Plans that demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to Enrollees, in accordance with this MOU, CMS guidance, and the three-way contract. Medicare covered benefits shall be provided in accordance with 42 CFR 422 and 42 CFR 423 et seq. Medicaid covered benefits shall be provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments, the 1115(a) MassHealth Demonstration, and in accordance with the requirements specified in the Commonwealth RFR and this MOU. In accordance with the three-way contract and this MOU, CMS and the Commonwealth may choose to allow for greater flexibility in offering supplemental benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, the Commonwealth, and Participating Plans will ensure that beneficiaries have access to an adequate network of medical, drug, behavioral health, and supportive service providers that are appropriate and

capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.

2. **Participating Plan Risk Arrangements:** CMS and the Commonwealth shall require each Participating Plan to provide a detailed description of its risk arrangements with providers under subcontract with the Participating Plan. This description shall be made available to Plan Enrollees upon request. It will not be permissible for any incentive arrangements to include any payment or other inducement that serves to withhold, limit or reduce necessary medical or non-medical services to Enrollees.

3. **Participating Plan Financial Solvency Arrangements:** CMS and the Commonwealth have established a standard for all Participating Plans, as articulated in Appendix 7.

E. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

1. **Choice of Plans and Providers:** As referenced in section C.2, Medicare-Medicaid beneficiaries will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose a different Demonstration Plan, a Medicare Advantage Plan, to receive care through Medicare Fee-For-Service (FFS) and a Prescription Drug Plan, and to receive Medicaid services in accordance with the Commonwealth's approved State Plan and any approved waiver programs.

2. **Continuity of Care:** CMS and the Commonwealth will require Participating Plans to ensure that individuals continue to have access to medically necessary items, services, and medical and long-term service and support providers for the transition period as specified in Appendix 7. In addition, Participating Plans will advise beneficiaries and providers that they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, Plans must also contact providers not already members of their network with information on becoming credentialed as in-network providers. Part D transition rules and rights will continue as provided for in current law and regulation.

3. **Enrollment Assistance and Options Counseling:** As referenced in section C.2 and Appendix 7, Medicaid-Medicare beneficiaries will be provided with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs.

4. **Person-Centered**, **Appropriate Care:** CMS, the Commonwealth, and Participating Plans shall ensure that all medically necessary covered benefits are provided to Enrollees and are provided in a manner that is sensitive to the beneficiary's functional and cognitive needs, language and culture, allows for involvement of the beneficiary and caregivers, and are in a care setting appropriate to their needs, with a preference for the home and the community. CMS, the Commonwealth, and Participating Plans shall ensure that care is person-centered and can accommodate and support self-direction. Participating Plans shall also ensure that medically necessary covered services are provided to beneficiaries, in the least restrictive community setting, and in accordance with the Enrollee's wishes and Individualized Care Plan.

5. **Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and MassHealth expect Plan and provider compliance with the ADA and the Civil Rights Act of 1964 to promote the success of the ICO model and will support better health outcomes for ICO Enrollees. In particular, CMS and MassHealth recognize that successful person-centered care requires physical access to buildings, services and equipment and flexibility in scheduling and processes. MassHealth and CMS will require ICOs to contract with providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their Enrollees. MassHealth and CMS also recognize that access includes effective communication. MassHealth and CMS will require ICOs and their providers to communicate with their Enrollees in a manner that accommodates their individual needs, including providing interpreters for those who are Deaf or hard of hearing and accommodations for members with cognitive limitations, and translators for those who do not speak English. Also, CMS and MassHealth recognize the importance of staff training on accessibility and accommodation, independent living and recovery models, and wellness

philosophies. CMS and MassHealth will continue to work with stakeholders, including Demonstration participants, to further develop learning opportunities, monitoring mechanisms and quality measures to ensure that ICOs and their providers comply with all requirements of the ADA. Finally, CMS and MassHealth are committed to compliance with the ADA, including application of the Supreme Court's Olmstead decision, and agree to ensure that ICOs provide for Demonstration Enrollees long-term services and supports in care settings appropriate to their needs.

6. **Enrollee Communications:** CMS and the Commonwealth agree that Enrollee and prospective Enrollee materials, in all forms, shall require prior approval by CMS and the Commonwealth unless CMS and the Commonwealth agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and the Commonwealth. CMS and the Commonwealth will also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or Commonwealth approval. All materials shall be integrated and include, but not be limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable to the beneficiaries that will be enrolled in the Participating Plans, and their caregivers. This includes individuals with disabilities, including, but not limited to, those with cognitive and functional limitations, and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard providing the greatest access to individuals with disabilities or limited English proficiency will apply.

7. **Beneficiary Participation on Governing and Advisory Boards:** As part of the three-way contract, CMS and the Commonwealth shall require Participating Plans to obtain consumer and community input on issues of program management and Enrollee care through a range of approaches, which may include beneficiary participation on Participating Plan governing

boards and quality review bodies. The ICO must also establish at least one consumer advisory committee and a process for that committee to provide input to the governing board. The ICO must also demonstrate participation of consumers with disabilities, including Enrollees, within the governance structure of the ICO.

8. **Participating Plan Customer Service Representatives:** CMS and the Commonwealth shall require Participating Plans to employ sufficient numbers of customer service representatives who shall answer all inquiries and respond to Enrollee complaints and concerns. In addition, CMS and the Commonwealth shall themselves employ or contract with sufficient call center and customer service representatives to address Enrollee questions and concerns. Participating Plans, CMS, and the Commonwealth shall work to assure the language and cultural competency of customer service representatives to adequately meet the needs of the Enrollee population. All services must be culturally and linguistically appropriate and accessible. More detailed information about customer service requirements is included in Appendix 7.

9. **Privacy and Security:** CMS and the Commonwealth shall require all Participating Plans to ensure privacy and security of Enrollee health records, and provide for access by Enrollees to such records as specified in the three-way contract.

10. **Integrated Appeals and Grievances:** As referenced in section F and Appendix 7, Medicare-Medicaid beneficiaries will have access to an integrated appeals and grievance process.

11. **Limited Cost Sharing:** Participating Plans will not charge Medicare Parts C or D premiums, nor assess any cost sharing for Medicare Parts A and B services. For drugs and pharmacy products (including both those covered by both Medicare Part D and MassHealth), Plans will be permitted to charge copays to individuals currently eligible to make such payments. Copays charged by Participating Plans must not exceed the lesser of: the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy, or the applicable MassHealth copay amounts. This will allow CMS to test whether reducing Enrollee cost sharing for pharmacy products improves health outcomes

and reduces overall health care expenditures through improved medication adherence under the Demonstration. Participating Plans will not assess any cost sharing for MassHealth services, beyond the pharmacy cost sharing described here.

12. **No Balance Billing:** No Enrollee may be balance billed by any provider for any reason for covered services.

F. INTEGRATED APPEALS AND GRIEVANCES

1. **Participating Plan Grievances and Internal Appeals Processes:** CMS and the Commonwealth agree to develop a unified set of requirements for Participating Plan grievances and internal appeals processes that incorporate relevant Medicare Advantage, and Medicaid managed care requirements, to create a more beneficiary-friendly and easily navigable system, which is discussed in further detail in Appendix 7 and will be specified in the three-way contract. All Participating Plan Grievances and Internal Appeals procedures shall be subject to the review and prior approval of CMS and the Commonwealth. Part D appeals and grievances will continue to be managed under existing Part D rules, and non-Part D pharmacy appeals will be managed by MassHealth. CMS and MassHealth will work to continue to coordinate grievances and appeals for pharmacy.

2. **External Appeals Processes:** CMS and the Commonwealth agree to utilize a streamlined Appeals process that will be developed conforming to both Medicare and Medicaid requirements, to create a more beneficiary-friendly and easily navigable system. Protocols will be developed to assure coordinated access to the appeals mechanism. This process and these protocols are discussed in further detail in Appendix 7. Part D appeals and grievances will continue to be managed under existing Part D rules.

G. ADMINISTRATION AND REPORTING

1. **Participating Plan Contract Management:** As more fully discussed in Appendix 7, CMS and the Commonwealth agree to designate representatives to serve on a CMS-State Contract Management team which shall conduct Participating Plan contract management activities related to ensuring access, quality, program integrity, program compliance, and financial solvency.

   These activities shall include but not be limited to:

   - Reviewing and analyzing Health Care Effectiveness Data and Information Set (HEDIS) data, Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey data, Health Outcomes Survey (HOS) data, enrollment and disenrollment reports.
   - Reviewing any other performance metrics applied for quality withhold or other purposes.
   - Reviewing reports of Enrollee complaints, reviewing compliance with applicable CMS and/or State Medicaid Agency standards, and initiating programmatic changes and/or changes in clinical protocols, as appropriate.
   - Reviewing and analyzing reports on Participating Plans' fiscal operations and financial solvency, conducting program integrity studies to monitor fraud, waste and abuse as may be agreed upon by CMS and the Commonwealth, and ensuring that Participating Plans take corrective action, as appropriate.
   - Reviewing and analyzing reports on Participating Plans' network adequacy, including the Plans' ongoing efforts to replenish their networks and to continually enroll qualified providers.
   - Reviewing any other applicable ratings and measures.
   - Responding to and investigating beneficiary complaints and quality of care issues.

2. **Day-to-Day Participating Plan Monitoring:** CMS and the Commonwealth will establish procedures for Participating Plan daily monitoring, as described in Appendix 7. Oversight shall generally be conducted in line with the following principles:

    - The Commonwealth and CMS will each retain, yet coordinate, current responsibilities toward the beneficiary such that beneficiaries maintain access to their benefits across both programs.
    - CMS and the Commonwealth will leverage existing protocols (for example, in responding to beneficiary complaints, conducting account management, and analyzing enrollment data) to identify and solve beneficiary access problems in real-time.
    - Oversight will be coordinated and subject to a unified set of requirements. CMS-State contract management teams, as described in Appendix 7, will be established. Oversight will build on areas of expertise and capacity of the Commonwealth and CMS.
    - Oversight of the Participating Plans and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and the Commonwealth's Medicaid managed care programs.
    - Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the Commonwealth. Demonstration Plans will be included in all existing Medicare Advantage and Part D oversight activities, including (but not limited to) data-driven monitoring, secret shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and possibly audits.
    - CMS and the Commonwealth will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poor performers from the program, leveraging existing CMS tools, such as the Complaints Tracking Module, and existing Commonwealth oversight and tracking tools. Standards for removal on the grounds of poor performance will be articulated in the three-way contract.

3. **Consolidated Reporting Requirements:** CMS and the Commonwealth shall define and specify in the three-way contract a Consolidated Reporting Process for Participating Plans that ensures the provision of the necessary data on diagnosis, HEDIS and other quality measures, Enrollee satisfaction and evidence-based measures and other information as may be beneficial in order to monitor each Participating Plan's performance. Participating Plans will be required to meet the encounter reporting requirements that are established for the Initiative. See Appendix 7 for more detail.

4. **Accept and Process Data:** CMS, or its designated agent(s), and the Commonwealth shall accept and process uniform person-level Enrollee Data, for the purposes of program eligibility, payment, and evaluation. Submission of data to the Commonwealth and CMS must comply with all relevant Federal and State laws and regulations, including, but not limited to, regulations related to HIPAA and to electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation. This is discussed in more detail in Appendix 7. CMS and the Commonwealth shall streamline data submissions for Participating Plans wherever practicable.

H. QUALITY MANAGEMENT

1. **Quality Management and Monitoring:** As a model conducted under the authority of Section 1115A of the Social Security Act, the Demonstration and independent evaluation will include and assess quality measures designed to ensure beneficiaries are receiving high quality care. In addition, CMS and the Commonwealth shall conduct a joint comprehensive performance and quality monitoring process that is at least as rigorous as Medicare Advantage, Medicare Prescription Drug, and Medicaid managed care requirements. The reporting frequency and monitoring process will be specified in the three-way contract.

2. **External Quality Reviews:** CMS and the Commonwealth shall coordinate the Participating Plan external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).

3. **Determination of Applicable Quality Standards:** CMS and the Commonwealth shall determine applicable quality standards and monitor the Participating Plans' compliance with those standards. These standards are articulated in Appendix 7 and the Participating Plan three-way contract.

I. FINANCING AND PAYMENT

1. **Rates and Financial Terms:** For each calendar year of the Demonstration, before rates are offered to Participating Plans, CMS shall share with the Commonwealth the amount of the Medicare portion of the capitated rate, as well as collaborate to establish the data and documentation needed to assure that the Medicaid portion of the capitation rate is consistent with all applicable Federal requirements.

2. **Blended Medicare and Medicaid Payment:** CMS will make separate payments to the Participating Plans for the Medicare A/B and Part D components of the rate. The Commonwealth will make a payment to the Participating Plans for the Medicaid component of the rate, as more fully detailed in Appendix 6.

J. EVALUATION

1. **Evaluation Data to be Collected:** CMS and the Commonwealth have developed processes and protocols, as specified in Appendix 7 and as will be further detailed in the three-way contract, for collecting or ensuring the Participating Plans or their contractors collect and report to CMS and the Commonwealth the data needed for the CMS evaluation.

2. **Monitoring and Evaluation:** CMS will fund an external evaluation. The Demonstration will be evaluated in accordance with Section 1115A(b)(4) of the Social Security Act. As further detailed in Appendix 7, CMS or its contractor will measure, monitor, and evaluate the overall impact of the Demonstration including the impacts on program expenditures and service utilization changes, including monitoring any shifting of services between medical and non-medical services. Changes in person-level health outcomes, experience of care, and costs by sub-population(s), and changes in patterns of primary, acute, and long-term care and social support services use and expenditures will be assessed. Rapid-cycle evaluation and feedback will be implemented. Key aspects and administrative features of the Demonstration, including but not limited to enrollment, marketing, and appeals and grievances will also be examined per qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives, and seek to isolate the effect of this Demonstration as appropriate. The Commonwealth will collaborate with CMS or its designated agent during all monitoring and evaluation activities. The Commonwealth and Participating Plans will submit all data required for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements listed in the three-way contract with Participating Plans. The Commonwealth and Participating Plans will submit both historical data relevant to the evaluation, including MSIS data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

K. EXTENSION OF AGREEMENT

The Commonwealth may request an extension of this Demonstration, which will be evaluated consistent with terms specified under Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any extension request will be subject to CMS approval.

L. MODIFICATION OR TERMINATION OF AGREEMENT

The Commonwealth agrees to provide notice to CMS of any State Plan or waiver changes that may have an impact on the Demonstration.

1. **Modification of this Agreement:** Either CMS or the Commonwealth may seek to modify or amend the MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any material modification shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.

2. **Termination of this Agreement** is allowed under the following circumstances:

    a. Termination without cause - Except as otherwise permitted below, a termination of this MOU by CMS or the Commonwealth for any reason will require that CMS or the Commonwealth provides a minimum of 90-day advance notice to the other party, 90-day advance notice to the Participating Plans, and 60-day advance notice to Enrollees and the general public. During the advance notice period, all Enrollees must be successfully enrolled in a Part D plan prior to termination of the Demonstration.

    b. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

    c. Termination for cause - Either party may terminate this Agreement upon 30 days' notice due to a material breach of a provision of this MOU or the three-way contract.

    d. Termination due to a Change in Law - In addition, CMS or the Commonwealth may terminate this agreement upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

3. **Demonstration phase-out:** Any planned termination at the end of the Demonstration must follow the following procedures:

   a. Notification of Suspension or Termination - The Commonwealth must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The Commonwealth must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the Commonwealth must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the Commonwealth must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. The Commonwealth shall summarize comments received and share such summary with CMS. The Commonwealth must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

   b. Phase-out Plan Requirements - The Commonwealth must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), and if applicable, the process by which the Commonwealth will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities. In addition, such plan must include any ongoing ICO and Commonwealth responsibilities.

c. Phase-out Procedures - The Commonwealth must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the Commonwealth must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the Commonwealth must maintain benefits as required in 42 CFR §431.230. If applicable, the Commonwealth must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d. FFP - If the Demonstration is terminated by either party, or any relevant waivers are suspended or withdrawn by CMS, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including covered services and administrative costs of disenrolling participants.

e. If the Demonstration is terminated as set forth in Paragraphs 2a.- 2d. above, CMS shall provide the Commonwealth with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Demonstration Enrollees. During the phase-out period, all enrollees must be successfully enrolled in a Part D plan prior to termination of the Demonstration.

M. SIGNATURES

This MOU is effective on this day forward [August 22, 2012] through the end of the Demonstration period [December 31, 2016]. Additionally, the terms of this MOU shall continue to apply to the Commonwealth and Participating Plans as they implement associated phase-out activities beyond the end of the Demonstration period.

In Witness Whereof, CMS and the Commonwealth of Massachusetts have caused this Agreement to be executed by their respective authorized officers:

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

Marilyn Tavenner — 8/22/12

(Authorized Signatory) (Date)

Administrator, CMS

(Title)

Commonwealth of Massachusetts, MassHealth:

8/22/12

JudyAnn Bigby, MD (Date)

Secretary, Executive Office of Health and Human Services

Appendix 1: Definitions

Appeals - an Enrollee's request for review of a Participating Plan's (Integrated Care Organization's) coverage or payment determination.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) - beneficiary survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care.

Care Coordinator - a clinician or other trained individual employed or contracted by the Primary Care Provider or the ICO who is accountable for providing care coordination services, which include assuring appropriate referrals and timely two-way transmission of useful patient information; obtaining reliable and timely information about services other than those provided by the primary care provider; participating in the initial assessment; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each Enrollee on whose ICT he or she serves.

Center for Medicare and Medicaid Innovation (CMMI) - established by Section 3021 of the Affordable Care Act, CMMI was established to test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under such titles.

Clinical Care Management - a set of services provided by a Clinical Care Manager that comprise intensive monitoring, follow-up, and care coordination, clinical management of high-risk Enrollees.

Clinical Care Manager - a licensed registered nurse or other individual licensed to provide Clinical Care Management.

CMS - Centers for Medicare & Medicaid Services.

CommonHealth - MassHealth coverage type as specified at 130 CMR 505.004 that offers health benefits to certain working and non-working disabled adults between the ages of 19 and 64.

Contract - the participation agreement that CMS and MassHealth have with an ICO for the terms and conditions pursuant to which an ICO may participate in this Demonstration.

Contract Management Team - a group of CMS and MassHealth representatives responsible for overseeing the contract.

Covered Services - the set of services to be offered by the Participating Plans (Integrated Care Organizations).

Covered Individuals - individuals enrolled in the Demonstration, including the duration of any month in which their eligibility for MassHealth or Medicare ends.

Cueing and monitoring - providing a prompt or direction to assist an individual in performing activities they are physically capable of performing but unable to independently initiate.

Cultural Competence - understanding those values, beliefs, and needs that are associated with patients' age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

Enrollee - any dual eligible individual who is enrolled in an ICO.

Enrollment - the processes by which an individual who is eligible for the Demonstration is enrolled in a Participating Plan. Such processes include completion of an enrollment form or application in order to become a member of an ICO. (Passive enrollment is defined below.)

Enrollee Communications - materials designed to communicate to Enrollees plan benefits, policies, processes and/or Enrollee rights. This includes pre-enrollment, post-enrollment, and operational materials.

Healthcare Effectiveness Data and Information Set (HEDIS) - tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

Health Outcomes Survey (HOS) - beneficiary survey used by the Centers for Medicare and Medicaid Services to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

Independent Living and Long Term Services and Supports (LTSS) - a wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities**.**

Independent Living and Long Term Services and Supports (IL-LTSS) Coordinator - a coordinator contracted by the ICO with a Community Based Organization (CBO) to ensure that an independent resource is assigned to and available to the Enrollee to assist with the coordination of his/her LTSS needs and to provide expertise and community supports to the Enrollee and his/her care team. The IL-LTSS Coordinator's primary responsibilities will be to: ensure person-centered care, counsel potential Enrollees; provide communication and support needs; and act as an independent facilitator and liaison between the Enrollee, ICO and service providers.

Individualized Care Plan - the plan of care developed by an Enrollee and an Enrollee's Interdisciplinary Care Team.

Integrated Care Organization (ICO) - a health plan or provider-based organization contracted to provide and accountable for providing integrated care to Enrollees. All Participating Plans shall be designated as ICOs.

Interdisciplinary Care Team (ICT) - a team of primary care provider, Care Coordinator, Independent Living and Long Term Services and Supports Coordinator and other individuals at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the Individualized Care Plan.

MassHealth - the medical assistance and benefit programs administered by the Massachusetts Executive Office of Health and Human Services pursuant to Title XIX of the Social Security Act, Section 1115 demonstration, M.G.c. 118E, and other applicable laws and regulations (Medicaid).

Medically Necessary Services - services must be provided in a way that provides all protections to the Enrollee provided by Medicare and MassHealth. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 USC 1395y. In accordance with Medicaid law and regulations, and per MassHealth, services must be:

- provided in accordance with MassHealth regulations at 130 CMR 450.204;
- which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and
- for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

Medicare-Medicaid Coordination Office - formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

Medicare-Medicaid Enrollees - for the purposes of this Demonstration, individuals who are enrolled in Medicare Parts A and B and eligible for and receiving MassHealth Standard or CommonHealth and no other comprehensive private or public health coverage.

Medicaid - the program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and Waivers thereof.

Medicare - Title XVIII of the Social Security Act, the Federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

Medicare Waiver - generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.

Medicaid Waiver - generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act.

Participating Plan - a health plan or other qualified entity serving as an Integrated Care Organization jointly selected by the Commonwealth and CMS for participation in this Demonstration.

Passive Enrollment - an enrollment process through which an eligible individual is enrolled by the Commonwealth (or its vendor) into a Participating Plan, following a minimum 60-day advance notification that includes the opportunity to make another enrollment decision or opt out of the Demonstration prior to the effective date.

Privacy - requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, as well as relevant Massachusetts privacy laws.

Readiness Review - prior to entering into a three way agreement with the Commonwealth and CMS, each Integrated Care Organization selected to participate in the Demonstration will undergo a readiness review. The readiness review will evaluate each ICO's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new members, and provide adequate access to all Medicare- and Medicaid-covered medically necessary services. CMS and the Commonwealth will use the results to inform their decision of whether the ICO is ready to participate in the Demonstration. At a minimum, each readiness review will include a desk review and potentially a site visit to the ICO's headquarters.

Recovery Model - framework for behavioral health that uses "recovery oriented" services in recognition that systems of care that focus primarily on symptom reduction and maintaining people at a baseline actually create long term disability and dysfunction. "Recovery oriented" systems shift the focus from illness to wellness, custodial care to community integration, and seek meaningful outcomes such as health, home, purpose and community. Core practices within recovery-oriented systems include peer support, individual choice and person-driven approaches. The recovery model recognizes that behavioral health issues involve an individualized complex interaction between social, environmental and physiological components, and the need to incorporate all of these factors within the care system in order to achieve health and wellness.

Solvency - standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by the Commonwealth and agreed to by CMS.

State - the Commonwealth of Massachusetts.

Appendix 2: CMS Standards and Conditions and Supporting State Documentation

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Integration of Benefits	Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services.	pp. 7-9, 14-18; Addendum1
Care Model	Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.	pp. 7-11, 17-18
Stakeholder Engagement	State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss the proposed model with relevant stakeholders. Stakeholders include, but are not limited to, beneficiaries and their families, consumer organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model.	pp. 21-23; Cover memo listing changes to proposal
	State has also established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis for the duration of the Demonstration (i.e., implementation, monitoring and evaluation), including a process for informing beneficiaries (and their representatives) of the changes related to this initiative.	p. 26

[1] The proposal Addendum attached to this MOU containing modifications made to the Massachusetts proposal, and agreed to by CMS, after the Commonwealth submitted its proposal to CMS.

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Beneficiary Protections	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary's needs. At a minimum, States will be required to:	
	• Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model (e.g., participation on Participating Plan governing boards and/or establishment of beneficiary advisory boards).	p. 26
	• Develop, in conjunction with CMS, uniform/integrated Enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency.	pp. 13-14, 25
	• Ensure privacy of Enrollee health records and provide for access by Enrollees to such records.	p. 25
	• Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community.	pp. 9, 11
	• Ensure access to services in a manner that is sensitive to the beneficiary's language and culture, including customer service representatives that are able to answer Enrollee questions and respond to complaints/concerns appropriately.	pp. 10, 12, 25
	• Ensure an adequate and appropriate provider network, as detailed below.	pp. 12

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	• Ensure that beneficiaries are meaningfully informed about their care options.	pp. 9-10, 25
	• Ensure access to grievance and appeals rights under Medicare and/or Medicaid.	
	• *For Capitated Model*, this includes development of a unified set of requirements for Participating Plan complaints and internal appeals processes.	pp. 24-26
	• *For Managed FFS Model*, the State will ensure a mechanism is in place for assisting the participant in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable.	
State Capacity	State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.	pp. 33-35
Network Adequacy	The Demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.	pp. 7, 11-12

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Measurement/ Reporting	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality and cost outcomes for the target population. These metrics may include, but are not limited to beneficiary experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote beneficiaries receiving high quality care and for purposes of the evaluation.	pp. 27-28, 31-34, xix-xx
Data	State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:	
	• Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models;	pp. 4-6, 37; Addendum
	• Description of any changes to the State Plan that would affect Medicare-Medicaid Enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and	pp. 19, 34; Addendum
	• State supplemental payments to providers (e.g., DSH, UPL) during the three-year period.	Addendum
Enrollment	State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting beneficiary education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.	pp. 2, 12-14

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Expected Savings	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	p. 30
Public Notice	State has provided sufficient public notice, including:	
	• At least a 30-day public notice process and comment period;	p. 23
	• At least two public meetings prior to submission of a proposal; and	p. 23
	• Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals.	p. 34; Addendum
Implementation	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones **by end of 2012**:	
	• Meaningful stakeholder engagement.	p. 26
	• Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments.	p. 34; Addendum
	• Receipt of any necessary State legislative or budget authority.	p. 36; Addendum
	• Joint procurement process (for capitated models only).	p. 35
	• Beneficiary outreach/notification of enrollment processes, etc. (CMS and Massachusetts subsequently agreed that outreach/notification would occur no earlier than January 2013 for April 1, 2013 effective enrollment.)	pp. 13

Appendix 3: Details of State Demonstration Area

All service areas with one or more successful ICO bids.

Appendix 4: Medicare Authorities and Waivers

Medicare provisions described below are waived as necessary to allow for implementation of the Demonstration. Except as waived, Medicare Advantage and Medicare Part D provide the authority and statutory and regulatory framework for the operation of the Demonstration to the extent that Medicare (versus Medicaid) authority applies. Unless waived, all applicable statutory and regulatory requirements of the Medicare program for Medicare Advantage plans that provide qualified Medicare Part D prescription coverage, including Medicare Parts A, B, C, and D, shall apply to Participating Plans and their sponsoring organizations for the Demonstration period beginning April 1, 2013 through December 31, 2016, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing Medicare manuals will be noted and reflected in an appendix to the three-way contracts.

Under the authority at Section 1115A of the Social Security Act, codified at 42 U.S.C. 1315a, the Center for Medicare and Medicaid Innovation is authorized to "…test payment and service delivery models …to determine the effect of applying such models under [Medicare and Medicaid]." 42 U.S.C. 1315a(b)(1). One of the models listed in Section 1315a(b)(2)(B) that the Center for Medicare and Medicaid Innovation is permitted to test is "[a]llowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals." § 1315a(b)(2)(B)(x). Section 1315a(d)(1) provides that "The Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) [of the Social Security Act] as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b)."

Pursuant to the foregoing authority, CMS will waive the following Statutory and Regulatory requirements:

- Section 1851(a), (c), (e), and (g) of the Social Security Act, and implementing regulations at 42 CFR, Part 422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in ICOs to Medicare-Medicaid beneficiaries who are between the ages of 21 and 64, including beneficiaries who may have end-stage renal disease, and (2) the passive enrollment process provided for under the Demonstration.
- Sections 1853, 1854, 1857(e), 1860D-11, 1860D-13, 1860D-14, and 1860D-15 of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subparts F and G, and Part 423, Subparts F and G, only insofar as such provisions are inconsistent with the methodology for determining payments and Enrollee liability under the Demonstration as specified in this MOU, including Appendix 6, which differs as to the method for calculating payment amounts and does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under Sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.
- The provisions regarding deemed approval of marketing materials in Sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 CFR 422.2266 and 423.2266, with respect to marketing and Enrollee communications materials in categories of materials that CMS and the State have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and the Commonwealth have agreed to approval.
- Sections 1852 (f) and (g) and implementing regulations at 42 CFR Part 422, Subpart M, only insofar as such provisions are inconsistent with the grievance and appeals processes provided for under the Demonstration.
- Section 1860D-14(a)(1)(D) and implementing regulations at 42 CFR Part 423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the low-income subsidy be greater than $0, to permit Participating Plans to reduce Part D cost sharing below the levels required under Section 1860D-14(a)(1)(D)(ii) and (iii).

Appendix 5: Medicaid Authorities and Waivers

All requirements of the Medicaid program expressed in law and regulation, not expressly waived in this list, shall apply to the Demonstration beginning April 1, 2013 through December 31, 2016, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing sub-regulatory guidance will be noted and reflected in an appendix to the three-way contracts.

Title XIX duals Demonstration savings may not be added to budget neutrality savings under the Commonwealth's existing Section 1115(a) demonstration. When Massachusetts' Section 1115(a) demonstration is considered for renewal and at the end of the duals Demonstration, the Office of the Actuary will estimate and certify actual Title XIX savings to date under the duals Demonstration attributable to populations and services authorized under the 1115(a) demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal.

1115A Medicaid Waivers

Under the authority of Section 1115A of the Social Security Act (the Act), the following waivers of State Plan requirements contained in Section 1902 and 1903 of the Act are granted to enable the Commonwealth of Massachusetts (State/Commonwealth) to carry out the State Demonstration to Integrate Care for Dual Eligible Individuals. These authorities shall be in addition to those in the State Plan and the existing Section 1115(a) MassHealth Demonstration.

1. Statewideness **Section 1902(a)(1)**

To enable Massachusetts to provide managed care plans or certain types of managed care plans (ICOs for Medicare-Medicaid Enrollees) only in certain geographical areas of the Commonwealth.

2. Provisions Related to Contract Requirements Section 1903(m)(2)(A)(iii) (as implemented in 42 C.F.R. 438.6)

Waiver of contract requirement rules at 42 CFR 438.6(a), insofar as its provisions are inconsistent with methods used for prior approval under this Demonstration, and rules at 42 CFR 438.6(c)(5)(ii) necessary to allow CMS and the Commonwealth to follow the specified methodology outlined in Appendix 6.

Actuarially sound capitation rates for this Demonstration refer to the total capitation rates paid to Participating Plans, including both Medicare and Medicaid contributions. For Medicare-Medicaid beneficiaries, CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary.

Appendix 6: Payments to Participating Plans

The Centers for Medicare and Medicaid Services (CMS) and the Commonwealth of Massachusetts will enter into a joint rate-setting process based on the following principles:

(1) Medicare and Medicaid will each contribute to the total capitation payment consistent with baseline spending contributions;

(2) Demonstration savings percentages assume that Participating Plans are responsible for the full range of services covered under the Demonstration;

(3) Aggregate savings percentages will be applied equally to the Medicaid and Medicare A/B components; and

(4) Both CMS and the Commonwealth will contribute to the methodologies used to develop their respective components of the overall blended rate as summarized in Figure 6-2 and further described below.

Figure 6-1 below outlines how the Demonstration Years will be defined for the purposes of this effort. (Note: rate updates will take place on January 1st of each calendar year, with changes to savings percentages and quality withholds applicable on a Demonstration Year basis.)

Figure 6-1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1	April 1, 2013 – December 31, 2014
2	January 1, 2015 – December 31, 2015
3	January 1, 2016 – December 31, 2016

Figure 6-2: Summary of Payment Methodology under Massachusetts Demonstration to Integrate Care for Dual Eligible Beneficiaries

State: Commonwealth of Massachusetts

Rate Element	Medicare A/B	Medicare D	Medicaid
2013 Baseline costs for the purposes of setting payment rates Medicare baseline spending will be established prospectively on a calendar year basis for each Demonstration county. Medicaid baseline spending amounts shall be set up front and will be applied in future years unless more recent historical data are available and/or CMS' actuaries and the Commonwealth determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.	Blend of Medicare Advantage payments and Medicare standardized Fee-For-Service weighted by where dual eligibles who meet the criteria and who are expected to transition into the Demonstration are enrolled in the prior year. Baseline costs will be calculated as a per member per month (PMPM) standardized cost.	National average monthly bid amount (NAMBA) will be used as the baseline for the direct subsidy portion of Part D spending. Note that additional costs associated with low-income subsidy payments, reinsurance payments, and risk-sharing are included in the Part D baseline for the purposes of tracking and evaluating Part D costs but not for the purposes of setting payment rates. These amounts will be factored into plan payments, but these amounts are subject to reconciliation consistent with Part D reconciliation rules.	Historical State data. Trend rates developed by State actuaries based on State Plan services, with oversight from CMS contractor and staff; projections completed by CMS.
Responsible for producing data	CMS	CMS	State Medicaid agency, validated by CMS
Savings percentages	Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 4%	Not Applicable	Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 4%

Rate Element	Medicare A/B	Medicare D	Medicaid
Risk adjustment	Medicare Advantage CMS-HCC Model	Part D RxHCC Model	Commonwealth will use rating categories as described in section I, plus high-cost risk pools
Quality withhold	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3%	Not applied	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3%
Risk Sharing	Combined (all eligible costs except Part D) ICO-level tiered risk corridors will be applied, in Demonstration Year 1 only	Existing Part D processes will apply	Combined (all eligible costs except Part D) ICO-level tiered risk corridors will be applied, in Demonstration Year 1 only

I. Underlying Rate Structure for Medicaid Components of the Rates

The rating categories to be utilized in the Massachusetts Demonstration to Integrate Care for Dual Eligible Beneficiaries are described below. The data sources listed below for Demonstration Year 1 may be updated in Demonstration Years 2 and 3 to take into account actual experience.

A. F1: Facility-based Care.

a. Includes individuals identified by MassHealth indication as having a long-term facility stay of more than 90 days.

b. Data based on member months in a facility beyond the first 90 days. Applicable facilities include nursing facilities and chronic, rehabilitation, and psychiatric hospitals.

B. C3: Community Tier 3 - High Community Needs.

   a. Includes individuals who do not meet F1 criteria, and for whom an MDS-HC assessment indicates:

      i. Have a skilled need to be met by the ICO seven days a week;

      ii. Have two or more Activities of Daily Living (ADL) limitations AND three or more days a week of skilled nursing need to be met by the ICO; or

      iii. Have four or more ADL limitations.

   b. Data based on member months not in F1, that are within episodes of 3+ consecutive months in which member is in a facility and/or using more than $500 in community-based LTSS.

C. C2: Community Tier 2 – Community High Behavioral Health.

   a. Includes individuals who do not meet F1 or C3 criteria, and who have one or more of the following Behavioral Health diagnoses, listed by ICD-9 code, validated by medical records, reflecting an ongoing, chronic condition such as schizophrenic or episodic mood disorders; psychosis; or alcohol or drug dependence not in remission.

      i. 295.xx
      ii. 296.xx
      iii. 298.9x
      iv. 303.90, 303.91, 303.92
      v. 304.xx excluding 304.x3

   b. Data based on member months not in F1 or C3, with the identified diagnoses in Medicaid claims data.

D. C1: Community Tier 1 - Community Other.

a. Includes individuals in the community who do not meet the F1, C2 or C3 criteria.

b. Data based on member months not in F1, C2 or C3.

II. Baseline Spending and Payment Rates for Target Population in the Demonstration Area

Baseline spending is an estimate of what would have been spent in the payment year had the Demonstration not existed. Medicare baselines will be expressed as standardized (1.0) amounts and applicable on a calendar year basis. The baseline costs include three components: Medicaid, Medicare Parts A and B, and Medicare Part D. Payment rates will be determined by applying savings percentages (see sections III and IV) to the baseline spending amounts.

A. Medicaid:

a. Prior to implementation of the Demonstration, the Commonwealth and its actuaries will be responsible for establishing the baseline spending for Medicaid services that will be included under the Demonstration using the most recent data available. The baseline will take into account historic costs, and will be trended forward to the Demonstration period.

   Baseline data will be calculated using historic data at least through calendar year 2010, but CMS may update in subsequent years for more recent historical Commonwealth data. CMS will review and validate the Medicaid baseline data.

b. The Commonwealth and its actuaries will provide the estimated baseline spending and underlying data for each year of the Demonstration at the beginning of the Demonstration period to the CMS contracted actuary, who will validate the estimate of projected costs in Medicaid (absent the Demonstration).

c. Medicaid payment rates will be determined by applying the annual savings percentages (see section III and IV) to the baseline spending amounts.

d. The Commonwealth may combine some counties into larger regions, with regional rates.

e. Except for updates based on more recent historical data, updates to the Medicaid baseline will not be allowable unless CMS and the Commonwealth determine the update would result in a substantial change to the baseline necessary to calculate accurate payment rates for the Demonstration.

B. Medicare Part A/B:

a. CMS will develop baseline spending (costs absent the Demonstration) and payment rates for Medicare A and B services using estimates of what Medicare would have spent on behalf of the beneficiaries absent the Demonstration.

b. The Medicare baseline rate for A/B services will be a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

c. Medicare A/B payment rates will be determined by applying the annual savings percentages (see section III and IV) to the baseline spending amounts.

d. Both baseline spending and payment rates under the Demonstration for Medicare A/B services will be calculated as pmpm standardized amounts for each county participating in the Commonwealth's Demonstration for each year. Beneficiary risk scores will be applied to the standardized payment rates at the time of payment.

e. Depending on the definition of the Demonstration-eligible group, CMS may require the Commonwealth to provide a data file for beneficiaries who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline spending. CMS will specify the format and layout of the file.

f. The Medicare portion of the baseline will be updated annually consistent with the annual Fee-For-Service (FFS) estimates and benchmarks released each year with the annual rate announcement.

g. CMS annually applies a coding intensity adjustment factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for 2013 is 3.41%. Virtually all new ICO Enrollees will come from Medicare FFS, and 2013 ICO risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the ICOs themselves. Therefore, CMS will not apply the coding intensity adjustment factor in calendar year 2013 to reflect the fact that virtually all Enrollees were receiving care in FFS Medicare and thus there should be no coding pattern differences for which to adjust. After calendar year 2013, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all ICO Enrollees.

C. Medicare Part D:

a. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

The CY 2013 Part D NAMBA is $79.64.

III. Aggregate Savings Percentages Under the Demonstration

A. Both parties agree that there is reasonable expectation for achieving savings while paying Participating Plans capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to beneficiary needs.

B. For the Commonwealth of Massachusetts, the savings percentages will be:

   a. Demonstration Year 1: 1%

   b. Demonstration Year 2: 2%

   c. Demonstration Year 3: 4%

   Rate updates will take place on January 1st of each calendar year, however savings percentages will be calculated and applied based on Demonstration Years.

IV. Apply Aggregate Savings Percentages to Medicare A/B and Medicaid Components of the Integrated Rate

The aggregate savings percentages identified above will be applied to the Medicare A/B and Medicaid per capita baseline estimates to determine standardized Demonstration payment rates. The Medicaid savings percentages may vary by Rating Category, but will in the aggregate equal the savings percentages identified above. Changes to the savings percentages under section III of Appendix 6 would only occur if and when CMS and the Commonwealth jointly determine the change is necessary to calculate accurate payment rates for the Demonstration.

Savings percentages will not be applied to the Part D component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

V. Risk Adjustment Methodology

A. The Medicare A/B Demonstration county rate will be risk adjusted based on the risk profile of each enrolled beneficiary. Except as specified in section II.B.g of this Appendix for calendar year 2013, the existing CMS-HCC risk adjustment methodology will be utilized for the Demonstration.

B. The Medicare Part D national average bid will be risk-adjusted in accordance with existing Part D RxHCC methodology.

C. The Medicaid component will be risk adjusted based on a methodology proposed by the Commonwealth and agreed to by CMS as described below:

   Under the Massachusetts Demonstration to Integrate Care for Dual Eligible Beneficiaries, the Commonwealth will rely on rating categories described in section I and use High Cost Risk Pools (HCRPs) for certain Rating Categories described in section IX to account for differences in risk among the eligible population.

D. The Commonwealth will be collecting functional data and will be working on the development of an enhanced risk adjustment methodology for the Medicaid component of the rate during the course of the Demonstration.

VI. Quality Withhold Policy for Medicaid and Medicare A/B Components of the Integrated, Risk-adjusted Rate

A. Under the Demonstration, both payors will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to Participating Plans' performance consistent with established quality thresholds. These thresholds are based on a combination of certain core quality withhold measures (across all Demonstrations under Financial Alignment), as well as Commonwealth-specified quality measures.

B. Withhold Measures in Demonstration Year 1.

a. Figure 6-3 below identifies core withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for the 1% withhold. Measure specifications and required thresholds will be included in the three-way contract.

b. Because Demonstration Year 1 crosses calendar/contract years, Participating Plans will be evaluated to determine whether they have met required quality withhold requirements at the end of both CY 2013 and CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Figure 6-3: Quality Withhold Measures for Demonstration Year 1

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	Commonwealth Specified Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined orocess measure	X	
Assessments	Percent of Enrollees with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X	X
Tracking of demographic information	Percent of all Demonstration participants for whom specific demographic data is collected and maintained in the ICO Centralized Enrollee Record, including race, ethnicity, disability type, primary language, and homelessness, in compliance with contract requirements.	CMS/State defined process measure		X
Documentation of care goals	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure		X
Access to an IL-LTSS Coordinator	Percent of Enrollees with LTSS needs who have an IL-LTSS Coordinator.	CMS/State defined process measure		X
Consumer governance board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Ensuring physical access to buildings, services and equipment	ICO has established a work plan and identified individual in its organization who is responsible for ADA compliance related to this Demonstration.	CMS/State defined process measure		X
Access to Care (for CY 2014 only)	Percent of respondents who always or usually were able to access care quickly when they needed it.	AHRQ/CAHPS	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	Commonwealth Specified Measure
Customer Service (for CY 2014 only)	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	X

C. Withhold Measures in Demonstration Years 2 and 3.

a. The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3 and will be based on performance on the core Demonstration and Commonwealth specified measures. Figure 6-4 below identifies the quality withhold measures for Demonstration Years 2 and 3.

Figure 6-4: Quality Withhold Measures for Demonstration Years 2 and 3

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	Commonwealth Specified Measure
Plan all-cause readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	X
Screening for clinical depression and follow-up care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	Commonwealth Specified Measure
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HOS	X	
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X
Part D medication adherence for oral diabetes medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	
Initiation and engagement of alcohol and other drug dependence treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS		X
Timely transmission of transition record.	Percent of Demonstration participants discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or to the health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI		X
Quality of life measure TBD	To be determined – specified in three-way contract.			X

(Note: Part D payments will not be subject to a quality withhold, however Participating Plans will be required to adhere to quality reporting requirements that currently exist under Part D.)

b. Additional detail regarding the agreed upon measures, including technical specifications and required thresholds, will be specified in the three-way contract. Metrics only applicable to individuals 65 and older based on technical specifications will be adjusted or removed, as possible and appropriate, to reflect the Commonwealth's Demonstration target population.

VII. Payments to Participating Plans

A. CMS will make separate monthly risk-adjusted payments to the Participating Plans for the Medicare A/B and Part D components of the rate, based on standardized Demonstration payment rates. Medicare A/B payments and Part D payments will be subject to the same payment adjustments that are made for payments to Medicare Advantage and Part D plans, including but not limited to adjustments for user fees and Medicare Secondary Payer adjustment factors.

B. The Commonwealth will make a payment to the Participating Plans for the Medicaid component of the rate.

C. The blended payment from CMS and the Commonwealth is intended to be adequate to support access to and utilization of covered services, according to Enrollee Individualized Care Plans. CMS and the Commonwealth will jointly monitor access to care and overall financial viability of Plans accordingly.

VIII. Evaluate and Pay Participating Plans Relative to Quality Withhold Requirements

A. CMS and the Commonwealth will evaluate Plan performance according to the specified metrics required in order to earn back the quality withhold for a given year. CMS and the Commonwealth will share information as needed to determine whether quality requirements have been met and calculate final payments to each Participating Plan from each payor.

B. Whether or not each Plan has met the quality requirements in a given year will be made public, as will relevant quality results of Participating Plans in Demonstration Years 2 and 3.

IX. Risk Mitigation Strategies

- The Commonwealth will establish High Cost Risk Pools (HCRP) to account for enrollment of high cost members, defined based on spending for select Medicaid long-term supports and services above a defined threshold within Medicaid rating categories across ICOs. For each rating category with a HCRP, a portion of the base Medicaid capitation rate will be withheld from all ICOs into a risk pool. The risk pool will be divided across ICOs based on their percent of total costs above the threshold amount associated with the high cost members.

    A. Applicable Medicaid rating categories:

        a. F1- Facility-based Care

        b. C3- Community Tier 3 - High Community Needs

    B. Timing. HCRPs will be utilized until additional long-term care risk adjustment methodology is in place.

    C. Amount. To be specified in the three-way contract subject to CMS review and approval.

- Risk Corridors will be established for Demonstration Year 1 in order to account for possible enrollment bias and to protect Plans and payors against uncertainty in rate-setting that could result in either overpayment or underpayment until actual program experience is available. Risk corridors will not be applied for Demonstration Years 2 or 3. The Demonstration will utilize a tiered ICO-level symmetrical risk corridor to include all Medicare A/B and Medicaid eligible costs. The risk corridors will be reconciled after application of any HCRP or risk adjustment methodologies (e.g., CMS-HCC). Risk corridors will be reconciled as if all ICOs had received the full quality withhold payment. The three-way contract will include further details on how risk corridors will be operationalized under this Demonstration.

    A. Process for collecting cost information. CMS and the Commonwealth will evaluate encounter data, cost data, and ICO financial reports to determine ICO incurred costs of services and care management.

B. Risk corridor share. The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the capitated rates, not including Part D, with the maximum Medicare payment/recoupment equaling 1% of the risk-adjusted Medicare baseline. All remaining payments once Medicare has reached its maximum obligation shall be treated as Medicaid expenditures eligible for FMAP. Risk corridors will consider both service and care management costs.

C. Risk corridor tiers

a. CMS and the Commonwealth will use the following bands to address potential Participating Plan gains/losses in Demonstration Year 1:

1. Greater than 10.0% gain/loss, Participating Plans would bear 100% of the risk/reward.

2. Between 5% and 10% gain/loss, Participating Plans would bear 50% of the risk/reward; the Commonwealth and CMS would share in the other 50%, as described in B above.

3. Between 0% and 5% gain/loss, Participating Plans would bear 100% of the risk/reward.

b.Risk Mitigation Process: In the event that broad risk corridor payments or receipts in Section IX are incurred, CMS will convene the following parties to assess the factors resulting in the payment or loss and, as warranted, evaluate the payment parameters, including the respective projected baselines, savings percentages, and risk adjustment methodology: (1) CMS participants: Administrator, Chief Actuary, Director of the Center for Medicare, Director of the Center for Medicaid and CHIP Services, Director of the Medicare-Medicaid Coordination Office; (2) Office of Management and Budget participants: Medicare Branch Chief, Medicaid Branch Chief; (3) Commonwealth participants: Medicaid Director. These parties will review available data, as applicable, including data on enrollment, utilization patterns, health plan expenditures, and risk adjustment to assess the appropriateness of capitation rates and identify any potential prospective adjustments that would ensure the rate-setting process is meeting the objective of Medicare and Medicaid jointly financing the costs and sharing in the savings. Cost reconciliation under Part D will continue as is under the Demonstration. CMS will monitor Part D costs closely on an on-going

basis. Any material increase in Part D costs relative to the baseline may be factored into future Demonstration Year savings percentages.

X. Payments in Future Years and Mid-Year Rate Adjustments

A. Rates will be updated using a similar process for each calendar year. Changes to the Medicare and Medicaid baselines outside of the annual Medicare Advantage rate announcement would occur only if and when CMS and the Commonwealth jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in enrollment assumptions; major changes in Federal law and/or State policy; and changes in coding intensity.

B. If Congress acts to delay or replace the Sustainable Growth Rate (SGR) formula used to adjust Medicare physician payment rates, CMS will adjust the Medicare baseline for beneficiaries who otherwise would have been enrolled in Original Fee-for-Service Medicare to reflect the revised current law physician payment rates. If Congress acts after the SGR cuts are scheduled to go in effect but applies changes retroactively, CMS will adjust the rates retroactively as well.

   If other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and the Commonwealth to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

C. Changes to the savings percentages would occur if and when CMS and the Commonwealth jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

Appendix 7: Demonstration Parameters

The purpose of this Appendix is to describe the parameters that will govern this Federal-State partnership; the parameters are based upon those articulated by CMS in its January 25, 2012 and March 29, 2012 Health Plan Management System (HPMS) guidance. CMS and the Commonwealth have further negotiated these parameters, as specified below.

The following sections explain details of the Demonstration design, implementation and evaluation. Where waivers from current Medicare and Medicaid requirements are required, such waivers are indicated. Further detail on each of these areas will be provided in the three-way contract.

I. Commonwealth of Massachusetts Delegation of Administrative Authority and Operational Roles and Responsibilities

The Massachusetts Executive Office of Health and Human Services (EOHHS) is the single state agency for the Medicaid program. The Health and Human Services Secretary directly oversees the multiple human services agencies and offices that will be involved with implementing and monitoring the Demonstration. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across EOHHS as described below.

Massachusetts' Medicaid Director reports directly to the Secretary and will oversee the Demonstration through his or her Deputy Medicaid Director for Policy and Programs, who will report directly to the Medicaid Director on all aspects of the Demonstration. MassHealth recently restructured its organization to consolidate oversight and management of key units under the Deputy Medicaid Director in order to fully support integration goals, and to align policy development with program implementation. This team will oversee the ICOs, with dedicated program management staff taking on daily management responsibilities.

II. Plan or Qualified Entity Selection

EOHHS, in consultation with CMS, has issued a Request for Responses (RFR) that includes the MassHealth and CMS requirements to become an Integrated Care Organization (ICO) under this Demonstration. MassHealth and CMS will engage in a joint selection process that will take into account previous performance in Medicare and Medicaid, and ensure that bidders have met CMS' requirements, as specified in

this MOU. EOHHS and CMS may limit the number of selected ICOs per service area to a certain number (no less than two provided there are at least two qualified bidders) from the qualifying bids, utilizing information from the RFR that will allow EOHHS to rank the bidders. This section is subject to update, and any updates will be reflected in the three-way contract.

III. State Level Enrollment Operations Requirements

a. Eligible Populations/Excluded Populations - As described in the body of the MOU.

b. Enrollment and Disenrollment Processes - All enrollments and disenrollment-related transactions will be processed through the MassHealth Customer Service Team (CST) vendor. MassHealth (or its vendor) will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third party CMS designates to receive such transactions.

c. Uniform Enrollment and Disenrollment Letter and Forms - Letters and forms will be appended to the three-way contract when they are completed and agreed to by both CMS and the Commonwealth.

d. Enrollment Effective Date(s) - All enrollment effective dates are prospective. Beneficiary-elected enrollment is the first day of the month following receipt of an eligible beneficiary's request to enroll, or the first day of the month following the month in which the beneficiary is eligible, as applicable for an individual Enrollee. Passive enrollment is effective not sooner than 60 days after beneficiary notification.

    i. ICOs will be required to accept enrollments no earlier than January 1, 2013 for an effective date of April 1, 2013 and begin providing coverage for enrolled individuals on April 1, 2013.

    ii. The Commonwealth will initially conduct two passive enrollment periods. The effective dates for the two periods are tentatively July 1, 2013 and October 1, 2013, subject to Participating Plans meeting CMS and Commonwealth requirements including Plans' capacity to accept new Enrollees. The Commonwealth will provide notice of passive enrollments at least 60 days prior to the effective dates to eligible individuals, and will accept opt-out requests prior to the effective date of enrollment.

Individuals who otherwise would be eligible for Medicare reassignment in 2013 or 2014 from their current (2012 or 2013, respectively) Medicare Prescriptions Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP, will be eligible for passive enrollment, with an opportunity to opt-out, into a Demonstration Plan effective January 1, 2014. The Commonwealth and CMS must agree in writing to any changes to the enrollment effective dates.

iii. Following this start-up period, members who are eligible for the Demonstration and who have neither selected a Plan nor opted out of the Demonstration will receive a notice of passive enrollment into an ICO and an enrollment package that describes their options, including that of opting out of the Demonstration. Members will then have 60 days to select a different ICO or opt out of the Demonstration. MassHealth will proceed with passive enrollment into the identified ICO for Members who do not make a different choice, with an effective date of the first day of the month following the end of the 60-day period.

iv. Requests to disenroll will be accepted at any point after enrollment occurs and are effective on the first of the following month.

e. No enrollments will be accepted within 6 months (or less) of the end of the Demonstration.

f. Notification of passive enrollment options will be provided by the Commonwealth to each beneficiary not less than 60 calendar days prior to the effective date of the proposed enrollment.

g. Passive enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto-assignment for individuals with the Part D Low Income Subsidy.

h. The Commonwealth will work to develop an "intelligent assignment" algorithm for passive enrollment (e.g. that prioritizes continuity of providers and/or services), with further details to be provided in the three-way contracts.

i. The Commonwealth will provide customer service, including mechanisms to counsel beneficiaries notified of passive enrollment and to receive and communicate beneficiary choice of opt out to CMS via transactions to CMS' MARx system. Beneficiaries will also be provided a notice upon the completion

of the opt-out process. Medicare resources, including 1800-Medicare, will remain a resource for Medicare beneficiaries.

j. The Commonwealth will provide notices, as approved by CMS, to ensure complete and accurate information is provided in concert with other Medicare communications, such as the Medicare & You handbook. CMS may also send a notice to individuals, and will coordinate such notice with any State notice(s).

k. Data in State and CMS systems will be reconciled on a timely basis to prevent discrepancies between such systems.

IV. State Level Delivery System Requirements

a. Provision of Integrated Care Services

i. State Requirements for Integrated Primary Care and Behavioral Health Care - With support from the ICOs, contracted primary care providers will offer integrated primary care and behavioral health services.

ii. State Requirements for Care Coordination - ICOs will offer care coordination services to all Enrollees:

1. through a Care Coordinator or Clinical Care Manager, for medical and behavioral health services; and

2. through an Independent Living and LTSS (IL-LTSS) Coordinator, contracted from a community-based organization, for LTSS. The IL-LTSS Coordinator would be a full member of the Interdisciplinary Care Team as appropriate, serving at the discretion of the Enrollee.

3. Information about the roles and qualifications of the Care Coordinator, Clinical Care Manager, and IL-LTSS Coordinator will be included in the three-way contract.

iii. State Requirements for an Interdisciplinary Care Team – ICOs will support an Interdisciplinary Care Team (ICT) for each member, which will ensure the integration of the member's medical, behavioral health, and LTSS care. The primary care provider and ICT will be person-centered: built on the Enrollee's specific preferences and needs, delivering

services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

1. All members of the ICT must agree to participate in approved training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the Commonwealth.

iv. State Requirements for member Assessment, Care Planning, Monitoring and Continuous Improvement.

1. Assessments and Individualized Care Plan - Each Enrollee shall receive, and be an active participant in, an initial assessment of medical, behavioral health and LTSS needs. This initial assessment, using the MDS-HC tool, must be done by an RN and entered into the Virtual Gateway portal in order to establish the appropriate rating category.

   In addition, upon enrollment and as appropriate thereafter, the ICO will perform in-person comprehensive assessments, which will be the starting point for creating an Individualized Care Plan. The comprehensive assessment may be done at the same time or a different time as the initial assessment, and must be conducted by care teams using a MassHealth/CMS approved assessment tool in a location that meets the needs of the Enrollee. Such comprehensive assessments will encompass social, functional, medical, behavioral, wellness and prevention domains, as well as the Enrollees' strengths and goals, need for any specialists and the Plan for care management and coordination.

   Each element of the comprehensive assessment, including a description of the LTSS and other covered services to be provided until the next Individualized Care Plan review, will be reflected in the Enrollee's Individualized Care Plan, and the ICO will ensure that all relevant aspects of the Enrollee's care are addressed in a fully integrated manner on an ongoing basis.

2. Clinical Care Management - The ICO will ensure the provision of Clinical Care Management and LTSS needs, directly or through the Primary Care Provider and IL-LTSS coordinator, as feasible, to

Enrollees identified as high risk. Specific Clinical Care Management services will include:

a. Assessment of the clinical risks and needs of each Enrollee;

b. Medication review and reconciliation;

c. Medication adjustment by protocol;

d. Enhanced self-management training and support for complex clinical conditions, including coaching to family members and other caregivers, as appropriate; and

e. Frequent Enrollee contact, as appropriate.

b. Network Adequacy – State Medicaid standards shall be utilized for long-term supports and services or for other services for which Medicaid is primary, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary. Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to State Medicaid standards, so long as the Commonwealth can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards; otherwise, Medicare standards or an alternative standard that meets or exceeds Medicare and Medicaid standards shall apply.

State MassHealth standards for Participating Plans require the following within a 15-mile radius or 30 minutes from the Enrollee's ZIP code of residence:

– At least two PCPs;

– At least two outpatient behavioral health providers;

– Two hospitals (when feasible);

– Two nursing facilities; and

– Two community LTSS Providers per covered service.

For any covered services for which Medicare requires a more rigorous network adequacy standard than described above (including time, distance, and/or

minimum number of providers or facilities), the ICO must meet the Medicare requirements.

Medicare network standards account for the type of service area (rural, urban, suburban, etc.), travel time, and minimum number of the type of providers, as well as distance in certain circumstances. The Commonwealth and CMS may grant exceptions to these general rules to account for patterns of care for Medicare-Medicaid beneficiaries, but will not do so in a manner that will dilute access to care for Medicare-Medicaid beneficiaries. Networks will be subject to confirmation through readiness reviews.

c. Solvency - ICOs will be required to meet solvency requirements:

    i. consistent with 42 CFR § 422.402, and

    ii. as specified in the Commonwealth procurement, including:

        1. Financial Viability

            a. Minimum Net Worth

            The ICO must demonstrate and maintain minimum net worth as specified below. For the purposes of the contract, minimum net worth is defined as assets minus liabilities.

            Throughout the term of the contract, the ICO must maintain a minimum net worth of $1,500,000, subject to the following conditions:

            – A minimum of $1,200,000 of this requirement must be in cash;

            – The ICO may include 100% of the book value (the depreciated value according to generally accepted accounting principles (GAAP)) of tangible health care delivery assets carried on its balance sheet; and

            – If at least $1,200,000 of the minimum net worth requirement is met by cash, then the GAAP value of intangible assets up to 20% of the minimum net worth required will be allowed.

b. Working Capital Requirements

The ICO must demonstrate and maintain working capital as specified below. For the purposes of the contract, working capital is defined as current assets minus current liabilities. Throughout the terms of the contract, the ICO must maintain a positive working capital, subject to the following conditions:

If an ICO's working capital falls below zero, the ICO must immediately notify EOHHS and submit a written plan within 30 days, certified by an independent auditor, to reestablish a positive working capital balance for approval by EOHHS.

EOHHS may take any action it deems appropriate, including termination of the contract, if the ICO:

Fails to report a negative working capital balance that is subsequently identified through an audit;

Does not propose a plan to reestablish a positive working-capital balance within a reasonable period of time as determined by EOHHS;

Violates a corrective plan approved by EOHHS; or

EOHHS determines that negative working capital cannot be corrected within a reasonable amount of time as determined by EOHHS.

2. Financial Stability

a. Financial Stability Plan

Throughout the term of the contract, the ICO must:

i. Remain financially stable;

ii. Maintain adequate protection against insolvency in an amount determined by EOHHS, as follows:

– Provide to Enrollees all covered services required by the contract for a period of at least

45 calendar days following the date of insolvency or until written approval to cease providing such services is received from EOHHS, whichever comes sooner;

- Continue to provide all such services to Enrollees who are receiving inpatient services at the date of insolvency until the date of their discharge or written approval to cease providing such services is received from EOHHS, whichever comes sooner; and

- Guarantee that Enrollees and EOHHS do not incur liability for payment of any expense that is the legal obligation of the ICO, any of its subcontractors, or other entities that have provided services to Enrollees at the direction of the ICO or its subcontractors;

iii. Immediately notify EOHHS when the ICO has reason to consider insolvency or otherwise has reason to believe it or any subcontractors is other than financially sound and stable, or when financial difficulties are significant enough for the chief executive officer or chief financial officer to notify the ICO's board of the potential for insolvency; and

iv. Maintain liability protection sufficient to protect itself against any losses arising from any claims against itself or any provider, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance.

b. Insolvency Reserve

The Insolvency Reserve shall be defined as the funding resources available to meet costs of providing services to Enrollees for a period of 45 days in the event that the ICO is determined insolvent. Funding the Insolvency Reserve shall be

the sole responsibility of the ICO, regardless of any risk sharing arrangements with EOHHS or CMS.

EOHHS shall calculate the amount of the Insolvency Reserve annually and provide this calculation to the ICO within 45 days of the start of the contract year.

The Insolvency Reserve calculation shall be an amount equal to 45 days of the ICO's estimated medical expenses, not to exceed 88% of the calculated value of 45 days of capitation payment revenue.

Within 30 calendar days of receipt of the Insolvency Reserve calculation, the ICO must submit to EOHHS written documentation of its ability to satisfy EOHHS' Insolvency Reserve Requirement. The documentation must be signed and certified by the ICO's chief financial officer.

Subject to EOHHS' approval, the ICO may satisfy the Insolvency Reserve Requirement through any combination of the following: restricted cash reserves; performance guarantee as specified in Section 5.8.C.3 of the RFR; insolvency insurance or reinsurance, performance bonds; irrevocable letter of credit; and other letters of credit or admitted assets as specified in Appendix F of the RFR.

c. Performance Guarantees and Additional Security

Throughout the term of the contract, the ICO must provide EOHHS with performance guarantees that are subject to prior review and approval from EOHHS. Performance guarantees must include:

i. A promissory note from the ICO's parent(s) or a performance bond from an independent agent in the amount of $1,500,000 to guarantee performance of the ICO's obligation to provide covered services in the event of the ICO's impending or actual insolvency; and

ii. A promissory note from the ICO's parent(s) or a performance bond from an independent agent in the amount of $600,000 to guarantee performance of the ICO's obligations to perform activities related to the administration of the contract in the event of the ICO's impending or actual insolvency.

d. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts-

i. The ICO provider network shall be comprised of a sufficient number of appropriately credentialed, licensed, or otherwise qualified providers to meet the requirements of the three-way contract, assure access to all covered services, and that all providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the covered services;

ii. The ICO shall implement written policies and procedures that comply with the requirements of 42 CFR 422.204 and 438.214 regarding the selection, credentialing, retention, and exclusion of providers and meet, at a minimum, the requirements below in addition to those described in the three-way contract. The ICO shall submit such policies and procedures annually to EOHHS, if amended, and shall demonstrate to EOHHS, by reporting annually, that all providers within the ICO's provider network are credentialed according to such policies and procedures. The ICO shall:

1. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers who participate in the ICO's provider network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards and relevant state regulations, including regulations issued by the Board of Registration in Medicine at 243 CMR 3.13;

2. Ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted with

recognized managed care industry standards and relevant state regulations;

3. Maintain a documented re-credentialing process which shall occur regularly, as specified in the three-way contract, and requires that physician providers and other licensed and certified professional providers, including behavioral health providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform with recognized managed care industry standards;

4. Upon notice from EOHHS or CMS, not authorize any providers barred from participation in MassHealth, Medicare or from another state's Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided. In addition:

    a. If a provider is terminated or suspended from MassHealth, Medicare, or another state's Medicaid program or is the subject of a state or Federal licensing action or for any other independent action, the ICO shall terminate, suspend, or decline a provider from its network as appropriate, and notify EOHHS of such action.

5. Not contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a provider that has been excluded from participation in Federal health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901;

6. Not establish provider selection policies and procedures that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

7. Ensure that no credentialed provider engages in any practice with respect to any Enrollee that constitutes unlawful

discrimination under any other state or Federal law or regulation, including, but not limited to, practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90, and M.G.L. Ch. 118E s. 40; and

8. Notify EOHHS and CMS when a provider fails credentialing or re-credentialing because of a program integrity reason, and shall provide related and relevant information to EOHHS and CMS as required by EOHHS, CMS or state or Federal laws, rules, or regulations.

iii. Board Certification Requirements

1. The ICO shall maintain a policy with respect to board certification for primary care providers and specialty physicians that ensures that the percentage of board certified primary care providers and specialty physicians participating in the provider network, at a minimum, is approximately equivalent to the community average for primary care providers and specialty physicians in the ICO's service area.

iv. Laboratory Credentialing

1. The ICO shall require all laboratories performing services under the three-way contract to comply with the Clinical Laboratory Improvement Amendments.

V. Benefits

a. Medical Necessity Determinations - Medically necessary services will be defined as services:

   i. (per Medicare) that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y.

   ii. (per MassHealth):

      1. that are provided in accordance with MassHealth regulations at 130 CMR 450.204;

      2. which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and

      3. for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

   ICOs will be required to provide services in a way that preserves all protections to the Enrollee and provides the Enrollee with coverage to at least the same extent provided by Medicare and MassHealth. Where there is overlap, coverage and rules will be delineated in the three-way contract.

b. Supplemental Benefits - Integrated benefit package must include Medicare and Medicaid-covered benefits as well as any required Demonstration-specific supplemental items and services, and expanded State Plan services.

   As a term and condition of this Demonstration, the Participating Plans are required to provide the services listed in Tables 7-A, 7-B, and 7-C below.

Table 7-A. Diversionary Behavioral Health Services Provided Through Managed Care Under the Demonstration[2]

Diversionary Behavioral Health Service	Setting	Definition of Service
Community Crisis Stabilization	24-hour facility	Services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.
Community Support Program (CSP)	Non-24-hour facility	An array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.
Partial Hospitalization	Non-24-hour facility	An alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.

[2] Coverage of these diversionary behavioral health services is required as a term and condition for participating in this demonstration. These are services that currently are covered under the existing MassHealth section 1115(a) demonstration (extension approved on December 20, 2011, through June 30, 2014) and any subsequent extension approvals.

Diversionary Behavioral Health Service	Setting	Definition of Service
Acute Treatment Services for Substance Abuse	24-hour facility	24-hour, seven days a week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.
Clinical Support Services for Substance Abuse	24-hour facility	24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.
Psychiatric Day Treatment	Non-24-hour facility	Services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.

Diversionary Behavioral Health Service	Setting	Definition of Service
Intensive Outpatient Program	Non-24-hour facility	A clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.
Structured Outpatient Addiction Program	Non-24-hour facility	Clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing (as defined by Substance Abuse and Mental Health Services Administration) into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring.
Program of Assertive Community Treatment	Non-24-hour facility	A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.
Emergency Services Program	Non-24-hour facility	Services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.

Table 7-B. Community Support Services Provided Through Managed Care Under the Demonstration

Community Support Service	Setting	Is this service currently available under the Medicaid State Plan?	Definition of Service (including description of how service differs from what is currently available under the State Plan)
Day Services	Site-based service	No – however, Day Habilitation services are available under the State Plan	Day services provide for structured day activity typically for individuals with pervasive and extensive support needs who are not ready to join the general workforce. Services are individually designed around consumer choice and preferences with a focus on improvement or maintenance of the person's skills and their ability to live as independently as possible in the community. Day Services often include assistance to learn activities of daily living and functional skills; language and communication training; compensatory, cognitive and other strategies; interpersonal skills; prevocational skills and recreational/socialization skills.

Community Support Service	Setting	Is this service currently available under the Medicaid State Plan?	Definition of Service (including description of how service differs from what is currently available under the State Plan)
Home Care Services	Enrollee's home or community	No	Home Care services include several types of home supports, including: • Providing a worker or support person to perform general household tasks such as preparing meals, doing laundry and routine housekeeping, and/or to provide companionship to the member; • Providing a range of personal support and assistance to enable an individual to accomplish tasks that they would normally do for themselves if they could, including such things as help with bathing, dressing, personal hygiene and other activities of daily living. This assistance may take the form of hands-on assistance or cueing and supervision to prompt the member to perform a task, and; • A variety of activities to help the member acquire, retain or improve his/her skills related to personal finance, health, shopping, use of community resources, community safety, and other social and adaptive skills to live in the community. This may include skills training and education in self-determination and self-advocacy to enable the member to acquire skills to exercise control and responsibility over the services and supports they receive, and to become more independent, integrated, and productive in their communities. All such services/supports would be appropriate when the individual needs them and/or when the person who is regularly responsible for the activities, such as a family caregiver, is absent or unable to manage the tasks.

Community Support Service	Setting	Is this service currently available under the Medicaid State Plan?	Definition of Service (including description of how service differs from what is currently available under the State Plan)
Respite Care	Enrollee's home or in locations such as hospitals, rest homes, nursing facilities, assisted living residences, adult day health, or adult foster care	No (unless member has elected Hospice benefit, then Hospice Respite may be available in a facility setting)	Respite includes services provided to a member to support his/her caregiver (family member, friend). Respite may be provided to relieve informal caregivers from the daily stresses and demands of caring for a member in order to strengthen or support the informal support system.
Peer Support/ Counseling/Navigation	Enrollee's home or community	No	Peer Support is designed to provide training, instruction and mentoring to individuals about self-advocacy, participant direction, civic participation, leadership, benefits, and participation in the community. Peer support may be provided in small groups or may involve one peer providing support to another peer to promote and support the individual's ability to participate in self-advocacy. The one-to-one peer support is instructional; it is not counseling. The service enhances the skills of the individual to function in the community and/or family home.

Community Support Service	Setting	Is this service currently available under the Medicaid State Plan?	Definition of Service (including description of how service differs from what is currently available under the State Plan)
Care Transitions Assistance (across settings)	Facility or community	No	Services that facilitate safe and coordinated transitions across care settings, which may be particularly appropriate for members who have experienced or are expecting an inpatient stay, such as: • Ensuring appropriate two-way exchange of information about the member, including: o Primary diagnoses and major health problems o Care plan that includes patient goals and preferences, diagnosis and treatment plan, and community care/service plan (if applicable) o Patient's goals of care, advance directives, and power of attorney o Emergency plan and contact number and person o Reconciled medication list o Identification of, and contact information for, transferring clinician/institution o Patient's cognitive and functional status o Test results/pending results and planned interventions o Follow-up appointment schedule with contact information o Formal and informal caregiver status and contact information o Designated community-based care provider, long-term services, and social supports as appropriate;

Community Support Service	Setting	Is this service currently available under the Medicaid State Plan?	Definition of Service (including description of how service differs from what is currently available under the State Plan)
			• Telephonic or other follow-up with members within 48 hours of an inpatient encounter; • Culturally and linguistically competent post-discharge education regarding symptoms that may indicate additional health problems or a deteriorating condition; • Patient-centered self-management support and relevant information specific to the beneficiary's condition and any ongoing risks; and • Referral to and care coordination with post-acute and outpatient providers as needed, including community-based support services providers.

Community Support Service	Setting	Is this service currently available under the Medicaid State Plan?	Definition of Service (including description of how service differs from what is currently available under the State Plan)
Home Modifications	Enrollee's home	No, although some equipment, such as grab bars, raised toilet seat, may be purchased as DME, installation of such equipment is not covered under the State Plan	Home modifications are physical adaptations to a member's private residence that are necessary to ensure the health, welfare and safety of an individual or that enable the individual to function with greater independence in the home. Such modifications include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies required for the member. Excluded are those modifications or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, or which would normally be considered the responsibility of the landlord. Home modifications that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Community Support Service	Setting	Is this service currently available under the Medicaid State Plan?	Definition of Service (including description of how service differs from what is currently available under the State Plan)
Community Health Workers	Enrollee's home or community	No	• Public health workers who apply their unique understanding of the experience, language, and/or culture of the populations they serve in order to carry out one or more of the following roles: o Providing culturally appropriate health education, information, and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses, and community centers o Bridging/culturally mediating between individuals, communities, and health and human services, including actively building individual and community capacity o Assuring that people access the services they need o Providing direct services, such as informal counseling, social support, care coordination, and health screenings o Advocating for individual and community needs. CHWs are distinguished from other health professionals because they are hired primarily for their understanding of the populations and communities they serve; conduct outreach a significant portion of the time in one or more of the categories above; and have experience providing services in community settings.

Community Support Service	Setting	Is this service currently available under the Medicaid State Plan?	Definition of Service (including description of how service differs from what is currently available under the State Plan)
Medication Management	Enrollee's home	No	Medication management is the provision of support to a member capable of self-administration of prescription and over-the-counter medications, including the following activities provided by a support worker: reminding the member to take the medication; checking the package to ensure that the name on the package is that of the member; observing the member taking the medication; and documenting in writing the observation of the member's actions regarding the medication (e.g., whether the participant took or refused the medication, the date and time). If requested by the member, the support worker may open prepackaged medication or open containers, read the name of the medication and the directions on the label to the member, and respond to any questions the member may have regarding those directions.
Non-medical Transportation	Community	No	Non-medical transportation is provided to enable the member to access community services, activities and resources in order to foster the member's independence and support integration and full participation in his/her community. Non-emergency medical transportation (NEMT) provides transportation to medically-related services.

Table 7-C. Expanded State Plan Services Provided Through Managed Care Under the Demonstration

Expanded State Plan Service	Current State Plan Amount Duration and Scope	Demonstration Definition of Service & Description of How Amount, Duration, and Scope Differs From the State Plan
Preventive, Restorative, and Emergency Oral Health (Dental) Benefits	Preventive and emergency oral health benefits	Preventive, restorative, and emergency oral health benefits
Personal Care Assistance including cueing and monitoring (includes support for self-direction)	Member must have need for hands on assistance with two (2) or more ADLs	Member needs assistance with 2 or more ADLs, however, assistance may be hands on, or cueing and supervision of the member.

Expanded State Plan Service	Current State Plan Amount Duration and Scope	Demonstration Definition of Service & Description of How Amount, Duration, and Scope Differs From the State Plan
Durable Medical Equipment, including training in equipment, equipment repairs, modifications, and environmental aids and assistive/adaptive technology	Durable medical equipment that is fabricated primarily and customarily to fulfill a medical purpose; generally not useful in the absence of illness or injury; can withstand repeated use over an extended period; and appropriate for use in the member's home. Covered DME includes but is not limited to: absorbent products; ambulatory equipment, such as crutches and canes; compression devices; speech augmentative devices; enteral and parenteral nutrition; nutritional supplements; home infusion equipment and supplies; glucose monitors and diabetic supplies; mobility equipment and seating system; personal emergency response system; ostomy supplies; support surfaces; hospital bed and accessories; patient lifts; and bath and toilet equipment and supplies (commodes, grab bars, tub benches, etc.).	Timely and appropriate access to this benefit is often problematic for Medicare-Medicaid Enrollees, since conflicting Medicare and Medicaid rules create extensive delays in provision of needed services and equipment. An integrated benefit will allow, as demonstrated with SCO and PACE Enrollees, much simpler processes and prompt access and response to members for the purchase, training, maintenance and repair of DME. In FFS Medicaid, the State Plan requires Medicare-Medicaid Enrollees to first access their Medicare benefits before Medicaid will wrap.

c. Flexible Benefits – ICOs will have discretion to use the capitated payment to offer flexible benefits, as specified in the member's Individualized Care Plan, as appropriate to address the member's needs.

d. Excluded Services – Targeted case management services (TCM) provided by the Massachusetts Department of Mental Health (DMH) and the Massachusetts Department of Developmental Services (DDS), and rehabilitation option services purchased by DMH will continue to be purchased and provided by DMH and DDS, and will not be part of the ICO service package or included in the capitated payments to ICOs. Beneficiaries receiving these services who meet the eligibility requirements for this Demonstration will be eligible to participate in the Demonstration. ICOs and providers of TCM and rehabilitation option services will be required to coordinate these services with the rest of the Enrollee's care, and requirements for communication protocols will be included in the three-way contract.

e. Hospice Services – As in Medicare Advantage, Medicare hospice services will be provided through Original (i.e. Fee-For-Service) Medicare. Medicare hospice services will not be part of the ICO service package or included in Medicare capitated payments to ICOs. ICOs and providers of hospice services will be required to coordinate these services with the rest of the Enrollee's care, with requirements to be included in the three-way contract.

f. Continuity of Care

    i. The ICO must perform an initial assessment within 90 days of an individual's enrollment in the ICO.

    ii. ICOs must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for:

        i. a period of up to 90 days, unless the assessment is done sooner and the Enrollee agrees to the shorter time period; or

        ii. until the ICO completes an initial assessment of service needs, whichever is longer.

    iii. During the time period set forth in Appendix 7, **Section V.d.ii.**, the ICO will maintain the Enrollee's current providers at their current provider rates and honor prior authorizations issued by MassHealth, its contracted managed care entities, and Medicare.

iv. If, as a result of the initial assessment, the ICO proposes modifications to the Enrollee's prior authorized services, the ICO must provide written notification about and an opportunity to appeal the proposed modifications no less than 10 days prior to implementation of the Enrollee's ICP. The Enrollee shall be entitled to all appeal rights, including aid pending appeal, if applicable.

g. Out of Network Reimbursement Rules

i. In an urgent or emergency situation, ICOs must reimburse an out-of-network provider at the Medicare or Medicaid FFS rate applicable for that service. Where this service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. ICOs are also required to perform an initial assessment to determine the Enrollee's needs within the first 90 days of enrollment as described in Section III.E.2. Until that assessment has been completed, the ICO must continue to provide access to the same services and providers at the same levels and rates of payment as individuals were receiving prior to entering the ICO.

ii. Beyond this 90-day period, under certain defined circumstances, Participating Plans will be required to offer single-case out-of-network agreements to providers who are currently serving Enrollees and are willing to continue serving them at the Plan's in-network payment rate, but who are not willing to accept new patients or enroll in the Plan's network.

VI. Model of Care - All ICOs (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC) having explicit components consistent with the Special Needs Plan Model of Care. CMS' Demonstration Plan MOC approval process will be based on scoring each of the eleven clinical and non-clinical elements of the MOC. The scoring methodology is divided into three parts: (1) a standard; (2) elements; and (3) factors. These components of the MOC approval methodology are defined below:

(1) Standard: The standard is defined as a MOC that has achieved a score of 70 percent or greater based on the scoring methodology described in Appendix 2.

(2) Elements: The MOC has 11 clinical and non-clinical elements, as identified below, and each element will have a score that will be totaled and used to determine the final overall score. The 11 MOC elements are listed below:

- Description of the Plan-specific Target Population;
- Measurable Goals;
- Staff Structure and Care Management Goals;
- Interdisciplinary Care Team;
- Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
- MOC Training for Personnel and Provider Network;
- Health Risk Assessment;
- Individualized Care Plan;
- Integrated Communication Network;
- Care Management for the Most Vulnerable Subpopulations; and
- Performance and Health Outcomes Measurement.

(3) Factors: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the Demonstration Plan application. The factors for each element will be scored using a system from 0 to 4, where 4 is the highest score for a factor. Interested organizations are required to provide a response that addresses every factor within each of the 11 elements. The scores for each factor within a specific element are totaled to provide the overall score for that element out of a total of 160 possible points. Interested organizations must achieve a minimum score of 70 percent to meet the CMS approval standard.

It is our intent for MOC reviews and approvals to be a multi-year process that will allow Demonstration Plans to be granted up to a three-year approval of their MOC based on higher MOC scores above the passing standard. The specific time periods for approvals are as follows:

- Plans that receive a score of eighty-five (85) percent or higher will be granted an approval of the CMS MOC requirement for three (3) years.

- Plans that receive a score in the seventy-five (75) percent to eighty-four (84) percent range will be granted an approval of the CMS MOC requirement for two (2) years.

- Plans that receive a score in the seventy (70) percent to seventy-four (74) percent range will be granted an approval of the CMS MOC requirement for one (1) year.

Participating Plans will be permitted to cure problems with their MOC submissions after their initial submissions. Participating Plans with MOCs scoring below 85 percent will have the opportunity to improve their scores based on CMS and Commonwealth feedback on the elements and factors that need additional work. At the end of the review process, MOCs that do not meet CMS' standards for approval will not be eligible for selection as Demonstration Plans.

VII. Prescription Drugs - Integrated formulary must include any Medicaid-covered drugs that are excluded by Medicare Part D. Plans must also cover drugs covered by Medicare Parts A or B. In all respects, unless stated otherwise in this MOU or the three-way contract, Part D requirements will continue to apply.

VIII. Grievances - Enrollees shall be entitled to file internal grievances directly with the ICO. Each ICO must track and resolve its grievances, or if appropriate, re-route grievances to the coverage decision or appeals processes.

IX. Appeals - Other than Medicare Part D appeals, which shall remain unchanged, the following is the baseline for a unified Medicare-Medicaid appeals process:

a. Integrated/Unified Appeals Process:

i. Appeal time frames - Individuals, their authorized representatives and providers will have 60 days to file an appeal related to coverage. This matches the current 60-day time-frame for requesting an appeal related to benefits under Medicare, and exceeds the current 30-day time-frame for requesting appeal related to benefits under Medicaid.

ii. Appeal levels - Initial appeals will be filed with the ICO.

1. Subsequent appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE). Consistent with existing rules, Part D cases will be automatically forwarded to the IRE if the Plan misses the applicable adjudication timeframe.

2. Medicaid-only benefits may be appealed to the MassHealth Board of Hearings.

3. Services for which Medicare and Medicaid overlap (including Home Heath, Durable Medical Equipment and skilled therapies, but excluding Part D) will be defined in a unified way in the three-way contract and as required Plan benefits. Appeals related to these benefits will be auto-forwarded to the IRE, and may also be filed with the Board of Hearings.

iii. Appeal resolution time frames - All Plan appeals must be resolved (at each level) within 30 days of their submission for standard appeals and within 72 hours of their submission for expedited appeals. This excludes Part D appeals, which will be resolved in accordance with existing rules.

iv. Continuation of Benefits Pending an Appeal -

1. ICOs must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending internal ICO appeals. This means that such benefits will continue to be provided by providers to beneficiaries, and that ICOs must continue to pay providers for providing such services pending an internal ICO appeal. This right to aid pending an appeal currently exists in Medicaid, but is generally not available in Medicare.

2. For all appeals filed with the Board of Hearings, Enrollees may request continuation of benefits previously authorized. MassHealth will make a determination on these requests in accordance with the Commonwealth's existing appeals policy. Part D appeals may not be filed with the Board of Hearings.

v. Integrated Notice - ICO Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid appeal rights through a single notice.

vi. In the case of a decision where both BOH and the IRE issue a ruling, the ICO shall be bound by the ruling that is most favorable to the Enrollee.

X. Participating Plan Marketing, Outreach, and Education Activity

a. Marketing and Enrollee Communication Standards for Participating Plans – Participating Plans will be subject to rules governing their marketing and Enrollee communications as specified under section 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual).

b. Review and Approval of Marketing and Enrollee Communications – Participating Plans must receive prior approval of all marketing and Enrollee communications materials in categories of materials that CMS and the Commonwealth require to be prospectively reviewed. Participating Plan materials may be designated as eligible for the File & Use process, as described in 42 CFR §422.2262(b) and §423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and the Commonwealth. CMS and the Commonwealth may agree to defer to one or the other party for review of certain types of marketing and Enrollee communications, as agreed in advance by both parties. Participating Plans must submit all marketing and Enrollee communication materials, whether prospectively reviewed or not, via the CMS Health Plan Management System Marketing Module.

c. Permissible Start Date for Participating Plan Marketing Activity – Participating Plans may begin marketing activity no earlier than 90 days prior to the effective date of enrollment for the contract year.

d. Minimum Required Marketing and Enrollee Communications Materials – At a minimum, Participating Plans will provide current and prospective Enrollees the following materials. These materials will be subject to the same rules regarding content and timing of beneficiary receipt as applicable under Section 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual).

    i. An Evidence of Coverage (EOC) document that includes information about all State-covered and Plan-covered supplemental benefits, in addition to the required Medicare benefits information.

ii. An Annual Notice of Change (ANOC) summarizing all major changes to the Plan's covered benefits from one contract year to the next, starting in the second calendar year of the Demonstration.

iii. A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the Plan, as well as the benefits offered under the plan, including premiums, cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. Participating Plans will use a Demonstration-specific SB.

iv. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and supplemental benefits.

v. A comprehensive integrated formulary that includes outpatient prescription drugs covered under Medicare, Medicaid, or as Plan-covered supplemental benefits.

vi. A single identification (ID) card for accessing all covered services under the Plan.

vii. All Part D required notices, with the exception of the LIS Rider, the creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the late enrollment penalty notice requirements required under Chapter 13 of the Prescription Drug Benefit Manual.

e. Notification of Formulary Changes – The requirement at 42 CFR §423.120(b)(5) that Participating Plans provide at least 60 days advance notice regarding Part D formulary changes also applies to Participating Plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as supplemental benefits.

XI. Administration and Oversight

- **Oversight Framework**

  Under the Demonstration, there will be a CMS-State Contract Management Team that will ensure access, quality, program integrity, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and the Commonwealth will require Participating Plans to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. Participating Plans must have policies and procedures in place to identify and address fraud, waste, and abuse at both the Plan and the third-party levels in the delivery of Plan benefits, including prescription drugs, medical care, and long term services and supports. In addition, all Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to Demonstration Plans by CMS in the same way they are currently applied for PDP sponsors and Medicare Advantage organizations.

  These responsibilities are not meant to detract from or weaken any current State or CMS oversight responsibilities, including oversight by the Medicare Drug Benefit Group and other relevant CMS groups and divisions, as those responsibilities continue to apply, but rather to assure that such responsibilities are undertaken in a coordinated manner. Neither party shall take a unilateral enforcement action relating to day-to-day oversight without notifying the other party in advance.

- <u>The Contract Management Team</u>

  A. Structure- The Contract Management Team will include representatives from CMS and the Commonwealth Medicaid agency, authorized and empowered to represent CMS and the Medicaid Agency about all aspects of the three-way contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office Lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The precise makeup of each team will vary by state, and will include individuals who are knowledgeable about the full range of services and supports utilized by the target population, particularly long-term supports and services.

B. Reporting - Data reporting to CMS and the Commonwealth will be coordinated and unified to the extent possible. Specific reporting requirements and processes will be detailed in the three-way contract.

1. Quality (including HEDIS); core measures will be articulated in the MOU
2. Rebalancing from Institutional to HCBS Settings
3. Utilization
4. Encounter Reporting
5. Enrollee Satisfaction (including CAHPS)
6. Complaints and Appeals
7. Enrollment/Disenrollment Rates
8. Part C and Part D Reporting Requirements, as negotiated and applicable

- Day-to-Day Oversight and Coordination – The Contract Management Team will be responsible for day-to-day monitoring of each contractor. These responsibilities include, but are not limited to:

a. Monitoring compliance with the terms of the three-way contract, including issuance of joint notices of non-compliance/enforcement;

b. Coordination of periodic audits and surveys of the contractor;

c. Receipt and response to complaints;

d. Regular meetings with each contractor;

e. Coordination of requests for assistance from contractors, and assignment of appropriate Commonwealth and CMS staff to provide technical assistance;

f. Coordinate review of marketing materials and procedures; and

g. Coordinate review of grievance and appeals data, procedures, and materials.

- Centralized Program-Wide Monitoring, Surveillance, Compliance, and Enforcement – CMS' central office conducts a wide array of data analyses, monitoring studies, and audits. Demonstration contracts will be included in these activities, just as all Medicare Advantage and Part D organizations will be included. Demonstration contracts will be treated in the same manner, which includes analysis of their performance based on CMS internal data, active collection of additional information, and CMS issuance of compliance notices, where applicable. The Commonwealth and Contract Management Team will be informed about these activities and copied on notices, but will not take an active part in these ongoing projects or activities.
    - Emergency/Urgent Situations - Both CMS and the Commonwealth shall retain discretion to take immediate action where the health, safety or welfare of any Enrollee is imperiled or where significant financial risk is indicated. In such situations, CMS and the Commonwealth shall notify a member of the Contract Management Team no more than 24 hours from the date of such action, and the Contract Management Team will undertake subsequent action and coordination.

- ICO Call Center Requirement - In addition to current requirements for Medicare Advantage Plans, the following will be required call center elements:
    a. Participating Plans shall operate a toll-free Enrollee services telephone line a minimum of twelve hours per day, seven days per week.

    b. Operators must be available in sufficient numbers to support Enrollees.

    c. Oral interpretation services must be available free-of-charge to Enrollees in all non-English languages spoken by Enrollees.

    d. TTY services or comparable services must be available for the Deaf or hard of hearing.

e. Plans must ensure that customer service department representatives shall, upon request, make available to Enrollees and potential Enrollees information including, but not limited to, the following:

- The identity, locations, qualifications, and availability of providers;
- Enrollees' rights and responsibilities;
- The procedures available to an Enrollee and provider(s) to challenge or appeal the failure of the contractor to provide a covered service and to appeal any adverse actions (denials);
- How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;
- Information on all Participating Plan covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and
- The procedures for an Enrollee to change Plans or to opt out of the Demonstration.

- **Data System Specifications, Reporting Requirements, and Interoperability**

A. Data system description and architecture and performance requirements

B. Current information system upgrades and development plans and resource commitments necessary for implementation

C. Consolidated reporting requirements

D. Encounter reporting

E. Reporting data for evaluation and program integrity

F. Data Exchange among CMS, Commonwealth of Massachusetts Providers and Contractors, and Health Insurance Exchanges (2014)

- **Unified Quality Metrics and Reporting**

  Participating Plans and other qualified entities will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, patient/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report HEDIS, HOS and CAHPS data, as well as measures related to long term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS plus any additional Medicaid measures identified by the Commonwealth. All existing Part D metrics will be collected as well. CMS and the Commonwealth will utilize a subset of these reported quality metrics for the purpose of assessing Plan performance and outcomes and to allow quality to be evaluated and compared with other Plans in the model. The Commonwealth will supplement quality reporting requirements with additional State-specific measures. A preliminary combined set of core metrics is described below in Figure 7-1 and will be further specified in the three-way contract. A subset of these will also be used for calculating the quality withhold payment as addressed in section VI of Appendix 6 in this MOU.

  Participating Plans must submit data consistent with requirements established by CMS and/or the Commonwealth as further described below and in the three-way contract. Participating Plans will also be subject to monitoring efforts consistent with the requirements of Medicare Advantage and Part D as described in section XII of this Appendix.

Figure 7-1: Core Quality Measures under the Demonstration

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Antidepressant Medication Management	Percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X	X
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS	X	X
Follow-up After Hospitalization for Mental Illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	X
Screening for Clinical Depression and Follow-up Care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
SNP1: Complex Case Management	The organization coordinates services for members with complex conditions and helps them access needed resources. Element A: Identifying Members for Case Management Element B: Access to Case Management Element C: Case Management Systems Element D: Frequency of Member Identification Element E: Providing Members with Information Element F: Case Management Assessment Process Element G: Individualized Care Plan Element H: Informing and Educating Practitioners Element I: Satisfaction with Case Management Element J: Analyzing Effectiveness/Identifying Opportunities Element K: Implementing Interventions and Follow-up Evaluation	NCQA/ HEDIS	X	
SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members. Element A: Coordination of Benefits for Dual Eligible Members Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) Element D: Service Coordination Element E: Network Adequacy Assessment	NCQA/ HEDIS	X	
Care Transition Record Transmitted to Health Care Professional	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	X	
Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions Element B: Supporting Members through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E; Analyzing Transitions Element F: Reducing Transitions	NCQA/HEDIS	X	
CAHPS, various settings including: -Health Plan plus supplemental items/questions, including: -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home	Depends on Survey.	AHRQ/CAHPS	X	
Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the drug plan's pharmacy help desk.	CMS Call Center data	X	
Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number.	CMS Call Center data	X	
Part D Appeals Auto–Forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.	IRE	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Part D Appeals Upheld	How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100.	IRE	X	
Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 days.	Medicare Advantage Prescription Drug System (MARx)	X	
Part D Complaints about the Drug Plan	How many complaints Medicare received about the drug plan. For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data	X	
Part D Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Administrative data	X	
Part D Members Choosing to Leave the Plan	The percent of drug plan members who chose to leave the plan in 2013.	CMS Medicare Beneficiary Database Suite of Systems	X	
Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan	X	
Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Part D Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X	
Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
Plan Makes Timely Decisions about Appeals	Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage.	IRE	X	
Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	IRE	X	
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.	CMS Call Center data	X	
Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X	
Tracking of Demographic Information	Percent of all Demonstration participants for whom specific demographic data is collected and maintained in the ICO Centralized Enrollee Record, including race, ethnicity, disability type, primary language, and homelessness, in compliance with contract requirements.	CMS/State defined process measure		X
Documentation of Care Goals	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure		X
Access to IL-LTSS Coordinator	Percent of Enrollees with LTSS needs who have an IL-LTSS Coordinator.	CMS/State defined process measure		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Consumer Governance Board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements.	CMS/State defined process measure	X	X
Ensuring Physical Access to Buildings, Services and Equipment	ICO has established a work plan and identified individual in its organization who is responsible for ADA compliance related to this Demonstration.	CMS/State defined process measure		X
Access to Care	Percent of respondents who always or usually were able to access care quickly when they needed it.	AHRQ/CAHPS		X
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	X
Assessments	Percent of members with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X	
Individualized Care Plans	Percent of members with care plans by specified timeframe.	CMS/State defined process measure	X	
Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure	X	
Risk Stratification Based on LTSS or Other Factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/State defined process measure	X	
Discharge Follow-up	Percent of members with specified timeframe between discharge to first follow-up visit.	CMS/State defined process measure	X	
Self-direction	Percent of care coordinators that have undergone State-based training for supporting self-direction under the Demonstration.	CMS/State defined process measure	X	
Care for Older Adults – Medication Review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/ HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Care for Older Adults – Functional Status Assessment	Percent of plan members whose doctor has done a—functional status assessment to see how well they are doing —activities of daily living (such as dressing, eating, and bathing).	NCQA/HEDIS	X	
Care for Older Adults – Pain Screening	Percent of plan members who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS	X	
Diabetes Care – Eye Exam	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS	X	
Diabetes Care – Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS	X	
Diabetes Care – Blood Sugar Controlled	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS	X	
Rheumatoid Arthritis Management	Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS	X	
Reducing the Risk of Falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Plan All-Cause Readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Controlling Blood Pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	
Comprehensive medication review	Percentage of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA)	X	
Complaints about the Health Plan	How many complaints Medicare received about the health plan. Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Beneficiary database	X	
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2013.	CMS	X	
Getting Information From Drug Plan	The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost. -In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? -In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? -In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? -In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?	AHRQ/CAHPS	X	
Rating of Drug Plan	The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs. -Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	AHRQ/CAHPS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Getting Needed Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan. -In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? -In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	AHRQ/CAHPS	X	
Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists. • In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care. • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	AHRQ/CAHPS	X	
Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	AHRQ/CAHPS	X	
Overall Rating of Plan	Percent of best possible score the plan earned from plan members who rated the overall plan. • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	AHRQ/CAHPS	X	
Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X	X
Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for —bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Diabetes Care – Cholesterol Screening	Percent of plan members with diabetes who have had a test for —bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	X	
Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	CMS HOS	X	
Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS	X	
Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS	X	
Documented Discussion of Member Rights and Member Choices for Providers	Percent of members with documented discussion of their rights and choices for providers.	MassHealth		X
Screening for Preferred Language	Percent of members who are screened for their preferred language.	MassHealth		X
Wait Time for Interpreter	Percent of members who need an interpreter and always wait fewer than 15 minutes for the interpreter.	MassHealth		X
Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X	X
Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS	X	X
Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS	X	X
Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X	X
Frequency of Ongoing Prenatal Care	Proportion of pregnant women with expected number of prenatal visits.	NCQA/HEDIS		X
Documented Discussion of Care Goals	Percent of members with documented discussion of care goals.	MassHealth		X
Enrollees with LTSS Needs who have an IL-LTSS Coordinator	Percent of members with LTSS needs that have an IL-LTSS Coordinator on their interdisciplinary care team.	MassHealth		X
3-Item Care Transition Measure (CTM-3)	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.	University of Colorado		X
Chronic Obstructive Pulmonary Disease (PQI 5)	Assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	AHRQ		X
Congestive Heart Failure Admission Rate (PQI 8)	Percent of county population with an admission for CHF.	AHRQ		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Transition Record with Specified Elements Received by Discharged Patients	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other sites of care, or their caregiver(s), who received a transition record at the time of discharge including, at a minimum, all of the specified elements.	AMA-PCPI		X
Timely Transmission of Transition Record	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or to the health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI		X
Health Status/Function Status	Percent of members who report their health as excellent.	AHRQ/CAHPS	X	X
Annual Monitoring for Patients on Persistent Medications	Percent of members 18 years and older who received at least 180-day supply of medication therapy for the selected therapeutic agent and who received annual monitoring for the therapeutic agent.	NCQA/HEDIS		X
Use of Appropriate Medications for People with Asthma	Percent of members who were identified as having persistent asthma during the measurement year and the year prior to the measurement year and who were dispensed a prescription for either an inhaled corticosteroid or acceptable alternative medication during the year.	NCQA/HEDIS		X
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Percentage of adults 18-64 with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	NCQA/HEDIS		X
Ischemic vascular disease (IVD): blood pressure	The percentage of patients 18 years of age and older who were discharged alive with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) during the measurement year or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had BP reported as under control <140/90.	NCQA/HEDIS		X
Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	Percentage of members 18 and older with a diagnosis of heart failure with a current or prior LVEF < 40, who were prescribed ACE inihibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge.	AMA-PCPI		X
Evaluation of Left Ventricular Systolic Function	Percent of heart failure patients with documentation in the hospital record that left ventricular systolic function was evaluated before arrival, during hospitalization or is planned for after discharge.	CMS		X
Pain Assessment Conducted	Percent of home health episodes where the member had any pain at start of episode and was assessed using a standardized pain assessment tool.	University of Colorado		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Comprehensive Diabetes Care	Percent of individuals 18-75 with diabetes (type 1 and type 2) who had each of the following: - HbA1c poor control (>9.0%) -HbA1c control (<8.0%) - HbA1c control (<7.0%) * -Eye exam (retinal) performed - LDL-C screening -LDL-C control (<100 mg/dL) - Medical attention for nephropathy -BP control (<140/90 mm Hg) -Smoking status and cessation advice or treatment	NCQA/HEDIS		X
Ability to use Health Information Technology to Perform Care Management at Point of Care	Documents the extent to which a provider uses an electronic medical record.	CMS		X
Mental Health Utilization	Number and percentage of members receiving mental health services during the measurement year.	NCQA/HEDIS		X
Multiple Psychotropic Medications	Percent of members with intellectual disability who are taking multiple antipsychotic medications.	MassHealth		X
Unhealthy Alcohol Use: Screening and Brief Counseling	Screening and brief counseling for substance use.	AMA-PCI		X
HCAHPS	27 item survey instrument with 7 domain-level composites including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information.	AHRQ/CAHPS		X
Screening for Dementia	Percent of members with intellectual disability who are screened for dementia using a standardized instrument.	MassHealth		X
Tobacco Use Assessment and Tobacco Cessation Intervention	Percent of patients who were queried about tobacco use one or more times during the two-year measurement period (received cessation intervention during measurement period).	AMA-PCPI		X
Cervical Cancer Screening	Percent of women 21-64 who receive one or more Pap tests to screen for cervical cancer.	NCQA/HEDIS		X
Adult Weight Screening and Follow-up	Percentage of patients ages 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented.	NCQA/HEDIS		X
Prenatal and Postpartum Care	Percent of deliveries of live births between November 6 of the year prior to the measurement period and November 5 of the measurement year. For these women, the measure assesses facets of prenatal and postpartum care.	NCQA/HEDIS		X

CMS will work closely with the Commonwealth to monitor other measures related to community integration. CMS and the Commonwealth will continue to work jointly to refine and update these quality measures in years two and three of the Demonstration.

XII. Evaluation

CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the State Demonstrations to Integrate Care for Dual Eligibles and the Financial Alignment Demonstrations, including the Massachusetts capitated Demonstration, on cost, quality, utilization, and beneficiary experience of care. The evaluator will also explore how the Massachusetts initiative operates, how it transforms and evolves over time, and beneficiaries' perspectives and experiences. The key issues targeted by the evaluation will include (but are not limited to):

- Beneficiary health status and outcomes;
- Quality of care provided across care settings;
- Beneficiary access to and utilization of care across care settings;
- Beneficiary satisfaction and experience;
- Administrative and systems changes and efficiencies; and
- Overall costs or savings for Medicare and Medicaid.

The evaluator will design a State-specific evaluation plan for the Massachusetts Demonstration, and will also conduct a meta-analysis that will look at the State Demonstrations overall. A mixed methods approach will be used to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative analyses will consist of tracking changes in selected utilization, cost, and quality measures over the course of the Demonstration; evaluating the impact of the Demonstration on cost, quality, and utilization measures; and calculating savings attributable to the Demonstration. The evaluator will use a

comparison group for the impact analysis. The comparison group methodology will be detailed in the State-specific evaluation plan. Quarterly reports will provide rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit Massachusetts-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

Massachusetts is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. Massachusetts and Participating Plans must submit all required data for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements to be listed in the three-way contract. Massachusetts will also develop the capability to track beneficiaries eligible for the Demonstration, including which beneficiaries choose to enroll, disenroll, or opt out of the Demonstration, enabling the evaluation to identify differences in outcomes for these groups.