

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of Washington

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

**HealthPathWashington:
Medicare-Medicaid Integration Demonstration**

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I. Statement of Initiative

The Centers for Medicare & Medicaid Services (CMS) and the State of Washington (the Washington State Health Care Authority/Washington State Department of Social and Health Services) will establish a Federal-State partnership to implement HealthPathWashington: A Medicare-Medicaid Integration Demonstration to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees” or “beneficiaries”). The Federal-State partnership will include a Three-Way Contract with Medicare-Medicaid Integration Plans (MMIPs) that will provide integrated medical services, behavioral health services, and long-term services and supports to Medicare-Medicaid Enrollees in two geographic areas. The Demonstration will begin no earlier than July 1, 2014, and continue until December 31, 2017, unless terminated pursuant to Section III.L or continued pursuant to Section III.K of this Memorandum of Understanding (MOU). The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care, and reduce costs for both the State and the Federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

This Demonstration will operate in two counties in the State – King County and Snohomish County. The population that will be eligible to participate in the Demonstration are those beneficiaries aged 21 and older who are entitled to benefits under Medicare Part A, and enrolled under Medicare Parts B and D, receive full Medicaid benefits, and meet the requirements discussed in more detail in Section C.1.1 below. This Capitated Demonstration will complement the State’s Managed Fee-for-Service Demonstration (which will be active in all counties of the State except King County and Snohomish County).

Opportunities for better beneficiary outcomes, system efficiencies, and cost containment lie in the purchase of increasingly coordinated medical, mental health, chemical dependency, and long-term services and supports (LTSS). Fully financially integrated service delivery through health plans has the potential to yield long-term benefits through a single point of accountability over all services, greater flexibility to deliver person-centered services and supports, and aligned financial incentives. Under this initiative, MMIPs will be required to provide for, either directly

or through subcontracts, Medicare and Medicaid covered services under a capitated model of financing. CMS, the State, and the MMIPs will ensure that beneficiaries have access to an adequate network of providers and supportive services.

CMS and the State shall jointly select and monitor the MMIPs. CMS will implement this initiative under demonstration authority for Medicare and demonstration, State Plan, or waiver authority for Medicaid as described in Section III.A and detailed in Appendices 4 and 5.

Key objectives of this Demonstration are to evaluate an innovative payment and service delivery model that can improve the beneficiary experience in accessing care, promote person-centered care planning, promote independence in the community, assist beneficiaries in getting the right care at the right time and place, and, achieve cost savings for the State and Federal government through improvements gained in an integrated delivery system. CMS and the State expect this model of integrated care and financing to 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 Demonstration. The State and CMS expect the MMIPs to apply person-centered care, independent living and recovery philosophies, wellness principles, and cultural competence to contribute in achieving these goals.

The Demonstration will evaluate 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, benefits (including pharmacy), financial solvency, and oversight standards. Contract management will focus on performance measurement and continuous quality improvement. Except as otherwise specified in this MOU and/or applicable Medicaid waiver standards and conditions, MMIPs 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 MMIPs, the State, and CMS.

As part of this Demonstration, CMS and the State will implement a new Medicare and Medicaid payment methodology designed to support MMIPs 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 State 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 that are included in this MOU and the Three-Way Contract. MMIPs will have full accountability for managing the capitated payment to best meet the needs of Enrollees according to Individualized Care Plans (ICP) and Health Action Plans (HAP) developed by Enrollees, their caregivers, and Interdisciplinary Care Teams using a person-centered planning process. CMS and the State expect MMIPs to achieve savings through better integrated and coordinated care. Subject to CMS and State oversight, MMIPs 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 Enrollee's wishes, needs, Individualized Care Plan, and Health Action Plan.

Preceding the signing of this MOU, the State 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 principles under which CMS and Washington plan to implement and operate the aforementioned Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute a Three-Way Contract with MMIPs setting forth the terms and conditions of the Demonstration and initiate the Demonstration. Further detail about MMIP responsibilities will be included in and appended to the Three-Way Contract.

Following the signing of this MOU and prior to the implementation of the Demonstration, the State and CMS will ultimately enter into Three-Way Contracts with selected MMIPs, which will

have also met the Medicare components of the plan selection process, including submission of a successful Capitated Financial Alignment Application, and adherence to any annual contract renewal requirements and guidance updates.

III. Demonstration Design / Operational Plan

A. DEMONSTRATION AUTHORITY

The following is a summary of the terms and conditions the Parties intend to incorporate into the Three-Way Contracts, as well as those activities the Parties intend to conduct prior to entering into the Three-Way Contracts and initiating the Demonstration. This section and any appendices referenced herein are not intended to create contractual or other legal rights between the Parties and the Medicare-Medicaid Integration Plans.

1. Medicare Authority

The Medicare elements of the initiative shall operate according to existing Medicare Parts C and D laws and regulation, 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 Demonstration, MMIPs 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 CFR §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 Demonstration shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, including but not limited to all requirements of the 1915(c) waivers for those Enrollees in a 1915(c) waiver, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the Demonstration, the State and the MMIPs will be required

to comply with Medicaid managed care requirements under Title XIX of the Social Security Act and 42 CFR §438 et. seq., other applicable regulations, 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. The State will add concurrent authority to the relevant 1915(c) programs via amendments due no later than April 1, 2014. The State will also submit a 1932(a) SPA for CMS review. Implementation of this Demonstration is contingent upon the state receiving approval for the 1915(c) amendments and the 1932(a) authority.

B. CONTRACTING PROCESS

1. MMIP Procurement Document:

The State issued a Request for Application (RFA) that, consistent with applicable State law and regulations, included purchasing specifications that reflect the integration of Medicare and Medicaid payment and benefits. As articulated in January 9, 2013, guidance from CMS, MMIPs 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.

All applicable Medicare Advantage/Part D requirements and Medicaid managed care requirements will apply, unless otherwise waived, as specified by CMS and the State herein, in the Three-Way Contract, or in the State Specific Request for Application (RFA) No. 2013 003.

2. MMIP Selection

CMS and the State, through a plan selection and procurement process, selected entities that will be eligible to contract with CMS and the State. CMS and the State shall contract with qualified MMIPs on a selective basis. The State announced the awardees pending approval of this MOU. 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 State 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 Social Security Act, afford the State a reasonable opportunity to request reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section III.L of this MOU. If a waiver or expenditure authority is withdrawn, federal financial participation (FFP) is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling Enrollees.

4. Medicaid Waiver and/or Medicaid State Plan Approval

CMS approval of any new Medicaid State Plan amendments, waivers, and variances pursuant to Sections 1915(c), 1115, 1115A, or Title XIX of the Social Security Act authority and processes is discussed in Appendix 5. Implementation of this Demonstration is contingent upon the State submitting all documentation necessary to demonstrate compliance with the Medicaid requirements under 42 CFR Parts 438 and 441 for the enrollment of the Demonstration population into managed care. Delays in submission may delay the implementation of the Demonstration. 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 XIX. CMS will promptly notify the State 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 Social Security Act, afford the State an opportunity to request a reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section III.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 Enrollees.

5. Readiness Review

CMS and the State, either directly or with contractor support, shall conduct a Readiness Review of each selected MMIP. Prior to allowing a plan to accept enrollment, both CMS and the State must agree that a MMIP has satisfied all readiness requirements. CMS and the State 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 MMIP and its ability to meet all Demonstration requirements, including having an adequate network that addresses the full range of Enrollee needs and the capacity to uphold all Enrollee safeguards and protections.

6. Three-Way Contract

CMS and the State shall develop a single Three-Way Contract and contracting process that both Parties agree is administratively effective and ensures coordinated and comprehensive program operation, enforcement, monitoring, and oversight.

C. ENROLLMENT

1. Eligible Populations

The Demonstration will be available to individuals who meet all of the following criteria:

- Individuals age 21 and older entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits; and
- Reside in one of the two Demonstration counties – King County or Snohomish County.

Eligible populations include:

- Enrollees who meet all other Demonstration criteria who are:
 - Participating in the Aging and Long-Term Support Administration (AL TSA) Community Options Program Entry System (COPES) Home and Community-Based Services (HCBS) Medicaid 1915(c) waiver;
 - Receiving Medicaid Personal Care Services, including those individuals with developmental disabilities;
- Individuals with End Stage Renal Disease (ESRD);
- Individuals enrolled in Medicare Advantage (including a Medicare Advantage Special Needs Plan) that is operated by the same organization as a MMIP; and
- American Indians/Alaska Natives (will not be passively enrolled).

Individuals who meet at least one of the exclusion criteria listed below are not eligible and shall be excluded from enrollment in the Demonstration:

- Individuals with developmental disabilities who receive institutional services in Residential Habilitation Centers or Community Intermediate Care Facilities for Individuals with Intellectual Disabilities or who participate in the Developmental Disabilities Administration (DDA) HCBS waiver for Adults and Children with Developmental Disabilities;
- Individuals participating in the Money Follows the Person program;
- Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE). However, PACE participants may enroll in the Demonstration if they choose to disenroll from their PACE provider and enroll in the Demonstration;
- Individuals enrolled in a hospice program. Individuals receiving hospice services at the time of enrollment will be excluded from the Demonstration. If an individual enters a hospice program while enrolled in the Demonstration, he/she will remain in the Demonstration unless he/she disenrolls;
- Individuals enrolled in a Medicare Advantage Plan that is operated by a parent organization that is not offering a MMIP. Such individuals may enroll into the Demonstration if they elect to disenroll from their current Medicare Advantage Plan;

- The Medicaid Spend-down population who meet the criteria for SLMB Plus;
- Individuals with other comprehensive Third Party Insurance; and
- Individuals residing outside of the Demonstration counties.

2. Enrollment and Disenrollment Processes

Under this Demonstration, enrollment for eligible beneficiaries into a MMIP may be conducted – when no active choice has otherwise been made – using a seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the MMIP at any time. Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted MMIPs no fewer than sixty (60) days prior to the effective date of enrollment, and will have the opportunity to opt out until the last day of the month prior to the effective date of enrollment, as further detailed in Appendix 7.

If a choice to enroll in a MMIP is made by the second to the last business day of the month, enrollment will be effective the first calendar day of the following month. Disenrollment from MMIPs and enrollment from one MMIP to a different MMIP shall be allowed on a month-to-month basis any time during the year. All disenrollments will be effective the first day of the month after the choice is made.

MMIP enrollments, including enrollment from one MMIP to a different MMIP, and opt-outs shall become effective on the same day for both Medicare and Medicaid (the first day of the following month). For those who lose Medicaid eligibility during the month, coverage and FFP will continue through the end of that month. See Appendix 7 for a more detailed discussion on timing of enrollments and disenrollments.

CMS and the State will monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations and policies, for the purpose of identifying any inappropriate or illegal

marketing practices. As part of this analysis, CMS and the State will monitor any unusual shifts in enrollment by individuals identified for passive enrollment into a particular MMIP to a Medicare Advantage Plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS and the State may issue corrective action. Any illegal marketing practices will be referred to appropriate agencies for investigation.

3. Uniform Enrollment/Disenrollment Documents

CMS and the State shall develop uniform enrollment and disenrollment forms and other documents.

4. Outreach and Education

MMIP outreach and marketing materials will be subject to a single set of marketing rules defined by CMS and the State, as further detailed in Appendix 7.

5. Single MMIP Identification Card

CMS and the State shall work with MMIPs to develop a single plan identification card that can be used to access all health care needs, as further described in Appendix 7.

6. Interaction with other Demonstrations

To best ensure continuity of Enrollee care and provider relationships, CMS will work with the State to address Enrollee or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). An Enrollee enrolled in the Demonstration will not be enrolled in, nor have costs attributed to, a Medicare ACO or any other shared savings initiative for the purposes of calculating shared Medicare savings under those initiatives.

D. DELIVERY SYSTEMS AND BENEFITS

1. MMIP Service Capacity

CMS and the State shall contract with MMIPs 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 under the Demonstration shall be provided in accordance with 42 CFR 438 and with the requirements in the approved Medicaid State Plan, including any applicable State Plan amendments, 1915(c) waiver authorities, and in accordance with the requirements specified in the State's RFA and in this MOU. In accordance with the Three-Way Contract and this MOU, CMS and the State may choose to allow for greater flexibility in offering additional benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, the State, and MMIPs will ensure that Enrollees have access to an adequate network of medical, drug, behavioral health, and LTSS providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.

2. MMIP Risk Arrangements

CMS and the State shall require each MMIP to provide a detailed description of its risk arrangements with providers under subcontract with the MMIP. This description shall be made available to MMIP 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. MMIP Financial Solvency Arrangements

CMS and the State have established a standard for all MMIPs, as articulated in Appendix 7.

E. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

1. Choice of Plans and Providers

As referenced in Section III.C.2, Medicare-Medicaid Enrollees will maintain their choice of plans and providers for which they are eligible 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 MMIP, a Medicare Advantage Plan, a PACE plan (where applicable), to receive care through Medicare Fee-For-Service (FFS) and a Prescription Drug Plan, and to receive Medicaid services in accordance with the State's approved State Plan services and any approved waiver programs.

2. Continuity of Care

CMS and the State will require MMIPs to ensure that Enrollees continue to have access to medically necessary items, services, prescription drugs, and medical, behavioral health, and LTSS providers for the transition period as specified in Appendix 7. During the transition period, MMIPs will advise in writing Enrollees and providers that the Enrollees have received care that would not otherwise be covered at an in-network level. On an ongoing basis, MMIPs must also contact providers not already members of their network with information on becoming credentialed as in-network providers. Medicare Part D transition rules and rights will continue as provided for in current law and regulation.

MMIPs will continue to renew and fill all prescriptions held by the Enrollee on the date of enrollment consistent with Medicare Part D transition policies.

MMIPs will allow Enrollees to continue to receive care from out-of-network providers, including long term service and support providers, with whom an Enrollee has documented established relationship. MMIPs must make a good faith effort to contract with the established out-of-network provider and to complete the necessary screening and assessments to ensure continuity of care. If transition is necessary, the MMIP shall facilitate collaboration between the established out-of-network provider

and the new network provider to plan a safe, medically appropriate transition in care. If the established out-of-network provider or the Enrollee will not cooperate with a necessary transition but remains enrolled with the MMIP, the MMIP may transfer the Enrollee's care to a network provider the later of (a) one hundred and eighty (180) calendar days from the Enrollee's enrollment effective date for ESRD services, Nursing Facilities (unless the Enrollee chooses to return to the community or transfer to another Nursing Facility), Adult Family Homes and Assisted Living Facilities, and ninety (90) calendar days from the Enrollee's enrollment effective date for all other services, or (b) after completion of an Individualized Care Plan. The Enrollee must agree to the transition prior to the expiration of the applicable day transition period. For those individuals receiving LTSS, including existing HCBS-eligible Enrollees and Enrollees receiving Medicaid Personal Care Services, MMIPs will maintain the providers authorized in the HCBS Service Plan or Medicaid Personal Care Service Plan for the duration of the authorization period or the continuity of care periods above, whichever is later, with the exception of Adult Family Homes and Assisted Living Facilities for which the 180-day transition period applies. The MMIP may choose to pay the established out-of-network provider indefinitely to provide care to the Enrollee if the out-of-network provider will accept payment rates the MMIP has established for out-of-network non-participating providers as payment in full.

3. Enrollment Assistance and Options Counseling

As referenced in Section C.2 and Appendix 7, beneficiaries may access independent enrollment assistance and options counseling offered by the State's Area Agencies on Aging (AAAs) to help them make an enrollment decision that best meets their needs. In Washington, Aging and Disability Resource Centers (ADRCs), operated by the State's AAAs, serve as the point-of-entry to the options counseling program, ensuring that beneficiaries are informed of their health care and LTSS options. Under this Demonstration, the State will provide ADRCs with information about MMIPs so that the ADRCs can inform beneficiaries about all of their enrollment options. CMS and the State will work together to support the State Health Insurance Assistance Program (SHIP), ADRC options counseling, and other community-based, nonprofit

organizations to ensure ongoing outreach, education and support to beneficiaries in understanding their health care coverage options.

4. Ombudsman

The Office of the Insurance Commissioner (OIC), Statewide Health Insurance Benefits Advisors (SHIBA), and Consumer Advocacy Unit will provide consumer advocacy assistance through a 1-800 hotline, on-line access, and staff health analysts. The Consumer Advocacy Program is a key component of the OIC services to those needing help dealing with their health plans and information regarding their options. CMS will support Ombudsman training on the Demonstration and its objectives, and CMS, the Administration for Community Living (ACL) and the State will provide ongoing technical assistance to the Ombudsman. The Ombudsman will support individual advocacy and independent systematic oversight for the Demonstration, with a focus on compliance with principles of community integration, independent living, and person-centered care in the home and community-based care context. The Ombudsman will be responsible for gathering and reporting data on Ombudsman activities to the State and CMS via the Contract Management Team described in Appendix 7 of this MOU.

5. Person-Centered, Appropriate Care

CMS, the State, and MMIPs shall ensure that all medically necessary, covered benefits are provided to Enrollees and are provided in a manner that is sensitive to the individual's functional and cognitive needs, language, and culture, allows for involvement of the Enrollee and caregivers (as permitted by the Enrollee), and in a care setting appropriate to the Enrollee's needs, with a preference for the home and the community. CMS, the State, and MMIPs shall ensure that care is person-centered and can accommodate and support self-direction. MMIPs shall also ensure that Enrollees have the option to receive LTSS in the least restrictive setting when appropriate, with a preference for the home and the community, and in accordance with the Enrollee's wishes and Individualized Care Plan.

6. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964

CMS and the State require MMIP and provider compliance with the ADA and the Civil Rights Act of 1964 to promote the success of the Demonstration and to support better health outcomes for Enrollees. In particular, CMS and the State recognize that successful, person-centered care requires physical access to buildings, services, and equipment, and flexibility in scheduling and processes. The State and CMS will require MMIPs to provide access to contracted providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their Enrollees. The State and CMS also recognize that access includes effective communication. The State and CMS will require MMIPs 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, accommodations for Enrollees with cognitive limitations, and interpreters for those with limited English proficiency. Also, CMS and the State recognize the importance of staff training on accessibility and accommodation, independent living and recovery models, cultural competency, and wellness philosophies. CMS and the State will continue to work with stakeholders, including Enrollees, to further develop learning opportunities, monitoring mechanisms, and quality measures to ensure that MMIPs and their providers comply with all requirements of the ADA. Finally, CMS and the State are committed to compliance with the application of the Supreme Court's *Olmstead* decision, and agree to ensure that MMIPs provide Enrollees with LTSS in care settings appropriate to their needs consistent with Covered Services.

7. Enrollee Communications

CMS and the State agree that Enrollee and prospective Enrollee materials, in all forms, shall require prior approval by CMS and the State in accordance with all existing rules and regulations, unless CMS and the State agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and the State. CMS and the State will also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or State approval. All

materials shall be integrated and include, but are not 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 (i.e., 6th grade reading level) to the Enrollees and prospective Enrollees in the MMIPs and their caregivers. This includes individuals with disabilities, including, but not limited to, those with cognitive and functional limitations, those with limited English proficiency, and those with low functional literacy, in accordance with prevailing 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.

8. Enrollee Participation on Governing and Advisory Boards

As part of the Three-Way Contract, CMS and the State shall require MMIPs to obtain Enrollee and community input on issues of program management and Enrollee care through a range of approaches. Each MMIP will establish an independent MMIP Enrollee advisory committee. Throughout the operation of the Demonstration, MMIPs will be required to meet no less than quarterly with the Enrollee advisory committee. The MMIP must also assure that the Enrollee advisory committee composition reflects the diversity of the Demonstration population including Enrollees, caregivers, and local representation from key community stakeholders such as faith-based organizations, advocacy groups, and other community-based organizations.

The State will hold ongoing quarterly stakeholder meetings through forums such as the HealthPathWashington Advisory Team (HAT), the Project Governance Team and other stakeholder outreach. In addition, Washington will maintain its website to provide updates on the Demonstration. The State will maintain additional processes for ongoing stakeholder participation and public comment, as discussed in Appendix 7.

9. MMIP Customer Service Representatives

CMS and the State shall require MMIPs to employ or contract with sufficient numbers of customer service representatives who shall answer all inquiries and respond to Enrollee complaints and concerns in a reasonable period of time, as defined by CMS and the State. In addition, CMS and the State shall themselves employ or contract with sufficient call center and customer service representatives to address Enrollee questions and concerns. In Washington, this will be done through the Medical Assistance Customer Service Center (MACSC) within the Health Care Authority. MMIPs, CMS, and the State 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.

10. Privacy and Security

CMS and the State shall require all MMIPs to ensure privacy and security of Enrollee health records. MMIPs will provide for access by Enrollees to such records as specified in the Three-Way Contract and as otherwise mandated by state or federal law.

11. Integrated Appeals and Grievances

As referenced in Section III.F and Appendix 7, Enrollees will have access to an integrated Appeals and Grievance process.

12. Limited Cost Sharing

MMIPs 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 those covered by both Medicare Part D and the State Medicaid agency, MMIPs will be permitted to charge co-pays to individuals currently eligible to make such

payments, consistent with co-pays applicable for Medicare and Medicaid drugs, respectively. Co-pays charged by MMIPs for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy or State Medicaid program cost-sharing rules, as applicable, although MMIPs may elect to reduce this cost sharing for all Enrollees as a way of testing whether reducing Enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the Demonstration.

For Medicaid services beyond the pharmacy cost sharing described here, MMIPs will not charge cost sharing to Enrollees for Medicaid services, beyond the HCBS waiver cost sharing amounts allowed under the Medicaid State Plan. MMIPs are free to waive Medicaid cost sharing requirements in order to reduce Enrollees' out-of-pocket expenses.

13. No Balance Billing

No Enrollee may be balance billed by any provider for any reason for Covered Services or Supplemental Benefits.

F. INTEGRATED APPEALS AND GRIEVANCES

1. MMIP Grievances and Internal Appeals Processes

CMS and the State agree to develop a unified set of requirements for MMIP grievances and internal appeals processes that incorporate relevant Medicare Advantage and Medicaid managed care/appeals requirements to create a more Enrollee friendly and easily navigable system. All MMIP grievances and internal appeals procedures shall be subject to the review and prior approval of CMS and the State. Medicare Part D appeals and grievances will continue to be managed by CMS under existing Part D rules, and Medicaid non-Part D pharmacy appeals will be managed by the State. CMS and the State will work to continue to coordinate grievances and appeals for all services.

2. External Appeals Processes

CMS and the State agree to utilize a streamlined appeals process that will conform to both Medicare and Medicaid requirements, to create a more Enrollee 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. Medicare Part D appeals and grievances will continue to be managed by CMS under existing Part D rules.

G. ADMINISTRATION AND REPORTING

1. MMIP Contract Management

As more fully discussed in Appendix 7, CMS and the State agree to designate representatives to serve on a CMS-State Contract Management Team which shall conduct MMIP 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 for MMIPs;
- 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 MMIPs' fiscal operations and financial solvency, conducting program integrity studies to prevent and detect fraud, waste and abuse as agreed upon by CMS and the State, and ensuring that MMIPs take corrective action, as appropriate;

- Reviewing and analyzing reports on MMIPs’ network adequacy, as well as the MMIPs’ ongoing efforts to maintain, replenish and expand their networks, and to continually enroll qualified providers;
- Reviewing any other applicable ratings and measures;
- Reviewing reports from the Ombudsman;
- Reviewing direct stakeholder input into both MMIP-specific and systematic performance; and
- Responding to and investigating Enrollee complaints and quality of care issues.

2. Day-to-Day MMIP Monitoring

CMS and the State will establish procedures for MMIP daily monitoring, as described in Appendix 7. Oversight shall generally be conducted in line with the following principles:

- The State and CMS will each retain, yet coordinate current responsibilities toward the Enrollee, such that Enrollees maintain access to their benefits across both programs.
- CMS and the State will leverage existing protocols (e.g. in responding to Enrollee complaints, conducting account management, and analyzing enrollment data) to identify and solve Enrollee 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 State and CMS.
- Oversight of the MMIPs and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and the Washington Medicaid program.
- Medicare Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the State. MMIPs 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 audits.

- CMS and the State will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poor performing plans from the Demonstration, leveraging existing CMS tools, such as the Complaints Tracking Module or the Medicare Part D Critical Incidence Reporting System, and existing State oversight and tracking tools. Standards for removal on the grounds of poor performance, including continuous failure to meet quality and performance thresholds, or program integrity requirements, will be articulated in the Three-Way Contract.

3. Consolidated Reporting Requirements

CMS and the State shall define and specify in the Three-Way Contract a Consolidated Reporting Process for MMIPs 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 MMIP's performance. MMIPs will be required to meet the encounter reporting requirements that are established for the Demonstration.

4. Accept and Process Data

CMS, or its designated agent(s), and the State, or its designated agent(s), shall accept and process uniform, person-level Enrollee data for the purposes of program eligibility, payment, and evaluation. Submission of data to the State 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. CMS and the State shall streamline data submissions for MMIPs 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 Enrollees are receiving high quality care. In addition, CMS and the State 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 State shall coordinate the MMIP 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 State shall determine applicable quality standards and monitor the MMIPs' performance on those standards. These standards are articulated in Appendix 7 and the MMIP Three-Way Contract.

I. FINANCING AND PAYMENT

1. Rates and Financial Terms

For each calendar year of the Demonstration, before rates are offered to MMIPs, CMS shall share with the State 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 MMIPs for the Medicare Parts A and B and Part D components of the rate. The State will make a payment to the MMIPs 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 State have developed processes and protocols, as specified in Appendix 7 and which will be further detailed in the Three-Way Contract, for collecting or ensuring the MMIPs or their contractors collect and report to CMS and the State 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.

The evaluation will include changes in person-level health outcomes, experience of care, and costs by sub-population(s), and changes in patterns of primary, acute, behavioral health, and LTSS use and expenditures, using principles of rapid-cycle evaluation and feedback. Key aspects and administrative features of the Demonstration, including but not limited to enrollment, marketing, and grievances and appeals, 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 State will collaborate with CMS or its designated agent during all monitoring and evaluation activities. The State and MMIPs 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. The State and MMIPs will submit both historical data relevant to the evaluation, including Medicaid statistical information systems (MSIS) data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

K. EXTENSION OF AGREEMENT

The State 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 of care and reducing spending. Any extension request will be subject to CMS approval.

L. MODIFICATION OR TERMINATION OF MOU

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

1. Limitations of MOU

This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the State, the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person. Nothing in this MOU may be construed to obligate the Parties to any current or future expenditure of resources or from modifying the Medicare and Medicaid programs as allowed under the respective federal laws and regulations. This MOU does not obligate any funds by either of the Parties. Each Party acknowledges that it is entering into this MOU under its own authority.

2. Modification

Either CMS or the State may seek to modify or amend this 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.

3. Termination

The Parties may terminate this MOU under the following circumstances:

- Termination without cause – Except as otherwise permitted below, termination of this MOU by CMS or the State for any reason will require that CMS or the State provides a minimum of 90 days advance notice to the other party, 90 days advance notice to the MMIPs, and a minimum of 60 days advance notice to Enrollees and the general public.
- Termination pursuant to Social Security Act § 1115A(b)(3)(B).
- Termination for cause – Either party may terminate this MOU upon 30 days' notice due to a material breach of a provision of this MOU or the Three-Way Contract.
- Termination due to a Change in Law – In addition, CMS or the State may terminate this MOU upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

If the Demonstration is terminated as set forth above, CMS shall provide the State with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Demonstration Enrollees and, to the extent that timing permits, adheres to the phase-out plan requirements detailed below. All Enrollees must be successfully enrolled in a Part D plan prior to termination of the Demonstration, unless they choose to not enroll in Part D.

4. Demonstration phase-out

Termination at the end of the Demonstration must follow the following procedures:

- A. Notification – Unless CMS and the State agree to extend the Demonstration, the State must submit a draft phase-out plan to CMS no less than five (5) months before the effective date of the Demonstration’s suspension or termination. Prior to submitting the draft phase-out plan the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its Medicaid State Plan. The State shall summarize comments received and share such summary with CMS. Once the phase-out plan is approved by CMS, the phase-out activities must begin within 14 days.
- B. Phase-out Plan Requirements – The State must include, at a minimum, in its phase-out plan the process by which it will notify affected Enrollees, the content of said notices (including information on how the Enrollee’s appeal rights will continue to operate during the phase-out and any plan transition) and, if applicable, the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected Enrollees and ensure ongoing coverage for eligible individuals, including enrollment of all Enrollees in a Part D plan, unless they choose not to enroll in Part D, as well as any community outreach activities. In addition, such plan must include any ongoing MMIP and State responsibilities and closeout costs. If the Demonstration is terminated as set forth in Paragraphs 3a. – 3d. above, CMS shall provide the State with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Enrollees. During the phase-out period, all Enrollees must be successfully enrolled in a Medicare Part D plan prior to the termination of the Demonstration, unless they choose not to enroll in Part D.
- C. Phase-out Procedures – The State must comply with all notice requirements found in 42 CFR §431.206, 431.210, and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration Enrollees as outlined in 42 CFR §431.220 and 431.221. If a Demonstration Enrollee requests a hearing

before the date of action, the State must maintain benefits as required in 42 CFR §431.230. If applicable, the State must conduct administrative renewals for all affected Enrollees 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.

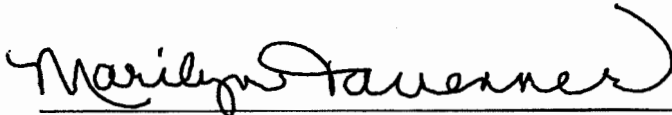
- D. FFP – If the Demonstration is terminated by either party, or any relevant waivers are suspended or withdrawn by CMS, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including Covered Services and administrative costs of disenrolling Enrollees.

M. SIGNATURES

This MOU is effective on this day forward, November 25, 2013, through the end of the Demonstration period, December 31, 2017. Additionally, the terms of this MOU shall continue to apply to the State and MMIPs as they implement associated phase-out activities beyond the end of the Demonstration period.

In Witness Whereof, CMS and the State of Washington 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**



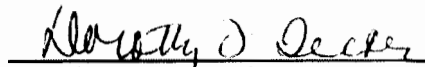
Marilyn Tavenner, Administrator

NOV 25 2013

Date

The State of Washington

Washington Health Care Authority

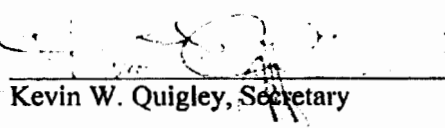


Dorothy Teeter, Assistant Secretary

11/25/13

Date

Washington State Department of Social and Health Services



Kevin W. Quigley, Secretary

11/25/13

Date

APPENDIX 1. DEFINITIONS

Adverse Action – Consistent with 42 CFR § 438.400, an action by the MMIP, subcontractor, service provider, the State, or other authorized entities, that constitutes a denial or limited authorization of a service authorization request, including the type or level of service; or reduction, suspension, or termination of a previously authorized service; or failure to provide services in a timely manner; or denial, in whole or in part of payment for a covered service for an Enrollee; or failure of the MMIP to render a decision within the required timeframes; or the denial of an Enrollee’s request to his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network.

ALTSA – The Washington State Aging and Long-Term Support Administration is the state agency responsible for LTSS policy and program development and monitoring.

Appeals – An Enrollee’s request for review of a MMIP’s coverage or payment determination. In accordance with 42 CFR 438.400, a Medicaid-based appeal is defined as a request for review of an Adverse Action, as defined herein. An appeal is an Enrollee’s challenge to the Adverse Actions regarding services, benefits, and reimbursement provided by the MMIP, its service providers or the State. An appeal may also be filed by service providers, for Adverse Actions related to payment or authorization for services rendered to an Enrollee, as defined herein under “provider appeal.”

Behavioral Health Services – Services that address the promotion of emotional health; the prevention of mental illness and substance use disorders; and the treatment of substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.

CARE – Comprehensive Assessment Report and Evaluation (CARE) tool used to determine Medicaid functional eligibility and level of care by the DSHS or its designee.

Care Management – The practice and procedures to improve overall health care and assist Enrollees and their support system to become engaged in a collaborative process designed to manage medical/social/behavioral health conditions more effectively. Care Management involves identifying Enrollees who will most benefit from planning and coordinating interventions tailored to meet the individual’s needs, respecting the role of the individual to be a decision maker in the care planning process, evaluating the results of interventions and implementing necessary adjustments, and aligning payment/financing to reward consumers and providers for participating in interventions/evaluations and establishing accountability for quality and cost of health care service delivery to complete a specified course of treatment or regular care monitoring. For Enrollees identified to have special health care needs, Intensive Care Management is employed to address complex conditions and includes comprehensive health assessment, care planning and monitoring of Enrollee status, implementation and coordination of

services, ongoing reassessment and consultation and crisis intervention and case conferencing as needed to facilitate improved outcomes and appropriate use of health services, including case closure as warranted by Enrollee improvement and stabilization

Care Manager – An appropriately qualified professional who is accountable point of contact for Enrollee receiving Care Management services who are in Tier One or Tier Two levels of service categories. The Care Manager is responsible for directing and delegating Care Management duties, as needed, and may include assessment of needs, developing and implementing care plans; and participating in the Interdisciplinary Care Team.

Center for Medicare and Medicaid Innovation (Innovation Center) – Established by Section 3021 of the Affordable Care Act, the Innovation Center 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.

CMS – The Centers for Medicare & Medicaid Services.

Complaint – A grievance.

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.

Contract Management Team – A group of CMS, HCA, and DSHS representatives responsible for overseeing the contract.

COPES Waiver – The Community Options Program Entry System (COPES) is a categorically needy (CN) waiver program that provides clients who meet the functional institutional level of care with alternatives to placement in a medical facility. These alternatives include remaining in their home or placement in an alternate living facility (ALF) approved by the Home and Community Services (HCS) division. The goal of this program is to provide a safe level of care with maximum independence.

Covered Services – The set of required services offered by the MMIPs.

Cultural Competence – Understanding those values, beliefs, and needs that are associated with Enrollee's 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. A competency based on the premise of respect for individual and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.

DDA – The Washington State Developmental Disabilities Administration.

Disabled – Defined by the Social Security Administration for Supplemental Security Income (SSI) as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months with available treatment.

Disenrollment – The process by which an Enrollee’s participation in the Demonstration is terminated. Reasons for disenrollment include death, loss of eligibility for the Demonstration, or choice not to participate in the Demonstration. Disenrollment at the direction of the Enrollee may also be referred to as “opt-out.”

DSHS – The Washington State Department of Social and Health Services.

Enrollee – A Medicare-Medicaid Enrollee who is enrolled in the Demonstration, including the duration of any month in which their eligibility for the Demonstration ends. “Enrollee” shall include the guardian, power of attorney, designated representative where the Enrollee is an adult for whom the above has been named, provided, however, that the MMIP is not obligated to cover services for the above who is not otherwise eligible as an Enrollee.

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.

Enrollment – The processes by which an individual who is eligible for the Demonstration is enrolled in a MMIP. This process includes transfers from one MMIP to another. Such processes include completion of a telephonic enrollment process or an enrollment form, when requested in order to become an Enrollee of a MMIP. (Passive enrollment is defined below.)

External Quality Review Organization (EQRO) – An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by managed care organizations to their Medicaid Enrollees.

Flexible Benefits – Benefits MMIPs may choose to offer outside of the required Covered Services.

Grievance – In accordance with 42 CFR §438.400, grievance means an expression of dissatisfaction about any matter other than an “Adverse Action.” A Grievance is filed and decided at the MMIP level. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee’s rights).

HCA – The Washington State Health Care Authority. The Medicaid agency responsible for purchasing Medicaid medical services.

Health Action Plan – A Tier Three Enrollee-prioritized plan identifying what the Enrollee plans to do to improve his or her health and/or self-management of health conditions. The Health Action Plan (HAP) should contain at least one Enrollee-developed and prioritized goal; identify what actions the Enrollee is taking to achieve the goal(s); and includes the actions of the Intensive Care Coordinator, including use of health care or community resources and services that support the Enrollee’s Health Action Plan.

Healthcare Effectiveness Data and Information Set (HEDIS) – A 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.

HealthPathWashington – Washington’s approach to integrating care for Medicare-Medicaid Enrollees, which includes both Managed Fee-for-Service and Capitated Financial Alignment models.

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.

HCBS Waiver – Home and Community Based Services 1915(c) waiver.

Home and Community Services (HCS) Office – The state agency within the Washington State Aging and Long-Term Support Administration (AL TSA) that is responsible for conducting initial and ongoing residential HCBS eligibility determinations.

Individualized Care Plan – An integrated, individualized, person-centered care plan jointly created and managed by the Enrollee, his or her selected support system, his or her health plan care management team, and his or her interdisciplinary team of care providers. The plan incorporates a holistic, preventative, and recovery focus and is based on a comprehensive assessment of clinical and non-clinical needs and addresses identified gaps in care and barriers to care.

Intensive Care Coordinator – An appropriately qualified professional who has successfully completed specialized training directly related to the Intensive Care Management Model of Service Delivery and is the accountable point of contact for Enrollees receiving Care Management services that are in Tier Three. The Intensive Care Coordinator is responsible for directing and delegating Intensive Care Management duties, as needed, and may include

assessment of needs, developing and implementing care plans; and participating in the Interdisciplinary Care Team.

Intensive Care Management – An approach to integrating care across existing care systems. Intensive Care Management is a person-centered system of care that provides a means of integrating and coordinating services across systems of care including institutions, acute medical care, preventive and wellness care, behavioral health care, community-based long-term services and supports, and community-based social services and supports for both children and adults with chronic conditions.

Interdisciplinary Care Team – A consistent grouping of people from relevant clinical and non-clinical disciplines, inclusive of the Enrollee and individuals of his or her choice, whose interactions are guided by specific team functions and processes to achieve team-defined favorable outcomes for the Enrollee. The team may include, but is not limited to, medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, doctors of chiropractic, physical therapists, licensed complementary and alternative medicine practitioners, the DDA Case Manager, home care and other LTSS providers, and physician assistants.

Long Term Services and Supports (LTSS) – A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. Examples include personal care assistance with daily activities such as bathing, dressing and personal hygiene, home-delivered meals, personal emergency response systems, adult day services, environmental modifications and other services designed to divert individuals from nursing facility care. LTSS are provided either in short periods of time when recovering from an injury or acute health episode or over an extended period and may be delivered in in-home, licensed community residential settings, or licensed nursing facilities. For the purposes of the Demonstration, LTSS includes both Home and Community-Based Services (HCBS) and Medicaid Personal Care Services.

Medicaid Statistical Information Statistics (MSIS) Data – Electronic Medicaid claims data submitted to CMS by the State.

Medically Necessary Services – 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 U.S.C. § 1395y. Per Washington Medicaid, a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client

requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

Where there is overlap between Medicare and Medicaid, coverage and rules will be delineated in the Three-Way Contract. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and the State Medicaid Program.

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 entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D and receiving full benefits under Medicaid, and otherwise meet eligibility criteria for the Demonstration. See also Enrollee.

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 Medicaid Integration Plan (MMIP) – A managed care organization that enters into a Three-Way Contract with CMS and the State to provide Covered Services and any chosen Flexible Benefits, and is accountable for providing integrated care to Medicare-Medicaid Enrollees.

Medicaid Waiver – Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act as approved by the Secretary of Health and Human Services or his/her designee.

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

Minimum Data Set (MDS) – Part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for nursing facility residents to return to community settings. Beginning October 1, 2010, all Medicare and Medicaid certified nursing facilities were required to use the MDS 3.0.

Money Follows the Person (MFP) – A Demonstration project designed to create a system of LTSS that better enables individuals to transition from certain long term care institutions into the community. In Washington, MFP is called Roads to Community Living.

Opt-in Enrollment – The processes by which an Enrollee who is eligible for the Demonstration actively takes an action to enroll in a MMIP. This process includes transfers from one MMIP to another. Such processes include completion of an enrollment process (internet or phone) or an enrollment form, when requested in order to become an Enrollee of a MMIP.

Opt Out – A process by which an Enrollee can choose not to participate in the Demonstration.

Patient Activation Measure (PAM) – The Patient Activation Measure® (PAM®) assessment gauges a consumer’s knowledge, skills and confidence in managing his/her own health and healthcare. The PAM assessment segments consumers into one of four progressively higher activation levels. Each level addresses a broad array of self-care behaviors and offers deep insight into the characteristics that drive health activation. A PAM score can also predict healthcare outcomes including medication adherence, ER utilization and hospitalization.

Parties – CMS and the State of Washington.

Passive Enrollment – An enrollment process through which an eligible beneficiary is enrolled by the State into a MMIP, when not otherwise affirmatively electing one, following a minimum 60-day advance notification that includes the plan selection and the opportunity to select a different MMIP, decline enrollment into an MMIP, or opt out of the Demonstration prior to the effective date.

Personal Care Services – Personal Care Services are provided to enable an individual to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal Care Services may be provided on an episodic or on a continuing basis. Personal Care Services include the assistance with bathing, bed mobility, body care, dressing, eating, locomotion outside room, walking in room, medication management, toileting, transfer and personal hygiene, meal preparation, ordinary housework, essential shopping, and wood supply (when wood is the sole source of heat), travel to medical services, assessment of the need for financial management and telephone use.

Person-centered – A requirement that services and care is built on the Enrollee’s specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and Cultural Competence, and dignity.

PRISM – A web-based tool used for predictive modeling and clinical decision support. PRISM provides prospective medical risk scores that are a measure of expected costs in the next 12 months based on the Enrollee’s disease profile and pharmacy utilization. PRISM identifies clients in most need of comprehensive care coordination based on risk scores; integrates information from primary, acute, social services, behavioral health, and long term care payment and assessment data systems; and displays health and demographic information from administrative data sources.

Privacy – Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 CFR 431.300 through 431.307, as well as relevant Washington privacy laws.

Program of All-Inclusive Care for the Elderly (PACE) – A capitated benefit for frail elderly authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE is a three-way partnership between the Federal government, the State of Washington, and the PACE organization.

Quality Improvement Organization (QIO) – As set forth in Section 1152 of the Social Security Act and 42 CFR Part 476, an organization under contract with CMS to perform utilization and quality reviews in the Medicare program or an organization designated as QIO-like by CMS.

Readiness Review – Prior to entering into a Three-Way Contract with Washington and CMS, each MMIP selected to participate in the Demonstration will undergo a Readiness Review. The Readiness Review will evaluate each MMIP’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 Enrollees, and provide adequate access to all Medicare and Medicaid Covered Services. CMS and the State will use the results to inform its decision of whether the MMIP 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 MMIP’s headquarters.

Regional Support Network (RSN) – A county authority or group of county authorities or other entity recognized by the Secretary of the Washington State Department of Social and Health Services to administer mental health services in a defined region within Washington State. RSNs are specialty behavioral health plans operating under 1915(b) Medicaid authority.

Solvency – Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by the State and agreed to by CMS.

Spend Down – The policy that allows an individual to qualify for Medicaid by incurring medical expenses at least equal to the amount by which his or her income or assets exceed financial eligibility limits. It operates similarly to deductibles in private insurance in that the Spend-down amount represents medical expenses the individual is responsible to pay.

State – The State of Washington.

State Plan – The Washington State Plan filed with CMS, in compliance with Title XIX of the Social Security Act.

Three-Way Contract – The three-way agreement that CMS and the State have with a MMIP specifying the terms and conditions pursuant to which a MMIP may participate in this Demonstration.

The Washington Department of Social and Health Services (DSHS) – The agency which is responsible for purchasing, program and service development for mental health, chemical dependency, long term services and supports, and services to individuals with developmental disabilities.

APPENDIX 2. CMS STANDARDS AND CONDITIONS AND SUPPORTING STATE DOCUMENTATION

To participate in the Demonstration, each State submitted a proposal outlining its approach. The proposal had to meet a set of standards and conditions. The table below crosswalks the standards and conditions to their location in the Washington proposal. Following the submission of the proposal, CMS asked the State a number of questions when there was ambiguity of whether or not the proposal met the Standards and Conditions. These questions and responses are included in the Addendum to the proposal, which will be posted on CMS’ website with the proposal.

Figure 2-1: 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. 1, 2, 7, 13-15, 17, 18, Appendix H (p. 50)
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. 5, 7, 8, 10, 11, 13-15, 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. 1, 3, 5, 10, 13-15, 19-22, 26, 33, Appendix I (p. 51), Appendix J (p. 52), Appendix L (p.57), Appendix V (p. 104)
	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, Appendix 1 (p. 51), Appendix N (pp. 61-64), Appendix O (pp.65-67)
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 MMIP governing boards and/or establishment of beneficiary advisory boards).	pp. 2-3, Appendix L (pp. 57-58), Appendix R (p.76)
	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. 5, 23-25, Appendix N (pp.61-64)
Beneficiary Protections (continued)	Ensure privacy of Enrollee health records and provide for access by Enrollees to such records.	pp. 24, 25, 104
	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. 2, 5, 9, 13-15,18-20
	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. 5,13-15, 23-25 Appendix N (pp.61-64)
	Ensure an adequate and appropriate provider network, as detailed below.	pp. 5, 10, 13-15, 17, 18 Appendix H (p. 50)
	Ensure that beneficiaries are meaningfully informed about their care options.	pp. 5, 13-15, 24-25
	Ensure access to grievance and appeals rights under Medicare and/or Medicaid.	pp. 23-25
	<i>For Capitated Model</i> , this includes development of a unified set of requirements for MMIP complaints and internal appeals processes.	pp. 23-25
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. 7, 32-34, Appendix C (pp. 39-41)
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. 5, 7, 10-11,13-15, 17-20, 24, 29, Appendix C (pp. 39-41), Appendix H (p. 50)
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	pp. 29-31, Appendix P (pp. 68-70)

	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.	
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.26,30, Appendix V (p. 105)
	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. 29, Appendix V (p. 105)
	State supplemental payments to providers (e.g. Disproportionate Share Hospital payments, Upper Payment Limit payments) during the three-year period.	p. 30, Appendix V (p. 105)
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, 5, 10-11,13-15, Appendix E (p. 45), Appendix H (p. 50)
Expected Savings	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	pp. 2, 26-28,30-31, 32, Appendix D (pp. 42-44), Appendix E (p. 45), Appendix Q (pp. 71-75)
Public Notice	State has provided sufficient public notice, including:	
	At least a 30-day public notice process and comment period;	pp. 3, 17, 22-23, 58-59
	At least two public meetings prior to submission of a proposal; and	pp. 2-3, 22, Appendix L (pp.57-59)
	Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals.	p. 22
Implementation	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation:	
	Meaningful stakeholder engagement.	p. 3, 10-11, 22-23, 25, Appendix I (p. 51), Appendix J (pp. 52-55), Appendix L (pp.57-59), Appendix N (pp. 61-64)
	Submission and approval of any necessary Medicaid waiver applications and/or State Plan Amendments.	pp. 2, 13-15, 19-20, 27
	Receipt of any necessary State legislative or budget	Appendix G (p. 49)

	authority.	
	Joint procurement process (for capitated models only)	pp. 3, 13-15, Appendix H (p. 50)
	Beneficiary outreach/notification of enrollment processes, etc.	pp. 13-15, 24, 26, 57-58, Appendix N (pp. 61-64)

APPENDIX 3. DETAILS OF STATE DEMONSTRATION AREA

The Demonstration will be implemented in two counties (service areas) of the State: King County and Snohomish County.

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 MMIPs and their sponsoring organizations for the Demonstration period beginning no earlier than July 1, 2014 through December 31, 2017, 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 “[t]he 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 MMIPs to Medicare-Medicaid Enrollees residing in King or

Snohomish County, and including beneficiaries who may have end-stage renal disease, and excluding individuals who may meet exclusion criteria specified in Section III.C.1 of this MOU, 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, medical loss ratios 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 medical loss ratio requirements, 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 State 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 MMIPs 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 regulations, not expressly waived in this list, shall apply to the Medicare-Medicaid Integration Demonstration beginning no earlier than July 1, 2014 through December 31, 2017 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.

This Demonstration and the additional authority referenced below are contingent upon submission and approval of all documentation necessary to demonstrate compliance with the Medicaid requirements under 42 CFR Parts 438 and 441 for enrollment of the Demonstration population into managed care, including, but not limited to the submission of concurrent authority to the relevant 1915(c) programs via the State's next amendments and the submission of a Social Security Act Section 1932(a) State Plan Amendment. The State will submit waiver amendments for the Demonstration no later than April 1, 2014. The State will also submit a 1932(a) SPA for CMS review. Implementation of this Demonstration is contingent upon the state receiving approval for the 1915(c) amendments and the 1932(a) authority. The State must meet all requirements of the State Plan and any approved Medicaid Waiver as expressed in the terms of those authority documents, including, but not limited to, all financial, quality, reporting and monitoring requirements of the waiver, and State financing contained in the State's waiver must be in compliance with Federal requirements. This MOU does not indicate or guarantee CMS approval of any necessary authority for managed care under 42 CFR Parts 438 and 441.

Assessment of actuarial soundness under 42 CFR 438.6, in the context of this Demonstration, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. 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 in the context of this Demonstration.

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 State to carry out the Demonstration. These authorities shall be in addition to those in the State Plan and 1915(c) waivers

Statewideness

Section 1902(a)(1)

To enable Washington to provide managed care plans or certain types of managed care plans (integrated care for Medicare-Medicaid enrollees) only in certain geographical areas of the State.

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 State to follow the specified methodology outlined in Appendix 6.

APPENDIX 6. PAYMENTS TO MMIPS

CMS and the Washington State Health Care Authority (HCA) and Department of Health Services (DSHS) 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 projected baseline spending contributions;
2. Demonstration savings percentages assume that MMIPs are responsible for the full range of Covered Services and Flexible Benefits under the Demonstration;
3. Aggregate savings percentages will be applied equally to the Medicaid and Medicare Parts A and B components; and
4. Both CMS and HCA 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, if any, 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	July 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

Figure 6-2: Summary of Payment Methodology under the Demonstration

Rate Element	Medicare Parts A and B	Medicare Part D	Medicaid
<p>2014 Baseline costs for the purposes of setting payment rates</p> <p>Medicare baseline spending will be established prospectively on a calendar year basis for each Demonstration county.</p> <p>Medicaid baseline spending amounts will be set up front and will be applied in future years unless more recent historical data are available and/or CMS’ actuaries and HCA determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.</p>	<p>Blend of Medicare Advantage payments and Medicare standardized Fee-For-Service (FFS) weighted by where Medicare Medicaid Enrollees 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.</p>	<p>National average monthly bid amount (NAMBA) will be used as the baseline for the direct subsidy portion of Part D spending.</p> <p>Note that additional costs associated with LIS 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.</p>	<p>Historical State data, with base data and trend rates developed by State actuaries, subject to CMS review.</p>
Responsible for producing data	CMS	CMS	HCA, validated by CMS
Savings percentages	<p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 2%</p> <p>Demonstration Year 3: 3%</p>	Not Applicable	<p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 2%</p> <p>Demonstration Year 3: 3%</p>
Risk adjustment	<p>Medicare Advantage</p> <p>CMS-HCC Model</p>	Medicare Part D RxHCC Model	Rate Cell Structure with Risk Adjustment using methodology described in section IV below
Quality withhold	<p>Applied</p> <p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 2%</p> <p>Demonstration Year 3: 3%</p>	Not applied	<p>Applied</p> <p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 2%</p> <p>Demonstration Year 3: 3%</p>
Other Payment Provisions	Minimum Medical Loss Ratio (MLR)	Existing Medicare Part D Processes will apply	MLR

I. 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 II and III) to the baseline spending amounts.

A. Medicaid:

1. The data sources for development of the Medicaid component of the rate for Demonstration Year 1 are based on Washington fee-for-service and encounter data for State Fiscal Years 2010 through 2012. The Medicaid component of the rate for Demonstration Years 2 and 3 will use updated Washington fee-for-service and encounter data, as available at the point of rate setting for each Demonstration Year.
2. Prior to implementation of the Demonstration, HCA 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 payments, and will be trended forward to the Demonstration period.
3. The State 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).
4. Except for updates based on more recent historical data, updates to the Medicaid baseline will not be allowable unless CMS determines the update would result in a substantial change to the baseline necessary to calculate accurate payment rates for the Demonstration.

5. Medicaid payment rates will be determined by applying annual saving percentages (see Sections II and III) to the applicable baseline spending amounts.

B. Medicare Parts A/B:

1. 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 Enrollees absent the Demonstration.
2. 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.

CMS may adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

3. Medicare A/B payment rates will be determined by applying the annual savings percentages (see Sections II and III) to the baseline spending amounts.
4. 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 Demonstration for each year. Enrollee risk scores will be applied to the standardized payment rates at the time of payment.

5. CMS may require HCA to provide a data file for Enrollees 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.
6. 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 Medicare Advantage rate announcement.
7. 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 (FFS) Medicare programs. The adjustment for 2014 is 4.91%. The majority of new Demonstration Enrollees will come from Medicare FFS, and 2014 Health Plan risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the MMIPs themselves. In calendar year 2014, CMS will apply an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis. In CY 2015, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration Enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2014. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Enrollees.

C. Medicare Part D:

1. 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 Medicare Part D sponsors.

2. The CY 2014 Medicare Part D NAMBA is \$75.88.

II. Aggregate Savings Percentages Under the Demonstration

- A. Both Parties agree that there is reasonable expectation for achieving savings while paying MMIPs capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to Enrollee needs. The savings percentages will be:
 1. Demonstration Year 1: 1%
 2. Demonstration Year 2: 2%
 3. Demonstration Year 3: 3%
- B. The savings percentages will be calculated and applied based on Demonstration Years. Rate updates will take place on January 1st of each calendar year.

III. Application of Aggregate Savings Percentages to Each Component of the Integrated Rate

The aggregate savings percentages identified above will be applied to the Medicare A/B and Medicaid components of the rate. Changes to the savings percentages under Section II of Appendix 6 would only occur if and when CMS and HCA jointly determine the change is necessary to calculate accurate payment rates for the Demonstration.

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

IV. Rate Structure and Risk Adjustment Methodology for the Medicaid Component of the Rates

- A. The Medicaid component will employ the rating categories described below, with the capitated rate paid to each MMIP under the Demonstration delivered as three composite

payment rates (medical and chemical dependency, mental health and LTSS) developed from the following rate categories:

Figure 6-3: Medicaid Component Rate Categories

Medical & Chemical Dependency	Mental Health	Long-Term Services and Supports (LTSS)
ILOC	Disabled	ILOC – Institutional
Non-ILOC	Non-Disabled	ILOC – HCBS
		Non-ILOC

ILOC = institutional level of care

Disabled = Disabled per the Social Security Administration (Defined by the Social Security Administration for Supplemental Security Income (SSI) as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months with available treatment.)

1. Rates paid in the period July 2014 to August 2014 will be based on an average mix of acuity for medical, chemical dependency, mental health and LTSS found in the eligible population, with geographic and age/gender adjustment factors. For Medical & Chemical Dependency and Long-Term Services and Supports, rates during this initial two month period will be paid at the Non-ILOC rates for the categories shown in Figure 6-3. To the extent ILOC individuals enroll during this period, rates for the ILOC cohorts will be applied retroactively. Mental Health rates will vary for disabled and non-disabled Enrollees during this period. The risk adjustment methodology described below applies to the period beginning after the initial two month opt-in enrollment period.
2. The Medicaid component will initially be risk adjusted during the rate setting process by establishing base medical costs, mental health and LTSS costs in the categories outlined above.
 - a. No diagnosis-based risk adjustment will be applied to the Medicaid medical and chemical dependency component of the rate.

- b. The mental health component of the Medicaid rate will be risk adjusted based on historical claims and encounter data for the eligible population. The risk adjustment model will use age and gender along with behavioral health diagnosis and psychotropic medication data initially derived from integrated Medicare Parts A, B and D data, and Regional Support Network encounter data. In subsequent years, MMIP encounter data will be integrated into mental health risk scoring for MMIP-enrolled clients. HCA, DSHS and their actuaries will finalize the mechanism for this risk adjustment prior to January 1, 2014, subject to CMS approval. The mental health risk adjustment process will include those eligible clients not enrolled in the MMIP as a separate cohort, or MMIP plan equivalent. The risk adjustment process will generate an aggregate risk score of 1.000; however, the impact on the MMIP plans may not be budget neutral due to variations in member mix and enrollment in the Demonstration. The mental health risk adjustment will be applied prospectively on July 1, 2014, for CY 2014 rates and on January 1 of each subsequent calendar year.
- c. The LTSS component of the Medicaid rate will be risk adjusted based on age, gender and classification levels derived from MDS and CARE functional assessment data for the enrolled population. Risk adjustment of the Medicaid LTSS component of the MMIP capitation for the institutional level of care population will use MDS classification levels, and risk adjustment for the ILOC-HCBS population will use CARE classification levels. HCA, DSHS, and their actuaries will finalize the mechanism for this risk adjustment prior to January 1, 2014, subject to CMS approval. The initial LTSS risk adjustment will be applied prospectively based on July 2014 enrollment; there will be a revised calculation of the prospective risk scores based on enrollment in the month following the last phase of passive enrollment, with prospective revised risk scores to be applied 4-6 months after launch of the program. The Medicaid LTSS adjustment process will include those eligible clients not enrolled in the MMIP as a separate cohort, or MMIP plan equivalent. The risk adjustment process will generate an aggregate risk score of 1.000; however, the impact on the MMIP plans may not be budget neutral due to variations in member mix and

enrollment in the Demonstration. The LTSS risk adjustment will be applied prospectively on January 1 of each subsequent calendar year.

- d. Geographic Variance – Rates will vary by county as determined by HCA and their actuaries.
- e. Age/Gender – Rates will vary by age and gender as deemed necessary after a review of the data by HCA and their actuaries, and subject to CMS review.
- f. The composite payment rate to each MMIP will reflect the membership mix at the beginning of the period (Demonstration Year). At the State’s discretion, changes in enrollment (due to new enrollment or disenrollment) in MMIPs during the contract period may result in a prospective update to the MMIPs’ composite rates. Updates to the membership mix outside of those resulting from changes in enrollment will occur no more frequently than each Demonstration Year.

V. Risk Adjustment Methodology for Medicare Components of the Rates

- 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 I.B.7. , the existing CMS-HCC and CMS-HCC ESRD risk adjustment methodologies 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.

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

- A. Under the Demonstration, both payers will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to MMIPs’ 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 State-specified quality

measures.

B. Withhold Measures in Demonstration Year One:

1. Figure 6-3 below identifies core withhold measures for Demonstration Year One. Together, these will be utilized as the basis for the 1% withhold. Additional detail regarding the agreed upon measures will be included in the Three-Way Contract.
2. Because Demonstration Year One crosses calendar/contract years, MMIPs will be evaluated to determine whether they have met required quality withhold requirements at the end of both CY 2014 and CY 2015. The determination in CY 2014 will be based solely on those measures that can be appropriately calculated based on actual enrollment volume during CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each CY.

Figure 6-4: Quality Withhold Measures for Demonstration Year 1

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/HCA defined process measure	X	X
Assessments	Percent of Enrollees with initial Individualized Care Plan assessments completed within 90 days of enrollment, per Washington’s Model of Care Requirements.	CMS/HCA defined process measure	X	
Enrollee Governance Board	Establishment of Enrollee advisory board or inclusion of Enrollees on governance board consistent with contract requirements.	CMS/HCA defined process measure	X	
Customer Service	Percent of best possible score the MMIP earned on how easy it is to get information and help when needed. <ul style="list-style-type: none"> 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	
Getting Appointments and Care Quickly	Percent of best possible score the MMIP earned on how quickly members get appointments and care <ul style="list-style-type: none"> In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last six 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? In the last six months, how often did you see the person you came to see within 15 	AHRQ/CAHPS	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
	minutes of your appointment time?			
Documentation of Care Goals	Percent of Enrollees in Tier 3 enrolled at least 90 days with documented discussion of care goals in the Health Action Plan.	State defined process measure		X
Retention Rate - All	Percent of Enrollees assigned to the MMIP who are retained for 6 months.	State defined process measure		X
Retention Rate - LTSS	Percent of Enrollees assigned to the MMIP who received long term care services and supports in month 1 and were retained for 6 months.	State defined process measure		X
Retention Rate – Mental Illness	Percent of Enrollees assigned to the MMIP with a history of mental illness retained for 6 months.			X
Retention Rate – Substance Abuse	Percent of Enrollees assigned to the MMIP with a history of substance abuse diagnosis retained for 6 months.			X
Transition of Enrollees Between Community, Waiver and LTSS Services	Report of the number of members moving from: institutional care to waiver services, community to waiver services, community to institutional care and waiver services to institutional care.	State defined process measure		X

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

C. Withhold Measures in Demonstration Years Two and Three

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

Figure 6-5: Quality Withhold Measures for Demonstration Years 2 and 3

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Plan All-Cause Hospital Readmissions	Percent of Enrollees 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 MMIP 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 Enrollees 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	
Screening for Clinical Depression and Follow-up Care	Percentage of Enrollees ages 21 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	
Reducing the Risk of Falling	Percent of Enrollees 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	
Controlling Blood Pressure	Percentage of Enrollees 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	
Part D Medication Adherence for Oral Diabetes Medications	Percent of MMIP 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	
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure		X
Documentation of Care	Percent of Enrollees in Tier 3	State defined		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Goals	enrolled at least 90 days with documented discussion of care goals in the Health Action Plan.	process measure		
Behavioral Health Utilization	The percentage of Medicare-Medicaid Enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	NQF #0004, CMS, NCQA		X
Behavioral Health Utilization	Percent of Medicaid-Medicare enrollees aged 12 and older screened for clinical depression using an age appropriate standardized tool and if positive, a follow-up plan is documented on the date of the positive screen.	NQF #0418, CMS		X
LTSS Utilization	HCBS Service Plans are delivered in accordance with the Individualized Care Plan, including in the type, scope, amount, duration, and frequency specified in the plan.	State defined process measure		X

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

2. Additional detail regarding the agreed upon measures will be specified in the Three-Way Contract. Metrics applicable to individuals younger than 21 based on technical specifications may be modified to reflect Washington’s Demonstration target population.

VII. Payments to MMIPs

- A. CMS will make separate monthly, risk-adjusted payments to the MMIPs for the Medicare Parts A/B, and D components of the rate, based on standardized Demonstration payment rates. Medicare A/B 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. HCA will make a payment to the MMIPs for the Medicaid component of the rate.
- C. The capitated payment from CMS and HCA is intended to be adequate to support access to and utilization of Covered Services, according to Enrollees' Individualized Care Plans. CMS and HCA will jointly monitor access to care and overall financial viability of MMIPs accordingly.

VIII. Evaluate and Pay MMIPs Relative to Quality Withhold Requirements

- A. CMS and HCA will evaluate MMIP performance according to the specified metrics required in order to earn back the quality withhold for a given year. CMS and HCA will share information as needed to determine whether quality requirements have been met and calculate final payments to each MMIP from each payer.
- B. Whether or not each MMIP has met the quality requirements in a given year will be made public, as will relevant quality scores of MMIPs in Demonstration Years Two and Three

IX. Minimum Medical Loss Ratio, Cost Reconciliation, and Rate Review

- A. **Minimum Medical Loss Ratio:** Each MMIP will be required each year to meet a minimum Medical Loss Ratio (MLR) threshold which regulates the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments after final risk adjustment) that must be used for expenses either directly related to medical claims or those which are related to the care and quality of Enrollees.
 - 1. If a MMIP has an MLR below 85% of the joint Medicare and Medicaid payment to the MMIPs, the MMIP must remit the amount by which the 85% threshold exceeds the MMIP's actual MLR multiplied by the total applicable revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicare and Medicaid programs on a percent of premium basis.

2. If a MMIP has an MLR between 85% and 90% of the joint Medicare and Medicaid payment to the MMIPs, such MMIP must remit 50% of the amount by which the 90% threshold exceeds the MMIP's actual MLR multiplied by the total applicable revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicare and Medicaid programs on a percent of premium basis.

The Three-Way Contracts will include additional specifications on the MLR. To the maximum extent possible, the methodology for calculating the MLR will conform to prevailing regulatory requirements applicable to the other products offered by organizations operating MMIPs.

- B. **Cost Reconciliation:** Cost reconciliation under Medicare Part D will continue as-is under the Demonstration. CMS will monitor Part D costs closely on an ongoing basis. Any material increase in Part D costs relative to the baseline may be factored into future Demonstration Year savings percentages.
- C. **Rate Review Process:** CMS and HCA will review MMIP financial reports, encounter data, and other information to assess the ongoing financial stability of the MMIPs and the appropriateness of capitation payments.

In the event that both MMIPs show MLRs below 85% when aggregated over both counties in which those MMIPs plans participate, or in the event that both MMIPs show MLRs above 95%, CMS and the State will review the MMIP financial reports, encounter data, and other information to assess the ongoing financial stability of the MMIPs and the appropriateness of capitation payments. At any point, the State may request CMS review documentation from specific MMIPs 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.

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 baselines (and therefore the corresponding payment rate) outside of the annual Medicare Advantage rate announcement would occur only if and when CMS and the State determine the change is necessary to calculate accurate payment rates for the Demonstration. For changes solely affecting the Medicare program baseline, CMS will consult with the State prior to making any adjustment, but State concurrence will not be required. Changes may be based on the following factors: shifts in enrollment assumptions; major changes or discrepancies in Federal law and/or State policy compared to the assumptions about Federal law and/or State law or policy used in the development of baseline estimates; and changes in coding intensity. CMS and/or the State will make changes to baseline estimates after identification of the need for such changes, and changes will be applied, if necessary on a retrospective basis, to effectuate accurate payment rates for each month.
- B. Changes to the savings percentages would occur if and when CMS and the State jointly determine that changes in Medicare 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 9, 2013 Health Plan Management System (HPMS) guidance. CMS and the State have further established 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 in Appendices 4 and 5.

I. Washington Delegation of Administrative Authority and Operational Roles and Responsibilities

The Washington State Health Care Authority (HCA) is the single state agency for the Medicaid program. Through authority delegated by the HCA, the Department of Social and Health Services (DSHS) is responsible for the provision and oversight of mental health, chemical dependency, developmental disability, and LTSS to individuals eligible for Medicaid. Together, these two agencies directly oversee the staff 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 HCA and DSHS as described below.

To fully support the State's integration efforts and to align the work of the two agencies to achieve the goals of integration, the Demonstration is jointly sponsored and oversight of the work of this Demonstration is shared across these agencies. An Integration Executive Leadership Team made up of the State's HCA Director, Medicaid Director, the Secretary of the Department of Social and Health Services, and policy and budget staff from the Governor's office meet on a routine basis to ensure the goals of the Demonstration are reached.

In addition the HCA, the DSHS, Snohomish County, King County, and the City of Seattle, as the sponsoring public agencies for the Demonstration in the King County and Snohomish County coverage areas, are committed to actively participate with the selected

MMIPs in the governance of the Demonstration to achieve the intended goals. The Project Governance Team will be a forum for open communication, shared expertise, and collective decision-making in an environment that fosters continuous review of the Demonstration's performance and timely action to resolve identified problems and undertake timely action on identified opportunities to improve service for Enrollees.

II. Plan or Qualified Entity Selection

Washington State issued a Request for Applications (RFA) in April 2013 that included Washington's HCA/DSHS and CMS requirements to function as a Medicare-Medicaid Integration Plan (MMIP) under this Demonstration. The State's RFA is available at the following websites: <http://www.hca.wa.gov/Pages/rfp.aspx> and <http://www.aasa.dshs.wa.gov/duals/>.

The HCA/DSHS engaged in a joint selection process that considered previous performance in Medicare and Medicaid. HCA/DSHS limited the number of selected MMIPs per county to a certain number (no more than 2 qualified bidders in each county) from the qualifying bids, utilizing information from the RFA allowed HCA/DSHS to rank the bidders.

Applicants are also required to meet the Medicare components of the plan selection process, including submission of a successful Medicare Capitated Financial Alignment application that encompasses Part C and Part D requirements to CMS. Successful applicants are required to adhere to annual contract renewal requirements and guidance updates.

Participation in the Demonstration is contingent on the selected entities passing a CMS and State of Washington sponsored Readiness Review. Upon final Readiness Review determinations, the State and CMS will ultimately enter into a Three-Way Contract with selected plans.

III. State Level Enrollment Operations Requirements

- A. Eligible Populations/Excluded Populations: As described in Section C.1 of the MOU.
- B. Enrollment and Disenrollment Processes: All Enrollment and Disenrollment-related

transactions, including enrollments from one MMIP to a different MMIP, will be processed through Washington's MMIS system – ProviderOne – except those transactions related to non-Demonstration plans participating in Medicare Advantage. The State 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. CMS will also submit a file to the State identifying individuals who have elected to disenroll from a MMIP, opt-out of Passive Enrollment or enroll in another type of available Medicare coverage. The State will share enrollment, disenrollment and opt-out transactions with MMIPs.

Enrollment and disenrollment methods include enrollment and disenrollment forms, Medical Assistance Customer Service Center (MACSC) staff, an Interactive Voice Recognition system and a web-based portal.

Enrollees may access independent enrollment assistance and options counseling offered by the State's Area Agencies on Aging (AAA) to help them make an enrollment decision that best meets their needs. CMS and the State will work together to support the State Health Insurance Assistance Program (SHIP), ADRC options counseling, and other community-based, nonprofit organizations to ensure ongoing outreach, education and support to Enrollees in understanding their health care coverage and LTSS options.

- C. Uniform Enrollment and Disenrollment Letters and Forms: Letters and forms will be agreed to by both CMS and the State, and will be made available to stakeholders. A state specific handbook will contain an enrollment and disenrollment form which may be mailed or faxed to the Medical Assistance Customer Service Center (MACSC) for processing.
- D. Enrollment and Disenrollment Effective Date(s): All enrollment effective dates are prospective. Enrollee-elected enrollment (opt-in enrollment) will be effective the first calendar day of the month following the initial receipt of a beneficiary's request to enroll, so long as the request is received by the 2nd to the last business day of the month (excluding weekends and holidays). Enrollment requests, including requests to change from one MMIP to a different MMIP, received after the 2nd to the last day of the month

(excluding weekends and holidays) will be effective the first day of the second month following the initial receipt of the request. Passive enrollment is effective no sooner than 60 days after Enrollee notification of plan selection and the option to decline passive enrollment.

All disenrollment requests will be effective from the first day of the month following the receipt of an Enrollee's request to disenroll from the Demonstration.

The Demonstration will use a phase-in approach, as follows:

1. Opt-in enrollment will begin no earlier than July 1, 2014. MMIPs will begin marketing for opt-in enrollment no earlier than June 1, 2014, with those opting into the Demonstration being able to receive services the following month. MMIPs will be required to accept opt-in enrollments no earlier than 30 days prior to the initial effective date of July 1, 2014, and MMIPs must begin providing coverage for those enrolled individuals on July 1, 2014.
2. The passive enrollment process for those Enrollees who have not made a plan selection will begin no earlier than July 1, 2014, with enrollment effective no earlier than September 1, 2014. Passive enrollment will be conducted in three phases, with enrollment for Phase One, Phase Two and Phase Three beginning September 1, 2014, November 1, 2014, and January 1, 2015, respectively. Enrollee assignment to each phase of passive enrollment will be based on random assignment within each county's eligible population. Such assignment will take into consideration the number of opt-in enrollments prior to Phase Two and Phase Three and the disenrollment rate for each MMIP. Starting February 2015, passive enrollment of newly eligible beneficiaries will be done monthly.
3. The effective dates above are subject to MMIPs meeting CMS and the State's requirements, including successfully passing the Readiness Review and MMIPs' capacity to accept new Enrollees.

4. Under passive enrollment, the State will provide notice of passive enrollments at least 60 days prior to the effective date of a passive enrollment period, and will accept opt-out requests through the last day of the month prior to the effective date of enrollment. The 60-day notice will include the name of the MMIP in which the Enrollee would be enrolled unless he/she selects another MMIP or indicates the option to opt out of the Demonstration. This notice will explain the Enrollee's options, including the option to opt-out of the Demonstration.
5. At least 30 days prior to the passive enrollment effective dates, the State will send a second notice to Enrollees who have not responded to the initial notice or opted in. The notice will include the name of the MMIP in which the Enrollee would be enrolled unless he/she selects another MMIP or indicates the option to opt out of the Demonstration. The State will proceed with passive enrollment into the identified MMIP for Enrollees who do not make a different choice, with an effective date of the first day of the month referenced in Section D.1 above. Requests to disenroll from a MMIP, enroll in a different MMIP, or opt-out will be accepted at any point after an individual's initial enrollment occurs and are effective on the first day of the month following receipt of request. Any time an individual requests to opt out of passive enrollment or disenrolls from the Demonstration, the State will send a letter confirming the opt-out and will provide information on the benefits available to the Enrollee once he/she has opted out or disenrolled.
6. Enrollees subject to Medicare reassignment effective January 1, 2014, either from their current (2013) Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Drug Plan (MA-PD) to another PDP, will not be eligible for passive enrollment during CY 2014. Individuals eligible to be reassigned to a new PDP effective January 1, 2015, and meeting all eligibility criteria for the Demonstration will be eligible for passive enrollment into a MMIP effective no earlier than January 1, 2015.

7. The State and CMS must agree in writing to any changes to the enrollment effective dates. CMS will provide identifying information to the State about Enrollees that CMS anticipates will be reassigned for a January 1 of the following year effective date, no later than 120 days prior to the date of the first passive enrollment period.
- E. Upon CMS' or the State's written determination that the Demonstration will not be renewed, no enrollments will be accepted within six (6) months of the end of the Demonstration.
 - F. Passive enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto and facilitated enrollment for individuals with the Medicare Part D Low Income Subsidy (LIS).
 - G. During July 1, 2014, to August 30, 2014, CMS and the State will monitor each MMIP's ability to manage opt-in enrollments. Dependent on each MMIP's capacity, as determined by its ability to manage the opt-in enrollments and the prior month's passive enrollments (once applicable), the State will passively enroll a number of Enrollees into MMIPs for Phase Two and Phase Three that takes into consideration the number of opt-in enrollments prior to the start of Phase Two and the disenrollment (excluding involuntary disenrollment) rate for each MMIP.
 - H. The State will provide customer service, including mechanisms to counsel Enrollees notified of passive enrollment. The HCA will receive and communicate Enrollee choice of opt-outs to CMS' contractor, who will communicate the choice to CMS via transactions to CMS' MARx system. Enrollees will also be provided a notice upon completion of the opt-out process. Medicare resources, including 1-800-Medicare, will remain available to Medicare Enrollees; Enrollee requests made to 1-800-Medicare for enrollment, changes among MMIPs, or disenrollment will be referred to the State for customer service and enrollment support.
 - I. CMS and the State will jointly approve all Demonstration enrollment notices 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 jointly approved notice to Enrollees and will coordinate such notice with any State notice(s).

- J. Enrollment data in State and CMS systems will be reconciled on a timely basis to resolve discrepancies between such systems.

IV. State Level Delivery System Requirements

- A. State Requirements for Care Management: Care Management services will be available to all MMIP Enrollees, as described below and summarized in Table 7-1.

Each Enrollee shall receive, and be an active participant in, initial screenings and ongoing health risk assessments of medical, behavioral health and LTSS needs, which will be used as the starting point for creating an Individualized Care Plan (ICP). MMIPs will be encouraged to coordinate the various screenings and assessments whenever possible, as appropriate. Enrollees in Tier Three will work with the MMIP to develop a Health Action Plan to be incorporated in the Enrollee ICP. The Interdisciplinary Care Team will convene to discuss and help develop the Enrollee's ICP to achieve team-defined health goals for the Enrollee, based upon his/her individual needs and preferences.

MMIPs will be required to address the following components as part of their comprehensive programs. Through the Readiness Review process, CMS, the State and County Representatives will review the MMIP capacity to deliver Care Management services to ensure that all required components are adequately addressed.

1. *Enrollee Assessment and Stratification*: Enrollees will be stratified into one of three tier levels using information from their initial and secondary screening, health risk assessment, PRISM, and/or other utilization data for Enrollees. Enrollees receiving LTSS services will be stratified into either Tier Two or Tier Three, depending on the criteria below:

- a. Tier One – Supported Self-Intervention: Enrollees who do not fall under Tier Two or Three.

- b. Tier Two – Disease/Episodic Care Management: Includes Enrollees who have chronic diseases that pose low to moderate risks for acute episodes, cognitive deficits, traumatic brain injury, no informal resources, are homeless, an anxiety diagnosis, frequently call 911 for assistance, have frequent hospitalizations/ER use, have had a psychological hospitalization in the past year or are receiving paid assistance with activities of daily living (ADLs). Includes, as applicable, Enrollees receiving LTSS services.

- c. Tier Three – Intensive Care Management for Enrollees with Special Health Care Needs: Includes Enrollees who have a PRISM risk score of 1.5 or greater and at least one chronic condition. Includes, as applicable, Enrollees receiving LTSS services.

MMIPs will continue to analyze PRISM reports and other utilization data for all Enrollees to identify potential tier level changes. A Health Risk reassessment may be completed prior to the regular timeline if warranted by a potential change in tier level as determined by PRISM and utilization data analysis.

MMIPs should coordinate screening and assessment visits as much as possible to minimize burden on the Enrollees.

Figure 7-1: Model of Care, Assessment, and Plan of Care Expectations

	Tier One Enrollees	Tier Two Enrollees	Tier Three Enrollees
Enrollee Tier Stratification	Supported Self-Intervention: Enrollees who do not fall under Tier Two or Three.	Disease/Episodic Care Management: Includes Enrollees who have chronic diseases that pose low to moderate risks for acute episodes, cognitive deficits, traumatic brain injury, no informal resources, are homeless, an anxiety diagnosis, frequently call 911 for assistance, have frequent hospitalizations/ER use, have had a psychological hospitalization in the past year or are receiving paid assistance with activities of daily living (ADLs). Includes, as applicable, Enrollees receiving LTSS services.	Intensive Care Management for Enrollees with Special Health Care Needs: Includes Enrollees who have a PRISM risk score of 1.5 or greater and at least one chronic condition. Includes, as applicable, Enrollees receiving LTSS services.
Initial Health Screen	Within 30 days of enrollment, evaluate the Enrollee's Tier Level	Same as Tier One.	N/A
Secondary Health Screen	Within 10 days after Initial Health Screen and if warranted based upon Initial Health Screen, evaluate the Enrollee's needs for further treatment (for example, screening positive for use of alcohol triggers additional questions about use).	Same as Tier One.	N/A

	Tier One Enrollees	Tier Two Enrollees	Tier Three Enrollees
Health Risk Assessment (HRA)	Within 60 days of enrollment when the initial and secondary health screening indicates a need for the HRA.	Within 60 days of enrollment when the Initial and Secondary Health Screens indicates a need for the HRA. Requires a face-to-face visit with the Enrollee at his/her home or place of his/her choice.	For Enrollees With Special Health Care Needs, bypass Initial and Secondary Health Screens and conduct the Health Risk Assessment within 30 days of enrollment. Requires a face-to-face visit with the Enrollee at his/her home or place of his/her choice.
On-going Health Risk Assessments	At least annually or whenever an Enrollee experiences a major change in health.	At least once every six months or whenever an Enrollee experiences a major change in health. Requires an annual face-to-face visit with the Enrollee at his/her home or place of his/her choice.	At least every four months or whenever an Enrollee experiences a major change in health. Requires an annual face-to-face visit with the Enrollee at his/her home or place of his/her choice.
Individualized Care Plan (ICP)	Within 90 days of enrollment, receive an ICP for a course of treatment or regular care monitoring. Enrollees must be evaluated and contacted annually and the ICP updated as part of that annual review.	Within 90 days of enrollment, receive an ICP for a course of treatment or regular care monitoring. Updated within 30 days of HCBS eligibility to include applicable services. Enrollees must be contacted every four months. The ICP must be evaluated every six months or more often if there are changes in an Enrollee's health. The ICP will act as the HCBS Service Plan for those who are receiving HCBS waiver services.	Within 90 days of enrollment, receive an ICP for a course of treatment or regular care monitoring. Updated within 30 days of HCBS eligibility to include applicable services. Enrollees must be contacted every four months. The ICP must be evaluated every six months or more often if there are changes in an Enrollee's health. The ICP will incorporate the HAP. The ICP will act as the HCBS Service Plan for those who are receiving HCBS waiver services.

	Tier One Enrollees	Tier Two Enrollees	Tier Three Enrollees
Health Action Plan (HAP)	N/A	N/A	Within 30 days of enrollment, conduct the Health Action Plan. Requires a face-to-face visit with the Enrollee at his/her home or place of his/her choice. The HAP will be incorporated into the ICP. HAPs are updated every six months, unless there is a change in circumstances that warrant an update. New HAPs are developed every 12 months.
Patient Activation Measure (PAM)	N/A	N/A	Within 30 days of enrollment and updated every four months, in conjunction with additional pre-approved and standardized health screen updates.
Interdisciplinary Care Team (ICT)	Access to an ICT and based upon need, include primary care providers, mental health providers, chemical dependency treatment providers, direct care workers, nutritionists/dieticians, social workers, pharmacists, peer specialists, family members or housing representative.	Same for all Tiers.	Same for all Tiers.
Care Manager	Primarily responsible for coordination of the Enrollee's care. Provides referral assistance for covered and non-covered services, and connections to local community services.	Primarily responsible for coordination of Enrollee's care. Provides referral assistance for covered and non-covered services and connections to local community services. Provides prevention and wellness messaging and condition specific education materials.	N/A

	Tier One Enrollees	Tier Two Enrollees	Tier Three Enrollees
Intensive Care Coordinator	N/A	N/A	Primarily responsible for high touch coordination of Enrollee's care, using face-to-face interactions.
HCBS Level of Care Assessment	N/A—Enrollees with HCBS will be in Tiers Two and Three	Performed by the State or its designee at least annually or whenever an Enrollee experiences a major change in health.	Same as Tier Two.
Nursing Facility Level of Care Assessment	Performed by the State or its designee.	Same as Tier One.	Same as Tier One.

2. *Screening Tools* (See Figure 7-1): MMIPs will administer a State-approved Initial Health Screen within 30 days of an Enrollee's enrollment for Beneficiaries in Tier One and Tier Two. If warranted by a positive result of the Initial Health Screens for chemical dependency, mental health, or long term services and supports, or based on clinical judgment, a more in-depth Secondary Health Screen should be performed immediately and no later than 10 days of the Initial Health Screen. For Enrollees in Tier Three (Enrollees with Special Health Care Needs) the Initial and Secondary Health Screens will be bypassed based on a PRISM score of 1.5 or more, and a Health Risk Assessment will be conducted.

The Health Screenings will collect information about the Enrollee's medical, psychosocial, functional, cognitive needs, medical and behavioral health (including substance use) history. MMIPs will use the screening information, along with PRISM data, to determine what care management tier will best meet the Enrollee's needs and guide the development of an Individualized Care Plan (ICP, see Section 7.IV.A.5 below). MMIPs will supplement the Initial Health Screen with predictive modeling and utilization data to stratify Enrollees to the appropriate tier level of intervention.

3. *HCBS Level of Care Assessment* (See Figure 7-1): The Comprehensive Assessment Report and Evaluation (CARE) tool will be used by DSHS or its designee to determine HCBS Medicaid functional eligibility for Enrollees in Tiers Two and Three. Reassessments for functional eligibility via the CARE tool will be completed within the required timeframes under the appropriate 1915(c) waivers, at least annually and when there is a significant change in functioning
4. *Health Risk Assessment* (HRA, See Figure 7-1): MMIPs will administer a standardized HRA for all new Enrollees in Tier Three within 30 days after the Enrollee's enrollment date, and an ongoing HRA will be administered every four months for Tier Three Enrollees.

For Tier One and Tier Two Enrollees, MMIPs will administer the HRA for all new Enrollees within 60 days of enrollment. An ongoing HRA will be administered at least annually for Tier One and at least every six months for Tier Two Enrollees. For Tier Two and Tier Three Enrollees, the initial and on-going HRA requires a face-to-face visit with the Enrollee at his/her home or other place of his/her choice.

5. *Individualized Care Plan (ICP, See Figure 7-1)*: An ICP for a course of treatment or care monitoring will be developed for all Enrollees within 90 days of enrollment. The ICP is an integrated, individualized, person-centered care plan jointly created and managed by the Enrollee, his or her selected support system, his or her MMIP care management team, and his or her interdisciplinary team of care providers. The plan incorporates a holistic, preventative, and recovery focus and is based on a comprehensive assessment of clinical and non-clinical needs and addresses identified gaps in care and barriers to care.

When an Enrollee is found eligible to receive HCBS through the CARE assessment, the Individualized Care Plan must be updated to include the applicable HCBS services within 30 days of the assessment. Other ICP updates are required as follows:

- For Tier One Enrollees: The ICP must be updated as part of the annual Health Risk Assessment described above.
- For Tier Two Enrollees: The ICP must be updated every six months, or more often if there is a change in health or functional status, as part of the ongoing Health Risk Assessments described above.
- For Tier Three Enrollees: The ICP must be updated every six months, or more often if there is a change in health or functional status. In addition, the ICP for

these Enrollees must be updated as needed to incorporate the Health Action Plan which is conducted every four months.

- a. ICP Requirements: Following development of the ICP, MMIPs will evaluate each Enrollee based on his/her tier level to determine if the ICP is continuing to meet the Enrollee's needs. The ICP must:
 - i. Incorporate an Enrollee's medical, mental health, chemical dependency, LTSS, social, and functional needs;
 - ii. Include the Enrollee's identifiable goals to address the Enrollee's needs and preferences and to facilitate monitoring of an Enrollee's progress and evolving service needs. For Level Three Enrollees, the ICP should incorporate information from his/her Health Action Plan (HAP), discussed further below.
 - iii. Include, in the development, implementation, and ongoing assessment of the ICP, an opportunity for Enrollee participation and an opportunity for input from the Primary Care Provider, other providers, a designated representative, and the Enrollee's family and/or caregiver if appropriate; and
 - iv. Include a HCBS Service Plan , if appropriate:
 1. For Enrollees receiving HCBS waiver services, responsibilities regarding development of the HCBS waiver service plan (service plan) component of the ICP may differ depending on whether an Enrollee is already receiving HCBS waiver services at the time of enrollment in the Demonstration (existing HCBS eligible) or

is determined newly eligible for HCBS waiver services after enrollment in the Demonstration (newly HCBS eligible).

2. For those newly HCBS-eligible Enrollees, the MMIP will be involved in service plan development from the moment the Enrollee is determined eligible for services. The MMIPs will be responsible for HCBS waiver service planning, including the development, implementation, and monitoring of the service plan, and updating the service plan when an Enrollee's needs change. The MMIP Care Manager or Intensive Care Coordinator will coordinate with the DDA case manager for services, including service planning with the Enrollee.

3. For existing HCBS-eligible Enrollees, the MMIPs will maintain the existing HCBS Service Plan and the providers authorized in the HCBS Service Plan through the HCBS authorization period or the continuity of care periods described in 7.V.F.1 and 7.V.F.2, whichever is later. The 180-day transition period, as described in 7.V.F.2, applies to Adult Family Homes and Assisted Living Facilities, unless changed with the consent and input of the Enrollee after completion of the Health Risk Assessment. These HCBS Service Plans will be transmitted to MMIPs prior to the effective date of enrollment. The MMIP Care Manager or Intensive Care Coordinator will coordinate the process for changing or updating the HCBS Service Plan, as appropriate, with the Enrollee and the Interdisciplinary Care Team. The MMIP Care Manager or Intensive Care Coordinator will coordinate with the DDA case manager for services, including service planning with the Enrollee.

6. *Health Action Plan (HAP, See Figure 7-1)*: The HAP is a Tier Three Enrollee-prioritized plan identifying what the Enrollee plans to do to improve his or her health and/or self-management of health conditions. The HAP should contain at least one Enrollee-developed and prioritized goal; identify what actions the Enrollee is taking to achieve the goal(s); and includes the actions of the Intensive Care Coordinator, including use of health care or community resources and services that support the Enrollee's HAP. The HAP, including mandatory and optional screenings, shall be updated every four months. The HAP should be incorporated into the ICP.

7. *Patient Activation Measure Evaluation (See Figure 7-1)*: For Tier Three Enrollees the MMIP will administer a Patient Activation Measure (PAM) that will be used in addition to applicable screening tools to work with the Enrollee to develop a HAP. The PAM will be administered within the first 30 days of enrollment and updated every four months while the Enrollee is receiving Intensive Care Management services. For applicable Enrollees, the PAM will be administered every 12 months.

8. *Requirements for Care Management*: MMIPs at minimum will offer Care Management services to all Enrollees based on their tier level, needs and preferences to ensure effective linkages and coordination between the medical, behavioral health, LTSS, and other community providers to coordinate the full range of supports, as needed, both within and outside the MMIP. All Enrollees will be assigned a Care Manager or Intensive Care Coordinator and will have access to an Interdisciplinary Care Team (ICT).

The intensity of Care Management services will depend on the beneficiary's tier level.

- a. *Care Management for Tier Level One Enrollees*: For beneficiaries stratified as Tier One, MMIPs will have a designated Care Manager, have an ICP, have access to an ICT, and receive referral assistance when applicable. MMIPs

will be required to provide the full range of care coordination, including connecting beneficiaries with local community services, and coordinating referrals for other non-Covered Services, such as supportive housing and other social services, to maximize opportunities for independence in the community.

- b. Care Management for Tier Level Two Enrollees: For beneficiaries stratified as Level Two, MMIPs will provide Care Management services dedicated to problem-solving interventions, have an ICP, provide prevention and wellness messaging and condition-specific education materials, and provide access to an ICT. MMIPs will be required to provide the full range of care coordination, including HCBS waiver service planning when applicable, connecting beneficiaries with local community services, and coordinating referrals for other non-Covered Services, such as supportive housing and other social services, to maximize opportunities for independence in the community.

- c. Intensive Care Management for Tier Level Three Enrollees: For Enrollees stratified as Level Three, MMIPs will be required to provide Intensive Care Management provided by an Intensive Care Coordinator, have an ICP, and have access to an ICT Intensive Care Management which supports “high touch” Intensive Care Management that uses face-to-face interactions to build essential trusting relationships that will foster beneficiaries to effectively communicate their needs, expectations, and strategies to meet their self-defined health goals. MMIPs will be required to provide the full range of care coordination, including HCBS waiver service planning when applicable, connecting beneficiaries with local community services, and coordinating referrals for other non-Covered Services, such as supportive housing and other social services, to maximize opportunities for independence in the community.

9. The State and CMS will monitor MMIPs' performance throughout the Demonstration and will require that MMIPs have the capacity to perform the full range of Care Management activities, health screenings/assessments, and care planning.

B. Requirements for an Interdisciplinary Care Team (ICT): Every Enrollee must have access to an ICT to ensure the integration of the Enrollee's medical, mental health, chemical dependency use, LTSS, and social needs. The ICT will consist of clinical and non-clinical disciplines, inclusive of the Enrollee and individuals of his or her choice, whose interactions are guided by specific team functions and processes to achieve positive outcome for Enrollees. Members of the ICT may include, but are not limited to medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, doctors of chiropractic, physical therapists, licensed complementary and alternative medicine practitioners, DDA Case Manager, home care and other long-term care providers, and physician assistants.

The MMIP will require that each ICT is a composite of knowledgeable key competencies including, but not limited to: person-centered planning, cultural competence, disability, accessibility and accommodations, independent living and recovery, and wellness principles. Interdisciplinary Care Teams will:

1. Assure appropriate and efficient care transitions, including discharge planning;
2. Assess the physical, cognitive, social, behavioral, and LTSS risks and needs of each Enrollee;
3. Provide Enrollee health education on complex clinical conditions and wellness programs;
4. Assure integration of primary, specialty, behavioral health, LTSS, and referrals to community-based resources, as appropriate;

5. Maintain frequent contact with the Enrollee through various methods including face-to-face visits, email, and telephone options, as appropriate to the Enrollee's needs and tier level;
6. Assist in the development of an ICP within 90 days after enrollment; and
7. Assist in the implementation and monitoring of the ICP.

C. Care Manager and Intensive Care Coordinator Qualifications and Training: Care Managers and Intensive Care Coordinators must have the qualifications and training appropriate to meet the needs of the Enrollee. Each MMIP must establish policies for appropriate assignment of Care Managers and Intensive Care Coordinators. Unless further detailed in the Three-Way Contract, MMIPs will ensure the following educational and/or experience for care management/coordination:

1. Care Managers: Registered Nurse; Master's degree in behavioral health sciences and one year of paid on-the-job social service experience; Bachelor's degree in behavioral or health sciences and two years of paid on-the-job social service experience; or Bachelor's degree and four years of paid on-the-job social service experience.

Nothing in this definition precludes the MMIP, primary care provider, or Care Manager from using allied health care staff, such as community health workers, navigators, peer counselors and others to support and facilitate the work of the Care Manager.

2. Intensive Care Coordinators: Registered Nurse; Licensed Practical Nurse; Physician's Assistant; BDW or MSW prepared Social Worker; Chemical Dependency Professional; or Professional with significant experience working with applicable populations. Any professional, clinical or non-clinical, who is not listed

above must have written approval of HCA and DSHS before they can be an Intensive Care Coordinator.

- D. Care Manager/Intensive Care Coordinator Caseload: MMIPs must include a sufficient number of Care Managers and Intensive Care Coordinators with the background and training to serve all tier levels of Enrollees, based on an analysis of the population to be served.

Care Managers and Intensive Care Coordinators assigned to Enrollees with varying tier levels shall have their overall caseload weighted and a blended overall caseload limit set, taking into account the tier level of the Enrollees. Each MMIP will provide CMS and the State with its methodology for assigning weights to Enrollees with varying risk levels for prior approval and assessment during the Readiness Review.

- E. Individual Requirements for Self-Direction: MMIPs will support Enrollees in developing the Individualized Care Plan. Specifically, Enrollees or their designated representative will:

1. Decide how and what LTSS to receive to maintain independence and quality of life, subject to coverage rules for Covered Services.
2. Select their health care providers in the MMIP network (or allowed for by continuity of care provisions) and control care planning and coordination with their health care providers.
3. Have access to services that are culturally, linguistically, and operationally sensitive to meet their needs, and that improve their health outcomes, enhance independence, and promote living in home and community settings of their choice.
4. Be able to hire, fire, and supervise their personal care providers.

- F. Requirements for Demonstration Monitoring and Continuous Improvement:

1. Monitoring – CMS and the State will work intensively with MMIPs prior to implementation and will closely monitor them following implementation. Key

areas of oversight will include provider networks, claims payment, service authorization and delivery, participant direction, critical incident reporting and follow-up, and data transfers. Other monitoring activities will include reviews of Enrollee ICPs, service authorizations, and services received to ensure that MMIPs are providing services agreed to by the Enrollee in the plan of care.

2. Continuous Improvement – Performance will be monitored throughout the operation of the Demonstration and measured according to the quality metrics specified in Figure 7.1. The State, CMS, and MMIPs will be expected to continually improve the operation of the Demonstration through monitoring of compliance with performance measures. Other monitoring activities will include the Project Governance Team, MMIP Enrollee advisory committees and stakeholder meetings held by the State. The State will use the established Ombudsman through the Washington State Office of the Insurance Commissioner to assist in monitoring. In addition, HCA/DSHS along with CMS and ACL will respond to the appropriate inquiries from the Ombudsman to improve the functioning of the Demonstration.

G. Appointment Standards:

1. Transitional Healthcare:
 - a. The MMIP shall ensure that a Care Manager/Intensive Care Coordinator works with the hospital or other facility discharge planner to promote that an Enrollee being discharged from inpatient care has a follow up medical appointment within seven days (7) of release from the facility. If the Enrollee requests it, or there is a probability of the Enrollee not attending the appointment, the Care Manager/Intensive Care Coordinator shall accompany the Enrollee to the appointment. The Care Manager/Intensive Care Coordinator shall work with the Enrollee to ensure that all prescriptions and follow up instructions are followed by the Enrollee and that any additional appointments are scheduled and attended. The Care Manager/Intensive Care Coordinator shall also ensure that a clinical assessment is provided and the ICP is updated after discharge from one of these facilities. A referral to the Home and Community Services

(HCS) Office within ALTSA or the local DDA Office will occur within five (5) days of identification through the care coordination process or by the Enrollee that the Enrollee has unmet LTSS needs.

- b. The MMIP shall also ensure follow up activities described above are provided for Enrollees who are discharged from inpatient or institutional care for mental health disorders or discharged from a chemical dependency program, if ordered by the Enrollee's primary care provider or as part of the discharge plan. The Care Manager/Intensive Care Coordinator shall also ensure that a clinical assessment is provided and an ICP developed after discharge from one of these facilities

2. Urgent and Emergent Healthcare:

- a. Urgent, symptomatic office visits shall be available from the Enrollee's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.
- b. Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.
- c. Enrollees may access the following urgent and emergent medically necessary mental health services prior to the completion of an intake evaluation: Crisis Services; Freestanding Evaluation and Treatment; Stabilization; Rehabilitation Case Management; and Psychiatric Hospitalization.

3. Behavioral Health:

- a. An appointment for the initial mental health intake assessment by a Mental Health Professional shall be offered within ten (10) working days of the request for mental health services by an Enrollee or referral from a provider or Care Coordinator. A request for mental health services can be made by telephone, referral, clinic walk-in, or in writing.

- b. After initial assessment has been completed, routine mental health services must be offered to occur within fourteen (14) calendar days of a determination to initiate mental health services. The time from request for mental health services to first routine appointment must not exceed twenty eight (28) days unless the MMIP documents a reason for the delay.
- c. Comprehensive chemical dependency assessment and treatment services shall be provided no later than fourteen (14) calendar days after the services have been requested by the Enrollee. If the Enrollee cannot be placed in treatment within said number of days, interim services must be made available to the Enrollee.

4. Long Term Services Supports:

The MMIP shall make a referral to DSHS or its designee within five (5) calendar days upon identification through the care coordination process, referral, or by the Enrollee that the Enrollee has unmet LTSS needs.

- H. Requirements for Network Adequacy: State Medicaid standards shall be utilized for LTSS, as described below, or for other services for which Medicaid is exclusive, and Medicare standards shall be utilized for Medicare prescription drugs and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more stringent. 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 State can show that such standards are at least as stringent and Enrollee friendly as Medicare standards.

MMIPs must pay Enrollees' current service providers for at least the first 90 days of enrollment, as described in Section V.F below. MMIP must provide and arrange for timely access to all medically-necessary services covered by Medicaid, including those under the HCBS waiver. Both the State and the CMS will monitor access to services through survey, utilization, and complaints data to assess needs to MMIPs network corrective actions. In addition to these protections, minimum LTSS standards for MMIPs are stated below. CMS and the State will also monitor access to care and the

prevalence of needs indicated through Enrollee assessments, and based on those findings, may require that the MMIPs initiate further network expansion over the course of the Demonstration

1. LTSS Standards:

- a. Skilled Nursing Facilities – The MMIP will maintain contracts sufficient enough to ensure at least one skilled nursing facility within twenty (20) miles of an Enrollee’s location of choice.
- b. Residential Providers – The MMIP will maintain contracts sufficient to ensure enough capacity for Enrollees to move into a residential placement within one (1) week of referral or request and have the choice of three (3) different residential options, within at least two (2) residential licensed categories (Adult Family Home, Assisted Living) in a 10 mile radius (Urban) or 25 miles (Rural) of their preferred location. The MMIP must ensure there are an adequate number of residential providers who hold specialty designations proportionate to the number of Enrollees whose diagnosis would require the specialty Mental Health, Dementia, or Developmental Disability placement to ensure Enrollees would not experience a delay in placement due to lack of specialty providers.
- c. In-Home Personal Care Provider Network – The MMIP will develop contracts with both agency and individual providers. The network will be sufficient to ensure Enrollees will receive services through the provider type of their choice within five (5) business days of referral for in-home services. The provider network will be sufficient enough to allow Enrollees a choice between at least two (2) different providers for each of the services for which they qualify.
- d. Other LTSS Providers – The MMIP will provide or contract for services identified in the HCBS waiver, and will have access to at least two (2) of each provider type in the geographic area or enough within the (10) calendar days of referral in the setting most appropriate to their need or to the service.

2. Mental Health Service Clinic Sites (clinics that perform assessments and provide mental health services):

- a. Urban: 1 within 10 miles for 90% of Enrollees in the service area.
 - b. Rural: 1 within 25 miles for 90% of Enrollees in the service area.
3. Chemical Dependency Treatment Facilities:
- a. Urban: 1 within 10 miles for 90% of Enrollees in the service area.
 - b. Rural: 1 within 25 miles for 90% of Enrollees in the service area.
4. Outpatient Dialysis Services
- a. Urban: 2 within 10 miles for 90% of Enrollees in the MMIP's service area.
 - b. Rural: 1 within 25 miles for 90% of Enrollees in the MMIP's service area,

Networks will be subject to confirmation through Readiness Reviews and on an annual basis.

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 MMIP must meet the Medicare requirements.

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

- I. Solvency: MMIPs will be required to meet Solvency requirements consistent with Section 1903(m) of the Social Security Act, and regulations found at 42 CFR §422.402 and §438.116.
- J. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts

1. MMIPs will be required to adhere to managed care standards at 42 CFR §438.214 and 42 CFR §422.204, and to credential and recredential providers in accordance with NCQA credentialing standards as well as credentialing and recredentialing guidelines.
 2. The MMIP shall ensure that all providers and facilities who deliver LTSS meet licensing, certification, and qualifications as set forth by the HCBS waiver, DSHS Residential Care Services Administration, AL TSA, and the Department of Health.
- K. Eligibility Coordination: Financial and functional eligibility will remain with DSHS or its designee (the Area Agencies on Aging) for LTSS. The MMIPs will have agreements in place with those eligibility entities that define the processes that will be used to communicate and coordinate to share accurate and timely information to facilitate care delivery.

V. Benefits

- A. Medical Necessity Determinations: Medically necessary services will be defined as:
1. (per Medicare) Services 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.
 2. (per Washington): “Medically Necessary” is a term for describing service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

3. MMIPs will be required to provide services in a way that preserves all protections to the Enrollee provided by Medicare and the Washington Medicaid program.
 4. Where there is overlap between Medicare and Medicaid benefits, coverage and rules will be delineated in the Three-Way Contract; the benefits will maintain coverage as outlined in both State and Federal rules. MMIPs will be required to abide by the more generous of the applicable Medicare, the State or the combined Medicare-Medicaid standard.
 5. All care must be provided in accordance and compliance with the ADA, as specified in the *Olmstead* decision.
- B. As a term and condition of this Demonstration, in addition to all Medicare Parts A, B, C, and D, and Medicaid State Plan services not otherwise excluded, the MMIPs will be required to provide services as defined in the approved ALISA HCBS 1915(c) COPES Waiver.
- C. Flexible Benefits: MMIPs will have discretion to use the capitated payment to offer Flexible Benefits, as specified in the Enrollee's Individualized Care Plan, as appropriate to address the Enrollee's needs.
- D. Excluded Services: The following services will be provided in the fee-for-service delivery system. For those that are covered by Medicaid, services will be provided consistent with the prevailing State Medicaid coverage rules:
1. 24 hour crisis intervention services covered by the RSN;
 2. ITA (Involuntary Treatment Act) related transportation for judicial review;
 3. Voluntary termination of pregnancy;
 4. Transportation services other than ambulance or HCBS waiver transportation services;
 5. Dental services;
 6. First steps child care/Infant Case Management/Maternity Support Services;
 7. Services provided by a Neurodevelopmental Center recognized by HCA;

8. Health care services provided by a health department or family planning clinic when a client self refers;
 9. Pharmaceutical products by a provider related to services under a separate contract with HCA or DSHS;
 10. Surgical procedures for weight loss or reduction;
 11. Urinalysis for drug screening for pregnant and parenting women and Enrollees receiving opiate substitution treatment; and
 12. Prenatal diagnosis genetic counseling.
- E. Election of Medicare Hospice Benefit: As in Medicare Advantage, if an Enrollee elects to receive the Medicare hospice benefit when enrolled in the MMIP, the Enrollee will remain in the MMIP, but will obtain the hospice service through the Medicare FFS benefit and the MMIP would no longer receive Medicare Part C payment for that Enrollee. Medicare hospice services and hospice drugs and all other Original Medicare services would be paid for under Medicare fee-for-service. MMIPs and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care, including with Medicaid and Part D benefits and any additional benefits offered under the MMIPs. MMIPs would continue to receive Medicare Part D payment for all non-hospice covered drugs, as well as payment for Medicaid services.
- F. Continuity of Care:
1. For ESRD services, Nursing Facilities, Adult Family Homes and Assisted Living Facilities, MMIPs will be required to offer a continuity of care period of 180-days at minimum or until an Individualized Care Plan (ICP) is completed, whichever is later. During this period, Enrollees may maintain a current course of treatment with their current dialysis provider, Nursing Facility (unless the participant chooses to return to the community), Adult Family Home and Assisted Living Facility (including out-of-network providers). Out-of-network providers providing an ongoing course of treatment will be offered Single Case Agreements to continue to care for that Enrollee beyond the 180 days if the MMIP and out-of-network provider agree to terms. MMIPs may choose to transition Enrollees to a network provider earlier than the 180 days only if Enrollee agrees to the transition prior to

the expiration of the 180-day transition period. The discussion and approval must be documented in the Enrollee service record. The ICP would be updated to include any changes in services or supports.

2. For all other services, excepting those applicable under 7.V.F.3, MMIPs will be required to offer a continuity of care period of 90-days or until an ICP is completed, whichever is later. With the exception of services noted under 7.V.F.1 and 7.V.F.3, this 90-day period is applicable to all providers, including behavioral health providers and providers of LTSS. During this period, Enrollees may maintain a current course of treatment with their current provider (including out-of-network providers). Out-of-network providers providing an ongoing course of treatment will be offered Single Case Agreements to continue to care for that Enrollee beyond the applicable transition period if the MMIP and out-of-network provider agree to terms. MMIPs may choose to transition Enrollees to a network provider earlier than the applicable transition period only if the Enrollee agrees to the transition prior to the expiration of the transition period. The discussion and approval must be documented in the Enrollee service record. The ICP would be updated to include any changes in services or supports.
3. For those individuals receiving LTSS, including existing HCBS-eligible Enrollees and Enrollees receiving Medicaid Personal Care Services, the MMIP will maintain the providers authorized in the HCBS Service Plan or the Medicaid Personal Care Service Plan for the duration of the authorization period or the continuity of care periods described in 7.V.F.1 and 7.V.F.2 above, whichever is later, with the exception of Adult Family Homes and Assisted Living Facilities for which the MMIP will be required to maintain the HCBS Service Plan or the Medicaid Personal Care Service Plan authorized providers for the 180-day continuity of care period described in 7.V.F.1.
4. With the exception of Part D drugs, which are required to follow all Part D transition requirements, all prior approvals for drugs, therapies, or other services existing in Medicare or Medicaid at the time of enrollment will be honored for the

applicable transition period and will not be terminated at the end of the transition period without advance notice to the Enrollee and transition to other services, if needed.

G. Out of Network Reimbursement Rules: In an urgent or emergency situation, MMIPs must reimburse an out-of-network provider of emergent or urgent care, as defined by 42 CFR 424.101 and 42 CFR 405.400 respectively, at the Medicare or Medicaid FFS payment amount applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. Contractors may authorize other out-of-network services to promote access to and continuity of care. Where this service would traditionally be covered under Medicare FFS, the MMIP will pay out-of-network providers at least the lesser of the providers' charges or the Medicare FFS payment amount, regardless of the setting and type of care for authorized out-of-network services. Balance billing protections will still apply under this scenario.

H. Model of Care

MMIPs (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC). Participating MMIPs must meet all CMS MOC standards for Special Needs Plans as well as additional requirements established by the State.

The State's comprehensive care management program requirements summarized in Section IV will also apply and be outlined in the Three-Way Contract. CMS' MOC approval process is based on scoring each of the eleven clinical and non-clinical elements of the MOC. The State included supplemental information on Elements 2, 3, 4, 5, 7, 8, and 10. In addition Washington added 4 State specific elements noted under (4) below. CMS and the State do not believe the supplemental information conflicts with the SNP Model of Care elements. 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 NCQA's scoring methodology.
2. *Elements*: The MOC has eleven (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 eleven MOC elements are listed below:
 - a. Description of the Plan-specific Target Population;
 - b. Measurable Goals;
 - c. Staff Structure and Care Management Goals;
 - d. Interdisciplinary Care Team;
 - e. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
 - f. MOC Training for Personnel and Provider Network;
 - g. Health Risk Assessment;
 - h. Individualized Care Plan;
 - i. Integrated Communication Network;
 - j. Care Management for the Most Vulnerable Subpopulations; and
 - k. Performance and Health Outcomes Measurement.
3. *Factors*: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the Capitated Financial Alignment application. The factors for each element were scored using a system from 0 to 4, where four is the highest score for a factor. Interested organizations were required to provide a response that addressed every factor within each of the 11 elements. The scores for each factor within a specific element were 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. The State conducted a parallel review of the MOCs, focusing on the supplemental information

specific to the demonstration. Interested plans must meet both State and CMS approval standards.

4. *Washington State Specific Elements:* The MOC had 4 additional State Specific elements, as identified below, and each element was scored from 0-4, a passing score was a 3 or 4. The 4 MOC elements are listed below:
 - a. Integrated Delivery System and Care Coordination;
 - b. Health Action Plan (HAP);
 - c. Person-Centered Care; and
 - d. Transitional Care.

It is CMS' intent for MOC reviews and approvals to be a multi-year process that will allow MMIPs 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:

- a. Plans that receive a score of 85% or higher were granted an approval of the CMS MOC requirement for three years.
- b. Plans that receive a score in the 75% to 84% range were granted an approval of the CMS MOC requirement for two years.
- c. Plans that receive a score in the 70% to 74% range were granted an approval of the CMS MOC requirement for one year.

MMIPs were permitted to cure problems with their MOC submissions after their initial submission if the initial score was below 70 percent; however, any plans that resubmitted their MOCs were unable to receive more than a one-year approval by CMS.

VI. Prescription Drugs

The integrated formulary must include any Medicaid-covered drugs that are excluded by Medicare Part D. MMIPs 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.

VII. Grievances

Enrollees or their representatives may file a grievance with the MMIP. The Enrollee shall be entitled to file grievances directly with the MMIP. In addition, grievances may be forwarded to the MMIP by CMS, HCA or DSHS. Each MMIP must accept, document, record, process and resolve its grievances. MMIPs must have internal controls in place for properly identifying incoming requests as a grievance, an initial request for coverage, or an appeal to ensure that requests are processed timely through the appropriate procedures.

VIII. Appeals

Each MMIP must have mechanisms in place to track and report all Appeals. Other than Medicare Part D appeals, which shall continue to be adjudicated under processes set forth at 42 CFR Part 423, Subpart M, the following principles apply to the appeals process:

- An Enrollee or the Enrollee's representative may appeal a MMIP Adverse Action. Appeals for traditional Medicare A and B services may also be appealed by an Enrollee's provider or an Enrollee's provider acting on behalf of the Enrollee. For Medicaid-only benefits, a provider may only file an appeal on behalf of the Enrollee if the Enrollee consents. Note: Under the Medicare Part C and D programs, an Enrollee's physician may request a plan level appeal on the Enrollee's behalf without being appointed as the Enrollee's representative.
- At the MMIP Level, Medicaid and Medicare benefits will continue pending the result of a determination, with Medicaid benefits continuing as long as the Enrollee meets the Medicaid requirements for continuation of services.
- Integrated Notice – MMIP Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid appeal rights, including whether an individual may continue receiving benefits pending the decision, through a single notice jointly developed by the State and CMS.

A. Integrated Appeals Process:

1. Appeal Time Frames – An Enrollee, an Enrollee’s representative, or an Enrollee’s provider, will have: ninety (90) calendar days from the date on the MMIP’s notice of action to file an appeal, either orally or in writing, regarding standard service authorization. This appeal timeframe also applies to an Enrollee’s request for an expedited appeal.
2. Appeal Levels – Initial appeals must be filed with the MMIP. The filing of an internal appeal and exhaustion of the MMIP internal appeals process is a prerequisite to an external appeal to Medicare or Medicaid.
 - a. If the MMIP upholds its initial Adverse Action, in whole or in part, subsequent appeals for traditional Medicare A and B services will be automatically advanced by the MMIP to the Medicare Independent Review Entity (IRE). If the MMIP or the Enrollee disagrees with the IRE’s decision, further levels of appeal potentially are available, including a hearing before a federal Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review in accordance with federal rules and statutes.
 - b. If the MMIP upholds its initial Adverse Action, in whole or in part, subsequent appeals for Medicaid-only benefits will be automatically advanced to a state Independent Review Organization (IRO). If an Enrollee does not agree with the MMIP’s resolution of the appeal after receiving the IRO determination, the Enrollee may request a State Administrative Hearing through the Office of Administrative Hearings. If an Enrollee or the MMIP disagrees with the results of the State Administrative Hearing, either may appeal that decision to the HCA Board of Appeals, in accordance with state Medicaid rules. The Enrollee must exhaust all levels of resolution and appeal prior to filing a request for a hearing with HCA. HCA Board of Appeal determinations that are not favorable to the Enrollee may be appealed to Judicial Review at State Superior Court. All resolution and notification timeframes shall be in compliance with 42 CFR § 438.408 and 431.244(f).

c. **Overlap Services:** The process for appeals related to services for which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment, and skilled therapies, but excluding Part D) will as a default follow the Medicare appeals process and be further detailed in the Three-Way Contract. If the resolution following the appeals process is not wholly in favor of the Enrollee, the appeal related to these services will be forwarded to the IRE by the MMIP. Beneficiaries who choose to may also elect to request a review by a state IRO concurrently with the review by the IRE, if the beneficiary requests it.

B. Appeal resolution time frames: The MMIP shall resolve each appeal and provide notice, as expeditiously as the Enrollee's health condition requires, as follows:

1. For standard resolution of appeals and for appeals for termination, suspension, reduction of previously authorized services, or as applicable, new service authorization requests, a decision must be made within fourteen (14) calendar days after receipt of the appeal, unless the MMIP notifies the Enrollee that an extension is necessary to complete the appeal and that the delay is in the best interest of the Enrollee. In all circumstances the appeal determination must be made within 45 calendar days from the date MMIP receives the appeal request.
2. For expedited appeals, a decision shall be made as expeditiously as the Enrollee's health condition requires, no later than 72 hours after the MMIP receives the appeal.
3. For external appeals auto-forwarded to or filed with the IRO regarding termination, suspension, or reduction of a previously covered service, or as applicable, new service authorization requests, hearings shall be held within currently existing Medicaid timeframes in compliance with 42 CFR 438.408 and §431.244(f).
4. External appeals filed or auto-forwarded to the Medicare IRE must be resolved under the current Medicare appeals timeframes.

5. For Medicare-Medicaid overlap services, the timeframes described under 7.VII.B.1, 7.VII.B.2 and 7.VII.B.4 above apply. To the extent that an Enrollee also requests review by the IRO, the timeframe under 7.VII.B.3 will also apply.

C. Continuation of Benefits Pending an Appeal:

1. MMIPs must provide continuing Medicare and Medicaid benefits for all prior approved non-Medicare Part D benefits that are being terminated or modified pending internal MMIP appeals. This means that benefits will continue to be provided to beneficiaries, and that MMIPs must continue to pay providers for such services pending an internal MMIP appeal.
2. For Enrollee appeals of Adverse Actions related to Medicare services, services will only continue beyond the internal appeals process in certain health care settings, consistent with existing Medicare authority.
3. For Enrollee appeals of Adverse Actions related to Medicaid services, Medicaid services will continue so long as the Enrollee meets Medicaid requirements for continuation of services, per 42 CFR §438.420.

D. Notices: Notices of the resolution of the appeal shall be in writing. The notice must include the date the appeal was completed and specific reason(s) for the determination in easily understood language, and a written statement explaining the clinical rationale for the decision. For notice of an expedited resolution, the MMIP shall also make reasonable efforts to provide verbal notice.

E. In the case of a decision where both the State Administrative Hearing and the IRE issue a ruling regarding the same service/benefit, the MMIP shall be bound by the ruling that is most favorable to the Enrollee.

IX. MMIP Marketing, Outreach, and Education Activity

As indicated in the CMS “Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation rates and Medicare Advantage and Part D Payment Policies and Final Call Letter” released on April 1, 2012, CMS Medicare Marketing Guidelines do not

apply to communications by State governments, and materials created by the State do not need to be reviewed or submitted in HPMS. However, CMS and the State agree to work together in the development of these materials and the State will consult with CMS on the development of the materials.

A. Marketing and Enrollee Communication Standards for MMIPs: MMIPs will be subject to rules governing their marketing and Enrollee communications as specified under Sections 1851(h) and 1932(d)(2) 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 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual). The State and CMS will work to develop a single consolidated set of marketing rules and requirements and the Three-Way Contract will require MMIPs to comply with any unified, set of rules and requirements that are developed. The following exceptions apply:

1. MMIPs will not be allowed to market directly to individual potential Enrollees on a one-on-one basis but may provide responses to Enrollee-initiated request for information and/or enrollment. MMIPs may participate in group marketing events and provide general audience materials (such as general circulation brochures and media and billboard advertisements). The State reserves the right to develop predetermined marketing scripts for MMIP staff, subject to CMS review and approval. All processing of enrollments and disenrollments will occur as stated in this appendix.
2. CMS and the State will develop a process to mitigate Enrollee shifting from MMIPs to other plans operated by the same parent company. At a minimum, the Three-Way Contract will identify procedures to provide additional education to Enrollees that are considering opting out of a MMIP for a non-Participating Plan that may be part of the same corporate family. Enrollee choice regarding enrollment will be honored by CMS and the State.
3. The MMIP shall not:
 - a. Provide cash, gifts, prizes, or other monetary rebates to induce enrollment.

- b. Seek to influence a potential Enrollee's enrollment with a MMIP in conjunction with the sale of any other insurance.
 - c. Induce providers or employees of CMS or the State to reveal confidential information regarding Enrollees or otherwise use such confidential information in a fraudulent manner; or
 - d. Threaten, coerce, or make untruthful or misleading statements to potential Enrollees or Enrollees regarding the merits of enrollment with a MMIP or any other Plan.
- B. Review and Approval of Marketing and Enrollee Communications: MMIPs must receive prior approval of all marketing and Enrollee communications materials in categories of materials that CMS and the State require to be prospectively reviewed. MMIP 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 State. CMS and the State 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. MMIPs must submit all marketing and Enrollee communication materials, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.
- C. Permissible Start Date for MMIP Marketing Activity: MMIPs may begin marketing activity, as limited in Sections IX.A and IX.B of this Appendix above, no earlier than 90 days prior to the effective date of enrollment for the contract year.
- D. CMS and the State will work together to educate individuals about their MMIP options. Outreach and education activities may include letters, outreach events, and/or outbound telephone calls and will take into account the prevalence of cognitive impairments, mental illness, and limited English proficiency.
- E. Minimum Required Marketing and Enrollee Communications Materials: At a minimum, MMIPs will provide current and prospective Enrollees the following materials. These materials will be subject to the same rules regarding content and

timing of Enrollee 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.; §438.10; §438.104; and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual).

1. 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.
2. An Annual Notice of Change (ANOC) summarizing all major changes to the MMIP's covered benefits from one contract year to the next, starting in the second year of the Demonstration.
3. A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the MMIP and Enrollee rights, as well as the benefits offered under the MMIP, including cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. MMIPs will use a Demonstration-specific SB.
4. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits.
5. A comprehensive, integrated formulary that includes outpatient prescription drugs covered under Medicare, Medicaid, or as MMIP-covered additional benefits.
6. A single MMIP identification (ID) card for accessing all Covered Services under the MMIP. This will be provided to Enrollees in addition to the Medicaid P-1 card. CMS and the State will work together to determine if providing a single Demonstration identification card which incorporates the P-1 functionality in future years of the Demonstration if feasible.
7. All Medicare Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices, required under Chapter 4 of the Prescription

Drug Benefit Manual, and the LIS Rider required under Chapter 4 of the Prescription Drug Benefit Manual.

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

X. Administration and Oversight

A. Oversight Framework:

1. Under the Demonstration, there will be a CMS-State Contract Management Team that will ensure access, quality, program integrity, compliance with applicable laws, including but not limited to the Emergency Medical Treatment and Active Labor Act (EMTALA) and the ADA, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and the State will require MMIPs to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. MMIPs must have policies and procedures in place to identify and address fraud, waste, and abuse at both the MMIP and the third-party levels in the delivery of Demonstration benefits, including prescription drugs, medical care, behavioral health, and LTSS. In addition, all Medicare Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to MMIPs by CMS in the same way they are currently applied for PDP sponsors and Medicare Advantage organizations.
2. 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 and Washington oversight, 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.

B. The Contract Management Team:

1. Structure: The Contract Management Team will include representatives from CMS and the State, authorized and empowered to represent CMS and the State about aspects of the Three-Way Contract. Generally, the CMS members 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 will include individuals who are knowledgeable about the full range of services and supports utilized by the target population, particularly LTSS.

Two contract managers from the State, one from HCA and one from DSHS, will be assigned primary responsibility for the contract and will represent the State as part of the Contract Management Team.

2. Reporting: Data reporting to CMS and the State will be coordinated and unified to the extent possible. Specific reporting requirements and processes for the following areas of data will be detailed in the Three-Way Contract.
 - a. Quality (including HEDIS); core measures are articulated in Section H below
 - b. Rebalancing from Institutional to HCBS Settings
 - c. Utilization
 - d. Encounter Reporting
 - e. Enrollee Satisfaction (including CAHPS)
 - f. Complaints and Appeals
 - g. Enrollment/Disenrollment Rates
 - h. Medicare Part C and Part D Reporting Requirements, as applicable

- i. All required 1915(c) waiver reporting

C. Day-to-Day Oversight and Coordination:

1. The Contract Management Team will be responsible for the day-to-day monitoring of each MMIP. These responsibilities include, but are not limited to:
 - a. Meet with the MMIP's WA Demonstration Team on a periodic or as-needed basis, resolving issues that arise;
 - b. Monitoring MMIP compliance with reporting requirements;
 - c. Monitoring compliance with the terms of the Three-Way Contract, including issuance of joint notices of non-compliance/enforcement;
 - d. Coordination of periodic audits and surveys of the MMIPs;
 - e. Receipt and response to complaints;
 - f. Reviewing reports from and responses to the Ombudsman;
 - g. Reviewing direct stakeholder input on both plan-specific and systematic performance;
 - h. Regular meetings with each MMIP;
 - i. Coordinate requests for assistance from the MMIP, and assign CMS and HCA staff with appropriate expertise to provide technical assistance to the MMIP;
 - j. Coordination of review of marketing materials and procedures;
 - k. Coordinating review of grievance and appeals data, procedures, and materials;
 - l. Apply one or more of the sanctions as further detailed in the Three-Way Contract, including monetary penalties, if CMS and HCA determine that the MMIP is in violation of any of the Three-Way Contract terms stated herein;
 - m. Develop documentation to support contract termination if the MMIP does not correct contract violations in the timeframe specified by CMS and HCA for corrective action; and

- n. Coordinate the MMIP's external quality reviews conducted by the External Quality Review Organization Performance Evaluation.

D. Centralized Program-Wide Monitoring, Surveillance, Compliance, and Enforcement:

CMS' central office conducts a wide array of data analyses, monitoring studies, and audits. MMIP contracts will be included in these activities, just as all Medicare Advantage and Part D organizations will be included. MMIP 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 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.

E. Emergency/Urgent Situations:

Both CMS and the State 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 State 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.

F. MMIP Call Center Requirements: In addition to current Federal regulatory requirements and CMS guidance requirements for Medicare Advantage plans and Part D plans, the following will be required call center elements:

1. MMIPs will be required to operate a toll-free Enrollee services telephone line call center, available twenty-four hours, seven days a week, available statewide. The call center will allow for Enrollees to access medical professionals, either to the MMIP directly or to the PCPs, for consultation to obtain medical care.
2. Operators must be available in sufficient numbers to support Enrollees and meet all CMS and State specified standards.

3. Oral interpretation services must be available free-of-charge to Enrollees in all non-English languages spoken by Enrollees.
4. TTY services or comparable services must be available for people who are deaf or hard of hearing.
5. MMIPs 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
 - i. The identity, locations, qualifications, and availability of providers;
 - ii. Enrollees' rights and responsibilities;
 - iii. The procedures available to an Enrollee and/or provider(s) to challenge or appeal the failure of the MMIP to provide a covered service and to appeal any Adverse Actions (denials);
 - iv. Process by which an Enrollee can access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;
 - v. Process by which an Enrollee can access the Demonstration's Ombudsman, the Washington Medical Assistance Customer Service Center (MACSC), and 1-800-Medicare;
 - vi. Information on all MMIP Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization; and
 - vii. The procedures for an Enrollee to change MMIPs or to opt out of the Demonstration.

F. Data System Specifications, Reporting Requirements, and Interoperability:

To the maximum extent possible, CMS and the State will collaborate to achieve interoperability among data systems and reporting processes, including:

1. Data system description and architecture and performance requirements;
2. Current information system upgrades and development plans and resource commitments necessary for implementation;
3. Consolidated reporting requirements;
4. Encounter reporting;
5. Reporting data for evaluation and program integrity;
6. Data Exchange among CMS, Washington, Providers and MMIPs, and Health Insurance Exchanges.

G. Unified Quality Metrics and Reporting:

MMIPs 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 behavioral health, care coordination/transitions, and LTSS.

HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS plus any additional Medicaid measures identified by the State. All existing Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures.

The combined set of core metrics is described below in Figure 7-2; more detail on the measures will be provided in the Three-Way Contract. CMS and the State will utilize the reported measures in the combined set of core metrics for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and to allow quality to be evaluated and compared with other plans in the

model. 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.

MMIPs must submit data consistent with requirements established by CMS and/or the State as further described below and in the Three-Way Contract. MMIPs 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 7-2: Core Quality Measures under the Demonstration

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State 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	<p>The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.</p> <ul style="list-style-type: none"> • 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 screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	X
Comprehensive Medication Review	Percentage of Enrollees who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA)	X	
Customer Service	<p>Percent of best possible score the plan earned on how easy it is to get information and help when needed.</p> <ul style="list-style-type: none"> • 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

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Consumer Governance Board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements.	CMS	X	
SNP1: Complex Case Management	<p>The organization coordinates services for members with complex conditions and helps them access needed resources.</p> <p>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</p>	NCQA/ SNP Structure & Process Measures, HEDIS	X	X
SNP 6: Coordination of Medicare and Medicaid Benefits	<p>The organization coordinates Medicare and Medicaid benefits and services for members.</p> <p>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</p>	NCQA/ SNP Structure & Process Measures 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	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 Measure
SNP 4: Care Transitions	<p>The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions.</p> <p>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</p>	NCQA/ SNP Structure & Process Measures HEDIS	X	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	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	IRE	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
	auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.			
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 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 Enrollee 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 2014.	CMS Medicare Enrollee 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 State	X	
Part D Diabetes Treatment	Percentage of Medicare Part D Enrollees who were dispensed a medication for diabetes and a medication for hypertension who were	CMS PDE data	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
	receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	State		
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 State	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 State	X	
Risk Assessments	Percent of Enrollees stratified to medium or high risk with a completed comprehensive assessment within 90 days of enrollment.	CMS/State defined process measure	X	X
Care Plans	Percent of members with Care Plans by specified timeframe,	CMS/State defined process measure	X	X
Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Risk Stratification Based on LTSS or other Factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/State defined process measure	X	X
Discharge Follow-up	Percent of members with specified timeframe between hospital discharge to first follow-up visit.	CMS/State defined process measure State	X	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	X
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	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	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	X
Diabetes Care – Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS	X	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	X
Diabetes Care – Cholesterol Screening	Percent of plan members with diabetes who have had a test for —badl (LDL) cholesterol within the past year.	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	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 State / CAHPS	X	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	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
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
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	X
Enrollee 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 Enrollee database	X	X
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2014.	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	AHRQ/CAHPS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
	prescription drugs?			
Documentation of care goals	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure		X
Ensuring physical access to buildings, services and equipment	MMIP 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 Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X	
Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS	X	
Health Status/Function Status	Percent of members who report their health as excellent.	AHRQ/CAHPS	X	
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 can 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? -In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	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	AHRQ/CAHPS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
	possible, what number would you use to rate all your health care in the last 6 months?			
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	X
Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS	X	
Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X	X
Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X	
Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X	
Cervical Cancer Screening	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.	NCQA/HEDIS		X
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	
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS State	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 State / CAHPS	X	
Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS	X	
Pneumonia Vaccination Status for Older Adults	Percent of members 65 years of age and older who have ever received a pneumonia vaccine.	AHRQ/CAHPS		X
Medical Assistance with Smoking and Tobacco Use Cessation	Rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who received advice to quite during the measurement year. A rolling average represents the percentage of members 18 years of age and older who	AHRQ/CAHPS		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
	are current smokers or tobacco users and who discussed or were recommended medications to quit during the measurement year A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.			
Adult BMI Assessment	Percent of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	NCQA/HEDIS	X	X
Transition of Enrollees between community, waiver and LTSS services	Report of the number of members moving from: institutional care to waiver services, community to waiver services, community to institutional care and waiver services to institutional care.	State		X
Utilization of LTSS	Report of the personal care hours noted in the CARE eligibility tool and what was authorized, by Enrollee.	State		X
Utilization of LTSS	Report of the LTSS clients that had DME and SMES requests documented in the CARE eligibility tool and those that were authorized/provided, by Enrollee and request.	State		X
Documentation of care goals	Percent of Enrollees in Tier 3 enrolled at least 90 days with documented discussion of care goals in the Health Action Plan.	State defined process measure		X
Retention Rate – All	Percent of clients assigned to the MMIP who are retained for 6 months.	State defined process measure		X
Retention Rate – LTSS	Percent of clients assigned to the MMIP who received long term care services and support in month 1 and were retained for 6 months.	State defined process measure		X
Retention Rate – Mental Illness	Percent of clients assigned to the MMIP with a history of mental illness retained for 6 months.			X
Retention Rate – Substance Abuse	Percent of clients assigned to the MMIP with a history of substance abuse diagnosis retained for 6 months.			X
Behavioral Health Utilization	The percentage of Medicare-Medicaid Enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	NQF #0004, CMS, NCQA		X
Behavioral Health Utilization	Percent of Medicaid-Medicare enrollees aged 12 and older screened for clinical depression using an age appropriate standardized tool and if positive, a follow-up plan is documented on the date of the positive	NQF #0418, CMS		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
	screen.			
LTSS Utilization	HCBS Service Plans are delivered in accordance with the Individualized Care Plan, including in the type, scope, amount, duration, and frequency specified in the plan.	State defined process measure		X

XI. Stakeholder Engagement

The State and CMS will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. This will be accomplished through an ongoing process of public meetings and monitoring individual and provider experiences through a variety of means, including surveys, focus groups, website updates, and data analysis. The State will hold ongoing quarterly stakeholder meetings through forums such as the HealthPath Advisory Team (HAT), the Project Governance Team and other stakeholder outreach. In addition, Washington will maintain its website to provide updates on the Demonstration. The MMIP Enrollee advisory board, which will include Enrollees, will play an important role to provide ongoing input and a means to impact potential issues or challenges that may need to be addressed.

In addition, the State will require that MMIPs develop meaningful Enrollee input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to eligible individuals. Each MMIP will establish an independent MMIP Enrollee advisory committee. Throughout the operation of the Demonstration, MMIPs will be required to meet no less than quarterly with the Enrollee advisory committee. The MMIP must also assure that the Enrollee advisory committee composition reflects the diversity of the Demonstration population including Enrollees, caregivers, and local representation from key community stakeholders such as faith-based organizations, advocacy groups, and other community-based organizations

XII. Evaluation

A. CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the State Demonstrations to Integrate Care for Dual Eligible Enrollees and the Financial Alignment Demonstrations, including the Demonstration established in the MOU, on Enrollee experience of care, quality, utilization, and cost. The evaluator will also assess how the Washington Demonstration operates, how it transforms and evolves over time, and Enrollees' perspectives and experiences. The key issues targeted by the evaluation will include (but are not limited to):

1. Beneficiary health status and outcomes;
 2. Quality of care provided across care settings;
 3. Beneficiary access to and utilization of care across care settings;
 4. Beneficiary satisfaction and experience;
 5. Administrative and systems changes and efficiencies;
 6. Long-term care rebalancing and diversion effectiveness; and,
 7. Overall costs or savings for Medicare and Medicaid.
- B. The evaluator will design a State-specific evaluation plan for the Washington Capitated Model 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 quality, utilization, and cost 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. Quarterly reports will provide rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit Washington-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.
- C. The State is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. The State and MMIPs 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.

D. The State will track Enrollees eligible for the Demonstration, including which Enrollees choose to enroll, disenroll, or opt out of the Demonstration, enabling the evaluation to identify differences in outcomes for these groups. The State will need to provide information including but not limited to the following on a quarterly basis to CMS and/or the evaluator:

1. Beneficiary-level data identifying beneficiaries eligible and enrolled in the Demonstration:
 - a. Medicare Beneficiary Claim Account Number (HICN)
 - b. MSIS number
 - c. Social Security Number
 - d. CMS Beneficiary Link Key
 - e. Person First and Last Name, Birthdate, and Zip code
 - f. Eligibility identification flag - Coded zero if not identified as eligible for the Demonstration, 1 if identified as eligible for the Demonstration using criteria available in claims or other administrative data, and 2 if identified by criteria from non-administrative data sources.
 - g. Monthly eligibility indicator - Each monthly eligibility flag variable would be coded 1 if eligible, and zero if not.
 - h. Monthly enrollment indicator - Each monthly enrollment flag variable would be coded 1 if enrolled in the Demonstration, and zero if not
2. Summary level data for the State Data Reporting System, including but not limited to:
 - a. The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries *not* eligible for the Demonstration (e.g. individuals residing in Community Intermediate Care Facilities for Individuals with Intellectual Disabilities or Residential Habilitation Centers; New Freedom and DDA HCBS waivers; Money Follows the Person; PACE, etc.)

- b. The number of beneficiaries enrolled in the Demonstration
 - c. The number of beneficiaries who opt out of the Demonstration
 - d. The number of beneficiaries who disenroll from the Demonstration
 - e. The number of plans participating in the Demonstration
- E. The State will ensure that the evaluator at least annually receives information indicating the primary care provider of record for each Demonstration Enrollee. The State will also have the capability to track Enrollee-level data on grievances and appeals that identify the health plan and providers involved.
- F. The State will also develop the capability to identify and track Enrollees receiving care coordination, including the frequency and manner of care coordination contacts.