

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The Commonwealth of Virginia

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



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I. STATEMENT OF INITIATIVE

The Centers for Medicare & Medicaid Services (CMS) and the Commonwealth of Virginia (Commonwealth/Department of Medical Assistance Services/DMAS) will establish a Federal-State partnership to implement the Commonwealth Coordinated Care program (also referred to as the Demonstration) to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees” or “dual eligible individuals”). The Federal-State partnership will include a three-way contract with Participating Plans that will provide integrated benefits to Medicare-Medicaid Enrollees in the targeted geographic area(s). The Demonstration will begin on February 1, 2014 and will 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 Commonwealth/DMAS and the Federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

The Demonstration will operate in specific regions within the Commonwealth. In those regions, the population that will be eligible to participate in the Demonstration will be limited to individuals ages 21 years and older at the time of enrollment who are entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, receive full Medicaid benefits (including individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver and those residing in nursing facilities), and meet the requirements addressed in more detail in section C.1 below.

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

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

Built on principles of independent living, wellness promotion, and cultural competence, this initiative aims to improve the entire beneficiary care experience. By engaging beneficiaries in their care and allowing them to self-direct services as appropriate, the Demonstration will

address beneficiaries' health and functional needs in order to better equip individuals to live independently in their communities. Improving the beneficiary experience can then lead to system-wide benefits such as better quality, improved transitions between care settings, fewer health disparities, reduced costs for both payers, and the elimination of cost shifting between Medicare and Medicaid.

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, 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 or State Plan Amendments, Participating Plans will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as program specific and evaluation requirements, as will be further specified in a three-way contract to be executed among the Participating Plans, DMAS, and CMS.

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

CMS and DMAS 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 will also be in the three-way contract. Participating Plans will have full accountability for managing the capitated payment to best meet the needs of Enrollees according to Plans of Care developed by Enrollees, their caregivers, and Interdisciplinary Care Teams using a person-centered planning process. CMS and DMAS expect Participating Plans to achieve savings through better integrated and coordinated care. Subject to CMS and DMAS oversight, Participating Plans will have significant flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to or means to avoid high-cost services if indicated by the Enrollees' wishes, needs, and Plans of Care.

Preceding the signing of this MOU, DMAS 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 DMAS plan to implement and operate the aforementioned Demonstration. It also outlines the activities CMS and DMAS plan to conduct in preparation for implementation of the Demonstration, before the parties execute a three-way contract with Participating Plans setting forth the terms and conditions of the Demonstration and initiate the Demonstration. Further detail about Participating Plan 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, CMS and DMAS will ultimately enter into three-way contracts with selected plans, which will have also met the Medicare components of the Plan selection process, including submission of a successful 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 Participating 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 initiative, Participating Plans will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of

Title XVIII of the Social Security Act, and 42 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 initiative 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 initiative, the State and Participating Plans 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 in the next update or scheduled renewal—whichever occurs sooner.

B. CONTRACTING PROCESS

- 1. Participating Plan Procurement Document:** DMAS issued a Request for Proposal (RFP) that, consistent with applicable State law and regulations, includes purchasing specifications that reflect the integration of Medicare and Medicaid payment and benefits. As articulated in January 9, 2013 guidance from CMS, Participating Plans are also required to submit a Capitated Financial Alignment Demonstration application to CMS and meet all of the Medicare components of the plan selection process.

All applicable Medicare Advantage/ Part D requirements and Medicaid managed care requirements are cited in the RFP, and will apply as specified by CMS and the Commonwealth herein or in the three-way contract.

- 2. Participating Plan Selection:** The DMAS procurement and CMS plan selection process will be utilized to select entities that will be eligible to contract with CMS and the Commonwealth. CMS and DMAS shall contract with qualified Participating Plans on a selective basis. See Appendix 7 for more information on the plan selection process.
- 3. Medicare Waiver Approval:** CMS approval of Medicare waivers is reflected in Appendix 4. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the

public interest or promote the objectives of Title XVIII. CMS will promptly notify DMAS 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 DMAS a reasonable 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, 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 participants.

- 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. 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 DMAS 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 DMAS 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 participants.
- 5. Readiness Review:** CMS and DMAS, either directly or with contractor support, shall conduct a readiness review of each selected Plan. Prior to the three-way contract execution, both CMS and DMAS must agree that a Plan has satisfied all readiness requirements. CMS and DMAS will collaborate in the design and implementation of the readiness review process and requirements. This readiness review shall include an evaluation of the capacity of each potential Participating Plan and its ability to meet all Demonstration requirements, including having an adequate network that addresses the full range of beneficiary needs, and the capacity to uphold all beneficiary safeguards and protections.
- 6. Three-way Contract:** CMS and DMAS shall develop a single three-way contract and a 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:

- Age 21 and older at the time of enrollment;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits. This includes individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver and those residing in nursing facilities (NF); and,
- Reside in a Demonstration area.

Individuals who meet at least one of the exclusion criteria listed below shall be excluded from the Demonstration.

- Individuals under age 21.
- Individuals who are required to “spend down” income in order to meet Medicaid eligibility requirements.
- Individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full benefit Medicaid beneficiaries such as:
 - a. Qualified Medicare Beneficiaries (QMBs);
 - b. Special Low Income Medicare Beneficiaries (SLMBs);
 - c. Qualified Disabled Working Individuals (QDWIs); or,
 - d. Qualifying Individuals (QIs).

These individuals may receive Medicaid coverage for the following: Medicare monthly premiums for Part A, Part B, or both (carved-out payment); coinsurance, copayment, and deductible for Medicare-allowed services; Medicaid-covered services, including those that are not covered by Medicare.

- Individuals who are inpatients in State mental hospitals, including but not limited to those listed below:
 - Catawba Hospital,
 - Central State Hospital,
 - Eastern State Hospital,
 - HW Davis Medical Center,
 - Northern Virginia Mental Health Institution,
 - Piedmont Geriatric Hospital,
 - Southern Virginia Mental Health Institution,

- Southwestern State HM&S,
 - Southwestern VA Mental Health Institution
 - Western State HM&S, and
 - Western State Hospital
- Individuals who are residents of State Hospitals, ICF/MR facilities, Residential Treatment Facilities, or long stay hospitals defined in Appendix 1. Note that dual eligible individuals residing in NFs will be enrolled in the Demonstration.
- Individuals who are participating in federal waiver programs for home and-community-based Medicaid coverage other than the EDCD Waiver (e.g., Individual and Family Developmental Disability Support, Intellectual Disabilities, Day Support, Technology Assisted Waiver, and Alzheimer’s Assisted Living waivers).
- 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 be disenrolled from the Demonstration. However, plans shall refer these individuals to the EDCD Waiver pre-admission screening team for additional LTSS.
- Individuals receiving the end stage renal disease (ESRD) Medicare benefit at the time of enrollment into the Demonstration. However, an individual who develops ESRD while enrolled in the Demonstration will remain in the Demonstration, unless he/she opts out. If he/she opts out, the individual cannot opt back into the Demonstration.
- Individuals with other comprehensive group or individual health insurance coverage, other than full benefit Medicare; insurance provided to military dependents; and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP).
- Individuals who have a Medicaid eligibility period that is less than three months.
- Individuals who have a Medicaid eligibility period that is only retroactive.
- Individuals enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.
- Individuals enrolled in the Money Follows the Person (MFP) Program.
- Individuals residing outside of the Demonstration areas.

- 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.
- Individuals participating in the CMS Independence at Home (IAH) demonstration. However, IAH participants may enroll in the Demonstration if they choose to disenroll from IAH.

2. Enrollment and Disenrollment Processes: Under passive enrollment, eligible individuals will be notified of their right to select among contracted Participating Plans 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. When no active choice has been made, enrollment into a Participating Plan may be conducted using a seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the Participating Plan at any time. Prior to the effective date of their enrollment, individuals who would be passively enrolled will have the opportunity to opt out and will receive sufficient notice and information with which to do so, as further detailed in Appendix 7. Disenrollment from Participating Plans and transfers between Participating Plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month. CMS and DMAS will monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations and CMS policies, for the purposes of identifying any inappropriate or illegal marketing practices. As part of this analysis, CMS and DMAS will monitor any unusual shifts in enrollment by individuals identified for passive enrollment into a particular Participating Plan 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 DMAS may issue corrective action. Any illegal marketing practices will be referred to appropriate agencies for investigation. As mutually agreed upon, and as discussed further in Appendix 7 and the three-way contract, CMS and DMAS will utilize an independent third party entity to facilitate all enrollments into the Participating Plans. Participating Plan enrollments, transfers, 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 Federal financial participation will continue through the end of that month.

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

4. **Outreach and Education:** Participating Plan outreach and marketing materials will be subject to a single set of marketing rules defined by CMS and DMAS, as further detailed in Appendix 7.
5. **Single Identification Card:** CMS and DMAS shall work with Participating Plans to develop a single identification card that can be used to access all care needs, as further detailed in Appendix 7.
6. **Interaction with other Demonstrations:** To best ensure continuity of beneficiary care and provider relationships, CMS will work with the Commonwealth to address beneficiary or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). A beneficiary enrolled in the Demonstration will not be enrolled in, or 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. **Participating Plan Service Capacity:** CMS and DMAS shall contract with Participating Plans that demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to Enrollees, in accordance with this MOU, CMS guidance, and the three-way contract. Medicare covered benefits shall be provided in accordance with 42 CFR 422 and 42 CFR 423 et seq. Medicaid covered benefits 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 and §1915(c) EDCD Waiver, and in accordance with the requirements specified in DMAS' RFP and this MOU. In accordance with the three-way contract and this MOU, CMS and DMAS 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, DMAS, and Participating Plans will ensure that beneficiaries have access to an adequate network of medical, drug, behavioral health, and Long-Term Services and Supports (LTSS) providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.
2. **Participating Plan Risk Arrangements:** CMS and DMAS shall require each Participating Plan to provide a detailed description of its risk arrangements with providers under subcontract with the Participating Plan. This description shall be made available to Plan Enrollees upon request. It will not be permissible for any incentive arrangements to include

any payment or other inducement that serves to withhold, limit or reduce necessary medical or non-medical services to Enrollees.

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

E. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

- 1. Choice of Plans and Providers:** As referenced in section III. C.2, Medicare-Medicaid beneficiaries will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose a different Participating Plan, or a Medicare Advantage Plan, or to receive care through Medicaid and Medicare Fee-For-Service (FFS) and a Prescription Drug Plan, a PACE site (where applicable), or an Independence at Home program (where applicable), and to receive Medicaid services in accordance with DMAS' approved State Plan and any approved waiver programs.
- 2. Continuity of Care:** CMS and the DMAS will require Participating Plans 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. In addition, Participating Plans will advise in writing beneficiaries and providers that they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, Participating Plans must also contact providers not already members of their network with information on becoming credentialed as in-network providers. Part D transition rules and rights will continue as provided for in current law and regulation.
- 3. Enrollment Assistance and Options Counseling:** As referenced in section C.2 and Appendix 7, DMAS will provide Medicaid-Medicare Enrollees with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs.
- 4. Ombudsman:** DMAS intends to support an independent Ombudsman outside of the state Medicaid agency to advocate and investigate on behalf of Demonstration Enrollees, including home and community based care and nursing facility-based recipients, to safeguard due process and to serve as the early and consistent means of identifying systematic problems with the Demonstration. CMS will support Ombudsman training on the Demonstration and its objectives, and CMS and the Commonwealth will provide ongoing technical assistance to

the Ombudsman. The Ombudsman will support individual advocacy and independent systematic oversight for Participating Plans, 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 Commonwealth and CMS via the Contract Management Team described in Appendix 7 of this MOU.

- 5. Person-Centered, Appropriate Care:** CMS, DMAS, and Participating Plans shall ensure that all medically necessary covered benefits are provided to Enrollees and are provided in a manner that is sensitive to the Enrollee's functional and cognitive needs, language and culture, allows for involvement of the Enrollee and caregivers, and are in a care setting appropriate to the Enrollees' needs, with a preference for the home and the community. CMS, DMAS, and Participating Plans shall ensure that care is person-centered and can accommodate and support self-direction. Participating Plans shall also ensure that medically necessary covered services are provided to Enrollees in the least restrictive community setting, and in accordance with the Enrollee's wishes and Plan of Care.
- 6. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and DMAS require Plan 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 Demonstration Enrollees. In particular, CMS and DMAS recognize that successful person-centered care requires physical access to buildings, services and equipment and flexibility in scheduling and processes. DMAS and CMS will require Participating Plans to provide access to contracted providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their Enrollees. DMAS and CMS also recognize that access includes effective communication. DMAS and CMS will require Participating Plans 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 or who do not speak English and, accommodations for Enrollees with cognitive limitations, and interpretation for individuals with limited English proficiency. Also, CMS and DMAS recognize the importance of staff training on accessibility and accommodation, independent living and recovery models, cultural competency, and wellness philosophies. CMS and DMAS will continue to work with stakeholders, and Enrollees, to further develop learning opportunities, monitoring mechanisms and quality measures to promote compliance by Participating Plans and their providers comply with all requirements of the ADA. Finally, CMS and DMAS are committed to compliance with the ADA, including application of the Supreme Court's *Olmstead* decision, and agree to ensure that Participating Plans provide for Enrollees with LTSS in care settings appropriate to their needs consistent with covered services.

- 7. Enrollee Communications:** CMS and DMAS agree that Enrollee and prospective Enrollee materials, in all forms, shall require prior approval by CMS and DMAS in accordance with all existing rules and regulation, unless CMS and DMAS agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and DMAS. CMS and DMAS will also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or DMAS approval. CMS and DMAS will develop integrated materials that include, but not be limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable to Enrollees and prospective Enrollees in the Participating Plans, and their caregivers. This includes individuals with disabilities, including, but not limited to, those with cognitive and functional limitations, and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard providing the greatest access to individuals with disabilities or limited English proficiency will apply.
- 8. Beneficiary Participation on Governing and Advisory Boards:** As part of the three-way contract, CMS and DMAS shall require Participating Plans to obtain meaningful beneficiary input on issues of Demonstration management and Enrollee care through a range of approaches. Participating Plans must establish an independent Demonstration beneficiary advisory committee and a process for that committee to provide input to the governing board. The Participating Plan must also assure that the beneficiary advisory committee composition reflects the diversity of the Demonstration population. In addition to the advisory committees, Participating Plans must include participation of individuals with disabilities, including Enrollees, within the governance structure of the Participating Plan. The Commonwealth will maintain additional processes for ongoing stakeholder participation and public comment.
- 9. Participating Plan Customer Service Representatives:** CMS and the DMAS shall require Participating Plans 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 timely manner. In addition, CMS and DMAS shall themselves employ or contract with sufficient call center and customer service representatives to address Enrollee questions and concerns. Participating Plans, CMS, and DMAS 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 DMAS shall require all Participating Plans to ensure privacy and security of Enrollee health records, and provide for access by Enrollees to such records as specified in the three-way contract 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:** Participating Plans will not charge Medicare Parts C or D premiums, nor assess any cost sharing for Medicare Parts A and B services. For drugs and pharmacy products (including those covered by both Medicare Part D and DMAS), Plans 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 Participating Plans 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, although plans 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. Participating Plans will not assess any cost sharing for DMAS services, beyond the pharmacy cost sharing amounts allowed under Medicaid coverage rules.
- 13. No Balance Billing:** No Enrollee may be balance billed by any provider for any reason for covered services or Flexible Benefits.

F. INTEGRATED APPEALS AND GRIEVANCES

- 1. Participating Plan Grievances and Internal Appeals Processes:** CMS and DMAS agree to develop a unified set of requirements for Participating Plan grievances and internal appeals processes that incorporate relevant Medicare Advantage, and Medicaid managed care requirements, to create a more beneficiary-friendly and easily navigable system. All Participating Plan Grievances and Internal Appeals procedures shall be subject to the review and prior approval of CMS and DMAS. 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 DMAS. CMS and DMAS will work to continue to coordinate grievances and appeals for all services.
- 2. External Appeals Processes:** CMS and DMAS agree to utilize a streamlined Appeals process that will conform to both Medicare and Medicaid requirements, to create a more

beneficiary-friendly and easily navigable system. Protocols will be developed to assure coordinated access to the appeals mechanism. This process and these protocols are discussed in further detail in Appendix 7. Medicare Part D appeals and grievances will continue to be managed by CMS under existing Part D rules.

G. ADMINISTRATION AND REPORTING

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

These activities shall include but not be limited to:

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

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

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

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

4. Accept and Process Data: CMS, or its designated agent(s), and DMAS, 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 DMAS 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 DMAS shall streamline data submissions for Participating Plans wherever practicable.

H. QUALITY MANAGEMENT

- 1. Quality Management and Monitoring:** As a model conducted under the authority of Section 1115A of the Social Security Act, the Demonstration and independent evaluation will include and assess quality measures designed to ensure beneficiaries are receiving high quality care. In addition, CMS and DMAS shall conduct a joint comprehensive performance and quality monitoring process that is at least as rigorous as Medicare Advantage, Medicare Prescription Drug, Medicaid managed care, and the EDCD Waiver requirements. The reporting frequency and monitoring process will be specified in the three-way contract.
- 2. External Quality Reviews:** CMS and DMAS shall coordinate the Participating Plan external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).
- 3. Determination of Applicable Quality Standards:** CMS and DMAS shall determine applicable quality standards and monitor the Participating Plans' performance on those standards. These standards are articulated in Appendix 7 and will be articulated in the Participating Plan three-way contract.

I. FINANCING AND PAYMENT

- 1. Rates and Financial Terms:** For each calendar year of the Demonstration, before rates are offered to Participating Plans, CMS shall share with DMAS the amount of the Medicare portion of the capitated rate, as well as collaborate to establish the data and documentation needed to assure that the Medicaid portion of the capitation rate is consistent with all applicable Federal requirements.
- 2. Blended Medicare and Medicaid Payment:** CMS will make separate payments to the Participating Plans for the Medicare Parts A/B and Part D components of the rate. DMAS

will make a payment to the Participating Plans for the Medicaid component of the rate, as more fully detailed in Appendix 6.

J. EVALUATION

- 1. Evaluation Data to be Collected:** CMS and DMAS have developed processes and protocols, as specified in Appendix 7 and as will be further detailed in the three-way contract, for collecting or ensuring the Participating Plans or their contractors collect and report to CMS and DMAS 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, 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 appeals and grievances, will also be examined per qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives, and will seek to isolate the effect of this Demonstration as appropriate. DMAS will collaborate with CMS or its designated agent during all monitoring and evaluation activities. DMAS and Participating Plans will submit all data required for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements listed in the three-way contract with Participating Plans. DMAS and Participating Plans will submit both historical data relevant to the evaluation, including MSIS data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

K. EXTENSION OF AGREEMENT

DMAS may request an extension of this Demonstration, which will be evaluated consistent with terms specified under Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing

spending without reducing the quality of care; or improving the quality and care and reducing spending. Any extension request will be subject to CMS approval.

L. MODIFICATION OR TERMINATION OF MOU

DMAS agrees to provide notice to CMS of any State Plan or waiver, 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 Commonwealth, 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 DMAS 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:
 - a. Termination without cause - Except as otherwise permitted below, a termination of this MOU by CMS or DMAS for any reason will require that CMS or DMAS provide a minimum of 90 days advance notice to the other party, 90 day advance notice to the Participating Plan, and 60 days advance notice is given to beneficiaries and the general public.
 - b. Termination pursuant to Social Security Act § 1115A(b)(3)(B).
 - c. 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.

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

If the Demonstration is terminated as set forth above, CMS shall provide the Commonwealth with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Demonstration Enrollees, 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.

4. Demonstration phase-out: Termination at the end of the Demonstration must follow the following procedures:

- a. Notification - Unless CMS and DMAS agree to extend the Demonstration, DMAS 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, DMAS must publish on its website the draft phase-out plan for a 30-day public comment period. DMAS 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 - DMAS 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 beneficiary appeal rights, and if applicable, the process by which DMAS will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries and ensure ongoing coverage for eligible individuals, including plans for making an appropriate referral for enrollment of all Enrollees in a Medicare Part D Plan, as well as any community outreach activities. In addition, such plan must include any ongoing Participating Plan and DMAS responsibilities and close-out costs. If the Demonstration is terminated as set forth in Paragraphs 3a.- 3d. above, CMS shall provide DMAS with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Demonstration Enrollees. During the phase-out period, all enrollees must be successfully enrolled in a Medicare Part D plan prior to termination of the Demonstration

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


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

M. SIGNATURES

This MOU is effective on this day forward, May 21, 2013, through the end of the Demonstration period December 31, 2017. Additionally, the terms of this MOU shall continue to apply to DMAS and Participating Plans as they implement associated phase-out activities beyond the end of the Demonstration period.


In Witness Whereof, CMS and DMAS 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:


Jonathan Blum
Acting Principal Deputy Administrator

May 21, 2013
(Date)

Commonwealth of Virginia, DMAS:


Cynthia B. Jones
DMAS Agency Director

5/21/13
(Date)

Appendix 1: Definitions

Adverse Action - Consistent with 42 CFR § 438.400, is an action by the Participating Plan, subcontractor, service provider, DMAS, 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 a payment for a covered service for an enrolled member; or failure by the Participating Plan to render a decision within the required timeframes; or the denial of an enrollee's request to exercise his right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network.

Appeals - An Enrollee's request for review of a Participating Plan'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 Participating Plan, its service providers or the DMAS. 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."

Care Management – A collaborative, person-centered process that assists Enrollees in gaining access to needed services. Includes assessing and planning of services; linking the Enrollee to services and supports identified in the Plan of Care; working with the Enrollee directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies, providers and family members involved with the Enrollee; making collateral contacts to promote the implementation of the Plan of Care and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the Enrollee and develops a supportive relationship that promotes the Plan of Care.

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 or an appeal.

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 and DMAS representatives responsible for overseeing the contract.

Covered Services - The set of required services offered by the Participating Plan.

Cultural Competence - Understanding those values, beliefs, and needs that are associated with individuals' 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.

Department of Medical Assistance Services- single state agency for the Medicaid program in Virginia; responsible for implementation and oversight of the Demonstration.

Elderly or Disabled with Consumer Direction (EDCD) Waiver - The CMS-approved §1915(c) waiver that covers a range of community support services offered to individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care.

Enrollee – A Medicare-Medicaid individual enrolled in the Demonstration, including the duration of any month in which their eligibility for the Demonstration ends.

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 Participating Plan.

Expedited Appeal –The process by which a Participating Plan must respond to an appeal by an enrollee if a denial of care decision by a Participating Plan may jeopardize life, health or ability to attain, maintain or regain maximum function.

External Appeal – An appeal, subsequent to the Participating Plan appeal decision, to the State Fair Hearing process for Medicaid-based adverse decisions or the Medicare process for Medicare-based adverse decisions.

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

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 Participating Plan 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).

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

Health Outcomes Survey (HOS) - Beneficiary survey used by the Centers for Medicare & 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.

Health Risk Assessment (HRA) – A comprehensive assessment of an individual’s medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, LTSS, and social needs.

Interdisciplinary Care Team (ICT) - A team of professionals that collaborate, either in person or through other means, with the Enrollee to develop and implement a Plan of Care that meets their medical, behavioral, long term care and supports, and social needs. ICTs may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, and/or social workers appropriate for the Enrollee’s medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.

Long-Stay Hospitals – Specialty Medicaid facilities that target individuals who require a higher intensity of nursing care than that which is normally provided in a nursing facility and who do not require the degree of care and treatment that an acute care hospital is designed to provide. Residents of these long-stay hospitals must have long-term health conditions requiring close medical supervision, 24 hours of licensed nursing care, and specialized services or equipment. These individuals must meet one of the following categories: (1) requires mechanical vent; (2) has a communicable disease(s) that requires universal or respiratory precautions; (3) requires on-going intravenous medication or nutrition administration; or, (4) requires comprehensive rehabilitative therapy services. The majority of individuals served in this setting are children.

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

Medically Necessary or Medical Necessity - 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 Virginia Medicaid, an item or service provided for the diagnosis or treatment of a patient's condition consistent with community standards of medical practice and in accordance with Medicaid policy (12 VAC 30-130-600). Furthermore, as defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. Services must be provided in a way that provides all protections to covered individuals provided by Medicare and Virginia Medicaid.

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 Medicare Part A and enrolled in Medicare Parts B and D and receive full benefits under the Virginia Medicaid State Plan, 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 Waiver - Generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.

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

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) - Demonstration project designed to create a system of long-term services and supports that better enable individuals to transition from certain LTC institutions into the community. To participate in MFP, individuals must: 1) have lived for at 90 consecutive days in a nursing facility, an intermediate care facility for persons with mental retardation, a long-stay hospital licensed in Virginia, institute for mental disorders (IMD),

psychiatric residential treatment facility (PRTF), or a combination thereof; and 2) move to a qualified community-based residence. Individuals may participate in MFP for up to twelve (12) months. Individuals enrolled in MFP will be excluded from the Demonstration.

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

Participating Plan - A health plan or other qualified entity serving as a Managed Care Organization jointly selected by DMAS and CMS for participation in this Demonstration.

Passive Enrollment - An enrollment process through which an eligible individual is enrolled by DMAS (or its vendor) into a Participating Plan, when not otherwise affirmatively electing one, following a minimum 60-day advance notification that includes the opportunity to make another enrollment decision or opt out of the Demonstration prior to the effective date.

Plan of Care - A plan, primarily directed by the Enrollee, and family members of the Enrollee as appropriate, with the assistance of the Enrollee's Interdisciplinary Care Team to meet the medical, behavioral, long term care and supports, and social needs of the Enrollee.

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 Virginia 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 Commonwealth of Virginia, and the PACE organization.

Provider Appeal – An appeal filed by a Medicare, Medicaid or Waiver service provider that has already provided a service and has received an adverse action regarding payment or audit result. A provider must appeal to and exhaust the Participating Plan appeals process as a prerequisite to filing for an external appeal. A provider with written authorization from an enrollee may also file an appeal on behalf of an enrollee for a service that the provider has not yet provided. Such an appeal must be made to and exhaust the Participating Plan appeal process as a prerequisite to filing an external appeal.

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 control peer review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review in fee-for-service settings.

Readiness Review - Prior to entering into a three-way contract with DMAS and CMS, each Participating Plan selected to participate in the Demonstration will undergo a readiness review. The readiness review will evaluate each Participating Plan's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new members, and provide adequate access to all Medicare- and Medicaid-covered medically necessary services. CMS and DMAS will use the results to inform their decision of whether the Participating Plan 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 Participating Plan's headquarters.

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

Spend Down –When a Medicaid applicant meets all Medicaid eligibility requirements other than income, Medicaid eligibility staff conduct a “medically needy” calculation which compares the individual's income to a medically needy income limit for a specific period of time referred to as the “budget period” (not to exceed 6 months). When a Medicaid applicant's incurred medical expenses equal the spend down amount, the individual is eligible for full benefit Medicaid for the remainder of the spend down budget period. Individuals with a spend down are not eligible to participate in the Demonstration.

State Fair Hearing – The Department of Medical Assistance Services' evidentiary hearing process. Any adverse action upheld in whole or part by the Participating Plan appeals process may be appealed by the enrollee to the Department of Medical Assistance Services' Appeals Division. The Participating Plan's appeal process is a prerequisite to filing for a State Fair Hearing with the Department of Medical Assistance Services. The Department conducts evidentiary hearings in accordance with regulations at 42 CFR § 431, Subpart E, 12 VAC30-110-10 through 12VAC30-110-370, and § 2.2-4027 et seq. of the Virginia Code.

Store and Forward - Used in telehealth, when pre-recorded images, such as X-rays, video clips and photographs are captured and then forwarded to and retrieved, viewed, and assessed by a provider at a later time. Some common applications include (1) tele-dermatology where digital pictures of a skin problem are transmitted and assessed by a dermatologist; (2) tele-radiology where x-ray images are sent to and read by a radiologist; and, (3) tele-retinal imaging where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy.

Targeted Case Management (TCM) - Medicaid-funded State Plan case management service provided by private providers for individuals with substance use disorders or developmental disabilities and by Community Services Boards/Behavioral Health Authorities for individuals with behavioral health disorders or intellectual disabilities. TCM encompasses both referral/transition management and clinical services such as monitoring, self-management support, medication review and adjustment. In circumstances where individuals receive TCM services through the Medicaid State Plan, care management provided by the Participating Plan and TCM provider shall be collaborative with clearly delineated responsibilities and methods of sharing important information between the Participating Plan and the TCM provider. TCM is separate from “care management” as defined in this MOU; however, the two programs shall

work in concert for individuals receiving both services.

Telehealth - The real time or near real time two-way transfer of data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. This is also referred to as telemedicine.

Three-way Contract - The three-way agreement that CMS and DMAS have with an Participating Plan specifying the terms and conditions pursuant to which a Participating Plan may participate in this Demonstration.

Virginia Uniform Assessment Instrument (UAI) - The standardized multidimensional questionnaire that is completed by a Preadmission Screening Team or a hospital discharge planner for individuals residing in a hospital setting that assesses an individual's psychosocial, physical health, mental health, and functional abilities to determine if an individual meets level of care criteria for LTSS funded through Medicaid.

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 Virginia proposal. Following the submission of the proposal, CMS asked the Commonwealth 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.

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. 4, 6, 14, 15, 49-71
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. 11, 15-20
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. 6, 7, 22-24
	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.	pp. 24-25

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Beneficiary Protections	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary’s needs. At a minimum, State will be required to:	
	<ul style="list-style-type: none"> Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model (e.g., participation on Participating Plan governing boards and/or establishment of beneficiary advisory boards). 	pp. 25
	<ul style="list-style-type: none"> Develop, in conjunction with CMS, uniform/integrated Enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency. 	pp. 13, 26
	<ul style="list-style-type: none"> Ensure privacy of Enrollee health records and provide for access by Enrollees to such records. 	pp.20, 27
	<ul style="list-style-type: none"> 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. 18-19
	<ul style="list-style-type: none"> 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. 26-27
	<ul style="list-style-type: none"> Ensure an adequate and appropriate provider network, as detailed below. 	pp. 12-13, 25
Beneficiary Protections (continued)	<ul style="list-style-type: none"> Ensure that beneficiaries are meaningfully informed about their care options. 	pp. 19, 25-26
	<ul style="list-style-type: none"> Ensure access to grievance and appeals rights under Medicare and/or Medicaid. 	pp. 14, 26
	<ul style="list-style-type: none"> <i>For Capitated Model</i>, this includes development of a unified set of requirements for Participating Plan complaints and internal appeals processes. 	pp. 14, 26

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	<ul style="list-style-type: none"> For <i>Managed FFS Model</i>, the State will ensure a mechanism is in place for assisting the participant in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable. 	N/A
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. 32-35
Network Adequacy	The Demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.	pp. 12-13, 25
Measurement/ Reporting	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality and cost outcomes for the target population. These metrics may include, but are not limited to beneficiary experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote beneficiaries receiving high quality care and for purposes of the evaluation.	pp. 28-31
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:	
	<ul style="list-style-type: none"> Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models; 	Addendum
	<ul style="list-style-type: none"> 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 	Addendum
	<ul style="list-style-type: none"> State supplemental payments to providers (e.g., DSH, UPL) during the three-year period. 	Addendum

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
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. 11-12
Expected Savings	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	pp.27-28
Public Notice	State has provided sufficient public notice, including:	
	<ul style="list-style-type: none"> At least a 30-day public notice process and comment period; 	pp. 24
	<ul style="list-style-type: none"> At least two public meetings prior to submission of a proposal; and 	pp. 22-24
	<ul style="list-style-type: none"> Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals. 	N/A
Implementation	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation: :	
	<ul style="list-style-type: none"> Meaningful stakeholder engagement. 	pp. 22-25
	<ul style="list-style-type: none"> Submission and approval of any necessary Medicaid waiver applications and/or State Plan Amendments. 	pp.36, 38
	<ul style="list-style-type: none"> Receipt of any necessary State legislative or budget authority. 	pp. 38
	<ul style="list-style-type: none"> Joint procurement process (for capitated models only). 	pp. 33
	<ul style="list-style-type: none"> Beneficiary outreach/notification of enrollment processes, etc. 	pp.11-14, 26-27

Appendix 3: Details of State Demonstration Area

The Demonstration area consists of five (5) regions, as highlighted and illustrated in the map below.

Central Virginia

FIPS	Locality
7	Amelia
25	Brunswick
33	Caroline
36	Charles City
41	Chesterfield
49	Cumberland
53	Dinwiddie
57	Essex
75	Goochland
81	Greensville
85	Hanover
87	Henrico
97	King and Queen
99	King George
101	King William
103	Lancaster
111	Lunenburg
117	Mecklenburg
119	Middlesex
127	New Kent
133	Northumberland
135	Nottoway
145	Powhatan
147	Prince Edward
149	Prince George
159	Richmond Co.
175	Southampton
177	Spotsylvania
179	Stafford
181	Surry
183	Sussex
193	Westmoreland
570	Colonial Heights
595	Emporia
620	Franklin City
630	Fredericksburg
670	Hopewell
730	Petersburg
760	Richmond City

Northern Virginia

FIPS	Locality
13	Arlington
47	Culpeper
59	Fairfax County
61	Fauquier
107	Loudoun
153	Prince William
510	Alexandria
600	Fairfax City
610	Falls Church
683	City of Manassas
685	Manassas Park

Tidewater

FIPS	Locality
1	Accomack (Optional*)
73	Gloucester
93	Isle Of Wight
95	James City County
115	Mathews
131	Northampton (Optional*)
199	York
550	Chesapeake
650	Hampton
700	Newport News
710	Norfolk
735	Poquoson
740	Portsmouth
800	Suffolk
810	Virginia Beach
830	Williamsburg

**Note: Optional means interested plans are encouraged, but not required to participate in these localities. If no plan or only one plan applies to participate in these localities, the localities will not be included in the Demonstration. Non-participation will not result in a lower score for Plans that apply during the RFP process.*

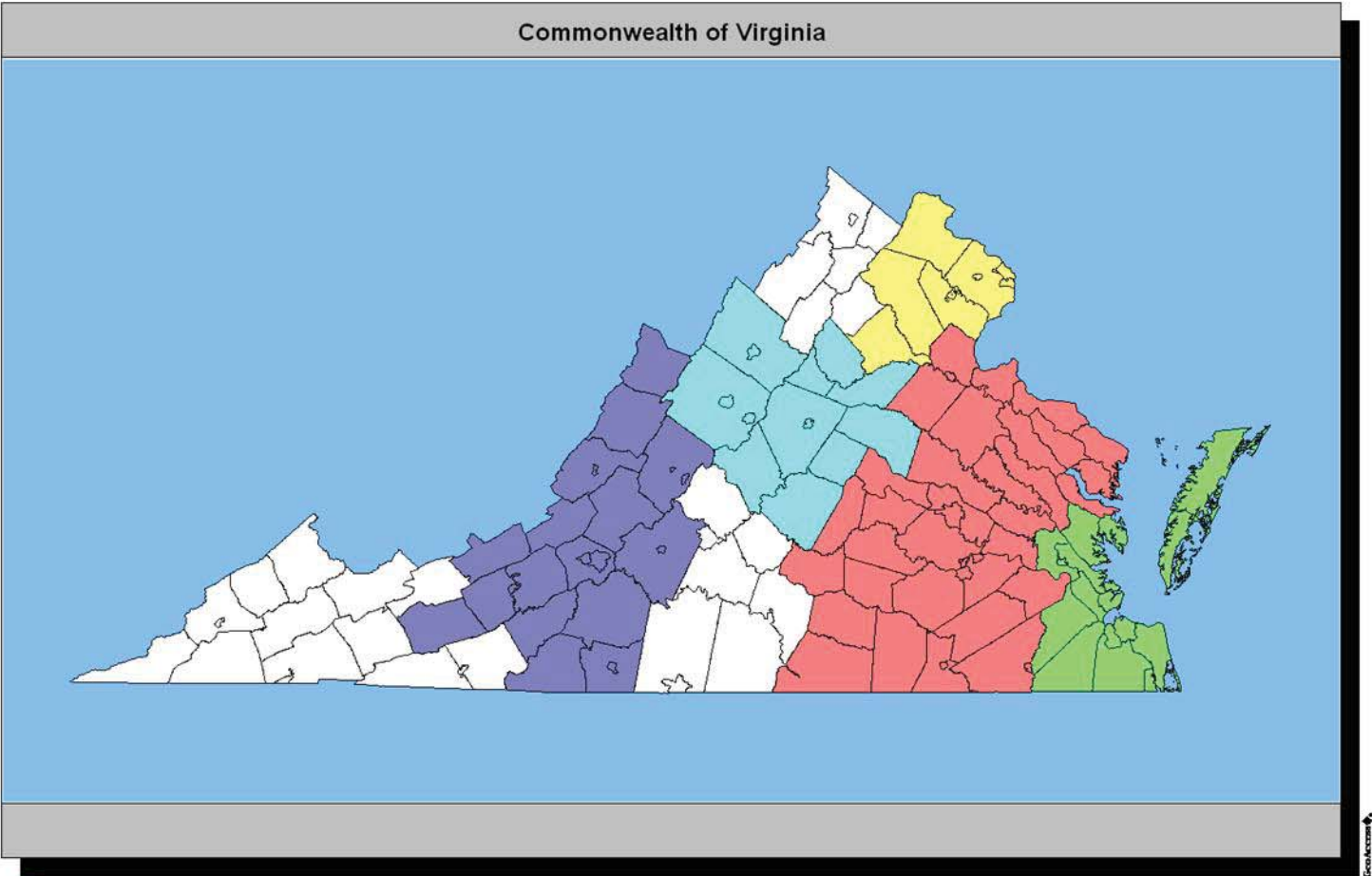
Western/Charlottesville

FIPS	Locality
3	Albemarle
15	Augusta
29	Buckingham
65	Fluvanna
79	Greene
109	Louisa
113	Madison
125	Nelson
137	Orange
165	Rockingham
540	Charlottesville
660	Harrisonburg
790	Staunton
820	Waynesboro

Roanoke

FIPS	Locality
005	Alleghany
017	Bath
019	Bedford County
023	Botetourt
045	Craig
063	Floyd
067	Franklin County
071	Giles
089	Henry
091	Highland
121	Montgomery
141	Patrick
155	Pulaski
161	Roanoke County
163	Rockbridge
197	Wythe
515	Bedford City
530	Buena Vista
580	Covington
678	Lexington
690	Martinsville
750	Radford
770	Roanoke City
775	Salem

Dual Demonstration Service Areas



Appendix 4: Medicare Authorities and Waivers

Medicare provisions described below are waived as necessary to allow for implementation of the Demonstration. Except as waived, Medicare Advantage and Medicare Part D provide the authority and statutory and regulatory framework for the operation of the Demonstration to the extent that Medicare (versus Medicaid) authority applies. Unless waived, all applicable statutory and regulatory requirements of the Medicare program for Medicare Advantage plans that provide qualified Medicare Part D prescription coverage, including Medicare Parts A, B, C, and D, shall apply to Participating Plans and their sponsoring organizations for the Demonstration period beginning February 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 "The Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) [of the Social Security Act] as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b)."

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

- Section 1851(a), (c), (e), and (g) of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in Participating Plans to Medicare-Medicaid beneficiaries who are 21 and older, including beneficiaries who may have end-stage renal disease, and excluding beneficiaries who may meet exclusion criteria specified in section C.1 (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 Commonwealth have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and DMAS have agreed to approval.
- Sections 1852 (f) and (g) and implementing regulations at 42 CFR Part 422, Subpart M, only insofar as such provisions are inconsistent with the grievance and appeals processes provided for under the Demonstration.
- Section 1860D-14(a)(1)(D) and implementing regulations at 42 CFR Part 423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the low-income subsidy be greater than \$0, to permit Participating Plans to reduce Part D cost sharing below the levels required under Section 1860D-14(a)(1)(D)(ii) and (iii).

Appendix 5: Medicaid Authorities and Waivers

All requirements of the Medicaid program expressed in law and regulation, not expressly waived in this list, shall apply to the Demonstration beginning February 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 a Social Security Act Section 1932(a) State Plan Amendment and concurrent authority to the relevant existing 1915(c) programs. CMS has received the 1932(a) State Plan Amendment. Since these delivery system changes do not alter covered benefits or eligibility in the 1915(c) waivers, the State may submit the required waiver amendments via the State's next amendment or renewal (whichever occurs first). The State must meet all requirements of the State Plan and any applicable Medicaid waiver(s) as expressed in the terms of those authority documents, including, but not limited to, all financial, quality, reporting and monitoring requirements of each waiver, and State financing contained in the State's waiver(s) 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 following waivers of State Plan requirements contained in Section 1902 and 1903 of the Social Security Act are granted to enable the Commonwealth of Virginia (Commonwealth) to carry out the Demonstration. These authorities shall be in addition to those in the State Plan, State Plan Amendment, and applicable 1915(c) waivers.

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.

Appendix 6: Payments to Participating Plans

The Centers for Medicare and Medicaid Services (CMS) and DMAS 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 Participating Plans are responsible for the full range of covered services and flexible benefits covered 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 DMAS will contribute to the methodologies used to develop their respective components of the overall blended rate as summarized in Figure 6-2 and further described below.

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

Figure 6-1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1	February 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

	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 shall be set up front and will be applied in future years unless more recent historical data are available and/or CMS’ actuaries and DMAS 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 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 purposes of tracking and evaluating Part D costs but not for purposes of setting payment rates. These amounts will be factored into Participating Plan payments, as appropriate, but these amounts are subject to reconciliation consistent with Medicare Part D reconciliation rules.</p>	<p>Historical state data. Trend rates developed by state actuaries based on State Plan and HCBS services, with oversight from CMS contractor and staff.</p>
Responsible for producing data	CMS	CMS	Virginia DMAS, validated by CMS
Savings percentages	Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 4%	Not Applicable	Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 4%
Risk adjustment	Medicare Advantage CMS-HCC Model	Medicare Part D RxHCC Model	Rate Cell Structure
Quality withhold	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3%	Not applied	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3%
Risk Sharing	Minimum Medical Loss Ratio (MMLR)	Existing Medicare Part D processes will apply	MMLR

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 the Medicaid component of the rate for the first Demonstration year are based on DMAS fee-for-service data for calendar years 2010 through 2013, as available at the point of rate-setting for each year.
2. Prior to implementation of the Demonstration, the State 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 section II and III) to the applicable baseline spending amounts).

B. Medicare Part 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 Medicare-Medicaid 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 section 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. Beneficiary risk scores will be applied to the standardized payment rates at the time of payment.
5. CMS may require DMAS to provide a data file for beneficiaries who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline spending. CMS will allow for a reasonable amount of time to compile this data and 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 Medicare programs. The adjustment for 2014 is 4.91%. The majority of new Enrollees will come from Medicare FFS, and 2014 risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the Participating Plans 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. After calendar year 2014, CMS will apply the prevailing Medicare Advantage coding intensity adjustment for 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.

The CY 2013 Part D NAMBA is \$79.64. CMS will publish the CY 2014 NAMBA in August 2013.

II. Aggregate Savings Percentages Under the Demonstration.

- A. Both parties agree that there is reasonable expectation for achieving savings while paying Participating Plans capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to beneficiary needs.
- B. The savings percentages will be:
 - a. Demonstration Year 1: 1%
 - b. Demonstration Year 2: 2%
 - c. Demonstration Year 3: 4%

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. The Medicaid savings percentages may vary by Rating Category, but will in the aggregate equal the savings percentages identified above. Changes to the savings percentages under section III of Appendix 6 would only occur if and when CMS and DMAS 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 increase in Medicare Part D costs relative to the baseline may be factored into future year savings percentages.

IV. Risk Adjustment Methodology

- A. The Medicare A/B Demonstration county rate will be risk adjusted based on the risk profile of each enrolled beneficiary. Except as specified in section I.B.7. , the existing CMS-HCC risk adjustment methodology will be utilized for the Demonstration.
- B. The Medicare Part D national average bid will be risk-adjusted in accordance with existing Part D RxHCC methodology.
- C. The Medicaid component will employ the rating categories described below:

Figure 6-3: Medicaid Component Rating Categories

Rating Category Rate Cell	Description
Community Well: age 21-64	<ul style="list-style-type: none"> • Enrollees age 21-64 who do not meet a Nursing Facility Level of Care (NFLOC) standard • Rates will vary for the five Demonstration regions
Community Well: age 65+	<ul style="list-style-type: none"> • Enrollees age 65 and older who do not meet a Nursing Facility Level of Care (NFLOC) standard • Rates will vary for the five Demonstration regions
Nursing Facility Level of Care:	<ul style="list-style-type: none"> • Single rate cell for all Enrollees age 21-64 meeting a NFLOC through waiver enrollment or currently in a nursing facility for 20 or more

Rating Category Rate Cell	Description
age 21-64	<p>consecutive days. Note: An individual’s initial screening to determine NFLOC will be conducted by a state-reimbursed, external preadmission screening team. Annual reassessment screenings for NFLOC will be conducted by the Plan, but monitored by DMAS for quality assurance.</p> <ul style="list-style-type: none"> • There will be a member enrollment mix adjustment (MEMA) that will provide more revenue to Plans that have a greater proportion of high risk/cost individuals (e.g. nursing facility residents) compared to Plans with a lower proportion of high risk/cost individuals. • Once a NFLOC recipient is determined to no longer need NFLOC services, either nursing facility or HCBS, the Plan continues to receive the higher NFLOC capitation rate for two full months following the change in determination. Beginning with the third month, the Plan would receive the Community Well capitation rate. • Rates will vary for the five Demonstration regions
Nursing Facility Level of Care: age 65+	<ul style="list-style-type: none"> • Single rate cell for all Enrollees age 65 and over meeting a NFLOC through waiver enrollment or currently in a nursing facility for 20 or more consecutive days. Note: An individual’s initial screening to determine NFLOC will be conducted by a state-reimbursed, external preadmission screening team. Annual reassessment screenings for NFLOC will be conducted by the Plan, but monitored by DMAS for quality assurance. • There will be a member enrollment mix adjustment (MEMA) that will provide more revenue to Plans that have a greater proportion of high risk/cost individuals (e.g. nursing facility residents) compared to Plans with a lower proportion of high risk/cost individuals • Once a NFLOC recipient is determined to no longer need NFLOC services, either nursing facility or HCBS, the Plan continues to receive the higher NFLOC capitation rate for two full months following the change in determination. Beginning with the third month, the Plan would receive the Community Well capitation rate. • Rates will vary for the five Demonstration regions

1. For the NFLOC members, the relative risk/cost differences of major and objectively identifiable sub-populations (e.g., nursing facility residents and individuals receiving waiver services in the community included in each base rate cell will be considered by using a member enrollment mix adjustment (MEMA). The MEMA utilizes the particular waiver enrollment and nursing facility placement of the NFLOC member and historical costs associated with nursing

facility and home and community based services to provide more revenue to plans that have a greater proportion of high risk/cost individuals and, conversely, less revenue to plans that have a lower proportion of high risk/cost individuals at the beginning of the rating period or enrollment within the year. The adjustment is budget neutral.

2. Rates will vary for the five contracting regions, with a MEMA adjustment as mentioned above to account for enrollment variations by Plan.

V. Quality withhold policy for Medicaid and Medicare A/B components of the integrated, risk-adjusted rate.

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

B. Withhold Measures in Demonstration Year 1.

1. Figure 6-4 below identifies core withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for the 1% withhold. Additional detail regarding the measures will be included in the three-way contract.

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

Domain	Measure	Source	CMS Core Withhold Measure	DMAS Specified Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/DMAS defined process measure	X	
Assessments	Percent of Enrollees with initial assessments completed within 60 & 90 days of enrollment, per Virginia’s Model of Care requirements.	CMS/DMAS defined process measure	X	
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.	CMS/DMAS defined process measure	X	

Domain	Measure	Source	CMS Core Withhold Measure	DMAS Specified Measure
Customer Service	Percent of best possible score the plan 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 plan earned on how quickly members get appointments and care <ul style="list-style-type: none"> 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	
Plans of Care and Documentation of Care Goals	Percent of Enrollees with Plans of Care developed within specified timeframes Percent of Enrollee Plans of Care that contain documented discussions of care goals	CMS/DMAS defined		X
Hospital, Nursing Facility, and Community Transitions	Participating Plan has established work plan and systems in place for ensuring smooth transitions to and from hospitals, nursing facilities, and the community.	CMS/DMAS defined		X
Adjudicated Claims	Percent of adjudicated claims submitted to Participating Plans that were paid within the timely filing requirements.	CMS/DMAS defined process measure		X

C. Withhold Measures in Demonstration Years 2 and 3.

1. The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3 and will be based on performance on the core

Demonstration and DMAS-specified measures. Figure 6-5 below identifies the quality withhold measures for Demonstration Years 2 and 3. (Note: Medicare Part D payments will not be subject to a quality withhold, however Participating Plans will be required to adhere to quality reporting requirements that currently exist under Part D.)

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

Domain	Measure	Source	CMS Core Withhold Measure	DMAS Specified Measure
Plan all-cause hospital readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	X
Screening for clinical depression and follow-up care	Percentage of patients ages 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 members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
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	
Part D medication adherence for oral diabetes medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	
Assessments	Percent of Enrollees with initial assessments completed within required timeframes, per Virginia's Model of Care requirements.	CMS/DMAS defined		X
Plans of Care	Percent of Enrollees with Plans of Care developed within specified timeframes	CMS/DMAS defined		X
Adjudicated Claims	Percent of adjudicated claims submitted to Participating Plans that were paid within the timely filing requirements.	CMS/DMAS defined process measure		X

Domain	Measure	Source	CMS Core Withhold Measure	DMAS Specified Measure
Hospital, Nursing Facility, and Community Transitions	Percent of individuals who transitioned to and from hospitals, nursing facilities and the community.	CMS/DMAS defined		X
Severe Mental Illness (SMI)	Percent of individuals with SMI who are receiving primary care services.	CMS/DMAS defined		X

2. Additional detail regarding the agreed upon measures, including technical specifications and required thresholds, will be specified in the three-way contract. Metrics applicable to individuals younger than 21 based on technical specifications may be modified to reflect Virginia’s Demonstration target population.

VI. Payments to Participating Plans

- A. CMS will make separate monthly risk-adjusted payments to the Participating Plans for the Medicare A/B and Part D components of the rate, based on standardized Demonstration payment rates. Medicare A/B payments and Part D payments will be subject to the same payment adjustments that are made for payments to Medicare Advantage and Part D plans, including but not limited to adjustments for user fees and Medicare Secondary Payer adjustment factors.
- B. DMAS will make a payment to the Participating Plans for the Medicaid component of the rate.
- C. The capitated payment from CMS and DMAS is designed to be adequate to support access to and utilization of covered services, according to enrollee Plans of Care. CMS and the DMAS will jointly monitor access to care and overall financial viability of Plans accordingly.

VII. Evaluate and pay Participating Plans relative to quality withhold requirements.

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

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

VIII. Minimum Loss Ratio, Reconciliation and Rate Review

- A. **Minimum Loss Ratio:** Each Participating Plan will be required each year to meet a Minimum Medical Loss Ratio (MMLR) threshold which regulates the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments) that must be used for expenses either directly related to medical claims or those which are related to the care and quality of Enrollees.
 - a. If a Participating Plan has an MMLR between 85% and 90% of the joint Medicare and Medicaid payment to the Participating Plans, the State and CMS may require a corrective action plan or levy a fine on the plan. Any collected fine would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis.
 - b. If a Participating Plan has an MMLR below 85% of the joint Medicare and Medicaid payment to the Participating Plans, the Participating Plan must remit the amount by which the 85% threshold exceeds the plan's actual MMLR multiplied by the total applicable revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis.

The three-way contracts will include additional specifications on the MMLR. To the maximum extent possible, the methodology for calculating the MMLR will conform to prevailing regulatory requirements applicable to the others products offered by organizations operating Participating Plans.

- B. **Cost Reconciliation:** Cost reconciliation under 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:** In the event that one-third of Participating Plans experience annual losses in Demonstration Year 1 exceeding 3% of revenue over all regions in which those plans participate, based on at least 20 months of data from Demonstration Year 1, the savings percentage for Demonstration Year 3 will be reduced to 3%. In the

event that one-third of Participating Plans show MMLRs below 90% over all regions in which those plans participate, CMS and the Commonwealth will review the Participating Plan financial reports, encounter data, and other information to assess the ongoing financial stability of the Participating Plans and the appropriateness of capitation payments. At any point, the Commonwealth may request that CMS review documentation from specific plans 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.

IX. 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 baseline (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage rate announcement would occur only if and when CMS and DMAS jointly 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 DMAS prior to making any adjustment, but DMAS 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 law or policy, compared to 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 DMAS will make changes to baseline estimates within 30 days of 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 DMAS jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

Appendix 7: Demonstration Parameters

The purpose of this Appendix is to describe the parameters that will govern this Federal-state partnership; the parameters are based upon those articulated by CMS in its January 9, 2013 Health Plan Management System (HPMS) guidance. CMS and the Commonwealth 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. DMAS Delegation of Administrative Authority and Operational Roles and Responsibilities

DMAS is the single state agency for the Medicaid program in Virginia. The Health and Human Services Secretary directly oversees DMAS. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across DMAS as described below.

DMAS is composed of an Agency Director, four Deputy Directors (Administration, Complex Care and Services, Health Management, and Finance), and fifteen divisions, each led by a Director. Throughout the Demonstration, DMAS' Agency Director and the Deputy Director of Complex Care and Services will provide executive oversight and guide the policies of the program. In addition, DMAS created a new Office of Coordinated Care with a dedicated Director. This Office will oversee the Participating Plans, with dedicated staff taking on daily management responsibilities. The Office of Coordinated Care will coordinate with other DMAS Divisions, State agencies, and other stakeholders when additional resources are needed to support activities of the Demonstration.

II. Plan or Qualified Entity Selection

DMAS, in consultation with CMS, issued a Request for Proposal (RFP) that includes the DMAS and CMS requirements to operate as a Participating Plan under this Demonstration. DMAS' RFP can be accessed from the following website (http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx). DMAS and CMS will work together to ensure that the overall plan selection process will take into account previous performance in Medicare and Medicaid, and ensure that applicants have met CMS' requirements, as specified in this MOU. 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. DMAS and CMS may limit the number of selected Participating Plans per service area to a certain number (a minimum of two Participating Plans in each region) from the qualifying applications, utilizing information from the RFP that will allow DMAS to rank the bidders.

Selections are contingent on the selected entities passing a CMS and Commonwealth sponsored readiness review. Upon final selection, the Commonwealth 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 the body of the MOU.
- B. Enrollment and Disenrollment Processes - All enrollments and disenrollment-related transactions will be processed through DMAS's contracted Enrollment Facilitator, except those transactions related to non-Demonstration plans participating in Medicare Advantage. DMAS (or its vendor) will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third party CMS designates to receive such transactions. CMS will also submit a file to DMAS identifying individuals who have elected to disenroll from a Participating Plan, opt-out of passive enrollment, or enroll in another type of available Medicare coverage. DMAS will share enrollment, disenrollment and opt-out transactions with contracted Participating Plans.
- C. Uniform Enrollment and Disenrollment Letter and Forms - Letters and forms will be made available to stakeholders by both CMS and DMAS.
- D. Enrollment Effective Date(s) - All enrollment effective dates are prospective. Beneficiary-elected enrollment is the first day of the month following a beneficiary's request to enroll, so long as the request is received by the 25th of the month. Enrollment requests, including requests to change among Participating Plans, received after the 25th of the month will be effectuated the first of the second month following the request. Passive Enrollment is effective not sooner than 60 days after beneficiary notification.

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

Passive enrollment is effective no sooner than 60 days after beneficiary notification of the right to select a Participating Plan.

1. Under the Demonstration, DMAS will conduct a regional phase-in. Phase I will impact Central Virginia and Tidewater. Phase II will impact Western/Charlottesville, Northern Virginia, and Roanoke.
2. Each regional phase-in will consist of an opt-in and a passive enrollment period for those beneficiaries who have not made a plan selection.
3. Phase I will take place in Central Virginia and Tidewater. Participating Plans will begin marketing for opt-in enrollment for Phase I no sooner than January 1, 2014, with those opting into the Demonstration being able to receive services the following month (e.g., an individuals who opts in January 5, 2014 will begin receiving services on February 1, 2014.). Passive enrollment for those beneficiaries who have not made a plan selection will begin May 1, 2014, with a July 1, 2014 service effective date.
4. Phase II will occur in Western/Charlottesville, Northern Virginia, and Roanoke. Participating Plans will begin marketing for opt-in enrollment for Phase II no sooner than May 1, 2014, with those opting into the Demonstration being able to receive services the following month, e.g., June 1, 2014. Passive enrollment for those beneficiaries who have not made a plan selection will begin August 1, 2014, with an October 1, 2014 service effective date.
5. The effective dates in 3 and 4 above are subject to Participating Plans meeting CMS and DMAS' requirements, including successfully passing the Readiness Review and Plans' capacity to accept new enrollees.
6. Under passive enrollment, DMAS will provide notice of the requirement to select a Participating Plan at least 60 days prior to the effective date of a passive enrollment period, and will accept opt-out requests prior to the effective date of enrollment. This notice will explain the beneficiary's options, including the option to opt-out of the Demonstration.
7. Thirty days prior to the enrollment effective dates above, a second notice will be provided to beneficiaries who have not responded to the initial notice. The notice will include the name of the Participating Plan in which the beneficiary would be enrolled unless he/she selects another

Participating Plan or indicates the option to opt out of the Demonstration. DMAS will proceed with passive enrollment into the identified Participating Plan for beneficiaries who do not opt-out or make a different choice, with an effective date of the first day of the month referenced in section D.2, above. Requests to change Participating Plans, opt out, or enroll with another Participating Plan will be accepted at any point after enrollment occurs and are effective on the first of the following month. Any time an individual requests to opt out of the Demonstration, DMAS will send a letter confirming the opt-out and provide information on the benefits available to the beneficiary once he/she has opted out.

8. Beneficiaries 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. However, those 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 Participating Plan effective January 1, 2015.

The Commonwealth and CMS must agree in writing to any changes to the enrollment effective dates. CMS will provide identifying information to DMAS about eligible beneficiaries no later than 120 days prior to the date of the first passive enrollment period.

- E. Upon CMS' or the Commonwealth's written determination that the Demonstration will not be renewed, no enrollments will be accepted within six months of the end of the Demonstration.
- F. Notification of passive enrollment options will be provided by DMAS to each beneficiary not less than 60 calendar days prior to the effective date of the proposed enrollment.
- G. Passive enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto and facilitated enrollment for individuals with the Medicare Part D Low Income Subsidy (LIS).
- H. DMAS will develop an "intelligent assignment" algorithm for passive enrollment. The algorithm will consider beneficiaries' previous managed care enrollment and historic utilization of certain provider types. At a minimum, individuals will be

pre-assigned with the following considerations in the following order of priority: 1) individuals in a nursing facility will be pre-assigned to a Participating Plan that includes the individuals' nursing facility in its network; 2) individuals in the EDCD waiver will be assigned to a Participating Plan that includes the individual's current adult day health care provider in its network; 3) if more than one Participating Plan's network includes the nursing facility or personal care provider used by an individual, they will be assigned to the Participating Plan with which they have previously been assigned in the past six (6) months. If they have no history of previous Participating Plan assignment, they will be assigned to a Participating Plan in which their provider participates; 4) individuals will be pre-assigned to a Participating Plan (searching for Medicare and then Medicaid Participating Plan) with whom they have previously been assigned within the past six (6) months. Further details will be agreed to and provided by CMS and the Commonwealth in future technical guidance.

- I. DMAS will provide customer service, including mechanisms to counsel beneficiaries notified of passive enrollment and to receive and communicate beneficiary choice of opt out to CMS via transactions to CMS' MARx system. Beneficiaries will also be provided a notice upon the completion of the opt-out process. Medicare resources, including 1-800-Medicare, will remain a resource for Medicare beneficiaries; calls related to Participating Plan enrollment will be referred to DMAS' contracted Enrollment Facilitator for customer service and enrollment support.
- J. CMS and DMAS will jointly approve all Demonstration 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 individuals, and will coordinate such notice with any Commonwealth notice(s).
- K. Enrollment data in state and CMS systems will be reconciled on a timely basis to prevent discrepancies between such systems.

IV. State Level Delivery System Requirements

- A. State Requirements for Care Management - Care management services must be available to all Enrollees. Participating Plans must address the following components as part of their comprehensive programs. Through the readiness review process, CMS and the Commonwealth will review Participating Plans' capacity to deliver care management services. The Commonwealth will also

review and approve the Participating Plans' care management programs to ensure that all of the following required components are adequately addressed.

1. Identification strategy: Participating Plans must develop and implement an identification strategy that uses a combination of predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information as appropriate, that will consider medical, behavioral health, substance use, and LTSS needs. Criteria and thresholds must be established by the Participating Plans and must be used to prioritize the timeframe by which Enrollees will receive timely health risk assessments in accordance with the requirements outlined below.
2. Health Risk Assessments (see Figure 7-1): Each Enrollee shall receive, and be an active participant in, a timely comprehensive assessment of medical, behavioral health, LTSS, and social needs completed by the Participating Plan care management team. All health risk assessment tools are subject to approval by DMAS. Assessment domains will include, but not be limited to, the following: medical, psychosocial, functional, cognitive, and behavioral health. Relevant and comprehensive data sources, including the Enrollee, providers, family/caregivers, etc., shall be used by the Participating Plans. More detail regarding required elements health risk assessments will be provided in the three-way contract. Results of the assessment will be used to confirm the appropriate stratification level for the enrollee and as the basis for developing the Plan of Care.

During the first year of the Demonstration, all Enrollees meeting any of the following criteria (referred to as "Vulnerable Subpopulations" in the Virginia RFP) must receive a health risk assessment to be completed no later than 60 days from the individual's enrollment date:

- a. Individuals enrolled in the EDCD Waiver;
- b. Individuals with intellectual/developmental disabilities;
- c. Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury);
- d. Individuals with physical or sensory disabilities;
- e. Individuals residing in nursing facilities;
- f. Individuals with serious and persistent mental illnesses;
- g. Individuals with end stage renal disease; and,
- h. Individuals with complex or multiple chronic conditions.

During the first year of the Demonstration, health risk assessments must be conducted within 90 days of enrollment for all other Enrollees.

Health risk assessments for individuals enrolled in the EDCD Waiver and for individuals residing in nursing facilities must be conducted face-to-face. The health risk assessments for individuals residing in nursing facilities must also incorporate the MDS.

During subsequent years of the Demonstration, individuals enrolled in the EDCD Waiver must receive a health risk assessment within 30 days of enrollment and all other Enrollees must receive a health risk assessment within 60 days of enrollment. The health risk assessments for individuals enrolled in the EDCD Waiver and for individuals residing in nursing facilities must be conducted face-to-face. The health risk assessments for individuals residing in nursing facilities must also incorporate the MDS.

3. Level of Care Determinations: Initial level of care determinations will be conducted by hospitals and local Pre-Admission Screening Teams that are contracted through the Virginia Departments of Health and Social Services.

Participating Plans must ensure that Level of Care (LOC) annual reassessments are conducted timely for EDCD Waiver participants (minimum within 365 days of the last annual reassessment) Participating Plans will need to conduct annual face-to-face assessments (functional) for continued eligibility for the EDCD Waiver and establish criteria for reassessments resulting from a health status change (the triggering events that precipitate a need for reassessment, including a change in the ability to perform activities of daily living and instrumental activities of daily living). The LOC annual reassessment must include all the elements on the DMAS 99-C LOC Review Instrument for individuals who are in the EDCD Waiver who have a change in status (available at: <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>). LOC annual reassessments for EDCD Waiver participants must be performed by providers with the following qualifications: (i) a registered nurse licensed in Virginia with at least one year of experience as an RN; (ii) a social worker; or (iii) an individual who holds at least a bachelor's degree in a health or human services field and has at least two years of

experience working with individuals who are elderly and/or have disabilities.

Participating Plans must ensure that LOC annual reassessments are conducted timely (minimum within one year of the last assessment) for nursing facility residents and work with nursing facilities to conduct these annual assessments (functional) for continued nursing facility placement.

Participating Plans must communicate annual LOC reassessment data for EDCD Waiver participants and nursing facility residents to DMAS in a timely manner.

4. Plans of Care (POC; see Figure 7-1): Participating Plans shall develop a person-centered, Plan of Care for each Enrollee in the Participating Plan. The Plan of Care will be tailored to individual needs. Participating Plans will implement a person-centered and culturally competent Plan of Care development process, Participating Plans will also have to develop a process that will incorporate but not duplicate Targeted Case Management for applicable Enrollees.

During the first year of the Demonstration, Participating Plans must ensure that plans of care for all individuals are completed within 90 days of enrollment. Participating Plans must honor all existing plans of care and prior authorizations (PAs) until the authorizations ends or 180 days from enrollment, whichever is sooner. For EDCD Waiver participants, the plan of care must be developed and implemented by the Participating Plan no later than the end date of any existing PA.

During subsequent years of the Demonstration, Participating Plans must ensure that plans of care are conducted within the following timeframes:

- Within 30 days of enrollment for EDCD Waiver participants;
- Within 60 days of enrollment for “Vulnerable Subpopulations” (as outlined in IV.A.2 above) (excluding EDCD Waiver participants); and,
- Within 90 days of enrollment for all other enrollees.

Participating Plans will incorporate information from the Uniform Assessment Instrument and the LOC into the POCs for individuals in the EDCD Waiver.¹

Participating Plans will develop a process for obtaining nursing facility MDS data and incorporating that information into the POC.

Furthermore, Participating Plans will need to ensure that individuals in nursing facilities who wish to move to the community will be referred to the preadmission screening teams or the Money Follows the Person (MFP) Program. If the individual enrolls in the MFP Program, he/she will be disenrolled from the Demonstration.

Lastly, the Participating Plans must develop a process for addressing health, safety (including minimizing risk), and welfare of the participant in the POC.

The POC will contain the following:

- a. Prioritized list of Enrollee's concerns, needs, and strengths;
- b. Attainable goals, outcome measures, and target dates selected by the Enrollee and/or caregiver;
- c. Strategies and actions, including interventions and services to be implemented and the person(s)/providers responsible for specific interventions/services and their frequency;
- d. Progress noting success, barriers or obstacles;
- e. Enrollee's informal support network and services;
- f. Back up plans as appropriate (for EDCD Waiver participants using personal care and respite services) in the event that the scheduled provider(s) is unable to provide services;
- g. Determined need and plan to access community resources and non-covered services;
- h. Enrollee choice of services (including consumer-direction) and service providers; and,
- i. Elements included in the DMAS-97AB form, (which can be downloaded from

¹ The UAI may be found at http://www.dss.virginia.gov/files/division/dfs/as/as_intro_page/forms/032-02-0168-01-eng.pdf and the UAI User's Manual may be found at http://www.dss.virginia.gov/files/division/dfs/as/as_intro_page/manuals/uai/manual.pdf. Pre-admission screening criteria is available in the Preadmission Screening manual at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>) for individuals enrolled in the EDCD Waiver.

Participating Plans must ensure that reassessments and plan of care reviews are conducted:

- By the plan of care anniversary for “Vulnerable Subpopulations” (as outlined in as outlined in IV.a.2 above) (excluding EDCD Waiver participants and nursing facility residents) and all other enrollees;
- By plan of care anniversary, not to exceed 365 days for EDCD Waiver participants (must be face-to-face); and,
- Participating Plans must follow MDS guidelines/timeframes for quarterly and annual plan of care development for nursing facility residents.

Participating Plans must ensure that plans of care are revised based on triggering events, such as hospitalizations or significant changes in health or functional status.

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

	Implementation Health Risk Assessment (Demonstration Year 1)	Implementation of Plan of Care (Demonstration Year 1)	Initial Health Risk Assessment (for new enrollees in Demonstration Years 2 and 3)	Initial Plan of Care (for new enrollees in Demonstration Years 2 and 3)	Reassessment and POC Review	As Needed POC Revised	Level of Care Annual Reassessment
Community Well	Within 90 days of plan enrollment ²	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner. ³)	Within 60 days of enrollment	Within 90 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment whichever is sooner.)	By POC anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
Vulnerable Subpopulation⁴ (Excluding EDCD & nursing facility)	Within 60 days of plan enrollment	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.)	Within 60 days of enrollment	Within 60 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment whichever is sooner.)	By POC anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
EDCD Enrollees	Within 60 days of plan enrollment (must be face-to-face)	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.) The POC must be developed and implemented by the Participating Plan no later than the end date of any existing PA.	Within 30 days of enrollment (must be face-to-face)	Within 30 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment whichever is sooner.)	By POC anniversary date, not to exceed 365 days ⁵ (must be face-to-face)	Upon triggering event such as a hospitalization or significant change in health or functional status	Plan conducts annual face to face assessment (functional) for continued eligibility for the EDCD Waiver. ⁶
Nursing Facility Enrollees	Within 60 days of plan enrollment (must be face-to-face and incorporate MDS)	Within 90 days of enrollment. (Plan must honor all existing POCs for 180 days from enrollment.)	Within 60 days of enrollment (must be face-to-face)	Within 60 days of enrollment (Plans must honor all existing POCs for 180 days from enrollment.)	Follow MDS guidelines/time frames for quarterly and annual POC development	Upon triggering event such as a hospitalization or significant change in health or functional status	Plan works with facility on annual assessment (functional) for continued nursing facility placement.

² The clock starts at the effective date of enrollment and days are measured in calendar days.

³ Prior authorizations for Medicaid services will be provided in the enrollee’s transition report.

⁴ Vulnerable Subpopulation is defined in IV.A.2.

⁵ Plans must comply with requirements for the EDCD Waiver as established in 12 VAC 30-120-900 et. seq.

⁶ Local and Hospital Preadmission Screening Teams conduct the initial assessment for eligibility for LTSS (including nursing facility, EDCD Waiver, and PACE).

B. Interdisciplinary Care Team (ICT): For each Enrollee, Participating Plans will support an ICT to ensure the integration of the Enrollee’s medical, behavioral health, substance use, LTSS and social needs. The team will be person-centered, built on the Enrollee’s specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

1. Participating Plan members of the team must agree to participate in approved training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, ADA/Olmstead requirements, and wellness principles, along with other required training, as specified by the Commonwealth. Participating Plans will offer similar trainings to additional members of the team: primary care providers, specialists, etc., as appropriate.
2. If an Enrollee is receiving Medicaid State Plan Targeted Case Management services, the Participating Plans must develop a mechanism to include the targeted case manager as a member of the ICT.

C. State Requirements for Care Coordination - The Participating Plan shall provide person-centered care management functions for all Enrollees.

All Enrollees shall have access to the following supports depending on their needs and preferences; however, care management for “vulnerable subpopulations” must include the items described in items 6-12:

1. A single, toll-free point of contact for all questions;
2. Ability to develop, maintain and monitor the POC;
3. Assurance that referrals result in timely appointments;
4. Communication and education regarding available services and community resources;
5. Assistance developing self-management skills to effectively access and use services.
6. Ensure that individuals receive needed medical and behavioral health services, preventative services, medications, LTSS, social services and enhanced benefits; this includes setting up appointments, in-person contacts as appropriate, strong working relationships between care

managers and physicians; evidence-based Enrollee education programs, and arranging transportation as needed;

7. Monitor functional and health status;
8. Ensure seamless transitions of care across specialties and settings;
9. Ensure that individuals with disabilities have effective communication with health care providers and participate in making decisions with respect to treatment options;
10. Connect individuals to services that promote community living and help avoid premature or unnecessary nursing facility placements;
11. Coordinate with social service agencies (e.g. local departments of health, social services, and Community Services Boards) and refer enrollees to state, local, and other community resources; and,
12. Work with nursing facilities to promote adoption of evidence-based interventions to reduce avoidable hospitalizations, and include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the NF benefit.

Participating Plans will be encouraged to develop innovative arrangements to provide care management. Participating Plans are encouraged to partner and/or contract with entities that currently perform care management and offer support services to individuals eligible for the Demonstration. This flexibility includes the use of innovations such as medical homes, sub-capitation, shared savings, and performance incentives. Entities can include, but are not limited to Community Services Boards (CSBs), adult day care centers, and nursing facilities.

Participating Plans and DMAS will work together to avoid duplication of care management services provided by these types of entities and those provided under the Demonstration.

- D. Care Management for Enrollees Affected by DOJ *Olmstead* Agreement: In January 2012, DMAS reached a settlement agreement with the Department of Justice (DOJ) regarding an *Olmstead* investigation.⁷ Many of the individuals who are the focus of the Settlement are individuals with intellectual or developmental disabilities who live in State-funded Intermediate Care Facilities for Individuals

⁷ See <http://www.dbhds.virginia.gov/Settlement.htm>, for additional information.

with Intellectual Disabilities (ICF-IDs), or are individuals who live in the community and who are on the waiting lists for the Intellectual Disability or Individual and Family Developmental Disability Support (DD) Waivers. Individuals who receive services in the ID and DD Waivers or ICF-IDs are excluded from participation in the Demonstration.

However, there could be some individuals with intellectual or developmental disabilities who live in nursing facilities who could participate in the Demonstration. (It is not anticipated that a large number of individuals would meet this category.) If a Demonstration enrollee is identified to be eligible to transition into the community through the DOJ Settlement Agreement, then the Participating Plan's ICT will work with the Community Services Boards and the Department of Behavioral Health and Developmental Services to successfully transition the enrollee into the community. If the individual transitions into the ID or DD Waivers, the individual will be disenrolled from the Demonstration. If the individual transitions to the EDCD Waiver, the individual could still remain in the Demonstration. The individual's CSB case manager would participate as a part of the Participating Plan's ICT to monitor their service needs.

- E. Consumer Direction: Under the Demonstration, many older Virginians or those who have a disability will continue to have the option to direct their own home-based LTSS. Many of these Virginians will be able to achieve greater independence if they hire and manage their own attendants rather than depend solely on home health care/nurses/aides or family members. Participating Plans will be required to use one state-wide Fiscal/Employer Agent (F/EA) to manage the F/EA services for individuals using consumer-direction.
- F. Network Adequacy – State Medicaid standards shall be utilized for long-term supports and services, as described below, or for other services for which Medicaid is exclusive, and Medicare standards shall be utilized for pharmacy benefits 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 the more stringent of the applicable Medicare and Medicaid standards.

Section V.F. describes transition requirements that specify continuation of existing services and providers for new Enrollees. DMAS also requires that Participating Plans provide and arrange for timely access to all medically-necessary services covered by Medicaid. In addition to these protections,

minimum LTSS and community mental health and substance abuse service standards for Participating Plans are below. CMS and DMAS will monitor access to care and the prevalence of needs indicated through Enrollee assessments, and, based on those findings, may require that Participating Plans initiate network expansions or other corrective actions over the course of the Demonstration.

Participating Plans shall ensure they maintain a network of providers that is sufficient in number, mix and geographic distribution to meet the complex and diverse needs of the anticipated number of Enrollees in the service area.

For services for which Medicaid is the traditional primary payer (including LTSS and community mental health and substance abuse services), each Enrollee shall have a choice of at least two (2) providers of each service type located within no more than thirty (30) minutes travel time from any Enrollee in urban areas unless the Participating Plan has a DMAS-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). The Participating Plan shall ensure that each enrollee shall have a choice of at least two (2) providers of each service type located within no more than sixty (60) minutes travel time from any enrollee in rural areas unless the Participating Plan has a Department approved alternative time standard. CMS and the Commonwealth will monitor access to care and the prevalence of needs indicated through Enrollee assessments, and, based on those findings, may require that Participating Plans initiate further network expansion over the course of the Demonstration.

DMAS shall require contractual agreements between nursing facilities and Participating Plans. Payment for services must be made to nursing facilities directly by the Participating Plans. Participating Plans will be required to contract with any nursing facility that is eligible to participate in Medicare and Medicaid and is willing to accept the Participating Plan payment rates and contract requirements.

For any covered services for which Medicare requires a more rigorous network adequacy standard than Medicaid (including time, distance, and/or minimum number of providers or facilities), the Participating Plan must meet the Medicare requirements.

Medicare network standards account for the type of service area (rural, urban, suburban, etc.), travel time, and minimum number of the type of providers, as well as distance in certain circumstances. DMAS 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 Medicare-Medicaid Enrollees.

Networks will be subject to confirmation through readiness reviews and on an ongoing basis.

G. Solvency - Participating Plans will be required to meet solvency requirements:

1. Consistent with section 1903 (m) of the Social Security Act, and regulations found at 42 CFR § 422.402⁸, and 42 CFR § 438.116, and;
2. As specified in DMAS' RFP, including:

The Bureau of Insurance of the Virginia State Corporation Commission regulates the financial stability of all licensed plans in Virginia. Participating plans shall agree to comply with all Bureau of Insurance standards. Bureau of Insurance standards may be found at <http://www.scc.virginia.gov/PublicForms/561/hmo.pdf> (see Item 22 on page 4).

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

1. Participating Plans must adhere to managed care standards at 42 CFR § 438.214 and 42 CFR § 422.204.
2. Providers of EDCD Waiver and nursing facility services must meet, at a minimum, DMAS provider qualifications and have received proper certification and/or training to perform the specific waiver service(s) for which they are contracted. Provider qualification requirements for services provided under the EDCD Waiver can be located at the following regulatory and DMAS manual cites:
 - a. Adult Day Health Care
Regulation: (12-30-120-940(B)); (12-30-120-940(C)) and 12 VAC 40-60-10 et seq (Licensing regulations)
<http://leg1.state.va.us/cgi->

⁸ 42 CFR § 422.402, The standards established under this part supersede any state law or regulation (other than state licensing laws or state laws relating to plan solvency) with respect to the Medicare Advantage (MA) plans that are offered by MA organizations.

[bin/legp504.exe?000+reg+12VAC30-120-940](http://www.virginiamedicaid.dmas.virginia.gov/wps/portal/bin/legp504.exe?000+reg+12VAC30-120-940)

EDCD Manual: (Chapter II, Pages 11-17):

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

b. Agency Directed Personal Care

Regulation: (12-30-120-950(D))

<http://leg1.state.va.us/cgi->

[bin/legp504.exe?000+reg+12VAC30-120-950](http://www.virginiamedicaid.dmas.virginia.gov/wps/portal/bin/legp504.exe?000+reg+12VAC30-120-950)

EDCD Manual: (Chapter II, Pages 8-11)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

c. Agency Directed Respite Care

Regulation: (12-30-120-960(D))

<http://leg1.state.va.us/cgi->

[bin/legp504.exe?000+reg+12VAC30-120-960](http://www.virginiamedicaid.dmas.virginia.gov/wps/portal/bin/legp504.exe?000+reg+12VAC30-120-960)

EDCD Manual: (Chapter II, Pages 8-11)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

d. Personal Emergency Response System (PERS)

Regulation: (12-30-120-970(D)) and (12-30-120-970(E))

<http://leg1.state.va.us/cgi->

[bin/legp504.exe?000+reg+12VAC30-120-970](http://www.virginiamedicaid.dmas.virginia.gov/wps/portal/bin/legp504.exe?000+reg+12VAC30-120-970)

EDCD Manual: (Chapter II, Pages 17-19)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

e. Consumer Directed Services (Service Facilitation)

Regulation: (12-30-120-980(D))

<http://leg1.state.va.us/cgi->

[bin/legp504.exe?000+reg+12VAC30-120-980](http://www.virginiamedicaid.dmas.virginia.gov/wps/portal/bin/legp504.exe?000+reg+12VAC30-120-980)

EDCD Manual: (Chapter II, Pages 19-21)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

f. Consumer Directed Services (Personal Care Aide)

Regulation: (12-30-120-980(D))(10)

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-980>

EDCD Manual: (Chapter II, Pages 21-22)

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

- g. Nursing Facility- Regulation: (12 VAC 30-60-300)

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-60-300>

Nursing Facility Manual: (Chapter II)

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

3. Providers of Medicaid covered Behavioral Health Services, must have the appropriate licensure and qualifications as outlined in DMAS' Community Mental Health Rehabilitative Services Manual.

V. Benefits

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

1. (per Medicare) that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y.
2. (per DMAS) an item or service provided for the diagnosis or treatment of a patient's condition consistent with community standards of medical practice and in accordance with Medicaid policy (12 VAC 30-130-600).

Furthermore, as defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. Participating Plans will be required to provide services in a way that preserves all protections to the Enrollee and provides the Enrollee with coverage to at least the same extent provided by Medicare and DMAS.

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 to at least the extent provided by Medicare and DMAS as outlined in both state and Federal rules. Participating Plans will be required to abide by the more generous of the applicable Medicare, DMAS, or the combined Medicare-Medicaid standard.

3. All care must be provided in accordance and compliance with the ADA, as specified by the *Olmstead* decision.
- B. As a term and condition of this Demonstration, in addition to all Medicare Parts A, B, and D, and Medicaid State Plan services, Participating Plans will be required to provide the covered medically necessary acute care services provided under the State Plan for Medical Assistance as found in 12VAC30-50, and further defined by written DMAS regulations, policies and instructions, except as otherwise modified or excluded in this contract; and, covered long-term services and supports provided under the EDCD Waiver program (adult day health care; personal care (agency and consumer-directed options); personal emergency response services (PERS); respite care (agency and consumer-directed options); transition coordination; and, transition services).
 - C. Flexible Benefits – Participating Plans will have discretion to use the capitated payment to offer flexible benefits, as specified in the Enrollee’s Plan of Care, as appropriate to address the Enrollee’s needs.
 - D. Telehealth - Participating Plans shall be allowed to use and reimburse telehealth for Medicare and Medicaid services as an innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in care, increase access, and increase timely interventions. Participating Plans shall also encourage the use of telehealth to promote community living and improve access to behavioral health services. Participating Plans shall be allowed to use telehealth in rural and urban settings and reimburse for store and forward applications (as defined in Appendix 1). Participating Plans shall also have the ability to cover remote patient monitoring. Remote patient monitoring must be agreed to by the individual and is often used for beneficiaries with one or more chronic conditions, such as congestive heart failure, cardiac arrhythmias, diabetes, pulmonary diseases or the need for anticoagulation. Examples of remote patient monitoring activities include transferring vital signs such as weight, blood pressure, blood sugar, and heart rate. All telehealth activities shall be compliant with HIPAA requirements and will be further outlined in the three-way contract.

- E. Under the Demonstration, skilled nursing level care may be provided in a long term care facility without a preceding acute care inpatient stay for individuals enrolled in the Demonstration, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.
- F. Excluded Services – The following services will be carved out from the Demonstration and will be provided in fee-for-service as described below.
- Targeted Case Management Services (this service will be provided under fee-for-service);
 - Dental services (in limited cases, these services will be provided under fee-for-service);
 - Participating Plans will be responsible for medically necessary procedures, including but not limited to, the following:
 - CPT codes billed for dental services performed as a result of a dental accident;
 - Medically necessary procedures, including but not limited to: preparation of the mouth for radiation therapy, maxillary or mandibular frenectomy when not related to a dental procedure, orthognathic surgery to attain functional capacity, and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.

Participating Plans must cover anesthesia and hospitalization for medically necessary dental services.

At their option, Participating Plans may cover additional certain dental services for individuals participating in the Demonstration.

- Case Management Services for Participants of Auxiliary Grants (although not widely used (this service is included as part of the annual reassessment screening process for assisted living recipients), this service will be provided under fee-for-service); and,

G. Continuity of Care

1. Participating Plans must allow Enrollees to maintain their current providers (including out of network providers) for 180 days from

enrollment. Participating Plans must also allow Enrollees to maintain their preauthorized services for the duration of the prior authorization or for 180 days from enrollment, whichever is sooner, except for individuals residing in a nursing facility at the date of Demonstration implementation. Individuals in nursing facilities at the time of program implementation may remain in the facility as long as they continue to meet DMAS criteria for nursing home care, unless they or their families prefer to move to a different nursing facility or return to the community.

2. Participating Plans are required to provide or arrange for all medically necessary services provided by the three-way contract, whether by sub-contract or by single-case agreement in order to meet the needs of the individual/beneficiary.

During the transition period referenced above, change from the existing provider can only occur in the following circumstances:

- 1) Enrollee requests a change;
 - 2) The provider chooses to discontinue providing services to an Enrollee as currently allowed by Medicare or Medicaid;
 - 3) The Participating Plan, CMS, or DMAS identify provider performance issues that affect an Enrollee's health and welfare; or
 - 4) The provider is excluded under State or Federal exclusion requirements.
3. During the time period set forth in Appendix 7, Section V.G.1.the Participating Plan will maintain the Enrollee's current providers at the Medicare or Medicaid FFS rate and honor prior authorizations issued by DMAS, its contracted managed care entities, and Medicare.

H. Out of Network Reimbursement Rules

1. In an urgent or emergency situation, Participating Plans must reimburse an out-of-network provider of emergent or urgent care at the Medicare or Medicaid FFS rate applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. For example, where this service would traditionally be covered under Medicare FFS, the Participating Plan will pay out of network providers the lesser of providers' charges or the Medicare FFS.

2. During the six month transition period (described in Appendix 7, Section V.G.1.), the Participating Plan must honor existing service authorization timeframes and continue to provide access to the same services and providers at the same levels and rates of Medicare or Medicaid FFS payment (not to exceed six months) as individuals were receiving prior to entering the Participating Plan.
3. Beyond this six (6) month period, under certain defined circumstances, Participating Plans will be required to offer single-case out-of-network agreements to providers who are currently serving Enrollees and are willing to continue serving them at the Participating Plan's in-network payment rate, but who are not willing to accept new patients or enroll in the Participating Plan's network.

VI. Model of Care - All Participating Plans (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC). Participating Plans must meet all CMS MOC standards for Special Needs Plans as well as additional requirements established by the Commonwealth. To download Virginia's Model of Care requirements, please go to http://www.dmas.virginia.gov/Content_atchs/altc/altc-ovr1.pdf. The Virginia-specific MOC elements are in addition to and separate from CMS' elements; likewise, the CMS and DMAS reviews and approvals are separate processes. Participating Plans must obtain approvals from both CMS and DMAS before a MOC is considered final and approved.

CMS' Participating Plan MOC approval process will be based on scoring each of the eleven clinical and non-clinical elements of the MOC. The scoring methodology is divided into three parts: (1) a standard; (2) elements; and (3) factors. These components of the MOC approval methodology are defined below:

(1) Standard: The standard is defined as a MOC that has achieved a score of 70 percent or greater based on NCQA's scoring methodology.

(2) Elements: The MOC has eleven 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:

- Description of the Plan-specific Target Population;
- Measurable Goals;
- Staff Structure and Care Management Goals;

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

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

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

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

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

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

VIII. Grievances – Enrollees shall be entitled to file internal grievances directly with the Participating Plan. Each Participating Plan must track, report and resolve its grievances or re-route requests to the coverage decision or appeals processes, as appropriate. Participating Plans 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.

IX. Appeals – Each Participating Plan must have mechanisms in place to track and report all Appeals. Other than Medicare Part D appeals, which shall remain unchanged, the following is the baseline for a unified Medicare-Medicaid appeals process:

A. Integrated/Unified Appeals Process:

1. Appeal time frames - Enrollees, their authorized representatives, including providers who are authorized by the Enrollee, will have 60 calendar days from the date of notice of action to file an appeal in writing related to coverage. Enrollees have the option of filing an expedited appeal by telephone as currently allowed for under Medicare. This matches the current 60-day time-frame for requesting an appeal related to benefits under Medicare, and exceeds the current 30-day time-frame for requesting appeal related to benefits under Medicaid.
2. Appeal levels - Initial appeals will be filed with the Participating Plan. The filing of an internal appeal and exhaustion of the Participating Plan internal appeal process is a prerequisite to filing an external appeal to Medicare or Medicaid.
 - a. Subsequent appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE).
 - b. Medicaid-only benefits may be appealed to the State fair hearing process, after the Participating Plan internal appeal process is exhausted. Appeals to the external State fair hearing process must be made to the DMAS Appeals Division in writing and may be

made via US Mail, fax transmission, hand-delivery or electronic transmission. The appropriate street address, electronic address and telephone fax number will be included in the unified notice of appeal rights provided at the time of enrollment and accompanying the Participating Plan internal appeals decision and set forth on the DMAS public Web site. Appeals to the external Medicaid State fair hearing process must be filed with the DMAS Appeals Division within 60 days of the date of the Participating Plan internal appeal decision, unless the time period is extended by DMAS upon a finding of “good cause” in accordance with current State fair hearing regulations.

- c. Services for which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D) will be defined in a unified way in the three-way contract and as required Participating Plan benefits. Appeals related to services for which Medicare and Medicaid overlap will be auto-forwarded to the IRE, and may also be filed through the State fair hearing process. Appeals to the external Medicaid State fair hearing process shall not be auto-forwarded to the IRE, but may be filed by the enrollee or the enrollee’s authorized representative in writing in accordance with the regular requirements and timelines set forth herein.

- B. Appeal resolution time frames - All Participating Plan internal appeals regarding coverage decisions must be resolved within 30 days of filing for standard appeals and within 72 hours or as expeditiously as the Enrollee’s condition requires for appeals qualifying as expedited appeals. This excludes Part D appeals, which will be resolved in accordance with existing rules. External appeals filed or auto-forwarded to the Medicare external appeal process shall be heard under currently existing Medicare appeal timelines. External appeals to the Medicaid State fair hearing process shall be resolved or a decision issued within 90 days of the date of filing the appeal for the first year of the Demonstration (as defined in Figure 6-1 in Appendix 6), and within 75 days of the date of filing the appeal for the second year of the Demonstration, and within 30 days of the date of filing the appeal for subsequent years thereafter. The timeline for resolution or issuance of a decision in Medicaid external appeals may be extended for delays not caused by DMAS, in accordance with existing federal court order in Shifflett v. Kozlowski (W.D.Va 1994), relating to the extension of Medicaid appeal decision deadlines for non-agency caused delays (e.g., the hearing officer leaves the hearing record

open after the hearing in order to receive additional evidence or argument from the appellant; the appellant or representative requests to reschedule/continue the hearing; the hearing officer receives additional evidence from a person other than the appellant or his representative and the appellant requests to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence). External appeals to the Medicaid State fair hearing process that qualify as expedited appeals shall be resolved within three business days or as expeditiously as the Enrollee's condition requires, in accordance with existing Medicaid law and policy.

C. Continuation of Benefits Pending an Appeal -

1. Participating Plans must provide continuing Medicare and Medicaid benefits for all prior approved non-Medicare Part D benefits that are terminated or modified pending internal Participating Plan appeals. This means that such benefits will continue to be provided by providers to beneficiaries, and that Participating Plans must continue to pay providers for providing such services pending an internal Participating Plan appeal. This right to aid pending an appeal currently exists in Medicaid, but is generally not currently available in Medicare. Existing Medicaid rules concerning benefits pending an appeal will not change.
2. For all appeals filed through the State fair hearing process, Enrollees may request continuation of benefits previously authorized. Enrollees may qualify for continuation of benefits under certain existing criteria set forth in current regulations and policy and DMAS will make a determination on these requests in accordance with DMAS' existing regulations and policies. Medicare Part D appeals may not be filed through the State fair hearing process.

D. Integrated Notice - Participating Plan Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid appeal rights, including whether an individual may receive benefits pending the appeal, through a single notice jointly developed by the Commonwealth and CMS.

E. In the case of a decision where both the State fair hearing and the IRE issue a ruling, the Participating Plan shall be bound by the ruling that is most favorable to the Enrollee.

X. Participating Plan 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 2, 2012, CMS Medicare Marketing Guidelines do not apply to communications by state governments and materials created by the Commonwealth do not need to be reviewed or submitted in HPMS. However, CMS and the Commonwealth agree to work together in the development of these materials and the Commonwealth will consult with CMS on the development of the materials.

- A. Marketing and Enrollee Communication Standards for Participating Plans – Participating Plans will be subject to rules governing their marketing and Enrollee communications as specified under 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 following exceptions apply:
1. Participating Plans will not be allowed to market directly to individual potential Enrollees. Instead, plans may participate in group marketing events, provide general audience materials (such as general circulation brochures, and media and billboard advertisements), and provide responses to beneficiary initiated requests for enrollment.
 2. CMS and DMAS will develop a process to mitigate beneficiary shifting from Participating Plans 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 Participating Plan for a non-Participating Plan that may be a part of the same corporate family. Beneficiary choices regarding enrollment will be honored by CMS and DMAS.
- B. Review and Approval of Marketing and Enrollee Communications – Participating Plans must receive prior approval of all marketing and Enrollee communications materials in categories of materials that CMS and DMAS require to be prospectively reviewed. Participating Plan materials may be designated as eligible for the File & Use process, as described in 42 CFR §422.2262(b) and §423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and DMAS. CMS and DMAS may agree to defer to one or the

other party for review of certain types of marketing and Enrollee communications, as agreed in advance by both parties. Participating Plans must submit all marketing and Enrollee communication materials, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

- C. Permissible Start Date for Participating Plan Marketing Activity – Plans may begin marketing activity, as limited in Section X, no earlier than 90 days prior to the effective date of enrollment for the contract year.
- D. CMS and DMAS will work together to educate individuals about their Participating Plan options. DMAS' independent enrollment facilitator will be responsible for educating Enrollees on all potential plan choices through a variety of mechanisms. Outreach and educational 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.

Minimum Required Marketing and Enrollee Communications Materials – At a minimum, Participating Plans will provide current and prospective Enrollees the following materials. These materials will be subject to the same rules regarding content and timing of beneficiary receipt as applicable under Section 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; §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 Commonwealth-covered and Plan-covered additional benefits, in addition to the required Medicare benefits information. Additional content will be required by the DMAS., e.g. eligibility requirements for Participating Plan enrollment; excluded services; member rights and responsibilities; services requiring prior authorization; self-referral services; explanation that the Participating Plan ID card replaces the Medicare and Medicaid cards; the Enrollee's requirement to select a PCP and how to change PCP; out of network policies; the right to change plans and the procedure for requesting a change; appeals processes; detailed information on co-payments required for any service; how to access additional information in alternative formats or languages; how to access the Participating Plan's provider directory; toll-free member services and care management and nurse advice 24-hour service lines; and any other content required by State or federal regulation.

2. An Annual Notice of Change (ANOC) summarizing all major changes to the Plan's covered benefits from one contract year to the next, starting in the second year of the Demonstration.
 3. A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the Plan and Enrollee rights, as well as the benefits offered under the plan, including cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. Participating Plans will use a Demonstration-specific SB.
 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 Participating Plan-covered additional benefits.
 6. A single identification (ID) card for accessing all covered services under the Plan.
 7. All Medicare Part D required notices, with the exception of the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual, and the creditable coverage and late enrollment penalty notice requirements required under Chapter 4 of the Prescription Drug Benefit Manual.
- E. Notification of Formulary Changes – The requirement at 42 CFR §423.120(b)(5) that Participating Plans provide at least 60 days advance notice regarding Medicare Part D formulary changes also applies to Participating Plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits.

XI. Administration and Oversight

A. Oversight Framework

1. Under the Demonstration, there will be a CMS-Commonwealth 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 DMAS will require Participating Plans to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. Participating Plans must have policies and procedures in place to identify and address fraud, waste, and abuse at both the Plan and the third-party levels in the delivery of Plan benefits, including prescription drugs, medical care, 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 Participating Plans by CMS in the same way they are currently applied for Prescription Drug Plan (PDP) sponsors and Medicare Advantage organizations.

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

B. The Contract Management Team

1. Structure- The Contract Management Team will include representatives from CMS and DMAS, authorized and empowered to represent CMS and DMAS 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.
2. Reporting – Data reporting to CMS and DMAS 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 –

The Contract Management Team will be responsible for day-to-day monitoring of each Participating Plan. These responsibilities include, but are not limited to:

- Monitoring compliance with reporting requirements;
- Monitoring compliance with the terms of the three-way contract, including issuance of joint notices of non-compliance/enforcement;
- Coordination of periodic audits and surveys of the Participating Plans;
- Receipt and response to complaints;
- Reviewing reports from and responses to the Ombudsman;
- Reviewing direct stakeholder input on both plan-specific and systematic performance;
- Regular meetings with each Participating Plan;
- Coordination of requests for assistance from Participating Plans, and assignment of appropriate DMAS and CMS staff to provide technical assistance;
- Coordinating review of marketing materials and procedures; and,
- Coordinating review of grievance and appeals data, procedures, and materials.

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

CMS' central office conducts a wide array of data analyses, monitoring studies, and audits. Participating Plan contracts will be included in these activities, just as all Medicare Advantage and Part D organizations will be included. Participating Plan 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 DMAS and Contract Management Team will be informed about these activities and copied on notices, but will not take an active part in these ongoing projects or activities.

E. Emergency/Urgent Situations –

Both CMS and DMAS shall retain discretion to take immediate action where the health, safety, or welfare of any Enrollee is imperiled or where significant financial risk is indicated. In such situations, CMS and the Commonwealth shall notify a member of the Contract Management Team no more than 24 hours from the date of such action, and the Contract Management Team will undertake subsequent action and coordination.

F. Participating Plan Call Center Requirements -

In addition to current requirements for Medicare Advantage Plans, the following will be required call center elements:

1. To support care management, Participating Plans shall operate a twenty-four hour, seven days a week, toll free call in system available nationwide that is staffed by appropriately trained and qualified health professionals who are able to access the Enrollee's records, assess the Enrollee's issues, and provide an appropriate course of action (i.e., medical advice, direct the Enrollee to an appropriate care setting, referral to a member of the care management team, etc.). The Participating Plan must ensure that if care management needs are identified for an enrollee that the Participating Plan staff person facilitating the Enrollee's issue has access to, and is familiar with, the Enrollee's Plan of Care. Participating Plans must ensure that follow-up is timely and appropriate to assure the Enrollee's health and welfare.
2. Operators must be available in sufficient numbers to support Enrollees and meet CMS and DMAS specified standards.
3. All Participating Plan sponsors' call centers must have interpreter services available to call center personnel to answer questions from non-English speaking and limited English proficient individuals. 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. Plans must ensure that customer service department representatives shall, upon request, make available to Enrollees and potential Enrollees information including, but not limited to, the following:

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

G. Data System Specifications, Reporting Requirements, and Interoperability

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

- i. Data system description and architecture and performance requirements
- ii. Current information system upgrades and development plans and resource commitments necessary for implementation
- iii. Consolidated reporting requirements
- iv. Encounter reporting
- v. Reporting data for evaluation and program integrity
- vi. Data Exchange among CMS, DMAS providers and Participating Plans, and Health Insurance Marketplaces (2014)

H. Unified Quality Metrics and Reporting

Participating Plans will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, beneficiary/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report Medicare HEDIS, HOS and CAHPS data, as well as measures related to long term supports and services. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS plus any additional Medicaid measures identified by DMAS. All existing Part D metrics will be collected as well. Participating Plans will also be required to comply with the requirements of the EDCD Waiver quality improvement strategy which address six assurances as required by CMS: (i) administrative authority, (ii) service plan, (iii) qualified

providers, (iv) financial authority, (v) health, safety, and welfare, (vi) level of care.

A combined set of core metrics is described below in Table 7-2; more detail on the measures will be provided in the three-way contract. CMS and DMAS 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.

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

Table 7-2: Core Quality Measures under the Demonstration

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
1. 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	
2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: <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	
3. 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	
4. Screening for Clinical Depression and Follow-up Care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	
5. SNP1: Complex Case Management	The organization coordinates services for members with complex conditions and helps them access needed resources. Element A: Identifying Members for Case Management Element B: Access to Case Management Element C: Case Management Systems Element D: Frequency of Member Identification Element E: Providing Members with Information Element F: Case Management Assessment Process Element G: Individualized Care Plan Element H: Informing and Educating Practitioners Element I: Satisfaction with Case Management Element J: Analyzing Effectiveness/Identifying Opportunities Element K: Implementing Interventions and Follow-up Evaluation	NCQA/ SNP Structure & Process Measures HEDIS	X	
6. SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members. Element A: Coordination of Benefits for Dual Eligible Members Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) Element D: Service Coordination Element E: Network Adequacy Assessment	NCQA/ SNP Structure & Process Measures HEDIS	X	

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
7. 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	
8. 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	
9. SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions Element B: Supporting Members through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E; Analyzing Transitions Element F: Reducing Transitions	NCQA/ SNP Structure & Process MeasuresHEDIS	X	
10. 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	
11. 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	
12. 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	
13. Part D Appeals Auto-Forward	How often the drug plan did not meet Medicare’s deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.	IRE	X	

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
14. 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	
15. Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 days.	Medicare Advantage Prescription Drug System (MARx)	X	
16. 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	
17. Part D Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Administrative data	X	
18. Part D Members Choosing to Leave the Plan	The percent of drug plan members who chose to leave the plan in 2014.	CMS Medicare Beneficiary Database Suite of Systems	X	
19. 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	
20. Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X	
21. Part D Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X	

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
22. 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	
23. 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	
24. Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
25. 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	
26. 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	
27. 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	
28. Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X	
29. Tracking of Demographic Information	Percent of all Demonstration participants for whom specific demographic data is collected and maintained in the Plan Centralized Enrollee Record, including race, ethnicity, disability type, primary language, and homelessness, in compliance with contract requirements.	CMS/Commonwealth defined process measure		X
30. Documentation of Care Goals	Percent of Enrollees with documented discussion of care goals	CMS/Commonwealth defined process measure		X
31. Beneficiary Governance Board	Establishment of beneficiary/ consumer advisory board or inclusion of beneficiaries/ consumers on governance board consistent with contract requirements.	CMS/Commonwealth defined process measure	X	
32. Ensuring physical access to buildings, services and equipment	Participating Plan has established a work plan and identified an individual in its organization who is responsible for ADA compliance related to this Demonstration.	CMS/Commonwealth defined process measure	X	

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
33. Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan’s customer service give you the information or help you needed? • In the last 6 months, how often did your health plan’s customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	
34. Assessments	Percent of Enrollees with initial assessments completed within required timeframes.	CMS/ Commonwealth defined process measure	X	
35. Individualized Care Plans	Percent of members with care plans by specified timeframe.	CMS /Commonwealth defined process measure	X	
36. Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/ Commonwealth defined process measure	X	
37. Risk Stratification Based on LTSS or Other Factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/Commonwe alth defined process measure	X	
38. Discharge Follow-up	Percent of members with specified timeframe between hospital discharge to first follow-up visit.	CMS/Commonwe alth defined process measure	X	
39. Self-direction	Percent of care coordinators that have undergone Commonwealth-based training for supporting self-direction under the Demonstration.	CMS/Commonwe alth defined process measure	X	
40. 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	
41. Care for Older Adults – Functional Status Assessment	Percent of plan members whose doctor has done a—functional status assessmentl to see how well they are doing —activities of daily livingl (such as dressing, eating, and bathing).	NCQA/HEDIS	X	
42. 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	
43. 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	
44. Diabetes Care – Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS	X	

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
45. 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	
46. 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	
47. Reducing the Risk of Falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
48. 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	
49. Controlling Blood Pressure	Percentage of members 18-aged 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	
50. Comprehensive medication review	Percentage of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA) Part D Reporting Data	X	
51. 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	
52. Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Beneficiary database	X	
53. Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2014.	CMS	X	

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
54. Getting Information From Drug Plan	<p>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.</p> <p>-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?</p> <p>-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?</p> <p>-In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered?</p> <p>-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?</p>	AHRQ/CAHPS	X	
55. Rating of Drug Plan	<p>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.</p> <p>-Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?</p>	AHRQ/CAHPS	X	
56. Getting Needed Prescription Drugs	<p>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.</p> <p>-In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed?</p> <p>-In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?</p>	AHRQ/CAHPS	X	
57. Getting Needed Care	<p>Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.</p> <p>• 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?</p>	AHRQ/CAHPS	X	
58. Getting Appointments and Care Quickly	<p>Percent of best possible score the plan earned on how quickly members can get appointments and care.</p> <p>• 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?</p>	AHRQ/CAHPS	X	
59. Overall Rating of Health Care Quality	<p>Percent of best possible score the plan earned from plan members who rated the overall health care received.</p> <p>Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?</p>	AHRQ/CAHPS	X	

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
60. 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	
61. Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X	
62. Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X	
63. Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for —badl (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
64. 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	
65. Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	X	
66. 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	
67. Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS	X	
68. Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS	X	
69. Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X	
70. Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS	X	
71. Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS	X	
72. Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X	
73. Health Status/Function Status	Percent of members who report their health as excellent.	AHRQ/CAHPS	X	
74. Consumer-Directed Services	Percent of waiver individuals who used consumer-directed services	State		X
75. Personal Care	Percent of waiver individuals who experienced a decrease in the authorization of personal care hours	State		X
76. Personal Care	Percent of waiver individuals who experienced an increase in the authorization of personal care hours	State		X

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
77. Respite Care	Percent of waiver individuals who experienced a decrease in the authorization of respite hours	State		X
78. Respite Care	Percent of waiver individuals who experienced an increase in the authorization of respite hours	State		X
79. Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Percentage of member's age 19 – 64 years with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	NCQA/HEDIS		X
80. Transition of members between Community, Waiver and LTC Services	Report number of members moving from: institutional care to waiver services, community to waiver services community to institutional care and waiver services to institutional care. (Exclude institutional stays ≤ 90 days)	State		X
81. Severe Mental Illness (SMI)	Recovery-oriented measures for persons with SMI receiving Mental Health Services (e.g., criminal involvement, employment status).	State		X
82. Level of Care Evaluation	Number and percent of all new enrollees who have a level of care indicating a need for institutional/waiver services.	State/1915(c) EDCD Waiver Requirement		X
83. Level of Care Re-evaluation	Number and percent of waiver participants who received an annual LOC evaluation of eligibility within 365 days of their initial LOC evaluation or within 365 days of their last annual LOC evaluation using the states approved form(s).	State/1915(c) EDCD Waiver Requirement		X
84. Level of Care Reviews	Number and percent of completed LOC forms entered into LOCERI system for standardized LOC review.	State/1915(c) EDCD Waiver Requirement		X
85. Level of Care Reviews	Number and percent of LOC reviews that LOCERI indicate do not meet LOC criteria sent for higher level review (HLR).	State/1915(c) EDCD Waiver Requirement		X
86. Level of Care Reviews	Number and percent of waiver individuals who did not meet LOC criteria after HLR who were terminated from the waiver after completion of appeal process (if any).	State/1915(c) EDCD Waiver Requirement		X
87. Service Plans	Number and percent of waiver individuals who have a service plan in the record.	State/1915(c) EDCD Waiver Requirement		X
88. Service Plans	Number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment.	State/1915(c) EDCD Waiver Requirement		X
89. Service Plans	Number and percent of service plans developed in accordance with the State's regulations and policies.	State/1915(c) EDCD Waiver Requirement		X
90. Service Plans	Number and percent of waiver individuals whose service plan was updated / revised at least annually.	State/1915(c) EDCD Waiver Requirement		X

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
91. Service Plans	Number and percent of waiver individuals whose service plan was revised as needed, to address changing needs.	State/1915(c) EDCD Waiver Requirement		X
92. Services	Number and percent of waiver individuals who received services of the type specified in the service plan.	State/1915(c) EDCD Waiver Requirement		X
93. Services	Number and percent of waiver individuals who received services in the scope specified in the service plan.	State/1915(c) EDCD Waiver Requirement		X
94. Services	Number and percent of waiver individuals who received services in the amount specified in the service plan.	State/1915(c) EDCD Waiver Requirement		X
95. Services	Number and percent of waiver individuals who received services for the duration specified in the service plan.	State/1915(c) EDCD Waiver Requirement		X
96. Services	Number and percent of waiver individuals who received services in the frequency specified in the service plan.	State/1915(c) EDCD Waiver Requirement		X
97. Choice	Number and percent of waiver individuals whose records contain an appropriately completed and signed form that specifies choice was offered between institutional care and waiver services.	State/1915(c) EDCD Waiver Requirement		X
98. Choice	Number and percent of waiver individuals whose records contain an appropriately completed and signed form that specifies choice was offered among waiver services.	State/1915(c) EDCD Waiver Requirement		X
99. Choice	Number and percent of waiver individuals whose records documented that choice of waiver providers was provided to the individual.	State/1915(c) EDCD Waiver Requirement		X
100. Licensure/Certification	Number and percent of licensed/certified waiver agency provider enrollments, for which appropriate licensure/certification were obtained in accordance with law & waiver requirements prior to service provision.	State/1915(c) EDCD Waiver Requirement		X
101. Continuing Licensure/Certification	Number and percent of licensed/certified waiver provider agencies continuing to meet applicable licensure/certification following initial enrollment.	State/1915(c) EDCD Waiver Requirement		X
102. Criminal Background Checks	Number and percent of licensed/certified waiver provider agency direct support staff who have criminal background checks as specified in policy/regulation with satisfactory results following initial enrollment.	State/1915(c) EDCD Waiver Requirement		X
103. Non-licensed/Non-certified Provider Enrollment	Number and percent of new non-licensed/non-certified waiver individual provider enrollments, who initially met waiver provider qualifications.	State/1915(c) EDCD Waiver Requirement		X
104. Non-licensed/Non-certified Consumer-Directed Employees	Number and percent of new non-licensed/non-certified consumer-directed employees who meet requirements.	State/1915(c) EDCD Waiver Requirement		X

Measure	Description	Data Source	CMS Core Measure	Commonwealth Specified Measure
105. Criminal Background Checks- Consumer-Directed Employees	Number and percent of new consumer-directed employees who have a criminal background check at initial enrollment.	State/1915(c) EDCD Waiver Requirement		X
106. Criminal Background Checks- Consumer-Directed Employees	Number and percent of consumer-directed employees with a failed criminal background check that are barred from employment.	State/1915(c) EDCD Waiver Requirement		X
107. Staff Training	Number and percent of waiver provider staff meeting provider staff training requirements.	State/1915(c) EDCD Waiver Requirement		X
108. Consumer-Directed Employers Trained	Number and percent of consumer-directed employers trained, as required, regarding employee management and training.	State/1915(c) EDCD Waiver Requirement		X
109. Abuse, Neglect or Exploitation	Number and percent of waiver individual's records with indications of abuse, neglect or exploitation documenting appropriate actions taken.	State/1915(c) EDCD Waiver Requirement		X
110. Safety	Number and percent of waiver individual's records with indications of safety concerns documenting appropriate actions taken.	State/1915(c) EDCD Waiver Requirement		X
111. Risks in Physical Environment	Number and percent of waiver individual's records with indications of risk in the physical environment documenting appropriate actions taken.	State/1915(c) EDCD Waiver Requirement		X
112. IAA/MOU/Contract Evaluations	Number and percent of satisfactory IAA/MOU/contract evaluations.	State/1915(c) EDCD Waiver Requirement		X
113. Adjudicated Waiver Claims	Number and percent of adjudicated waiver claims submitted to Participating Plans that were paid within the timely filing requirements.	State/1915(c) EDCD Waiver Requirement		X

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

XII. Stakeholder Engagement

DMAS 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. In addition, DMAS will require that Participating Plans develop meaningful beneficiary input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of services and care delivered to eligible individuals. Participating Plans must include Enrollee representation on their governing board and submit governing board agendas and minutes to DMAS. DMAS will also develop consumer notices and related materials about the Demonstration that are easily understood by persons with limited English proficiency, and will translate materials into prevalent languages as determined by CMS and DMAS.

XIII. Evaluation

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

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

The evaluator will design a Commonwealth-specific evaluation plan for the Virginia Demonstration, and will also conduct a meta-analysis that will look at the State Demonstrations overall. A mixed methods approach will be used to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative analyses will consist of tracking changes in selected

utilization, cost, and quality measures over the course of the Demonstration; evaluating the impact of the Demonstration on cost, quality, and utilization measures; and calculating savings attributable to the Demonstration. The evaluator will use a comparison group for the impact analysis. The comparison group methodology will be detailed in the State-specific evaluation plan. Quarterly reports will provide rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit Virginia-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

Virginia is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. Virginia and Participating Plans must submit all required data for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements to be listed in the three-way contract.

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

- Beneficiary-level data identifying beneficiaries eligible and enrolled in the Demonstration:
 - Medicare Beneficiary Claim Account Number (HICN)
 - MSIS number
 - Social Security Number
 - CMS Beneficiary Link Key
 - Person First and Last Name, Birthdate, and Zip code
 - Eligibility identification flag - Coded 0 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
 - Monthly eligibility indicator - Each monthly eligibility flag variable would be coded 1 if eligible, and zero if not.
 - Monthly enrollment indicator - Each monthly enrollment flag variable would be coded 1 if enrolled in the Demonstration, and zero if not.

- Summary level data for the State Data Reporting System, including but not limited to:

- The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries *not* eligible for the Demonstration (e.g. individuals residing in ICF/MRs or State mental hospitals; HCBS waiver, PACE, and Money Follows the Person enrollees, etc.)
- The number of beneficiaries enrolled in the Demonstration
- The number of beneficiaries who opt out of the Demonstration
- The number of beneficiaries who disenroll from the Demonstration
- The number of plans participating in the Demonstration

Virginia 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 beneficiary-level data on grievances, and appeals that identify the health plan and providers involved.