

**Memorandum of Understanding (MOU)**

*Between*

**The Centers for Medicare & Medicaid Services (CMS)**

*And*

**The State of California**

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

**California Demonstration to Integrate Care for  
Dual Eligible Beneficiaries**

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## **I. STATEMENT OF INITIATIVE**

The Centers for Medicare & Medicaid Services (CMS) and the State of California (California) will establish a Federal-State partnership to implement the Demonstration to Integrate Care for Dual Eligible Individuals (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees” or “dual eligibles”). The Federal-State partnership will include a three-way contract with Demonstration Plans (“Prime Contractor Plans”) that will provide integrated benefits to Medicare-Medicaid enrollees in the targeted geographic area(s). The Demonstration will begin no sooner than October 1, 2013 and continue until December 31, 2016, unless terminated pursuant to section III.L or continued pursuant to section III.K of this Memorandum of Understanding (MOU). The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid enrollees, enhance quality of care and reduce costs for both the State and the Federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

The individuals that will be eligible to participate in the Demonstration are those who are entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits (known as Medi-Cal in California) and who have no other comprehensive private or public health insurance with some exceptions, as discussed in more detail in section III.C.1 below. Section III.C.1 also provides more information on individuals who are not eligible for the Demonstration as well as individuals who are eligible if they disenroll from an existing program.

Under this initiative, Prime Contractor 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. Prime Contractor Plans were permitted to contract with Medicare Advantage Prescription Drug (MA-PD) plans (“Subcontracted Plans”), to offer enrollees multiple plan benefit packages (Prime Contractor Plans and Subcontracted Plans are referred to as “Participating Plans”). CMS, California, and the Participating Plans will ensure that beneficiaries have access to an adequate network of medical and supportive services.

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

Key objectives of the initiative are to evaluate an innovative payment and service delivery model that can improve the beneficiary experience in accessing care, promote person-centered planning, promote independence in the community, assist beneficiaries in getting the right care at the right time and place, and achieve cost savings for California and the Federal government through improvements in care and coordination. CMS and California expect this model of integrated care and financing to, among other things, improve quality of care and reduce health disparities, meet both health and functional needs, and improve transitions among care settings. Meeting beneficiary needs, including the ability to self-direct care, be involved in one's care, and live independently in the community, are central goals of this initiative.

The initiative 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, 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 Prime Contractor Plans, the State, and CMS.

As part of this initiative, CMS and California 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 California 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 Individual Care Plans developed using a person-centered planning process that includes the enrollee, primary care provider, In Home Supportive Services (IHSS) provider, behavioral health specialist, family and/or community supports, and other providers as appropriate. CMS and the State expect Participating Plans to achieve savings through better integrated and coordinated care. Subject to CMS and California oversight, Participating Plans will have significant flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to, or means to, avoid high-cost traditional services if indicated by the enrollees' wishes, needs, and Individual Care Plan.

Preceding the signing of this MOU, California 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 California plan to implement and operate the aforementioned Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute a three-way contract with Prime Contractor Plans setting forth the terms and conditions of the Demonstration and initiate the Demonstration. Further detail about Participating Plan responsibilities, including the additional operational and technical requirements pertinent to the implementation of the Demonstration, will be included in and appended to the three-way contract.

Following the signing of this MOU and prior to the implementation of the Demonstration, the State and CMS will ultimately enter into three-way contracts with Prime Contractor 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, as specified in Appendix 7.

### **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.

- 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 C.F.R. Parts 422 and 423, and applicable sub-regulatory guidance, as amended from time to time, except to the extent specified in this MOU including Appendix 4 and, for waivers of sub-regulatory guidance, the three-way contract.
- 2. Medicaid Authority:** The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the initiative, Participating Plans will be required to comply with Medicaid managed care requirements under Title XIX and 42 C.F.R. §438 et. seq., and applicable sub-regulatory

guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5 and, for waivers of sub-regulatory guidance, the three-way contract.

## ***B. CONTRACTING PROCESS***

- 1. Participating Plan Procurement Document:** The State issued a Request for Solutions that, consistent with applicable State law and regulations, includes purchasing specifications that reflect the integration of Medicare and Medicaid payment and benefits. As articulated in January 25, 2012 and March 29, 2012 guidance from CMS, Participating Plans are also required to submit a Capitated Financial Alignment 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 California Request for Solutions, and will be specified by CMS and the State herein or in the three-way contract.

- 2. Participating Plan Selection:** The State procurement and CMS plan selection process has been utilized to identify entities that will be eligible to contract with CMS and the State. California applicants were permitted to contract with Medicare Advantage Prescription Drug (MA-PD) plans (“Subcontracted Plans”) and other subcontracted plan partners to offer enrollees multiple plan benefit packages. See Appendix 7 for more information on the plan selection process.
- 3. Medicare Waiver Approval:** CMS approval of Medicare waivers is reflected in Appendix 4. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XVIII. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and subject to section 1115A(d)(2) of the Act, afford the State a reasonable opportunity to request reconsideration of CMS’ determination prior to the effective date. Termination and phase out would proceed as described in section III.L of this MOU. If a waiver or expenditure authority is withdrawn, Federal financial participation (FFP) is limited to normal

closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.

- 4. Medicaid Waiver and/or Medicaid State Plan Approval:** CMS approval of any new Medicaid waivers and variances pursuant to sections 1115, 1115A, or Title XIX of the Social Security Act authority and processes is reflected in Appendix 5. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify California 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 California 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 California, either directly or with contractor support, shall conduct a readiness review of each Participating Plan. Following the signing of the three-way contract, CMS and California must agree that a Participating Plan has passed readiness requirements prior to that Plan accepting any enrollment. CMS and California will collaborate in the design and implementation of the readiness review process and requirements. This readiness review shall include an evaluation of the capacity of each potential Participating Plan, and its ability to meet all program requirements, including having an adequate network that addresses the full range of beneficiary needs, the capacity and readiness to conduct delegation oversight over its Subcontracted Plans, and the capacity to uphold all beneficiary safeguards and protections. Subcontracted Plans shall participate in the readiness reviews and be subject to evaluation and approval by CMS and California. CMS and California will also conduct a readiness review of the enrollment systems, staffing capacity, and processes and its ability to meet enrollment requirements.

- 6. Three-way Contract:** CMS and California shall develop a single three-way contract for each Prime Contractor Plan and contracting process that both parties agree is administratively effective and ensures coordinated and comprehensive program operation, enforcement, monitoring, and oversight. The three-way contract for each Prime Contractor Plan shall contain provisions for CMS and California to evaluate the performance of contracts with Subcontracted Plans; Prime Contractor Plans will be held accountable for ensuring Subcontracted Plans adhere to the Medicare and Medicaid laws and including, but not limited to those regulations described in this MOU and as articulated in the three-way contract.

### ***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;
- Eligible for full Medicaid (Medi-Cal), including
  - Individuals enrolled in the Multipurpose Senior Services Program (MSSP).
  - Individuals who meet the share of cost provisions described below:
    - Nursing facility residents with a share of cost,
    - MSSP enrollees with a share of cost, and
    - IHSS recipients who met their share of cost on the first day of the month, in the fifth and fourth months prior to their effective passive enrollment date for the Demonstration;
  - Individuals eligible for full Medicaid (Medi-Cal) per the spousal impoverishment rule codified at section 1924 of the Social Security Act as described below:
    - For those enrollees who are nursing facility level of care, subacute facility level of care, or intermediate care facility level of care and reside or could reside outside of a hospital or nursing facility, the Department or its designee shall make a Medi-Cal eligibility determination “as if” the beneficiary were in a long-term care facility. Specifically, the spousal

impoverishment rule codified section 1924 of the Act will apply to beneficiaries enrolled in the Participating Plans. The terms “intermediate care facility level of care” and “nursing facility level of care” and “subacute facility level of care” shall have the same meaning as defined in Title 22 of the California Code of Regulations sections 51120, 51124, and 52224.5; and

- Reside in one of the following Demonstration counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
  - Up to 200,000 individuals in Los Angeles may be enrolled in Participating Plans for the Demonstration. CMS and the State will monitor the enrollment and stop participation when this enrollment cap is met.
- Individuals residing in San Mateo or Orange county with a diagnosis of end stage renal disease (ESRD) at the time of enrollment.

The following populations will be excluded from enrollment:

- Individuals under age 21;
- Individuals with other private or public health insurance;
- Individuals receiving services through California’s regional centers or state developmental centers or intermediate care facilities for the developmentally disabled;
- Individuals with a share of cost that do not meet the requirements outlined above;
- Individuals residing in one of the Veterans’ Homes of California;
- Individuals living in the following rural zip codes:
  - San Bernardino County – 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 92280, 93592, and 93558
  - Los Angeles County - 90704
  - Riverside County - 92225, 92226, 92239;
- Individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment and residing in Alameda, Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara, unless they are already enrolled in a separate line of business operated by the Prime Contractor. Individuals enrolled in the Demonstration who are subsequently

diagnosed with ESRD, as with all enrollees, may choose to disenroll from the Demonstration or may choose to stay enrolled.

Individuals that may enroll but may not be passively enrolled include (see section C.2 for a description of passive enrollment):

- Individuals residing in the following rural zip codes in San Bernardino County in which only one Prime Contractor Plan operates: 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92326, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, and 92398;
- Individuals in one of the following programs may enroll only after they have disenrolled from the program:
  - Individuals enrolled in the following 1915(c) waivers: Nursing Facility/Acute hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver;
  - Individuals enrolled in Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation;
- During 2013, individuals enrolled in a Medicare Advantage plan; or
- Individuals enrolled in a prepaid health plan that is a non-profit health care service plan with at least 3.5 million enrollees statewide, that owns or operates its own pharmacies and that provides medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it operates to provide services to enrollees.

The enrollment table below summarizes eligibility for the Demonstration.

**Table I: Demonstration Eligibility**

Population	Eligibility (CA Welfare and Institutions Code Section 14132.275)
Everyone eligible for the demonstration must be a full-benefit dual eligible	Included
Beneficiaries in rural zip codes excluded from managed care	Excluded
Beneficiaries with other Health Coverage – Two-Plan/Geographic Managed Care (GMC) county	Excluded
Beneficiaries with other Health Coverage – County Organized Health System (COHS) county	Excluded
Beneficiaries under age 21	Excluded
Beneficiaries in the following 1915(c) waivers: Nursing Facility/Acute Hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver.	Excluded
ICF-DD Residents	Excluded
Resident in one of the Veterans’ Homes of California;	Excluded
Beneficiaries with ESRD – previous diagnosis (excluding San Mateo and Orange counties)	Excluded
Beneficiaries with ESRD – subsequent diagnosis post-enrollment	Included
Beneficiaries with a Share of Cost – in skilled nursing facility, MSSP, or IHSS and continuously certified to meet share of cost as detailed in Appendix 7, section III.D.ix	Included
Beneficiaries with a Share of Cost – in community and not continuously certified	Excluded
Program of All-Inclusive Care for the Elderly (PACE) or AIDS Healthcare Foundation enrollees	Exempt from passive enrollment
Enrolled in a Medicare Advantage plan	Exempt from passive enrollment in 2013

<b>Population</b>	<b>Eligibility (CA Welfare and Institutions Code Section 14132.275)</b>
Individuals enrolled in a prepaid health plan that is a non-profit health care service plan with at least 3.5 million enrollees statewide, that owns or operates its own pharmacies and that provides medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it operates to provide services to enrollees	Exempt from passive enrollment

- 2. Enrollment and Disenrollment Processes:** Eligible individuals will be notified of their right to select a Participating Plan no fewer than sixty (60) days prior to the effective date of enrollment, and will have the opportunity to opt out up until the last day of the month prior to the effective date of enrollment, as further detailed in Appendix 7. 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; and will be effective on the first day of the month following the request to do so. CMS and the State 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 California 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 the State may discontinue further passive enrollment into a Participating Plan. 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 California will utilize an independent third party entity to facilitate enrollment into the Participating Plans in Two-Plan and Geographic Managed Care Counties (see Appendix 3 for Demonstration counties). In the two County Organized Health Systems (COHS) counties, the Prime Contractor Plans will facilitate enrollment, as done today. Participating Plan enrollments, transfers and opt-outs shall become effective on the same day for both Medicare and Medicaid (the first of the month). For those who lose Medicaid eligibility during the month, coverage and Federal financial participation will continue through the end of the month.

- 3. Uniform Enrollment/Disenrollment Documents:** CMS and California shall develop uniform enrollment and disenrollment forms and other documents.
- 4. Outreach and Education:** Participating Plan outreach and marketing materials will be subject to a single set of marketing rules by CMS and the State, as further detailed in Appendix 7.
- 5. Single Identification Card:** CMS and California 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 State to address beneficiary or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs) and the Community Care Transitions program. A beneficiary enrolled in the Demonstration will not be enrolled in, or have costs attributed to, an ACO or any other shared savings initiative for the purposes of calculating Medicare savings under those initiatives.

#### ***D. DELIVERY SYSTEMS AND BENEFITS***

- 1. Participating Plan Service Capacity:** CMS and California shall contract with Prime Contractor 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 42 CFR 438 and with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments and waiver authority discussed in Appendix 5, and in accordance with the requirements specified in the State Request for Solutions and this MOU. In accordance with the three-way contract and this MOU, CMS and California 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, California, and Participating Plans will ensure that beneficiaries have access to an adequate network of medical, drug, behavioral health, and supportive service providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.

- 2. Participating Plan Risk Arrangements:** CMS and California shall require each Participating Plan to provide a detailed description of its risk arrangements with providers under subcontract with the Participating Plan. This description shall be made available to plan enrollees upon request. It will not be permissible for any incentive arrangements to include any payment or other inducement that serves to withhold, limit or reduce necessary medical or non-medical services to enrollees.
- 3. Participating Plan Financial Solvency Arrangements:** CMS and the State 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 for which they are eligible and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose a different Participating Plan, a Medicare Advantage Plan, a PACE program, to receive care through Medicare Fee-For-Service (FFS) and a Prescription Drug Plan, and to receive Medicaid services in accordance with the State’s approved State Plan and any approved waiver programs.

- 2. Continuity of Care:** CMS and California will require Participating Plans to ensure that individuals continue to have access to medically necessary items, services, and medical and long-term service and support providers, and plans will be required to authorize payment to providers at Medicare rates for Medicare services or Medi-Cal rates for Medi-Cal services, for the transition period, as described in Appendix 7. Participating Plans will inform beneficiaries of their new service providers. In addition, Participating Plans will advise beneficiaries and providers that they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, and as appropriate, 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, Medicaid-Medicare beneficiaries will be provided with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs. CMS and the California Department of Health Care Services and Department of Aging will work together to support the State Health Insurance Assistance Program (SHIP), Aging and Disability Resource Center (ADRC) Options Counseling, and other community-based, nonprofit organizations to ensure ongoing outreach, education, and support to beneficiaries in understanding their health care coverage options.
- 4. Ombudsman:** California's Ombudsman office serves as an objective resource to resolve issues between Medi-Cal managed care members and managed care plans. CMS and the State Ombudsman office conduct impartial investigations of member complaints about managed care health plans and helps members with urgent and disenrollment problems. The Ombudsman will support individual advocacy and independent systematic oversight for the Demonstration, with a focus on compliance with principles of community integration, independent living, and person-centered care in the home and community based care context. The Ombudsman will be responsible for gathering and reporting data to the State and CMS via the contract management team described in Appendix 7 of this MOU.

- 5. Person-Centered, Appropriate Care:** CMS, California, and Participating Plans shall ensure that all medically necessary covered benefits are provided to enrollees and are provided in a manner that is sensitive to the beneficiary’s functional and cognitive needs, language and culture, allows for involvement of the beneficiary and caregivers (as permitted by the beneficiary), and is in a care setting appropriate to the beneficiary’s needs, with a preference for the home and the community. CMS, California, and Participating Plans shall ensure that care is person-centered and can accommodate and support self-direction. Participating Plans shall also ensure that medically necessary covered services are provided to beneficiaries in the least restrictive community setting, and in accordance with the enrollee’s wishes and Individual Care Plan.
- 6. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and California require plan and provider compliance with the ADA and 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 the State recognize that successful person-centered care requires physical access to buildings, services, and equipment, and flexibility in scheduling and processes. California 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. California and CMS also recognize that access includes effective communication. California 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 and accommodations for members with cognitive limitations, and interpreters for those who do not speak English. Also, CMS and California recognize the importance of staff training on accessibility and accommodation, independent living and recovery, and wellness philosophies. CMS and California will continue to work with stakeholders and enrollees to further develop learning opportunities, monitoring mechanisms and quality measures to ensure that Participating Plans and their providers comply with all requirements of the ADA. Finally, CMS and California are committed to compliance with the ADA, including application of the Supreme Court’s *Olmstead* decision, and agree to

ensure, through ongoing surveys and readiness and implementation monitoring, that Participating Plans provide for Demonstration enrollees long-term services and supports in care settings appropriate to their needs.

- 7. Enrollee Communications:** CMS and California agree that enrollee and prospective enrollee materials, in all forms, shall require prior approval by California and CMS and in accordance with all existing rules and regulation, unless CMS and California agree to changes to those rules, pursuant to applicable Medicare and Medicaid waiver authority and specific in Appendix 4 or 5, in order to meet the needs of the Demonstration. CMS and California will also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or State approval. CMS and California 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 their caregivers, including but not limited to those with cognitive and functional limitations and limited English proficiency, in accordance with 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 the State shall require Participating Plans to obtain beneficiary and community input on issues of program management and enrollee care through a range of approaches, which may include beneficiary participation on Participating Plan governing boards and quality review bodies. The Participating Plan must also establish at least one consumer advisory committee which will meet monthly and a process for that committee to provide input to the governing board. The Participating Plan must also demonstrate that the advisory committee composition reflects the diversity of the enrollee population in the plan, and participation of individuals with disabilities, including enrollees, within the governance structure or advisory board of the plan. The State will maintain additional processes for

ongoing stakeholder participation and public comment, as discussed in Appendix 7.

- 9. Participating Plan Customer Service Representatives:** CMS and California shall require Participating Plans to employ sufficient numbers of customer service representatives who shall answer all inquiries and respond to enrollee complaints and concerns within a reasonable period of time, as defined by CMS and California. In addition, CMS and California shall themselves employ or contract with sufficient call center and customer service representatives to address enrollee questions and concerns. Participating Plans, CMS, and California 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 California 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, Medicare-Medicaid beneficiaries will have access to an appeals and grievance process that will be integrated over time.
- 12. Limited Cost Sharing:** Participating Plans will not charge Medicare Parts C or D premiums, or assess any cost sharing for Medicare Parts A and B services. For drugs and pharmacy products (including both those covered by both Medicare Part D and Medi-Cal), Plans will be permitted to charge copays to individuals currently eligible to make such payments. Copays charged by Participating Plans must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy or Medi-Cal cost-sharing rules, as applicable, although Participating 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. Copays

charged to HIV-positive individuals for all drugs on the AIDS Drug Assistance Program (ADAP) formulary may be paid by the California Department of Public Health, Office of AIDS to ensure continuity of HIV drug treatment and utilization. Participating Plans will not assess any cost sharing for Medi-Cal services.

- 13. No Balance Billing:** No enrollee may be balance billed by any provider for any reason for covered services.

***F. INTEGRATED APPEALS AND GRIEVANCES***

- 1. Participating Plan Grievances and Internal Appeals Processes:** Over the period of the Demonstration, CMS and California agree to develop a unified set of requirements for Participating Plan grievances and internal appeals processes that incorporate relevant Medicare Advantage, and Medicaid managed care requirements, to create a more beneficiary friendly and easily navigable system, which is discussed in further detail in Appendix 7 and will be specified in the three-way contract. All Participating Plan Grievances and Internal Appeals procedures shall be subject to the review and prior approval of CMS and California. Part D appeals and grievances will continue to be managed by CMS under existing Part D rules, and non-Part D pharmacy appeals will be managed by California. CMS and California will work to continue to coordinate grievances and appeals for pharmacy. The IHSS fair hearing processes will continue for IHSS hours authorized by counties. More detail is specified in Appendix 7.
- 2. External Appeals Processes:** CMS and the State agree to utilize a streamlined Appeals process that will be developed conforming to both Medicare and Medicaid requirements, to create a more beneficiary friendly and easily navigable system. Protocols will be developed to assure coordinated access to the appeals mechanism. This process and these protocols are discussed in further detail in Appendix 7. Part D appeals and grievances will continue to be managed under existing Part D rules.

## ***G. ADMINISTRATION AND REPORTING***

- 1. Participating Plan Contract Management:** As more fully discussed in Appendix 7, CMS and California agree to designate representatives to serve on a CMS-State Contract Management team which shall conduct 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, including shared accountability strategies for virtual integration of Medi-Cal covered services and benefits not included in the capitated payment to Prime Contractor Plans.
- 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 California, and ensuring that Participating Plans take corrective action, as appropriate, including corrective action imposed on Prime Contractor Plans for the deficiencies of Subcontracted Plans.
- Reviewing and analyzing Prime Contractor Plan oversight and monitoring of delegated functions to Subcontracted Plans.
- Reviewing and analyzing reports on Participating Plans' network adequacy, including the network adequacy of each plan benefit package, as well as the Plans' ongoing efforts to replenish 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 California will establish procedures for Participating Plan daily monitoring, as described in Appendix 7. Oversight shall generally be conducted in line with the following principles:

- California 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 California 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 and California contract management teams, as described in Appendix 7, will be established. Oversight will build on areas of expertise and capacity of California and CMS.
- Oversight of the Participating Plans and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and the Medi-Cal program.
- Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the State. 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 possibly audits.
- CMS and California 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 Part D Critical Incidence Reporting System, and existing State 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 California 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. Prime Contractor Plans will be required to meet reporting requirements on behalf of Subcontracted Plans; however, reporting must separately identify each subcontracted plan's performance. Participating Plans will be required to meet the encounter reporting requirements that are established for the Initiative. See Appendix 7 for more detail.

- 4. Accept and Process Data:** CMS, or its designated agent(s), and California shall accept and process uniform person-level enrollee data, for the purposes of program eligibility, payment, and evaluation. Submission of data to California and CMS must comply with all relevant Federal and State laws and regulations, including, but not limited to, regulations related to HIPAA and to electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation. This is discussed in more detail in Appendix 7. CMS and California 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 California shall conduct a joint comprehensive performance and quality monitoring process that is at least as rigorous as Medicare Advantage, Medicare Prescription Drug, and Medicaid managed care requirements. The reporting frequency and monitoring process will be specified in the three-way contract.
- 2. External Quality Reviews:** CMS and California 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 California shall determine applicable quality standards and monitor the Participating Plans' compliance with those

standards. These standards are articulated in Appendix 7 and the Participating Plan three-way contract.

## ***I. FINANCING AND PAYMENT***

- 1. Rates and Financial Terms:** For each calendar year of the Demonstration, before rates are offered to Prime Contractor Plans, CMS shall share with the State the amount of the Medicare portion of the capitated rate, as well as collaborate to establish the data and documentation needed to assure that the Medicaid portion of the capitation rate is consistent with all applicable Federal requirements.
- 2. Blended Medicare and Medicaid Payment:** CMS will make separate payments to the Prime Contractor Plans for the Medicare A/B and Part D components of the rate. The State will make a payment to the Prime Contractor 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 California 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 Prime Contractor Plans or their contractors collect and report to CMS and California 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, and long-term care and social support services 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. California will collaborate with CMS or its designated agent during all monitoring and evaluation activities. California 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 Prime Contractor Plans. California 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***

California 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***

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

- 1. Limitations of MOU:** This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the 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. This MOU does not obligate any funds by either of the parties. Each party acknowledges that it is entering into this MOU under its own authority.
- 2. Modification:** Either CMS or the State may seek to modify or amend this MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security

Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any material modification shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.

- 3. Termination:** The parties may terminate this MOU under the following circumstances:
- a. Termination without cause - Except as otherwise permitted below, a termination by CMS or the State for any reason will require that CMS or the State provides a minimum of 90 days advance notice to the other entity 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.
  - d. Termination due to a Change in Law - In addition, CMS or the State may terminate this MOU upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

If the Demonstration is terminated as set forth above, CMS shall provide the State with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Demonstration enrollees, and, to the extent that timing permits, adheres to the phase-out plan requirements detailed below. All enrollees must be successfully enrolled in a Part D plan prior to termination of the Demonstration.

- 4. Demonstration phase-out.** Termination at the end of the Demonstration must follow the following procedures:
- a. Notification – Unless CMS and the State agree to extend the Demonstration, California must submit a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, California must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State

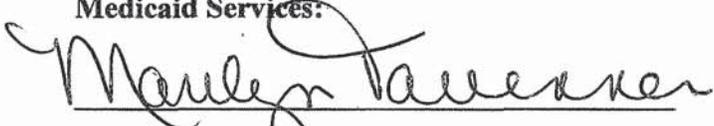
- must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. California shall summarize comments received and share such summary with CMS. Once the phase-out plan is approved by CMS, the phase-out activities must begin within 14 days.
- b. Phase-out Plan Requirements - California must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on how the beneficiary's appeal rights will continue to operate during the phase-out and any plan transition), the process by which California will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, including plans for enrollment of all enrollees in a Part D plan, as well as any community outreach activities. In addition, such plan must include any ongoing Participating Plan and State responsibilities and closeout costs.
  - c. Phase-out Procedures - California must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, California 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, California must maintain benefits as required in 42 CFR §431.230. If applicable, California 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, March 27, 2013, through the end of the Demonstration period, December 31, 2016. Additionally, the terms of this MOU shall continue to apply to California and the Participating Plans as they implement associated phase-out activities beyond the end of the Demonstration period.

In Witness Whereof, CMS and California 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:**

 3/27/13  
Marilyn Tavenner (Date)  
Acting Administrator

**California**  3/27/13  
Toby Douglas, (Date)  
Director, Department of Health Care Services

## Appendix 1: Definitions

**Appeal** - An enrollee's request for review of a Participating Plan's coverage or payment determination.

**California** – For purposes of this document, California is used to refer to the state of California, and generally the California Department of Health Care Services (DHCS).

**California In-Home Supportive Services Authority**- The joint powers authority created pursuant to statute (Section 6531.5 of the Government Code) shall be the entity authorized to meet and confer in good faith regarding wages, benefits and other terms and conditions of employment with representatives of recognized employee organizations representing individual providers of in-home supportive services, no sooner than March 1, 2013, and upon notification by the director of DHCS that the enrollment of eligible Medi-Cal beneficiaries in the demonstration has been completed in that county.

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

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

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

**Clinical Care Manager** – A licensed registered nurse or other individual licensed to provide Clinical Care Management.

**CMS** - Centers for Medicare & Medicaid Services.

**Community-Based Adult Services (CBAS)** – CBAS is an outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family and caregiver training, and support, meals and transportation, as defined in California's 1115(a) demonstration project.

**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** – Also referred to as the three-way contract, this is the participation agreement that CMS and the State have with a Prime Contractor Plan for the terms and conditions pursuant to which a Participating Plans may participate in this Demonstration.

**Contract Management Team** - A group of CMS and Medi-Cal representatives responsible for overseeing the contract.

**Coordinated Care Initiative (CCI)** – A state legislative package (SB 1008, Chapter 33, Statutes of 2012, and SB 1036, Chapter 45 Statutes of 2012, and AB 1471, Chapter 439 statutes of 2012 and AB 1468, Chapter 438, Statutes of 2012) that established the Demonstration project to provide coordinated health care through Medi-Cal managed care plans, that also met Medicare requirements, for beneficiaries eligible for both Medicare and Medi-Cal (dual eligible) in selected California counties. CCI also calls for the integration of long-term services and supports (LTSS); mental health services; and substance use disorder treatment services. The CCI enables the State to establish three-way contracts with both the CMS and managed care health plans.

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

**Covered Services** - The set of services to be offered by the Participating Plans.

**Cultural Competence** - Understanding those values, beliefs, and needs that are associated with beneficiary’ 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.

**CA Department of Aging (CDA)** - Administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State. The Department administers funds allocated under the Federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program. CDA certifies CBAS centers for participation in the Medi-Cal Program and provides administrative oversight for the MSSP waiver.

**Department of Health Care Services (DHCS)** – The primary state agency responsible for administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, generally referred to as the State in this document.

**Department of Managed Health Care (DMHC)** – California state agency charged with

overseeing health care service plans licensed under the Knox-Keene Act.

**CA Department of Social Services (CDSS)** – California state agency for overseeing and providing social services, including the In Home Support Services (IHSS) program.

**Enrollee** - Any Medicare-Medicaid beneficiary who is enrolled in a Participating Plan.

**Enrollment** - The processes by which an individual who is eligible for the Demonstration is enrolled in a Participating Plan.

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

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

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

**Health Insurance Counseling and Advocacy Program (HICAP)** – A consumer health insurance counseling and education program for Medicare beneficiaries and those about to become eligible for Medicare. HICAP provides objective information about Medicare, Medicare health plans, Medicare supplement policies, and long-term care insurance.

**Individualized Care Plan (ICP)** - The plan of care developed by an enrollee and an enrollee's Interdisciplinary Care Team or health plan.

**Interdisciplinary Care Team (ICT)** – A team of primary care provider and Care Coordinator, and other providers at the discretion of the enrollee that work with the enrollee to develop, implement, and maintain the Individualized Care Plan.

**In-Home Supportive Services (IHSS)** – pursuant to Article 7 of California Welfare and Institutions Code (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.), California program that provides in-home care for people who cannot safely remain in their own homes without assistance. To qualify for IHSS, an enrollee must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program. IHSS includes the Community First Choice Option (CFCO), Personal Care Services Program (PCSP), and IHSS-Plus Option (IPO).

**Long Term Services and Supports (LTSS)** – A wide variety of services and supports that help eligible beneficiaries 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. As described in California Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following:

- 1) In-Home Supportive Services (IHSS) provided pursuant to Article 7 of California Welfare and Institutions Code (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.)
- 2) Community-Based Adult Services (CBAS)
- 3) Multipurpose Senior Services Program (MSSP) services
- 4) Skilled nursing facility services and subacute care services

**Medicaid** - The national program, known as Medi-Cal in California, of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

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

**Medi-Cal** – The Medicaid program administered by California.

**Medically Necessary Services** – Services must be provided in a way that provides all protections to the enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 USC 1395y. In accordance with Medicaid law and regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

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

**Medicare-Medicaid Coordination Office** - Formally the Federal Coordinated Health Care Office, established by section 2602 of the Affordable Care Act.

**Medicare-Medicaid Enrollees** - For the purposes of this Demonstration, individuals who are entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits (Medi-Cal) and no other comprehensive private or public health coverage.

**Medicare Waiver** - Generally, a waiver of existing law authorized under section 1115A of the

Social Security Act.

**Memorandum of Understanding (MOU)** – For purposes of the Demonstration, this is the document that details the principles under which CMS and the State plan to implement and operate the aforementioned Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute a three-way contract setting forth the terms and conditions of the Demonstration and initiate the Demonstration.

**Multi-purpose Senior Services Program (MSSP)** – A California specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

**Participating Plan** – A Prime Contractor Plan, or a Subcontracted Plan partner, contracted to provide and accountable for providing integrated care to enrollees.

**Passive Enrollment** – An enrollment process through which an eligible individual is enrolled by the State (or its vendor) into a participating plan, following a minimum 90 day advance notification that includes the opportunity to make another enrollment decision prior to the effective date.

**Prime Contractor Plan (selected plan)** - A health plan or other qualified entity jointly selected by the State and CMS for participation in this Demonstration. A health plan contracted to provide and accountable for providing integrated care to enrollees.

**Privacy Rules** – Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, as well as relevant California privacy laws.

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

**Readiness Review** – Following the signing of the three-way contract, California and CMS must agree that a Participating Plan has passed readiness prior to that Plan accepting any enrollment. 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 the State will use the results to inform its 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.

**Recovery Model** - Framework for behavioral health that uses “recovery-oriented” services in recognition that systems of care should ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care necessary to achieve meaningful outcomes such as health, home, purpose and community, consistent with the system of care as set forth in California Welfare and Institutions Code §5802 and 5806. Core practices within recovery-oriented systems include peer support, individual choice and person-driven approaches. The recovery model recognizes that behavioral health issues involve an individualized complex interaction between social, environmental and physiological components, and the need to incorporate all of these factors within the care system in order to achieve health and wellness.

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

**Special needs plans (SNPs):** Specialized Medicare Advantage plans designed to provide targeted care to individuals with special needs. In the Medicare Modernization Act of 2003 (MMA), Congress identified "special needs individuals" as: 1) institutionalized beneficiaries; 2) dual eligibles; and/or 3) individuals with severe or disabling chronic conditions as specified by CMS. SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care.

**Subcontracted Plans:** Participating Plans may enter into direct subcontracts with other MA-PDs to implement plan benefit packages (PBPs) under their contract. Subcontracted Plans must adhere to the requirements in this MOU and in the Participating Plan three-way contracts. The Participating Plan oversees and is accountable for any functions or responsibilities that are delegated to Plan Subcontractors.

**State – California**

**Threshold languages-** Languages identified in the California’s Medicaid (Medi-Cal) Eligibility Data System (MEDS) as the primary language of at least 3,000 beneficiaries in a given county. Depending on the county, these languages include English, Spanish, Vietnamese, Chinese, Korean, Tagalog, Russian, Armenian, Khmer, Arabic, and Hmong.

## 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 California proposal. Following the submission of the proposal, CMS asked the State a number of questions when there was ambiguity of whether or not the proposal met the Standards and Conditions. These questions and responses are included in the Addendum to the proposal, which has been posted on CMS' website with the proposal.

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
<b>Integration of Benefits</b>	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. 8-10, 13-19, 22-23, 27-28, Appendix 2, and addendum
<b>Care Model</b>	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. 14-20, 28, Appendices 2 and 4, and addendum
<b>Stakeholder Engagement</b>	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. 22-25, Appendix 9, and addendum

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	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.	
<b>Beneficiary Protections</b>	<p>State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary’s needs. At a minimum, States will be required to:</p> <ul style="list-style-type: none"> <li>• 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).</li> <li>• 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.</li> <li>• Ensure privacy of Enrollee health records and provide for access by Enrollees to such records.</li> <li>• Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community.</li> </ul>	<p style="background-color: #cccccc; height: 150px; margin: 0;"></p> <p>p. 23-26 and addendum</p> <p>pp. 26-27</p> <p>p. 26-28 and addendum</p> <p>pp. 26-28</p>

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	<ul style="list-style-type: none"> <li>• 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.</li> </ul>	pp. 26-27
	<ul style="list-style-type: none"> <li>• Ensure an adequate and appropriate provider network, as detailed below.</li> </ul>	pp. 27 and addendum
	<ul style="list-style-type: none"> <li>• Ensure that beneficiaries are meaningfully informed about their care options.</li> </ul>	pp. 10-11, 35, and addendum
	<ul style="list-style-type: none"> <li>• Ensure access to grievance and appeals rights under Medicare and/or Medicaid.</li> </ul>	
	<ul style="list-style-type: none"> <li>• <i>For Capitated Model</i>, this includes development of a unified set of requirements for Participating Plan complaints and internal appeals processes.</li> </ul>	pp. 20, 29-30, and addendum
<b>State Capacity</b>	State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.	pp. 33-35, Appendices 7 and 8, and addendum
<b>Network Adequacy</b>	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. 10-13, 27-29, and addendum

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
<b>Measurement/ Reporting</b>	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. 30-33, 37-38, Appendix 2, and addendum
<b>Data</b>	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"> <li>Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models;</li> </ul>	Addendum
	<ul style="list-style-type: none"> <li>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</li> </ul>	Addendum
	<ul style="list-style-type: none"> <li>State supplemental payments to providers (e.g., DSH, UPL) during the three-year period.</li> </ul>	Addendum
<b>Enrollment</b>	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. 7-12 and addendum

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
<b>Expected Savings</b>	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	pp. 32-33
<b>Public Notice</b>	State has provided sufficient public notice, including:	
	<ul style="list-style-type: none"> <li>• At least a 30-day public notice process and comment period;</li> </ul>	pp. 23-27
	<ul style="list-style-type: none"> <li>• At least two public meetings prior to submission of a proposal; and</li> </ul>	pp. 23-27
	<ul style="list-style-type: none"> <li>• Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals.</li> </ul>	p. 24
<b>Implementation</b>	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"> <li>• Meaningful stakeholder engagement.</li> </ul>	pp. 23-27
	<ul style="list-style-type: none"> <li>• Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments.</li> </ul>	P9. 35 and addendum
	<ul style="list-style-type: none"> <li>• Receipt of any necessary State legislative or budget authority.</li> </ul>	p. 38
	<ul style="list-style-type: none"> <li>• Joint procurement process (for capitated models only).</li> </ul>	pp. 9-10
	<ul style="list-style-type: none"> <li>• Beneficiary outreach/notification of enrollment processes, etc.</li> </ul>	pp. 10-11

### **Appendix 3: Details of State Demonstration Area**

The eight California counties for the Demonstration are indicated below:

- Two-Plan Model counties: Alameda, Los Angeles, Riverside, San Bernardino, and Santa Clara.
- County Organized Health System (COHS): Orange and San Mateo.
- Geographic Managed Care: San Diego.

The Demonstration service area is subject to the geographic limitations detailed in C.1, Participating Plan network standards detailed in Appendix 7, and the joint CMS-State readiness review.

## 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 no sooner than October 1, 2013 through December 31, 2016 as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing Medicare manuals will be noted and reflected in an appendix to the three-way contracts.

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

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

- Section 1851(a), (c), (e), and (g) of the Social Security Act, and implementing regulations at 42 CFR, Part 422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in Participating plans to Medicare-Medicaid beneficiaries who are 21 and older, including beneficiaries who may have end-stage renal disease, and (2) the passive enrollment process provided for under the Demonstration.
- Sections 1853, 1854, 1857(e), 1860D-11, 1860D-13, 1860D-14, and 1860D-15 of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subparts F and G, and Part 423, Subparts F and G, only insofar as such provisions

are inconsistent with the methodology for determining payments, medical loss ratios and enrollee liability under the Demonstration as specified in this MOU, including Appendix 6, which differs as to the method for calculating payment amounts and medical loss ratio requirements, and does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.

- The provisions regarding deemed approval of marketing materials in sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 CFR 422.2266 and 423.2266, with respect to marketing and enrollee communications materials in categories of materials that CMS and the State have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and the California 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 regulations, not expressly waived in this list, shall apply to the Demonstration beginning no sooner than October 1, 2013 through December 31, 2016, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing sub-regulatory guidance will be noted and reflected in an appendix to the three-way contracts.

This Demonstration and the additional authority referenced below are contingent upon CMS-approved Social Security Act Section 1115(a) authority through an amendment to the state's existing section 1115(a) [Bridge to Reform] demonstration. The State must meet all requirements of any approved Medicaid waiver authority as expressed in the terms of the section 1115(a) demonstration, including, but not limited to, all financial, quality, reporting and monitoring requirements of the section 1115(a) demonstration, and State financing contained in the State's section 1115(a) demonstration must be in compliance with Federal requirements. This MOU does not indicate or guarantee CMS approval of the section 1115(a) demonstration. If the necessary section 1115(a) demonstration authority is approved, Title XIX duals Demonstration savings may not be added to budget neutrality savings under California's existing section 1115(a) demonstration. When California's section 1115(a) demonstration is considered for renewal and at the end of the duals Demonstration, CMS' Office of the Actuary will estimate and certify actual Title XIX savings to date under the duals Demonstration attributable to populations and services provided under the 1115(a) demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal.

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.

California and its contractors will develop actuarially sound Medicaid capitation rates in accordance with 42 CFR 438.6(c). The basis for these rates will begin with costs developed prior to the application of the Medicare and Medicaid composite savings percentages established by California and CMS, informed by estimates from CMS and its contractors. The certification provided by the State's actuaries will assure that the Medicaid capitation rates were set consistent with 42 CFR 438.6(c) in combination with a qualification that the Medicare capitation rates were established by CMS and the Medicare and Medicaid composite savings percentages were

established by the State and CMS.

## **1115A Medicaid Waivers**

Under the authority of section 1115A of the Social Security Act (the Act), the following waivers of State Plan requirements contained in section 1902 and 1903 of the Act are granted to enable California to carry out the State Demonstration to Integrate Care for Dual Eligible Beneficiaries. These authorities shall be in addition to those in the State Plan and all existing waivers.

### **1. Statewideness**

#### **Section 1902(a)(1)**

To enable California to provide managed care plans or certain types of managed care plans (integrated care for dual eligible individuals] only in certain geographical areas of the State.

### **2. Provisions Related to Contract Requirements implemented in 42 C.F.R. 438.6)**

#### **Section 1903(m)(2)(A)(iii) (as**

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

## Appendix 6: Payments to Prime Contractor Plans

The Centers for Medicare and Medicaid Services (CMS) and California 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 Prime Contractor Plans are responsible for the full range of services covered under the Demonstration;
- (3) Aggregate savings percentages will be applied equally to the Medicaid and Medicare Parts A and B components; and
- (4) Both CMS and the State 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.

**Figure 6-1: Demonstration Year Dates**

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

**Figure 6-2: Summary of Payment Methodology**

	Medicare Parts A and B	Medicare Part D	Medicaid
<p><b>Baseline costs for the purposes of setting payment rates</b></p> <p>Medicare baseline spending will be established</p>	<p>Blend of Medicare Advantage payments and Medicare standardized fee-for-service projections weighted by where Medicare-Medicaid beneficiaries who meet the criteria and</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>Medicaid capitation rates that are associated with the contracts that support the 1115(a) demonstration program that would apply for beneficiaries in the</p>

	<b>Medicare Parts A and B</b>	<b>Medicare Part D</b>	<b>Medicaid</b>
prospectively on a calendar basis for each Demonstration county.	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.	Note that additional costs associated with low-income subsidy 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 plan payments, as appropriate, but these amounts are subject to reconciliation consistent with Part D reconciliation rules.	target population but who choose not to participate in the Demonstration established under this MOU
<b>Responsible for producing data</b>	CMS	CMS	California Department of Health Care Services

	<b>Medicare Parts A and B</b>	<b>Medicare Part D</b>	<b>Medicaid</b>
<b>Savings Percentages</b>	Minimum savings percentages: Year 1 (1%) Year 2 (2%) Year 3 (4%)	Not Applicable	Minimum savings percentages: Year 1 (1%) Year 2 (2%) Year 3 (4%)
<b>Risk adjustment</b>	Medicare Advantage CMS-HCC Model	Part D RxHCC Model	State-developed three step risk adjustment methodology described in section IV
<b>Quality withhold</b>	Applied  Year 1 (1%) Year 2 (2%) Year 3 (3%)	Not applied	Applied  Year 1 (1%) Year 2 (2%) Year 3 (3%)
<b>Risk Sharing</b>	Risk corridors will be applied as described in section IX	Existing Part D processes will apply	Risk corridors will be applied as described in section IX

### **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) rates 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 section III) to the baseline spending amounts.

#### **A. Medicaid:**

- a. The State and its actuaries will establish actuarially sound capitation rates for the contracts that support the 1115(a) demonstration program for beneficiaries in the target population for this Demonstration. These rates will be reviewed by the Regional Office. The CMS approved rates will serve as the baseline Medicaid costs.

- b. Upon request prior to and throughout the Demonstration, the State and its actuaries will provide to CMS the underlying data for the rate calculations associated with the contracts that support the 1115(a) demonstration.
- c. Medicaid payment rates will be determined by applying annual savings percentages (see section III) to the applicable capitation rates for the contracts that support the 1115(a) demonstration.
  - i. As allowed under the rates for the contracts that support the 1115(a) demonstration, California and its actuaries will calculate a range of actuarially sound capitation payment rates including lower bound and upper rates. The application of the savings percentage (see section III) will apply to all rates, including any prospective or retroactive adjustments, within actuarially sound rate range.

B. Medicare Parts A and B:

- a. CMS will develop baseline spending (costs absent the Demonstration) and payment rates for Medicare Parts A and B services using estimates of what Medicare would have spent on behalf of the beneficiaries absent the Demonstration.
- b. The Medicare baseline rate for Parts A and 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 rates will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans. The standardized county FFS rates reflect projected FFS United States per capita costs (USPCC), adjusted to reflect the historic relationship between the county's FFS per capita costs and the USPCC. CMS calculates these geographic adjustments based on historical FFS claims data. The USPCC includes expenditures for Parts A and B services and the associated bad debt payment, DSH payments, amounts related to direct and indirect medical education, and federal administrative costs but excludes hospice services, which are reimbursed through Medicare fee-for-service for Medicare Advantage beneficiaries receiving hospice services. CMS excludes operating IME and DGME payments in establishing standardized county FFS rates, and therefore they will not be factored into the Medicare baseline, consistent with plan payments under Medicare Advantage.

- c. Medicare Parts A and B payment rates will be determined by applying the annual savings percentages (see section III) to the baseline spending amounts.
- d. Both baseline rates and payment rates under the Demonstration for Medicare Parts A and 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.

As needed, CMS may require the State to provide a data file for beneficiaries who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline spending. CMS will specify the format and layout of the file.

- e. The Medicare portion of the baseline will be updated annually consistent with the annual FFS estimates and benchmarks released each year with the annual rate announcement.
- f. CMS annually applies a coding intensity adjustment factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for 2013 is 3.41 percent. Virtually all new Demonstration enrollees will come from Medicare FFS in 2013, and 2013 risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the Participating Plans themselves. Therefore, CMS will not apply the coding intensity adjustment factor in calendar year 2013 to reflect the fact that a high percentage of enrollees were receiving care in FFS Medicare and thus there should be no coding pattern differences for which to adjust. In calendar year 2014, CMS will apply an appropriate Medicare Advantage coding intensity adjustment reflective of all Prime Contractor Plan enrollees. In 2015 and 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment factor.

#### C. Medicare Part D:

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

The CY 2013 Part D NAMBA is \$79.64.

## **II. Aggregate minimum savings percentages under the Demonstration.**

- A. Both parties agree that there is reasonable expectation for achieving savings while paying Prime Contractor Plans capitated rates that are reasonable, appropriate, and attainable to support access to and utilization of medical and non-medical benefits according to beneficiary needs.
- B. For the State of California, the minimum savings percentages will be:
  - a. Demonstration Year 1: 1%
  - b. Demonstration Year 2: 2%
  - c. Demonstration Year 3: 4%

Application of the savings percentages is described further in section IX. Rate updates will take place at least annually, as noted in section X of Appendix 6. However, savings percentages will be calculated and applied based on Demonstration Years.

## **III. Apply savings percentages to Medicare Parts A and B and Medicaid components of the integrated rate.**

Savings percentages will be applied to the Medicare Parts A and B and Medicaid components of the rate. Application of the minimum savings percentages is described in more detail as part of the risk mitigation strategy in section IX. Changes to the savings percentages under section II of Appendix 6 would only occur if and when CMS and the State jointly determine the change is necessary to calculate reasonable, appropriate and attainable payment rates for the Demonstration.

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

## **IV. Rate structure and risk adjustment methodology for Medicaid components of the rates**

The Medicaid component will be paid as a single, blended rate that takes into account the relative risk of the population actually enrolled in the Prime Contractor Plan and is weighted accordingly.

The Medicaid risk adjusted blended rate as described in this section is intended to appropriately incent Prime Contractor Plans to ensure beneficiaries are served, as appropriate, in the lower cost, home/community based settings. This incentive is provided through all phases of the risk adjustment by placing plans at risk, for increasingly longer durations of time, for beneficiaries shifting between institutional and home/community based settings. In addition, the prospective adjustments made to the relative cost factors described below reflect an assumption of incremental improvement in population distribution (e.g. fewer individuals in institutional settings).

The population will be categorized into four risk adjustment population categories:

- Institutionalized: Individuals in long-term care aid codes and/or residing in a long-term care facility for 90 or more days
- HCBS High: Individuals identified as high utilizers of home and community-based services. These are individuals who meet one or more of the following criteria:
  - Individuals who receive Community Based Adult Services (CBAS)
  - Individuals who are clients of Multipurpose Senior Service Program sites (MSSP); or
  - Individuals who receive In-Home Supportive Services (IHSS) and are classified under the IHSS program as “severely impaired” (SI).
- HCBS Low: Individuals identified as low utilizers of home and community-based services. These individuals are IHSS recipients and classified under the IHSS program as “not severely impaired.”
- Community Well: All other individuals living in the community with no Medi-Cal covered HCBS services. These are all other individuals who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

The Medicaid component will utilize the risk adjustment methodology in the contracts that support the 1115(a) demonstration for the eligible population.

- A. It will employ the population categories described above. Relative Cost Factors (RCF) will be established for each of the four populations based on evaluation of the PMPM for each of the individual population groups, relative to the total Medicaid rate. As the total Medicaid rate incorporates incremental changes in population distribution (e.g. fewer individuals in institutional settings, increase in

HCBS low for higher cost community well that may be more appropriately served by HCBS benefits), the calculation of the RCFs is also impacted by the assumed population distribution.

- B. Prime Contractor Plan specific relative mix factors (RMF) will be computed through the use of RCFs and the proportion of each of the population category enrollees in the plan. The RMFs will be computed by multiplying each plans' distribution of each of the population categories with the established RCFs to calculate a weighted average Prime Contractor Plan-specific RMF.
- C. Prime Contractor Plan RMFs will be multiplied by the established capitation rate to determine the risk-adjusted Demonstration capitation payment rate for each Prime Contractor Plan.
- D. The risk adjustment process will include three distinct phases to address the stability of enrollment and to establish appropriate financial incentives for Participating Plans.
- E. The risk adjustment process described above will be administered by county in three phases during the Demonstration period:
  - i. Phase I: The risk adjustment methodology will be applied monthly and retroactively to match actual enrollment into the Prime Contractor Plans. This phase will continue through each county's phase-in enrollment period for a minimum of one year and will end at the start of the next fiscal quarter. For example, in a county with a 12-month phase-in that begins enrollment in October 2013, this phase would last through the end of September 2014. For the county of San Mateo, due to the different enrollment phasing as described in Appendix 7, there will be no Phase I.
  - ii. Phase II: This phase will be for one fiscal quarter. The risk adjustment methodology will be prospectively applied at the start of the quarter. Weighting the risk categories will be based on the preceding month to the quarter enrollment snapshot, which will be available after the quarter ends and will be retroactively applied to that period. For example, in a county with a 12-month phase-in that begins enrollment in October 2013, this Phase II would be applicable for the fiscal quarter of October 2014 through December 2014. Enrollment data from September 2014 would be utilized although the rate update would not occur until several months after the quarter to ensure data availability. For the county of San Mateo, due to the different enrollment phasing as described in Appendix 7, the

county will immediately enter Phase II of the risk adjustment. The Phase II for San Mateo will be done according to a separate timeline, such that the risk adjustment methodology will be prospectively applied at the start of the Demonstration in October 2013 and again for a second quarter from January 2014 through March 2014 after which San Mateo will move into Phase III.

- iii. Phase III: Prime Contractor Plan rates will be based on a targeted relative mix of the population and will not be adjusted during the year. If Phase III starts during a state fiscal year, the first year of this phase will be the remaining period in the state fiscal year. Phase III for the county of San Mateo will begin with the fiscal year starting July 2014. The targeted relative mix of the population for the year would be based on enrollment in the plan leading up to the start of the phase III year and will include an assumed shift in population mix.
  1. Specific to Phase III, a targeted relative mix will be projected by the State and its actuaries. This mix will be designed to be achievable by the Prime Contractor Plan, based on assumptions about the plan's ability to promote community services and prevent or delay institutional placement.
  2. If the population mix for the Prime Contractor Plan for the year results in a greater than 2.5% impact to the Medicaid component of the rate paid as compared to the rate that would have been paid based on the actual mix, then the Prime Contractor Plan and Medicaid would share equally in any cost increases/decreases beyond the 2.5%. Actual plan gain or loss does not factor into this calculation.

#### **V. Medicare risk adjustment methodology.**

- A. The Medicare Parts A and B Demonstration county rate will be risk adjusted based on the risk profile of each enrolled beneficiary. Except as specified in section I.B.f., the existing CMS-HCC and CMS-HCC ESRD 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.

**VI. Quality withhold policy to Medicaid and Medicare Parts A and B components of the integrated, risk-adjusted rate.**

- A. Under the Demonstration, both payers will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to Prime Contractor 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 State-specified quality measures.
- B. Withhold measures in Demonstration Year 1.
  - a. Figure 6-3 below identifies core withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for the 1% withhold. Additional detail regarding the agreed upon measures will be included in the three-way contract.
  - b. Although Demonstration Year 1 crosses calendar/contract years, Prime Contractor Plans will be evaluated to determine whether they have met required quality withhold requirements at the end of CY 2014.

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

Domain	Measure	Source	CMS Core Withhold Measure	California Specified Withhold Measure
Encounter data	Encounter data submitted in compliance with contract requirements	CMS/State defined process measure	X	
Assessments	Percent of enrollees with initial health assessments completed within 90 days of enrollment	CMS/State defined process measure	X	
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.	CMS/State defined process measure	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"> <li>• In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? •</li> <li>• 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</li> </ul>	AHRQ/CAHPS	X	

Domain	Measure	Source	CMS Core Withhold Measure	California Specified Withhold Measure
	<p>you thought you needed?</p> <ul style="list-style-type: none"> <li>□ In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?</li> </ul>			
Customer Service (for CY 2014 only)	<p>Percent of best possible score the plan earned on how easy it is to get information and help when needed.</p> <ul style="list-style-type: none"> <li>In the last 6 months, how often did your health plan's customer service give you the information or help you needed? •</li> <li>In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?</li> </ul> <p>In the last 6 months, how often were the forms for your health plan easy to fill out?</p>	AHRQ/CAHPS	X	
Behavioral Health Shared Accountability Process Measure: Phase A: 9/1/13 – 12/31/13	Policies and procedures attached to an MOU with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing	CMS/State defined process measure		X
Behavioral Health Shared Accountability Process Measure: Phase B: 1/1/14 – 12/31/14	Percent of Demonstration enrollees receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services receiving coordinated care plan as indicated by having an individual care plan that includes evidence of collaboration with the primary behavioral health provider	CMS/State defined process measure		X
Documentation of care goals	Percent of enrollees with documented discussions of care goals.	CMS/State defined process measure		X
Ensuring physical access to buildings, services and equipment	The health plan has an established work plan and identified an individual who is responsible for physical access compliance.	CMS/State defined process measure		X
Case manager contact with member	Percent of members who have a case manager and have at least one case manager contact during the measurement year.	State defined process measure		X

C. Withhold measures in Demonstration Years 2 and 3.

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

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

Domain	Measure	Source	CMS Core Withhold Measure	California Specified Withhold Measure
Plan all-cause readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
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	
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HOS	X	
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	
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	
Behavioral Health Shared Accountability Outcome Measure	Reduction in emergency department use for seriously mentally ill and substance use disorder enrollees	State-defined measure		X
Documentation of care goals	Percent of enrollees with documented discussions of care goals.	CMS/State defined process measure		X
Case manager contact with member	Percent of members who have a case manager and have at least one case manager contact during the measurement year.	State defined process measure		X

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

- b. Additional detail regarding the agreed upon measures will be included in the three-way contract.

## **VII. Payments to Prime Contractor Plans.**

- A. CMS will make separate risk-adjusted payments to the Prime Contractor Plans for the Medicare Parts A and B and Part D components of the rate, based on standardized Demonstration payment rates. Medicare Parts A and B payments and Part D payments will be subject to the same payment adjustments that are made for payments to Medicare Advantage and Part D plans, including but not limited to adjustments for user fees and Medicare Secondary Payer adjustment factors.
- B. The State will make a payment to the Prime Contractor Plans for the Medicaid component of the rate subject to the rate structure specified in section IV. Specialty behavioral health services that are financed and managed by county behavioral health agencies will not be included in the capitated payment to the Prime Contractor Plans. Costs for county activities to administer IHSS, such as determining eligibility, assessing authorized hours and providing a provider registry, will not be included in the capitated payment to Prime Contractor Plans.
- C. The capitated payment from CMS and the State is intended to be reasonable, appropriate, and attainable to support access to and utilization of covered services, according to enrollee Individual Care Plans. CMS and the State will jointly monitor access to care and overall financial viability of plans accordingly.

## **VIII. Evaluate and pay Prime Contractor Plans relative to quality withhold requirements.**

- A. CMS and the State will evaluate plan performance according to the specified metrics required in order to determine if a Prime Contractor Plan may earn back the quality withhold for a given year. CMS and the State will share information as needed to determine whether quality requirements have been met and calculate final payments to each Prime Contractor 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 health plans in years 2 and 3.
- C. Prime Contractor Plans and county agencies responsible for delivery of specialty behavioral health services (see Appendix 7) will describe formal financial arrangements in contracts that include performance measures to improve health outcomes and reduce medical costs.
  - a. Shared financial accountability will build on the Behavioral Health Shared Accountability quality withhold measures with at least one metric in each year pertaining to the coordination of services for the beneficiaries with serious mental

illness and chronic substance disorders. Based on achievement of that metric, the Prime Contractor Plans will be required to develop agreements to provide incentive payments from the withhold funds to county mental health and substance use agencies. These incentive payments should not be considered patient care revenue and should not be offset against the certified public expenditures incurred by county behavioral health agencies and their affiliated government entity providers for health care services or administrative activities as defined under the State plan. Additional details will be in the forthcoming three-way contracts.

## **IX. Risk Mitigation Strategies**

- A. Cost reconciliation** under Part D will continue as is under the Demonstration. CMS will monitor Part D costs closely on an on-going basis. Any material increase in Part D costs relative to the baseline may be factored into future Demonstration Year savings percentages.
- B. Rate Review Process:** CMS and the State will review the Prime Contractor Plan financial reports, encounter data, and other information to assess the ongoing financial stability of the Prime Contractor Plans and the appropriateness of capitation payments. At any point, the State 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.
- C. Limited Risk Corridors:** Limited risk corridors will be established for all Demonstration Years in order to provide a level of protection to Prime Contractor Plans and payers against uncertainty in rate-setting that could result in either overpayment or underpayment. The Demonstration will utilize a limited down-side risk corridor and a limited up-side risk corridor to include all Medicare Parts A and B and Medicaid eligible costs. The corridors will be applied on a Prime contract specific basis and will be reconciled after application of any risk adjustment methodologies and any other adjustments. Risk corridors will be reconciled as if the Prime Contractor Plan had received the full quality withhold payment. The three-way contract will include further details on how risk corridors will be operationalized under this Demonstration.
  - a. Process for collecting cost information. CMS and the State will evaluate encounter data, cost data, and Plan financial reports to determine Plan incurred costs. For the purposes of this risk corridor methodology, CMS and the State may make downward

adjustments to Prime Contractor Plan costs for any excessive payments to Plan-affiliated providers.

- b. Limited down-side risk corridor:
  - To reflect the underlying characteristics of the eligible population and differences between counties, initial payments will be made on a county specific basis and reconciled based on plan costs within the limits specified below.
  - The application of county-specific interim savings percentages in Figure 6-5 establishes the initial capitation rates for purposes of this risk corridor calculation.

**Figure 6-5: County-Specific Interim Savings Percentages**

	Demonstration Year 1	Demonstration Year 2	Demonstration Year 3
<b>Minimum Savings Percentages</b>	<b>1.00%</b>	<b>2.00%</b>	<b>4.00%</b>
<b>County Specific Interim Savings Percentages: the sum of the minimum savings percentages and the county-specific addition</b>			
<b>Alameda</b>	+ 0.19%	+ 1.41%	+ 0.97%
<b>Los Angeles</b>	+ 0.00%	+ 1.50%	+ 1.50%
<b>Orange</b>	+ 0.42%	+ 1.50%	+ 1.50%
<b>Riverside</b>	+ 0.22%	+ 1.50%	+ 1.14%
<b>San Bernardino</b>	+ 0.44%	+ 1.50%	+ 1.50%
<b>San Diego</b>	+ 0.23%	+ 1.50%	+ 1.10%
<b>San Mateo</b>	+ 0.47%	+ 0.33%	+ 0.00%
<b>Santa Clara</b>	+ 0.23%	+ 1.45%	+ 0.95%

- If the Prime Contractor Plan costs exceed the initial capitation rates, excluding both Part D payments and costs, Medicare and Medicaid will reimburse the Prime Contractor Plan 67% of the costs above the initial capitation rates, provided that total federal/State payments to the Prime Contract Plan (including initial capitation payment amounts and risk corridor payment amounts) cannot exceed the total capitation amounts that would have been paid by the federal government/State with the minimum savings percentages in Section II applied to the rates.
- The Medicare and Medicaid contributions to the reconciled capitated payments will be in proportion to their contribution to the initial capitated rates, not including Part D.

c. Limited up-side risk corridor:

- If the Prime Contractor Plan costs, excluding both Part D payments and costs, are lower than the initial capitation rates, this risk corridor will be triggered.
- The risk corridor will contain three bands. The percentages specified below are expressed as a percentage of the combined baseline amount for Medicaid and Medicare Part A and B.
  - The first band will be equal to the difference between the minimum savings percentage identified in Section II and the county specific savings percentage identified in Figure 6-5. In this band, Prime Contractor Plans will retain 100% of the excess. If a plan is in a county where the interim savings percentage is equal to the minimum savings percentage for that Demonstration year, the first band will be the difference between the minimum savings percentage and the following maximum savings percentages: 1.5% in Demonstration Year 1, 3.5% in Demonstration Year 2, and 5.5% in Demonstration Year 3.
  - The second band is the same size as the first band. It starts from the upper limit of the first band and is the equivalent amount of percentage points. In this band, Medicare and Medicaid would share in 50 percent of plan savings and the Prime Contractor Plan would share in the excess 50 percent.
  - The final band will be all amounts above the upper limit of the second band. In this band, the Prime Contractor Plan will retain 100% of the excess.
- Medicare and Medicaid recoupments in the risk corridor will be in proportion to their contribution to the initial capitated rates, not including Part D. Medicaid recoupments will be shared between the State and Federal government according to the State's FMAP.

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

- A. Rates will be updated using a similar process for each calendar year. Rate updates will take place on January 1<sup>st</sup> of each calendar year for the Medicare components of the rates, with changes to savings percentages applicable on a Demonstration Year basis. Rate updates for the Medicaid component of the rates will take place at least once each California state fiscal

year and may be more often as necessary to match adjustments made to the Medicaid capitation rates in the contracts that support the 1115(a) demonstration program that would apply for beneficiaries in the target population who do not enroll in this Demonstration. Adjustments to the Medicaid component of the rates may be done retroactively, if necessary to match the Medicaid baseline rates. Changes to the baseline outside of the annual Medicare Advantage rate announcement and/or typical Medicaid rate adjustment process would occur only if and when CMS and the State jointly determine the change is necessary to calculate reasonable, appropriate, and attainable payment rates for the Demonstration. Such changes may be based on, the following factors: shifts in enrollment assumptions; changes due to litigation; changes in Federal law and/or State policy; changes in coding intensity, and other factors as determined appropriate and approved by CMS and the State.

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

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

- C. IHSS wage adjustments may change during the Demonstration. Changes to the Medicaid portion of the capitated rate will be done annually by county and may be retroactively applied to account for IHSS wage adjustments that occurred during the calendar year, subject to CMS review.
- D. Changes to the savings percentages would occur if and when CMS and the State 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 Parts A and B baselines or if and when CMS and the State jointly determine the change is necessary to calculate reasonable, appropriate and attainable payment rates for the Demonstration.

## **Appendix 7: Demonstration Parameters**

The purpose of this appendix is to describe the parameters that will govern this Federal-State partnership; the parameters are based upon those articulated by CMS in its January 25, 2012 and March 29, 2012 Health Plan Management System (HPMS) guidance. CMS and California 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. Further detail on each of these areas will be provided in the three-way contract.

### **I. California Delegation of Administrative Authority and Operational Roles and Responsibilities:**

The California Health and Human Services Agency (CHHS) oversees thirteen departments and one board that provide a range of health care services, social services, mental health services, alcohol and drug treatment services, income assistance and public health services to Californians. The California Secretary of the Health and Human Services directly oversees the multiple agencies and offices that will be involved with implementing and monitoring the demonstration.

The California Department of Health Care Services (DHCS) is the single state agency for the Medicaid program, known as Medi-Cal, and is part of CHHS. DHCS will partner with the Department of Managed Health Care (DMHC), California Department of Social Services (CDSS), and the California Department of Aging (CDA) to implement the Demonstration. This collaboration will ensure policy and program development will align with and fully support the integration goals of the demonstration.

The California Medicaid Director will oversee the Demonstration through the Deputy Director of Health Care Delivery Systems, who will report directly to the Medicaid Director on all aspects of the Demonstration. The Deputy Director is responsible for ensuring the overall success of the Demonstration, including IHSS coordination with Participating Plans and monitoring of behavioral health coordination in the Demonstration.

Among partner agencies, DMHC licenses and regulates managed health care plans, conducts routine and non-routine financial and medical surveys, and operates a Help Center where beneficiaries can lodge complaints and get assistance with problems they are having with their plans. Each Participating Plan seeking to participate in the Demonstration may hold a current license issued by the DMHC under the Knox-Keene Act, the California Department of Insurance, or is a county organized health system. To maintain its license, Participating

Plans are required to continuously meet defined regulatory standards, including timely access to care through adequate provider networks, care coordination, continuity of care, financial solvency, and treatment decisions unencumbered by fiscal or administrative considerations.

CDSS provides state-level oversight and fiscal services for the county-administered In-Home Supportive Services (IHSS) Program. CDSS and DHCS will jointly develop processes for ensuring IHSS coordination with Participating Plans. CDA administers Multipurpose Senior Services Program (MSSP), which offers home and community based services and care coordination, and the Health Insurance Counseling and Advocacy Program (HICAP), which offers consumer counseling on Medicare, Medicare supplement policies, health plans, and long-term care insurance. DHCS and CDA will jointly develop processes for ensuring MSSP coordination with Participating Plans.

In addition to state agency staff, the State will use contractors for project management, rate development, data analysis, enrollment planning, demonstration evaluation, provider outreach, and facilitating stakeholder workgroups and external communications.

## **II. Participating Plan Selection**

California, in consultation with CMS, drafted a Request for Solutions that included all of the California and CMS requirements to become a Prime Contractor Plan under this Demonstration. California and CMS engaged in a joint selection process that considered previous performance in Medicare and Medi-Cal and ensured that bidders met CMS' requirements, as specified in this MOU.

The State selection criteria included the following mandatory qualifications:

- a. Applicant has a current Knox Keene Act License or is a county organized health system.
- b. Applicant is in good financial standing with DMHC.
- c. Applicant has experience operating a Medicare Dual Eligible Special Needs Plan (D-SNP) in the county in which it is applying in the last three years, or applicant has not operated a D-SNP in the county in which it is applying in the last three years but agrees to work in good faith to meet all D-SNP requirements by the time the Demonstration begins.
- d. Applicant has a current Medi-Cal contract with DHCS. Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals.
- e. Applicant has listed all sanctions and penalties taken by Medicare or a state of

California government entity in the last five years.

- f. Applicant is not under sanction by Centers for Medicare & Medicaid Services within California.
- g. Applicant currently holds, or will work in good faith to achieve National Committee for Quality Assurance (NCQA) Managed Care Accreditation by the end of the third year of the Demonstration.
- h. Applicant will provide complete and accurate encounter data to support the monitoring and evaluation of the Demonstration.
- i. Applicant has certified that it intends to fully comply with all state and Federal disability accessibility and civil rights laws, including but not limited to the ADA and the Rehabilitation Act of 1973.
- j. Applicant has demonstrated its establishment of a local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders regarding the development, implementation, and continued operation of the Demonstration.

The State evaluated the responses to the Request for Solutions and identified counties and plans that met the State's criteria.<sup>1</sup> Applicants were also required to meet the Medicare components of plan selection process, including submission of a successful Capitated Financial Alignment Application to CMS, and adherence to annual contractual renewal requirements and guidance updates, as specified in appendix 7.

California applicants were permitted to contract with Medicare Advantage Prescription Drug (MA-PD) plans ("Subcontracted Plans") to offer enrollees multiple plan benefit packages. Prime Contractor Plans are responsible for ensuring that Subcontracted Plans adhere to the Medicare and Medicaid laws and regulations described in this MOU and as articulated in the three-way contracts between CMS, California, and the Prime Contractor Plan, as indicated in the body of the MOU. No additional Participating Plans will be added after completion of the initial plan selection process unless CMS and the State both agree to reconsider to address access to care issues.

These selections are contingent on the selected entities passing a CMS and State sponsored readiness review. Upon final selection, the State and CMS will ultimately enter into a three-way contract with selected Prime Contractor Plans.

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<sup>1</sup> State selected plans and more detail on the related procurement documents can be reviewed at: <http://www.dhcs.ca.gov/Pages/DualsDemonstration.aspx>

Any future revisions to the final selections will be presented to CMS for prior approval.

### **III. State Level Enrollment Operations Requirements**

- a. Eligible Populations/Excluded Populations - As described in the body of the MOU.
- b. Enrollment and Disenrollment Processes - All enrollments and disenrollment-related transactions will be processed through the Medi-Cal Eligibility Data System (MEDS), except those transactions related to non- Demonstration plans participating in Medicare Advantage. Medi-Cal operates a Health Care Options program via an enrollment broker contract for Two-Plan and Geographic Managed Care counties (see Appendix 3). This supports the enrollment process. California will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system via a third party CMS designates to receive such transactions. Medi-Cal will share enrollment, disenrollment, and opt-out transactions with Participating Plans.
  - i. In San Mateo and Orange counties, the Participating Plans will submit enrollment transactions directly to CMS or via the third party processor that CMS designates, consistent with how Medi-Cal enrollment is processed today.
- c. Uniform Enrollment and Disenrollment Letter and Forms - Letters and forms will be made available to stakeholders when they are completed and agreed to by both CMS and California.
- 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, or the first day of the month following the month in which the beneficiary is eligible, as applicable for an individual enrollee. Passive enrollment is effective not sooner than 60 days after beneficiary notification of the right to select a Participating Plan.
  - i. Participating Plans will be required to accept enrollments beginning no earlier than August 1, 2013 for an effective date of no sooner than October 1, 2013 and begin providing coverage for enrolled individuals on the effective date.
  - ii. Beneficiaries who are eligible for passive enrollment into the Demonstration will receive an informational notice about the

Demonstration and process of passive enrollment 90 days prior to the effective date of enrollment.

- iii. Sixty (60) days prior to the effective date of enrollment, beneficiaries will receive a notice that identifies the Participating Plan in which the beneficiary would be enrolled unless he/she selects another plan or the option to opt out of the Demonstration. The notice will include an enrollment packet with information about other health plan choices in their county.
- iv. A third notice sent 30 days prior to effective enrollment date will remind beneficiaries of their options and the assigned Participating Plan for individuals who do not select a plan or do not opt out. California will proceed with passive enrollment into the identified plan for beneficiaries who do not make a different choice or opt out. CMS communication on the Demonstration will be coordinated with the State.
  - 1. Enrollment materials will be written at no more than a sixth-grade reading level in the threshold languages and available upon request in alternative formats.
  - 2. This information will include, at a minimum: how the beneficiary's system of care would change, when the changes will occur, how to contact the State's enrollment broker for questions or assistance with choosing a Participating Plan, and how to opt out of the Demonstration.
- v. Requests to change Participating Plans, opt out, or enroll with a Participating Plan will be accepted at any point after the notification of passive enrollment has been provided and are effective on the first of the following month. Any time an individual requests to opt out of the Demonstration, the State will send a letter confirming the opt-out and providing information on the benefits available to the beneficiary once they have opted out. Any time an individual requests to disenroll from the Demonstration, the State will send a letter confirming the disenrollment and providing information on the benefits available to the beneficiary once they have disenrolled from the Participating Plan.
- vi. The State will conduct passive enrollment periods specific to each county for those beneficiaries who have not made a plan selection as described below. Beneficiaries included in Medicare reassignment or currently

enrolled in a Medicare Advantage Plan will be eligible for passive enrollment as detailed in Appendix 7, section II.D.vii and Appendix 7, section II.D.viii, immediately following this section. The enrollment periods below are only applicable to beneficiaries in Medicare fee-for-service.

1. Alameda County: Beneficiaries that have enrolled in Medi-Cal managed care will have an enrollment effective date of no sooner than October 1, 2013. Beneficiaries in FFS Medi-Cal will have an enrollment effective date on the 1st of the month of birth, beginning no sooner than October 1, 2013 and ending after twelve months. Beneficiaries with a birth month of January 2014 will be enrolled into the plans on February 1, 2014.
2. Riverside County: Beneficiaries that have enrolled in Medi-Cal managed care and beneficiaries in FFS Medi-Cal will have an enrollment effective date on the 1st of the month of birth, beginning no sooner than October 1, 2013 and ending after twelve months. Beneficiaries with a birth month of January 2014 will be enrolled into the plans on February 1, 2014.
3. San Bernardino County: Beneficiaries that have enrolled in Medi-Cal managed care and beneficiaries in FFS Medi-Cal will have an enrollment effective date on the 1st of the month of birth, beginning no sooner than October 1, 2013 and ending after twelve months. Beneficiaries with a birth month of January 2014 will be enrolled into the plans on February 1, 2014.
4. San Diego County: Beneficiaries that have enrolled in Medi-Cal managed care and beneficiaries in FFS Medi-Cal will have an enrollment effective date on the 1st of the month of birth, beginning no sooner than October 1, 2013 and ending after twelve months. Beneficiaries with a birth month of January 2014 will be enrolled into the plans on February 1, 2014.
5. Santa Clara County: Beneficiaries that have enrolled in Medi-Cal managed care will have an enrollment effective date no sooner than October 1, 2013. Beneficiaries in FFS Medi-Cal will have an enrollment effective date on the 1st of the month of birth,

beginning no sooner than October 1, 2013 and ending after twelve months. Beneficiaries with a birth month of January 2014 will be enrolled into the plans on February 1, 2014.

6. San Mateo: Beneficiaries will have an enrollment effective date of no sooner than October 1, 2013.
7. Orange: Beneficiaries will have an enrollment effective date on the 1st of the month of birth, beginning no sooner than October 1, 2013 and ending after twelve months. Beneficiaries with a birth month of January 2014 will be enrolled into the plans on February 1, 2014.
8. Los Angeles: California will propose an enrollment approach for eligible beneficiaries within 30 days of the signing of the MOU. It will start with a three-month opt-in only period; with passive enrollment phased over twelve months starting January 1, 2014. Enrollment will not exceed 200,000 individuals. The proposal will be posted for a 30 day public comment period before finalization, and is subject to CMS approval. Enrollment will begin no sooner than October 1, 2013.
9. MSSP: Beneficiaries enrolled in MSSP, in the seven counties with passive enrollment beginning October 2013, will have an enrollment effective date no sooner than October 1, 2013. LA County will enroll all MSSP beneficiaries January 1, 2014. Passive enrollment based on MSSP status supersedes the county-specific phase in detailed above.

The effective dates above are subject to Participating Plans meeting CMS and State requirements, including Plans' capacity to accept new enrollees. Additionally, the rules for passive enrollment below supersede the phase in timelines detailed above. Effective no sooner than October 1, 2013, beneficiaries in the participating counties may opt in at any time prior to the phase-in dates.

- vii. Beneficiaries who otherwise are included in Medicare reassignment to a different Medicare Prescription Drug Plan (PDP) effective January 1 of a given year (whether due to their previous year's PDP's premium increase or because their current PDP or Medicare Advantage Prescription Drug Plan (MA-PD) is terminating) will be eligible for passive enrollment, with

an opportunity to opt out, into a Participating Plan. For example, beneficiaries identified as requiring reassignment effective January 1, 2014, will be eligible for passive enrollment into a Participating Plan effective January 1, 2014, unless eligible for passive enrollment by birth month in 2013. Those reassigned to a new PDP on January 1, 2013, will be eligible for passive enrollment into a Participating Plan effective January 1, 2014.

- viii. Beneficiaries in Medicare Advantage will have an enrollment effective date of January 1, 2014.
- ix. IHSS recipients who met their share of cost on the first day of the month, in the fifth and fourth months prior to their effective passive enrollment date for the Demonstration will be eligible for passive enrollment as described in the body of the MOU. If these enrollees do not meet their share of cost, they will be disenrolled effective the following month. For those who are disenrolled, beneficiaries may only opt in the following January 1st if they meet the fifth and fourth month criteria described above.
- e. No enrollments will be accepted within 6 months (or less) of the end of the Demonstration.
- f. For the counties with multiple plan benefit packages, California will finalize an “intelligent assignment” process for determining passive enrollment (that prioritizes continuity of care) into a specific Participating Plan, subject to CMS review and approval. The intelligent assignment process will use the most recent 12 months of Medicare and Medi-Cal claim history data to identify the individual’s most frequently utilized providers. The providers may be individual physicians, medical groups and/or clinics. The process will also determine if an individual is currently residing in a long-term care facility to ensure that the individual will not need to change facilities. The individual’s providers will be matched to providers in the Participating Plan network. A Participating Plan will be selected that best meets the current circumstances of the individual.
- g. Only beneficiaries subject to passive enrollment and those residing in certain rural zip codes in San Bernardino County who can opt-in (refer to MOU, section III.C) will be mailed enrollment materials.
  - i. Beneficiaries residing in rural zip codes with the option to enroll, as indicated in MOU, section III.C, will receive informational notice about

the Demonstration no less than 45 days prior to the Demonstration start. A choice packet for opting-in and informational materials will be included in this mailing. They will not receive notice of passive enrollment.

- ii. The enrollment approach proposal for Los Angeles, as indicated in section III.d.vi.8 of this appendix, will include a process for providing a choice packet for opting-in and informational materials to beneficiaries during the opt-in period in 2013.
- h. Passive enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto-assignment for individuals with the Part D Low Income Subsidy.
- i. California or Health Care Options 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 Demonstration enrollment will be referred to either Health Care Options or Health Plan of San Mateo or Orange County Health Authority, as applicable, depending on geographic location of the beneficiary, for customer service and enrollment support.
- j. CMS and the State will jointly approve all Demonstration notices to ensure complete and accurate information is provided in concert with other Medicare communications, such as Medicare & You handbook. CMS may also send a jointly-approved notice to individuals, and will coordinate such notice with any State notice(s).
- k. State and CMS systems will be reconciled on a timely basis to resolve discrepancies between systems.

#### **IV. State Level Delivery System Requirements**

- a. Provision of Integrated Care Services
  - i. State Requirements for Care Coordination –
    - 1. Participating plans shall have care coordination and management activities that reflect a member-centered, outcome-based approach

Welfare and Institutions Code section 14182.17(d)(2)(I)(4). Care coordination services will be available to all enrollees.

Specifically, this care coordination will:

- Follow the beneficiary's direction about the level of involvement of his or her caregivers or medical providers.
- Span medical and LTSS care systems, with a focus on transitions between service locations.
- Consider behavioral health needs and coordinate with county services.
- Develop individualized care plans with enrollees.
- Be performed by nurses, social workers, primary care providers, if appropriate, other medical or long-term services and supports professionals and health plan care coordinators, as applicable.
- Ensure access to appropriate community resources and monitor skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between the facilities and community.

2. The State has developed, in consultation with stakeholders, comprehensive Care Coordination standards for which Participating Plans must show compliance during the readiness review. These standards cover the Care Coordination process from enrollment and assessment of a beneficiary's health and functional status, to the delivery of basic and complex case management services as needed. These standards also include requirements for the development of referral processes for behavioral health, IHSS, and other home- and community based services.

ii. State Requirements for an Interdisciplinary Care Team – Participating Plans will offer an Interdisciplinary Care Team (ICT) for each enrollee, as necessary, which will be built around the enrollee and ensure the integration of the member's medical, behavioral health, and LTSS care. Teams may include the enrollee, family members and other caregivers, designated primary physician, nurse, case manager, social worker, patient

navigator, county IHSS social worker, IHSS providers, MSSP coordinator, pharmacist, behavioral health service providers, and other professional staff within the provider network. The ICT will be person-centered: built on the enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity. The enrollee can choose to limit or disallow altogether the role of IHSS providers, family members and other caregivers on the team. Participating Plans will require that each ICT has a composite of members that are knowledgeable on key competencies including, but not limited to: person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles.

- iii. State Requirements for member Assessment, Care Planning, Monitoring and Continuous Improvement
  1. Risk Stratification: At the time of enrollment, Participating Plans will use a mechanism or algorithm approved by the State and CMS for risk stratification of members. Health plans will review historical Medi-Cal and Medicare data upon enrollment to prioritize assessment and care planning.
  2. Health Risk Assessment (HRA): The health risk assessment will be performed in accordance with all applicable Federal and state laws Welfare and Institutions Code section 14182.17(d)(2). The HRA will be the starting point for the development of the individual care plan. This assessment will serve as the basis for further assessment needs that may include, but are not limited to, mental health, substance use, chronic physical conditions, incapacity in key activities of daily living, dementia, cognitive status, and the capacity to make informed decisions. Plans shall use an HRA survey tool that must be approved by the state and CMS:
    - Participating plans will provide enrollees with an in-depth assessment process to identify primary, acute, long-term supports and services, and behavioral health and functional needs. This assessment will incorporate standard assessment questions, such as SF-12, specified by the State.
    - The Participating Plan shall assess the enrollee's needs and

health or functional status, and the preference of the enrollee, when determining how the HRA will be completed. The majority of HRAs will be completed in person or by telephone. The State will work with stakeholders to propose limited circumstances in which the initial HRA and reassessments may be completed by mail or web-based mail. This proposal will be posted for public comment for at least 14 days and is subject to CMS approval. To allow adequate time to assess plan readiness, the standards for how the HRA will be completed must be finalized by April 30, 2013.

- Participating plans will contact enrollees within the required assessment timeframes through a variety of communication methods that will include repeated documented efforts to contact each enrollee, such as letter followed by at least two phone calls or in-person visits.
  - i. For enrollees identified by the risk-stratification mechanism or algorithm as higher-risk, the assessment tool shall be used within 45 calendar days of enrollment. “Higher-risk” for risk-assessment purposes means enrollees who are at increased risk of having an adverse health outcome or worsening of their health and functional status if they do not receive their initial contact by the Participating Plan within 45 calendar days of enrollment.
  - ii. For enrollees in nursing facilities or those identified as lower-risk for the purpose of developing individual care management plans, the assessment shall be used within 90 calendar days of enrollment.
- To facilitate identification of individual enrollee needs, the assessment process will incorporate review of all Medicare and Medi-Cal utilization data (including Medicare Parts A, B, and D, and Medi-Cal IHSS, Multipurpose Senior Service Program (MSSP), Skilled Nursing Facility (SNF), and behavioral health pharmacy data), as well as results of

previously administered assessments, and other medical, IHSS, nursing facility, and behavioral health assessments

- For all enrollees, the assessment process will, at a minimum, identify:
  - i. Referrals to appropriate LTSS and home- and community-based services, such as behavioral health, IHSS, Community-Based Adult Services (CBAS), MSSP, personal care services, and nutrition programs.
  - ii. Caregivers and authorized representatives who may be involved in the individual care plan per the enrollees' approval.
  - iii. The need for facilitating timely access to primary care, specialty care, DME, medications, and other health services needed by the enrollee, including the need for referrals to resolve any physical or cognitive barriers to access.
  - iv. The need for facilitating communication among the Member's health care providers, including mental health and substance use providers when appropriate.
  - v. The need for providing other activities or services needed to assist enrollees in optimizing their health or functional status, including assisting with self-management skills or techniques, health education, and other modalities to improve health or functional status.
  - vi. Enrollees who need more complex case management, such as discharge planning.
- Reassessments will be conducted at least annually, within 12 months of last assessment, or as often as the health of the enrollee requires. The Participating Plan shall consider the reason why the assessment needs to be updated, the enrollee's needs and health or functional status, and the

preference of the enrollee when determining the mode by which updates will be completed.

3. Individual Care Plan: An individualized care plan will be developed for each enrollee that includes member goals and preferences, measurable objectives and timetables to meet medical needs, behavioral health and long-term support needs. It must include timeframes for reassessment. Participating Plans are required to engage enrollees and/or their representatives to play an active role in designing their care plans. Service coordination for behavioral health is discussed further in section IV.D.iv of this appendix.
  4. Person-Centered Medical Homes and Interdisciplinary Care Teams (ICT): Participating Plans will offer person-centered medical homes with interdisciplinary care teams, which will be built around the enrollee. Decisions will be made collaboratively and with respect to the individual's right to direct care. ICTs may include the designated primary physician, nurse case manager, social worker, patient navigator, pharmacist, and behavioral health service providers. The beneficiary can choose to limit or disallow altogether the role of IHSS providers, family members, and other caregivers on the care team
  5. Universal LTSS Assessment Process in 2015: The state will design, develop and test a universal assessment process, including a universal assessment tool, in 2015 for long-term services and supports. The process will be developed with stakeholder input, and will be initially be tested by a specified group of beneficiaries, in a limited number of counties. The development, testing, and implementation of the tool will subject to the provisions of Welfare and Institutions Code section 14186.36.
- iv. State Requirements for Integrated Primary Care and Behavioral Health Care – Participating Plans will be responsible for providing enrollees access to mental health and substance use services covered by Medicare and Medicaid with a focus on the recovery model. Some specialty mental health and substance use services financed and administered by county mental health and substance use agencies will not be included in the capitated payment made to the Prime Contractor Plans. Participating Plans

will have a local Behavioral Health Memorandum of Understanding (BH-MOU) and may have contracts with county agencies to ensure seamless access and delivery of services to enrollees.

1. Participating Plans will be responsible for all Medicare and Medicaid mental health and substance use benefits except for those listed in the table below. Prime Contractor Plans will be responsible for coordinating with their local county agency(ies) to provide seamless access to these specialty mental health and substance use services for individuals who meet the medical necessity criteria.
2. The Specialty Mental Health Services (1915(b) waiver services) and Drug Medi-Cal services listed in the table below will be financed and administered by county agencies and excluded from the capitation payment to the Prime Contractor Plans:

**Table X: County Administered Medi-Cal Mental Health and Substance Use Benefits**

<b>Specialty Mental Health Services not covered by Medicare (1915b waiver services)</b>	<b>Drug Medi-Cal benefits</b>
<ol style="list-style-type: none"> <li>1. Portion of psychiatric inpatient hospital services not covered by Medicare as the primary coverage/payer</li> <li>2. Mental health services (rehabilitation and care plan development)</li> <li>3. Medication support services (instruction in the use, risks and benefits of alternatives for medication and plan development)</li> <li>4. Day treatment intensive</li> <li>5. Day rehabilitation</li> <li>6. Crisis intervention</li> <li>7. Crisis stabilization</li> <li>8. Adult Residential treatment services</li> <li>9. Crisis residential treatment services</li> <li>10. Targeted Case Management</li> </ol>	<ol style="list-style-type: none"> <li>1. Levoalphacetylmethadol (LAAM) and methadone maintenance therapy</li> <li>2. Day care rehabilitation</li> <li>3. Outpatient individual and group counseling</li> <li>4. Perinatal residential services</li> <li>5. Naltrexone treatment for narcotic dependence</li> </ol>

3. Integration of behavioral health services –Participating Plans and county agencies will work together to coordinate care and develop strategies for shared accountability through local Behavioral Health Memorandum of Understanding (BH-MOU) and contracts. BH-MOUs, which will be reviewed by CMS and the State during the readiness review process and in place by October 1, 2013, will include policies and procedures for the following categories: 1) service coordination; 2) administrative coordination; 3) information exchange; 4) performance tracking measures; and 5) shared financial accountability.
  - **Service coordination** – Participating Plans will include comprehensive screening for behavioral health as part of the health risk assessment and individualized care plan, further described in section IV.D.iii of this appendix. The BH-MOU will have clear policies and procedures that describe:
    1. Delineation of clinical responsibilities and provider contracting responsibilities;
    2. Point of contact within the Participating Plan and county entity(ies) and the various communications processes to address issues related to clinical coordination, including pharmaceutical coordination.
    3. A process for resolving disagreements related to clinical decision making.
    4. Standardized approaches to screening, referral, and linkages and coordination for mental health and substance use services with timelines specified.
    5. Standardized approaches to screening, referral, and linkages and coordination for substance use services with timelines specified.
    6. Processes for clinical consultation and coordination of care plans.

- **Administrative coordination** – BH-MOUs will have clear policies and procedures that describe:
  1. Clear delineation of administrative responsibilities and provider contracting responsibilities.
  2. Point of contact within the Participating Plan and county entity(ies) and the various communications processes to address issues related to administrative coordination.
  3. A process for conducting an annual review and evaluation of the administrative management programs.
  4. A process for demonstrating how administrative problem identification and resolution occurs.
  
- **Information exchange** – CMS and California will describe how the state will monitor progress regarding information sharing in the three way contract with the Prime Contractor Plan. Participating Plans and county agencies will develop data sharing mechanisms, to the greatest extent practicable under State and Federal privacy laws, to share accurate and timely information to inform care delivery. BH MOUs will have clear policies and procedures that describe:
  1. How information will flow between the county departments and Participating Plan that meets HIPAA and other privacy laws.
  2. Process for the exchange of medical records information that maintains confidentiality in accordance with Federal and State laws and regulations.
  
- 4. **Medical Necessity** – To determine responsibility for covering Medi-Cal specialty mental health services, Participating Plans and counties will follow the medical necessity criteria for specialty mental health 1915(b) waiver services described in Title 9, California Code of Regulations (CCR), sections 1820.205, 1830.205, and 1830.210. The outpatient criteria can be summarized as the following three criteria: 1) Diagnosis – one or more of the specified diagnosis; 2) Impairment – significant impairment or probability of deterioration of an important area of

life functioning, or; 3) Intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to a physical health care based treatment.

5. To determine medical necessity for Drug Medi-Cal Substance Use Services, Participating Plans and counties will follow Title 22, California Code of Regulations section 51303 and 54301. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Title 22 section 51159.
  6. Performance measures – Prime Contractor Plans will be required to report on measures related to behavioral health services, including those financed and administered by county agencies. The combined set of core metrics and State specified measures are described in section XI of this appendix.
  7. Shared financial accountability – As per Appendix 6.
- v. State Requirements for Coordination Between In Home Supportive Service (IHSS) and Participating Plans:
1. Participating Plans shall ensure access to, provision of, and payment for IHSS for individuals who meet the eligibility criteria for IHSS.
  2. Participating Plans shall maintain enrollees’ right to be the employer, to select, engage, direct, supervise, schedule, and terminate IHSS providers.
  3. Participating Plans shall assume all financial liability for payment of IHSS services for enrollees receiving services under this Demonstration.
  4. Participating Plans and counties shall coordinate to facilitate IHSS participation on the Interdisciplinary Care Team (ICT), as needed unless the enrollee objects, that shall include county IHSS social workers, enrollees and their representatives, Participating Plans, and may include IHSS providers and others as applicable, for individual care plan development. Participating Plans and counties shall develop a detailed plan regarding the coordination and

integration of IHSS which shall include, but not be limited to, provision of intake activities and redeterminations by IHSS social workers using the current IHSS Assessment process and allocation of IHSS hours according to Hourly Task Guidelines. This plan shall also include a framework for referrals to IHSS, coordination for a change of condition, discharge planning, joint reassessments, and the ICT. The ICT is described in additional detail in section IV.A.ii.

5. State law (Welfare and Institutions Code Section 14186.35) mandates that Prime Contractor Plans will enter into a Memorandum of Understanding with participating counties to have counties perform the following:
  - Assess, approve and authorize each IHSS recipient's initial and continuing need for services. Assessments shall be shared with Participating Plans and ICTs, and additional input from the ICT may be received and considered by the county.
  - Enroll IHSS providers, conduct provider orientation, and retain enrollment documentation consistent with state law.
  - Conduct criminal background checks on all potential providers of IHSS and exclude providers consistent with statutory provisions.
  - Provide assistance to IHSS recipients in finding eligible providers through the establishment of a registry as well as provide training for recipients, or may contract this responsibility to a county entity.
  - Continue to provide their local public authority with referral information of all IHSS providers for the purposes of wages and benefits until the transition to the California In-Home Supportive Services Authority (Statewide Authority) is complete.
  - Pursue overpayment recovery as set forth in Welfare and Institutions Code Section 12305.83.

- Perform quality assurance activities including routine case reviews, home visits, and detecting and reporting suspected fraud pursuant to state law.
- Share confidential data regarding IHSS authorized hours and services as necessary for the Demonstration.
- Appoint an advisory committee of not more than 11 people, and no less than 50 percent of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.
- Continue to perform other functions necessary for the administration of the IHSS program pursuant to State law and regulations.

6. Under a separate Memorandum of Understanding between the Prime Contractor Plan and local Public Authority, local Public Authorities in the participating counties will have responsibilities for the following:

- Conduct criminal background checks on all potential providers and exclude certain providers consistent with state law.
- Provide assistance to IHSS recipients in finding eligible providers through the establishment of a provider registry as well as provide training for providers and recipients.
- Operate as the employer of record for IHSS personnel, as defined in statute, until this function has been transitioned to the California In-Home Supportive Services Authority.

b. State Requirements for Beneficiary Protections: Several key beneficiary protections for demonstration participants are included in SB 1008 (Chapter 33, Statutes of 2012), in Welfare and Institutions Code Section 14182.17, as specified below. Additional beneficiary protections for Demonstration participants required by Medicare and Medicaid are articulated in the MOU, Section III.E.

i. Continuity of Care. The State will require Participating Plans to follow all

continuity of care requirements established in current law, as applicable for Medi-Cal beneficiaries and covered services, where applicable under the Demonstration, as described further in section V.F.

- ii. Care Coordination. Participating Plans shall have care coordination and management activities that reflect a member-centered, outcome-based approach established in current law as further described in section IV.A.
- iii. Self-Directed Care. Participants in the Demonstration will continue to have the choice to self-direct their care Welfare and Institutions Code section 14186(b)(5). Specifically, when appropriate, participants will:
  - Decide whether, how and what long-term services and supports to receive to maintain independence and quality of life, as authorized by a physician or other appropriate medical professional, if the participant is an IHSS recipient, and within state rules.
  - Select their health care providers in the Participating Plan network (or as allowed for by continuity of care provisions) and control care planning and coordination with their health care providers.
  - Have access to services that are culturally, linguistically, and operationally sensitive to meet their needs, and that improve their health outcomes, enhance independence, and promote living in home and community settings.
  - Be able to hire, fire, and supervise their IHSS provider, as currently allowed in California's IHSS program.
- iv. Notification and Enrollment Processes. The State will ensure beneficiaries are meaningfully informed about their care options with sufficient time to make informed choices Welfare and Institutions Code section 14182.17(d)(1). Additional detail on the Demonstration enrollment operations requirements, including California and CMS coordination of enrollment notices, is further described in section III. In addition, the State will also:
  - Develop and implement an outreach and education program for beneficiaries to inform them of their enrollment options

and rights, including specific steps to work with consumer and beneficiary community groups.

- Ensure that Participating Plans and their provider networks are able to provide communication and services to dual eligible beneficiaries in alternative formats that are culturally, linguistically, and physically appropriate through means including, but not limited to the following: assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations.
  - Ensure that Participating Plans inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures that are offered by the plan or are available through the Medi-Cal program.
  - Contract with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting dual eligible beneficiaries in understanding their health care coverage options and accessing their care.
  - The enrollment contractor will recognize, as under current state law, a caregiver, family member, conservator or legal services advocate who is recognized as an authorized representative by any program the beneficiary is receiving.
- v. Health-Risk Assessment. The State will require that Participating Plans perform an assessment process that is performed in accordance with all applicable Federal and state laws, and evaluates members' medical, long-term care and behavioral health needs Welfare and Institutions Code section 14182.17(d)(2). The HRA tool and process is described in section IV.A.III.
- vi. Network Adequacy. Network adequacy standards are described in section IV.C. Under these standards, beneficiaries will have a choice of providers among a broad network of primary care providers, behavioral health providers, specialists, ancillary providers, hospitals, pharmacists, and

providers of long-term services and supports. Welfare and Institutions Code section 14182.17 (d)(1)(I)(5).

vii. Appeals and Grievances. Grievances and appeals processes are described in sections VIII and IX. Under no circumstance shall the process for appeals be more restrictive for Medi-Cal services than what is required under the Medi-Cal program. The Demonstration appeals process shall not diminish the current grievance and appeals rights of IHSS recipients. Enrollees will receive notices of their appeals rights in a format and language understandable and accessible to them. On all notices that deny, reduce or otherwise amend a request for services, Participating Plans are required to notify the beneficiary of the right to appeal the decision Welfare and Institutions Code section 14182.17(d)(7). Specifically, California will require that health plans provide a grievance and appeals process that:

- Provides a clear, timely, and fair process for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits, as specified by the state. Each participating plan shall have a grievance process that complies with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.
- Complies with Medicare and Medi-Cal grievance and appeal processes, as applicable.

viii. Quality Monitoring. California and CMS shall monitor the participating plans' performance and accountability for providing beneficiaries seamless access to medically necessary services. Unified quality metrics and reporting requirements are described in section XI. In addition to these requirements, California will:

- Summarize the Participating Plan performance annually to the legislature, including financial reviews and independent audits performed by the Department of Managed Health Care.
- Monitor utilization of covered services on a quarterly basis.
- Develop requirements for Participating Plans to solicit

stakeholder and member participation in advisory groups for the planning and development of the demonstration.

- c. Network Adequacy –Medi-Cal standards shall be utilized for long term services and supports, as described below, or for other services for which Medi-Cal is exclusive, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medi-Cal standards 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 Medi-Cal standards.

California has developed transition requirements that specify continuation of existing providers (see section V). Both the State and CMS will monitor access to services through survey, utilization, and complaints data to assess needs to Participating Plan network corrective actions. Participating Plans are responsible for access to services for beneficiaries. In addition to these protections, minimum LTSS standards for Participating Plans are below. CMS and the State 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.

- i. Specifically, CMS and the state will require that Participating Plans:
  - Meet enrollees' needs by contracting with a sufficient number of health facilities and providers that comply with applicable state and Federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.
  - Maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients, which shall be made available to beneficiaries, at a minimum, by phone, written material, and Internet web site, upon request.
  - Maintain an appropriate provider network that includes an adequate number of specialists, primary care physicians, hospitals, long-term care providers and accessible facilities within each service area, per applicable Federal and state rules.

- Contract with safety net and traditional providers, as defined state regulations, to ensure access to care and services.
- Employ care managers directly or contract with care management organizations in sufficient numbers to provide coordinated care services for long-term services and supports as needed for all members.

ii. Medi-Cal standards require the following:

- IHSS: Prime Contractor Plan Plans are required to have an IHSS Memorandum of Understanding (IHSS MOU) or contract with their respective county social services agency regarding the provision of IHSS for their enrollees. The agreement will address topics including, but not limited to:
  1. County eligibility assessment and authorization of IHSS hours.
  2. Coordination of IHSS delivery with other Participating Plan covered benefits
  3. Provider enrollment
  4. Background checks and registry services
  5. Data sharing

Prime Contractor Plans must have a contract with the Department of Social Services to address topics including, but not limited to:

1. Pay wages to IHSS providers and perform provider payroll obligations and related technical assistance.
2. Share beneficiary and provider data. Data shall be provided and shared between county agencies, Participating Plans, and State Department of Social Services, as appropriate under state law and applicable beneficiary protections.
3. Establish a referral process, care coordination team processes, and other coordination that needs to be established or enhanced to promote the integration of the IHSS Program into managed care.

As discussed under section V.B describing supplemental and flexible benefits, the State will work with the Participating Plans and counties to develop a process for administration and oversight of additional personal care hours.

- iii. Nursing facility: At their discretion, and according to state policy set forth regarding Demonstration plan readiness, Participating Plans may contract with licensed and certified nursing facilities, to access all levels of care in covered zip codes of the Demonstration and, to the extent possible, in adjacent zip code areas. Given the continuity of care provisions, it is unlikely enrollees will be required under the Demonstration to change facilities for the first 12 months.
- iv. Multipurpose Senior Services Program (MSSP) on site services: Prime Contractor Plans must contract with all MSSP organizations in good standing with the California Department of Aging (CDA) in the covered zip codes of the Demonstration. Prime Contractor Plans must allocate to MSSP providers the same level of funding those providers would have otherwise received under their MSSP contract with CDA until March 31, 2015 or 19 months after the commencement of beneficiary enrollment into a Participating Plan, whichever is later.
- v. CBAS: Prime Contractor Plans must contract with all willing, licensed, and certified CBAS centers that are located in the covered zip codes areas and in adjacent zip code areas, not more than 60 minutes driving time away from the enrollee's residence. The transportation service may only exceed 60 minutes when necessary to ensure regular and planned attendance at the CBAS center and when there is documentation in the participant's health record that there is no medical contraindication under Welfare and Institutions Code section 14550(h). If a CBAS center does not exist in the targeted zip codes, does not have service capacity, or does not have cultural competence to service specific Participating Plan enrollees, then Participating Plans must coordinate IHSS and home health care services for eligible enrollees.

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

For any covered services for which Medicare requires a more rigorous network adequacy standard than Medi-Cal (including time, distance, and/or minimum

number of providers or facilities), the Participating Plans 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. California and CMS may grant exceptions to these general rules to account for patterns of care for Medicare-Medicaid beneficiaries, but will not do so in a manner that will dilute access to care for Medicare-Medicaid beneficiaries. Networks will be subject to confirmation through readiness reviews and annual reporting.

- d. Solvency—Participating Plans will be required to meet solvency requirements:
  - i. Consistent with section 1903(m) of the Social Security Act, and regulations found at 42 CFR 43 and 438.116, and
  - ii. California’s Knox-Keene Health Care Service Plan Act of 1975 as amended, (Health and Safety Code Section 1340, et seq), as implemented by California’s Department of Managed Health Care, and
  - iii. As specified in the California Request for Solutions procurement, including:

- 1. Financial Viability

- Minimum Required Tangible Net Equity

- The Request for Solutions required Participating Plan applicants to demonstrate and maintain minimum required tangible net equity requirements set forth in Title 28, California Code of Regulations, Section 1300.76. The three-way contract will articulate a process for corrective action should the Participating Plan not meet TNE in any given period. Participating Plans must provide assurances satisfactory to the State showing that its provision against the risk of financial instability is adequate to ensure that its enrollees will not be liable for the entity’s debts if the entity becomes insolvent.

- Working Capital Requirements

- The Participating Plan receiving Demonstration enrollment, must demonstrate and maintain adequate working capital as

required in California Health and Safety Code Section 1375.1, which requires consideration of:

The financial soundness of the plan's arrangements for health care services and the schedule of rates and charges used by the plan;

The adequacy of working capital; and

Arrangements with providers for the provision of health care services.

Throughout the term of the Contract, the Prime Contractor Plan must maintain adequate working capital.

## 2. Financial Stability

### - Financial Stability Plan

Throughout the term of the contract, the Prime Contractor Plans, and any Subcontracted Plans receiving Demonstration enrollment, must:

- i. Remain financially stable;
- ii. Maintain adequate protection against insolvency in an amount determined by the Department of Managed Health Care [Title 28, California Code of Regulations, Section 1300.75.1.]

(a) A Participating Plan shall demonstrate fiscal soundness and assumption of full financial risk as follows:

- (1) Demonstrate through its history of operations and through projections (which shall be supported by a statement as to the facts and assumptions upon which they are based) that the plan's arrangements for health care services and the schedule of its rates and charges are financially sound, and provide for the achievement and

maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.

(2) Demonstrate that its working capital is adequate, including provisions for contingencies.

(3) Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the contract period for which payment has been made, the continuation of benefits to subscribers and enrollees who are confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for services rendered.

(b) As a part of its program pursuant to subsection (a), a plan may obtain insurance or make other arrangements:

(1) For the cost of providing to any enrollee covered health care services the aggregate value of which exceeds \$5,000 in any year;

(2) For the cost of covered health care services provided to its enrollees other than through the plan because medical necessity required their provision before they could be secured through the plan; and

(3) For not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year.

- Insolvency Reserve

The Insolvency Reserve shall be defined by DMHC, consistent with existing rules regarding minimum required

Tangible Net Equity (TNE).

1. According to Title 28, California Code of Regulations, Section 1300.76(e), California defines TNE as net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits.
- e. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts-
    - i. Participating Plans will use procedures consistent with DHCS policy for all of Medi-Cal. DHCS can modify these rules at any time and is required to notify CMS within 90 days of any such changes.
  - f. Credentialing and Recredentialing
    - i. Participating Plans shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of physicians including Primary Care Physicians and specialists in accordance with the DHCS Policy Letter 02-03 (through the Medi-Cal Managed Care Division), Credentialing and Recredentialing, and adhere to managed care standards at 42 CFR 422.204. Participating Plans shall ensure those policies and procedures are reviewed and approved by the plan governing body, or designee. Participating Plans shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body. Note: Counties enroll IHSS providers and conduct criminal background checks on all potential providers and exclude providers consistent with the provisions set for in Welfare and Institutions Code section 12305.81, 12305.86, and 12305.87.

ii. Standards

1. All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medicaid/Medi-Cal programs and a valid National Provider Identifier (NPI) number. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Participating Plans' provider network.
2. Participating Plans shall ensure that all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

iii. Delegated Credentialing

1. Participating Plans may delegate credentialing and recredentialing activities. If Participating Plans delegate these activities, Participating Plans shall comply with California rules of Delegation of Quality Improvement Activities that will be established in the contract with the Participating Plans.

iv. Credentialing Provider Organization Certification

1. Participating Plans and medical providers they contract with (e.g. a medical group or independent physician organization) may obtain credentialing provider organization certification (POC) from the NCQA.

v. Disciplinary Actions

1. Participating Plans shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Participating Plans shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges.

vi. Provider Rights

1. California and Participating Plans shall both implement and maintain a provider appeal process to address provider enrollment issues.
2. Provider appeals for IHSS shall be consistent with current applicable regulations and shall be forwarded to the appropriate county/State agency for resolution. For IHSS, providers have specific appeal rights for being terminated from the program due to a criminal conviction.

vii. Medi-Cal and Medicare Provider Status

1. Participating Plans will verify that their subcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider List. Terminated providers in either Medicare or Medi-Cal or on the Suspended and Ineligible Provider List cannot participate in the Participating Plan's provider network.

viii. Health Plan Accreditation

1. If Participating Plans have received a rating of "Excellent," "Commendable" or "Accredited" from NCQA, the Participating Plans shall be "deemed" to meet the California requirements for credentialing and will be exempt from the California medical review audit of credentialing.
2. Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.

ix. Credentialing of Other Non-Physician Medical Practitioners

1. Participating Plans shall develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse Specialists and Physician Assistants have been verified in accordance with State requirements applicable to the provider category.

## V. Benefits

- a. Medical Necessity Determinations- Medically necessary services will be defined as services:
  - i. (per Medicare) that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y.
  - ii. (per Medi-Cal) Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury as under Title 22 CCR Section 51303.
  - iii. Where there is overlap between Medicare and Medicaid benefits, coverage and rules will be delineated in the three-way contract; the benefits will maintain coverage as outlined in both State and Federal rules. Participating Plans will be required to abide by the more generous of the applicable Medicare and California Medi-Cal standards.
    1. Durable Medical Equipment (DME): The California Administrative Code Title 22, § 51321 is the regulatory authority for DME. Medi-Cal covers DME when provided on the written prescription of a licensed practitioner within the scope of his/her practice. The Medi-Cal definition of medical necessity limits health care services to those necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Medi-Cal rules for coverage of DME will apply, unless Medicare coverage rules would provide greater beneficiary access to DME.
  - iv. Any services will be provided in a manner that is fully compliant with requirements of 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, C, and D, and Medicaid State-plan services, the Participating Plans will be required to provide services as defined in the approved 1115(a) waiver.
- c. The integrated benefit package must include all required Medicare and Medi-Cal-covered benefits, as well as the following additional benefits. The minimum requirements for each benefit will be defined in the three-way contract and will be subject to the Medicare appeals process.

- i. Dental: CMS and California will require that each Participating Plan provide preventive, restorative, and emergency oral health benefits.
  - ii. Vision: CMS and California will require that each Participating Plan provide preventive, restorative, and emergency vision benefits.
  - iii. Transportation: CMS and California will require that each Participating Plans has non-emergency, accessible medical transportation available in sufficient supply so that individuals have timely access to scheduled and unscheduled medical care appointments.
  
- d. Home and Community Based Services (HCBS) – Participating Plans will have discretion to use the capitated payment to offer HCBS, as specified in the member’s Individual Care Plan, as appropriate to address the member’s needs.
  - i. Participating plans are permitted to cover these services for enrollees in order to enhance a member’s care, allowing them to stay in their own homes safely and preventing institutionalization. Participating Plans may list their HCBS in their Member Handbook and/or evidence of coverage. Plans will develop internal procedures as part of developing a care plan that is patient centered.
  - ii. Participating Plans may provide additional personal care services, in addition to IHSS, for members already receiving IHSS, or who are pending a county assessment for IHSS. This benefit shall not be authorized to replace IHSS hours available pursuant to Article 7 of California Welfare and Institutions Code (commencing with Section 12300) of Chapter 3. Participating Plans are to directly assess the authorized hours for this benefit, or may contract with other providers for the assessment.
  - iii. Participating Plans have the discretion to provide additional HCBS, including but not limited to:
    - Supplemental personal care services
    - Supplemental chore
    - Supplemental protective supervision
    - In home skilled nursing care and therapies services for

chronic conditions

- Respite care (in home or out-of-home)
- Nutritional supplements and home delivered meals
- Care in licensed residential care facilities
- Home maintenance and minor home or environmental adaption
- Medical equipment operating expenses and Personal Emergency Response System (PERS)
- Non-medical transportation
- Non-emergency medical transportation

iv. Participating Plans will have discretion to use the capitated payment to offer behavioral health services, beyond those traditionally reimbursed by Medicare, to help prevent enrollees from needing institutionalized care in a hospital, skilled nursing facility or other setting. This flexibility will enable Participating Plans to address gaps in today's continuum of care for Medicare-Medicaid enrollees with mental illness.

- a. Election of Medicare Hospice Benefit - As in Medicare Advantage, if an enrollee elects to receive the Medicare hospice benefit, the enrollee will remain in the Participating Plan, but will obtain the hospice service through the Medicare FFS benefit, and the Participating Plan would no longer receive Medicare Part C payment for that enrollee. Medicare hospice services and all other Original Medicare services would be paid for under Medicare fee-for-service. Participating Plans and providers of hospice services would be required to coordinate these services with the rest of the enrollee's care, including with Medicaid and Part D benefits and any additional benefits offered under the Plans. Plans would continue to receive Medicare Part D payment, for which no changes would occur. Medicaid services and payments for hospice enrollees must comply with the 1115(a) waiver requirements.
- b. Continuity of Care – The State will require Participating Plans to follow continuity of care requirements established in current law.

- i. As part of a process to ensure that continuity of care and coordination of care requirements are met, Participating Plans must perform an assessment process within 90 days of an individual's enrollment in the Participating Plan as described in section IV of Appendix 7.
- ii. Participating Plans must allow enrollees to maintain their current providers and service authorizations at the time of enrollment for:
  1. A period up to 6 months for Medicare services if all of the following criteria are met under Welfare and Institutions Code section 14132.275(k)(2)(A):
    - a. Beneficiary demonstrates an existing relationship with the provider prior to enrollment. This will be established by the Participating Plan by identifying whether the beneficiary has seen the requested out-of-network provider at least twice within the previous 12 months from the date of the request. The link between the newly enrolled beneficiary and the out-of-network provider may be established by the Participating Plan using Medicare data provided by California or by documentation by the provider or enrollee.
    - b. Provider is willing to accept payment from the Participating Plan based on the current Medicare fee schedule; and
    - c. Participating Plan would not otherwise exclude the provider from their provider network due to documented quality of care concerns or State or Federal exclusion requirements.
  2. A period of up to 12 months for Medi-Cal services if all of the following criteria are met under Welfare and Institutions Code section 14182.17(d)(5)(G).
    - a. Beneficiary demonstrates an existing relationship with the provider prior to enrollment. This will be established by the Participating Plan by identifying whether the beneficiary has seen the requested out-of-network provider at least twice within the previous 12 months from the date of the request. The link between the newly enrolled beneficiary and the out-of-network provider may be

established by the Participating Plan using Medi-Cal Fee-For-Service claims data or Medi-Cal managed care encounter data provided by the state or by documentation from the provider or enrollee.

- b. Provider is willing to accept payment from the Participating Plan based on the Participating Plan's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and
    - c. Participating Plan would not otherwise exclude the provider from their provider network due to documented quality of care concerns or State or Federal exclusion requirements.
    - d. This does not apply to IHSS providers, durable medical equipment, medical supplies, transportation, or other ancillary services.
  - iii. Descriptions of continuity of care rights will be developed in all threshold languages and distributed to enrollees in their enrollment choice packet, distributed 60 days before they are enrolled in a Participating Plan.
  - iv. As part of a process to ensure that continuity of care requirements are met, Participating Plans must perform an assessment process within 90 days of an individual's enrollment in the Participating Plan, to identify existing providers and establish a care plan that addresses how continuity of care and coordination of care provisions will be carried out. This is further described in section IV.A.III.
- c. Out of Network Reimbursement Rules
- i. In an urgent or emergency situation, Participating Plans must reimburse an out-of-network provider at the Medicare or Medicaid FFS rate applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. Where this service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Participating Plans must also meet 42 CFR 438(b)(4) requirements for out of network providers under Medicaid. This does not apply to IHSS providers.

**VI. Model of Care-** All Participating Plans (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC) having explicit components consistent with the SNP Model of Care. California's comprehensive care coordination requirements summarized in section IV will also apply and be outlined in the three-way contract. CMS' MOC approval process is based on scoring each of the eleven clinical and non-clinical elements of the MOC. California included supplemental information in each of the eleven elements specific to integrated benefits and services under the demonstration. The supplemental information included care coordination, long-term services and supports, and behavioral health. CMS and California do not believe the supplemental information conflicts with the SNP Model of Care elements. The scoring methodology is divided into three parts: (1) a standard; (2) elements; and (3) factors. These components of the MOC approval methodology are defined below:

- (1) Standard: The standard is defined as a MOC that has achieved a score of 70 percent or greater based on the scoring methodology described in Appendix 2.
- (2) Elements: The MOC has 11 clinical and non-clinical elements, as identified below, and each element will have a score that will be totaled and used to determine the final overall score. The 11 MOC elements are listed below:
  1. Description of the Plan-specific Target Population;
  2. Measurable Goals;
  3. Staff Structure and Care Management Goals;
  4. Interdisciplinary Care Team;
  5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
  6. MOC Training for Personnel and Provider Network;
  7. Health Risk Assessment;
  8. Individualized Care Plan;
  9. Integrated Communication Network;
  10. Care Management for the Most Vulnerable Subpopulations; and
  11. Performance and Health Outcomes Measurement.
- (3) Factors: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the Capitated Financial Alignment application. The factors for each element will be scored using a system from 0 to 4, where 4 is the highest score for a factor. Interested organizations are required to provide a response that addresses every

factor within each of the 11 elements. The scores for each factor within a specific element are totaled to provide the overall score for that element out of a total of 160 possible points. Interested organizations must achieve a minimum score of 70 percent to meet the CMS approval standard. California conducted a parallel review of the MOCs, focusing on the supplemental information specific to the demonstration. Interested organizations must meet both State and CMS approval standards.

MOC reviews and approvals were for up to three-years based on higher MOC scores above the passing standard. The specific time periods for approvals were as follows:

- Plans that received a score of eighty-five (85) percent or higher were granted an approval of the CMS MOC requirement for three (3) years.
- Plans that received a score in the seventy-five (75) percent to eighty-four (84) percent range were granted an approval of the CMS MOC requirement for two (2) years.
- Plans that received a score in the seventy (70) percent to seventy-four (74) percent range were granted an approval of the CMS MOC requirement for one (1) year.

Participating Plans were permitted to cure problems with their MOC submissions after their initial submission. Participating Plans with MOCs scoring below 85 percent had the opportunity to improve their scores based on CMS and State feedback on the elements and factors that needed additional work.

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

**VIII. Grievances** – Enrollees shall be entitled to file internal grievances directly with the Participating Plan. Each Participating Plan must track and resolve its grievances, or re-route requests to the coverage decision or appeals processes, as appropriate. 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. Grievances for IHSS hours authorized by counties shall be referred to county agencies, consistent with the IHSS grievance and appeals process governed by State law and regulation.

**IX. Appeals**—Other than appeals for Medicare Part D, county-authorized IHSS hours, and county-authorized behavioral health services, which shall remain unchanged, the following is the beginning of a three-year process for a unified Medicare-Medicaid appeals process:

- a. Appeals Process - Leveraging the Current System: For the first year of the Demonstration and until a new system (described below) is put in place, no changes will be made in the appeals process, with Medicare appeals and Medi-Cal appeals following the systems in place today for managed care.
  - i. As a first step, enrollees will be encouraged to take appeals to a navigation office or member services office at the health plan which will support the beneficiary in pursuing his or her appeal. Beneficiaries are not required to seek support from the plan. Consistent with building on the existing process, beneficiaries will be allowed to seek a state fair hearing at any time for Medi-Cal covered services (including IHSS). For County-authorized IHSS benefits, members must file a request for a state fair hearing to appeal the county's decision regarding authorized hours (please see complete description of IHSS appeals process below).
  - ii. Initial appeals, excluding those for county-administered IHSS or behavioral health, will be sent to the health plan: appeals must be filed within 90 days; and, for Medi-Cal, appeals must be filed within 90 days of receiving a Notice of Action (NOA) or may use the State Fair Hearing process.
  - iii. Second level appeals for Medicare benefits are automatically sent by the plan to the Medicare Independent Review Entity (IRE) if the plan upholds its initial denial. For certain Medi-Cal appeals, members may request an Independent Medical Review (IMR) regarding the NOA from the Department of Managed Health Care. In most cases members must complete the health plan appeals process before requesting an IMR. An IMR may not be requested if a State Fair Hearing has already been requested for that NOA.
  - iv. Third level appeals for Medicare benefits are made to the Office of Medicare Hearings and Appeals (OMHA). Medi-Cal-only benefits are appealed to the State fair hearing.
  - v. Overlapping Services. 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 and will have a designated appeal pathway, to be set forth in the three-way contract. An individual with an overlapping health issue will retain his/her right to a State Fair Hearing regardless of the designated appeal pathway.

- vi. Appeal time frames- Individuals, their authorized representatives and providers will have the same number of days to file an appeal as allowed under current applicable laws.
  - vii. Appeal resolution time frames- All appeals must be resolved in timeframes allowed by current law.
  - viii. Integrated Notice- Participating Plan enrollees will be notified of all applicable Demonstration, Medicare and Medicaid appeal rights through a single integrated notice (except for county-authorized IHSS benefits, which are sent from the county).
  - ix. To appeal the county's decision regarding authorized hours for IHSS benefits, members must request a state fair hearing under Welfare and Institutions Code section 10950 et seq. A recipient must file a request with the county for a State Fair Hearing within 90 days after the date of county action or inaction. CDSS will commence a hearing within 30 days of the request. A CDSS Administrative Law Judge will conduct the hearing. A proposed decision must be issued within 75 days and adopted or alternated by the CDSS Director within 30 days after that.
- b. Appeals Process: Future Years - Creating a more Integrated appeals process: To provide clarity for enrollees and providers under the demonstration's integrated benefit package, California will work with stakeholders and CMS in good faith to further integrate the appeals process based on the current Medicare Advantage appeals process as set forth at 42 CFR Part 422, Subpart M and the below working principles. The Part D appeals process will not be integrated with the Medi-Cal appeals process.
- i. Appeal time frames- Individuals, their authorized representatives and providers will have a 90 day time-frame for requesting an appeal.
  - ii. State fair hearings would not be immediately available and beneficiaries will be required to exhaust plan and external review appeals.

- iii. There will be clear systems for:
  - a) Explicitly identifying the points at which the Participating Plan is notified of actions and outcomes.
  - b) Developing process and mechanisms by which information will be shared between the plan and the county regarding findings on the appeals for the county-administered IHSS and behavioral health benefits.
- iv. **Overlapping Services.** 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 plan benefits. Appeals related to these designated benefits will start with the health plan and proceed to either IMR or IRE. The decision of the deciding entity is controlling on the health plan. In the case of an IMR decision, it may also be appealed to the State Fair Hearing. Subject to applicable time frames, and only for Medicaid appeals, certain decisions rendered by IRE may also be appealed to State Fair Hearing.
- v. **Integrated Notice-** Participating Plan enrollees will be notified of all applicable Demonstration, Medicare and Medicaid appeal rights through a single integrated notice.
- vi. The state will seek additional input from stakeholders to consider options to align the appeals processes for county-authorized IHSS and behavioral health services with the integrated appeals process for all other Medicare and Medi-Cal benefits.

**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, 2013, CMS Medicare Marketing Guidelines do not apply to communication by State governments and materials created by the State do not need to be reviewed or submitted in HPMS. However, CMS and the State agree to work together in the development of these materials and the State will consult with CMS on the development of the materials.

- a. Marketing and Enrollee Communication Standards for 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 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual). The following exception applies:
  - i. CMS and California 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-Demonstration plan that may be part of the same corporate family. Beneficiary choices regarding enrollment will be honored by CMS and the State.
- b. Review and Approval of Marketing and Enrollee Communications – Participating Plans must receive prior approval of all marketing and enrollee communications materials in categories of materials that CMS and the State require to be prospectively reviewed. Participating Plan materials may be designated as eligible for the File & Use process, as described in 42 CFR §422.2262(b) and §423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and the State. CMS and California may agree to defer to one or the other party for review of certain types of marketing and enrollee communications, as agreed in advance by both parties. Participating Plans must submit all marketing and enrollee communication materials, whether prospectively reviewed or not, via the CMS Health Plan Management System Marketing Module. Prime Contractor Plans are responsible for the review and submission of all materials of Subcontracted Plans.
- c. Permissible Start Date for Participating Plan Marketing Activity – Participating Plans may begin marketing activity no earlier than 90 days prior to the effective date of enrollment for the contract year.
- d. CMS and California will work together to educate individuals about their Participating Plan options. In the Two-Plan and Geographic Managed Care counties, the State’s independent enrollment broker will be responsible for educating enrollees on all potential plan choices through a variety of mechanisms. In the COHS counties, the Prime Contractor Plans will be responsible. Outreach and educational activities may include letters and outreach events and will take

into account the prevalence of cognitive impairments, mental illness, and limited English proficiency. CMS and the State will assess and monitor the ongoing capacity of the enrollment systems and staffing to implement Demonstration responsibilities.

- e. 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 sections 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual). Participating Plans will use a Demonstration-specific Summary of Benefits.
  - i. An Evidence of Coverage (EOC) document that includes information about all State-covered and plan-covered supplemental benefits, in addition to the required Medicare benefits information.
  - ii. An Annual Notice of Change (ANOC) summarizing all major changes to the plan’s covered benefits from one contract year to the next, starting in the second year of the Demonstration.
  - iii. A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.
  - iv. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits.
  - v. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs provided under the Participating Plan.
  - vi. A single identification (ID) card for accessing all covered services under the plan.
  - vii. All Part D required notices, with the exception of the LIS Rider, the creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the late enrollment penalty notice requirements

required under Chapter 13 of the Prescription Drug Benefit Manual.

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

## **XI. Administration and Oversight**

### **a. Oversight Framework**

Under the Demonstration, there will be a CMS-State Contract Management Team that will ensure access, quality, program integrity, compliance with applicable laws, including but not limited to EMTALA and ADA, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and California will require Participating Plans to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. Prime Contractor 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, including Subcontracted Plans, in the delivery of Plan benefits, including prescription drugs, medical care, and long term services and supports. In addition, all Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to Participating Plans by CMS in the same way they are currently applied for PDP sponsors and Medicare Advantage organizations.

These responsibilities are not meant to detract from, weaken, or change any current California or CMS oversight responsibilities, including oversight by the California Department of Health Care Services, the California Department of Managed Health Care, the California Department of Social Services, CMS' 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 of contractual requirements of the health plans participating in the demonstration without notifying the other party in advance.

### **b. The Contract Management Team**

- i. Structure – The Contract Management Team will include representatives from CMS and the California (DHCS), authorized and empowered to represent CMS and DHCS about all aspects of the three-way contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), regional

office lead from the Centers for Medicaid & CHIP Services (CMCS), an account manager from the Consortium for Health Plan Operations (CMHPO), and a regional office lead from the Consortium for Medicaid and Children’s Health Operations (CMCHO). The State Team may include relevant leads from the Department of Health Care Services, and also the California Department of Managed Health Care, the California Department of Social Services, and the California Department of Aging. The precise makeup of each team will vary by state, and will include individuals who are knowledgeable about the full range of services and supports utilized by the target population, particularly long-term supports and services.

- ii. Reporting – Data reporting to CMS and the State will be coordinated and unified to the extent possible. Specific reporting requirements and processes for the following areas will be detailed in the three-way contract.
  - 1. Quality (including HEDIS); core measures will be articulated in the MOU.
  - 2. Rebalancing from Institutional to HCBS Settings
  - 3. Utilization
  - 4. Encounter Reporting
  - 5. Enrollee satisfaction (including CAHPS)
  - 6. Complaints and Appeals
  - 7. Enrollment/ Disenrollment Rates
  - 8. Part C and Part D Reporting Requirements, as negotiated and applicable
  - 9. All required reporting under section 1115(a) of the Social Security Act
  - 10. Data elements and metrics that will be included in the Participating Plan dashboard being developed by California
- 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:
  - a. Monitoring contractor compliance with reporting requirements.
  - b. Monitoring compliance with the terms of the three-way contract, including issuance of joint notices of non-compliance/enforcement;
  - c. Coordination of periodic audits and surveys of the contractor;
  - d. Receipt and response to complaints;
  - e. Review reports from the Ombudsman;

- f. Reviewing direct stakeholder input on both plan-specific and systematic performance;
  - g. Regular meetings with each Prime Contractor Plan;
  - h. Coordination of requests for assistance from Contractors, and assignment of appropriate State and CMS staff to provide technical assistance;
  - i. Coordinate review of marketing materials and procedures; and
  - j. Coordinate 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. Demonstration contracts will be included in these activities, just as all Medicare Advantage and Part D organizations will be included. Demonstration contracts will be treated in the same manner, which includes analysis of their performance based on CMS internal data, active collection of additional information, and CMS issuance of compliance notices, where applicable. The State 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. California audits its health plans to ensure compliance with the requirements of state law, including but not limited to the Knox Keene Act. California also collects data and conducts data analysis and oversight over many components of long term services and supports, as defined in the demonstration. CMS will not take an active part in these activities, but California will keep the Contract Management Team apprised of these activities as delineated in the three-way contract to ensure that activities are undertaken in a coordinated manner.
- f. Emergency/ Urgent Situations – Both CMS and California 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 California 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.
- g. Legislative Reporting – Sections 14182.17 and 14186.36 of the Welfare and Institutions Code sets forth reporting requirements for the California and California Department of Social Services. The State will share copies of programmatic transition plans, including the transition of the MSSP waiver, with

CMS at the time of submission to the State legislature.

- h. Participating Plan Call Center Requirement- In addition to current requirements for Medicare Advantage and Part D Plans, the following will be required call center elements:
    - A. Participating Plans, and where applicable, Subcontracted Plans, shall operate a toll-free enrollee services telephone line for administrative purposes per Medicare Advantage and Part D requirements.
    - B. 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 by phone, written materials, and Internet website upon request,
      - Registry for assisting IHSS recipients in finding eligible providers;
      - Enrollees' rights and responsibilities;
      - The procedures available to an enrollee and provider(s) to challenge or appeal the failure of the contractor to provide a covered service and to appeal any adverse actions (denials);
      - How to access oral interpretation services and written materials in threshold languages and alternative, cognitively accessible formats;
      - Information on all Participating Plan covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and
      - The procedures for an enrollee to change plans or to opt out of the Demonstration.
- **Data System Specifications, Reporting Requirements, and Interoperability**
    - Data system description and architecture and performance requirements
    - Current information system upgrades and development plans and resource

commitments necessary for implementation

- Consolidated reporting requirements
- Encounter reporting
- Reporting data for evaluation and program integrity
- Data Exchange among CMS, State, Providers and Contractors, and Health Insurance Exchanges (2014)
- **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, patient-caregiver experience, screening and prevention, and quality of life. This includes a requirement to report HEDIS, HOS and CAHPS data, as well as measures related to long term supports and services. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS plus any additional Medicaid measures identified by the State. All existing Part D metrics will be collected as well.

The combined set of core metrics is described below in Figure 7-1; more detail on the measures will be provided in the three-way contract. CMS and the State will utilize the reported measures in the combined set of core metrics for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and to allow quality to be evaluated and compared with other plans in the model. A subset of these will also be used for calculating the quality withhold payment as addressed in section VI of Appendix 6 in this MOU.

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

**Figure 7-1: Core Quality Measures under the Demonstration**

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Antidepressant medication management	Percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X	
Initiation and Engagement of Alcohol and Other Drug Dependence	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD)	NCQA/HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Treatment	dependence who received the following. <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>			
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	
Screening for Clinical Depression and Follow-up	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	
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	X	
SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members.  Element A: Coordination of Benefits for Dual Eligible Members Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) Element D: Service Coordination Element E: Network Adequacy Assessment	NCQA/ SNP Structure & Process Measures	X	
Care Transition Record Transmitted to Health Care Professional	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	X	
Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented	NCQA/HEDIS	X	
SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions.	NCQA/ SNP Structure & Process Measures	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	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			
CAHPS, various settings including: -Health Plan plus supplemental items/questions, including:  -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home	Depends on Survey	AHRQ/CAHPS	X	
Part D Call Center – Pharmacy Hold Time	Average time spent on hold when pharmacists call the drug plan's pharmacy help desk	CMS Call Center data	X	
Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number.	CMS Call Center data	X	
Part D Appeals Auto–Forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions.  This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.	IRE	X	
Part D Appeals Upheld	How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal.  This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100.	IRE	X	
Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 days.	Medicare Advantage Prescription Drug System (MARx)	X	
Part D Complaints about the Drug Plan	How many complaints Medicare received about the drug plan.  For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data	X	
Part D Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Administrative data	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Part D Members Choosing to Leave the Plan	The percent of drug plan members who chose to leave the plan in 2013.	CMS Medicare Beneficiary Database Suite of Systems	X	
Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan	X	
Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X	
Part D Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X	
Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication	CMS PDE data	X	
Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
Plan Makes Timely Decisions about Appeals	Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage.	IRE	X	
Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	IRE	X	
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.	CMS Call Center data	X	
Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X	
Risk assessments	Percent of members with initial assessments completed within 90 days of enrollment	CMS/State defined process measure	X	
Individualized care plans	Percent of members with care plans by specified timeframe	CMS/State defined process measure	X	
Real time hospital admission notifications	Percent of hospital admission notifications occurring within specified timeframe	CMS/State defined process measure	X	
Risk stratification based on LTSS or	Percent of risk stratifications using BH/LTSS	CMS/State defined	X	

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

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in current year..	CMS	X	
Getting Information From Drug Plan	The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost.  -In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? -In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? -In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? -In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?	AHRQ/CAHPS	X	
Rating of Drug Plan	The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs.  -Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	AHRQ/CAHPS	X	
Getting Needed Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan.  -In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? -In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	AHRQ/CAHPS	X	
Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.  • In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care.  • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	AHRQ/CAHPS	X	
Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received.  Using any number from 0 to 10, where 0 is the worst	AHRQ/CAHPS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	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?			
Overall Rating of Plan	Percent of best possible score the plan earned from plan members who rated the overall plan.  • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	AHRQ/CAHPS	X	
Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X	
Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X	
Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for –bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Diabetes Care – Cholesterol Screening	Percent of plan members with diabetes who have had a test for –bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	X	
Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	CMS HOS	X	
Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS	X	
Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS	X	
Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists	AHRQ/CAHPS	X	
Getting Care Quickly	Composite of access to urgent care	AHRQ/CAHPS	X	
Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table	AHRQ/CAHPS	X	
Help with Transportation	Composite of getting needed help with transportation	AHRQ/CAHPS	X	
Health Status/Function Status	Percent of members who report their health as excellent	AHRQ/CAHPS	X	
Transition Record with Specified elements	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other sites of care, or their caregivers(s), who received a transition record at the time of discharge including, at a minimum, all of the specified elements.	AMA-PCI		X
Behavioral Health Shared Accountability Process Measure. Phase A (9/1/13 – 12/31/13)  Phase B (1/1/14 – 12/31/14)	Phase A: Policies and procedures attached to an MOU with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing.  Phase B: Percent of demonstration enrollees receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services receiving coordinated care plan as indicated by having an individual care plan that includes the evidence of collaboration with the primary behavioral health provider	State-defined measures		X
Behavioral Health Shared Accountability Outcome Measure	Reduction in Emergency Department Use for Seriously Mentally Ill and Substance Use Disorder enrollees (greater reduction in Demonstration Year 3)	State defined measure		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Complaints and appeals	Utilization measure	State defined measure		X
Physician Access	Utilization measure	State defined measure		X
Psychiatric bed days	Utilization measure	State defined measure		X
ER utilization rates	Utilization measure, potentially revised to reflect avoidable ER visits	State defined measure		X
IHSS utilization	Utilization measure	State defined measure		
Nursing facility utilization measures	Utilization measure	State defined measure		X
Unmet need in LTSS	Unmet need in ADLs/IADLs, and IHSS functional level	State defined measure		X
Case manager contact with member	Ability to identify case manager or contact case manager	State defined measure		X
LTSS consumer satisfaction measures	Satisfaction with case manager, home workers, personal care.	Modified CAHPS		X
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements	CMS/State defined measure	X	x
Consumer governance board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements	CMS/State defined measure	X	X
Customer service	Percent of best possible score the plan earned on how easy it is to get information and help when needed	AHRQ/CAHPS	X	X
Access to care	Percent of respondents who always or usually were able to access care quickly when they needed it	AHRQ/CAHPS	X	X

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

DHCS, DMHC, and CDSS will implement the monitoring requirements by doing the following:

- DMHC and DHCS will submit an annual joint report on financial audits performed on Participating Plans.
- DHCS will coordinate with DMHC, DSS, and CMS to monitor Participating Plans and institute corrective action plans, when appropriate.
- DHCS will continue to work with stakeholders and CMS to develop ongoing quality measures for Participating Plans for the demonstration, which will include primary and acute care, LTSS, and behavioral health services.
- The State will continue to contract with an External Quality Review Organization (EQRO) to audit participating plans for quality measures and will contract with an

EQRO to validate encounter data as well.

- In conjunction with the demonstration evaluation efforts, DHCS, CDSS and CDA will monitor the utilization of medical services and LTSS (including IHSS), and will identify and share any significant changes in aggregate or average utilization among beneficiaries participating in the demonstration or the CCI.

## **XII. Stakeholder Engagement**

California 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 regular calls, surveys, focus groups, and data analysis. Existing state level advisory groups will be periodically called on for input. In addition, California has developed a robust outreach and education plan that will ensure that information is released to stakeholders in audience friendly formats, including through an updated version of the currently existing CalDuals.org website for the implementation phase. In addition, California 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 service and care delivered to eligible individuals. CMS and California 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 threshold languages as determined by CMS and the State.

## **XIII. Evaluation**

CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the State Demonstrations to Integrate Care for Dual Eligible Beneficiaries and the Financial Alignment Demonstrations, including the Demonstration established in this MOU, on beneficiary experience of care, quality, utilization, and cost. The evaluator will also assess how the California 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 State-specific evaluation plan for the California Demonstration, and will also conduct a meta-analysis that will look at the State Demonstrations overall. A mixed methods approach will be used to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative analyses will consist of tracking changes in selected quality, utilization, and cost measures over the course of the Demonstration; evaluating the impact of the Demonstration on cost, quality, and utilization measures; and calculating savings attributable to the Demonstration. The evaluator will use a comparison group, which may include beneficiaries in Los Angeles who are withheld from the Demonstration as described in section III.C of the MOU, for the impact analysis. Quarterly reports will provide rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit California -specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

California is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. California 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.

California will also collect data on case management and care coordination, including identification of beneficiaries who receive care coordination, frequency of contacts, and classification into risk tiers. California will also maintain the capability to track beneficiaries eligible for the Demonstration, including which beneficiaries choose to enroll, disenroll, or opt out of the Demonstration and the reason for the disenrollment, enabling the evaluation to identify differences in outcomes for these groups.

California 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. enrolled in certain 1915(c) HCBS waivers, 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

California 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.