

**Memorandum of Understanding (MOU)**

*Between*

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

*And*

**The State of Illinois**

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

**Illinois Medicare-Medicaid Alignment Initiative**

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## **I. STATEMENT OF INITIATIVE**

The Centers for Medicare & Medicaid Services (CMS) and State of Illinois will establish a Federal-State partnership to implement the Medicare-Medicaid Alignment Initiative (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees). The Federal-State partnership will include a Three-way Contract with Demonstration Plans that will provide integrated benefits to Medicare-Medicaid Enrollees in the targeted geographic areas. The Demonstration will begin on October 1, 2013, subject to the conditions described in this Memorandum of Understanding (MOU). It will continue until December 31, 2016, unless terminated pursuant to section L or extended pursuant to section K of this MOU. The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care, and reduce costs for both the State and the Federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

This Demonstration is one in a series of the State's initiatives to transform the health care environment in Illinois to one that is more person-centered with a focus on improved health outcomes, enhanced beneficiary access, and beneficiary safety. State law requires moving 50% of all Medicaid beneficiaries from fee-for-service (FFS) to risk-based care coordination by January 2015. This Demonstration helps support the State's health reform efforts by testing integration with Medicare.

The population that will be eligible to participate in this Demonstration includes those beneficiaries who are entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and receive full Medicaid benefits, and meet the requirements discussed in more detail in Section C.1 below.

Under this initiative, Demonstration Plans will be required to provide for, either directly or through subcontracts, Medicare and Medicaid-Covered Services under a capitated model of financing. CMS, the State, and the Demonstration Plans will ensure that beneficiaries have access to an adequate network of medical and supportive services.

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

Key objectives of this Demonstration are to improve the beneficiary experience in accessing care, promote person-centered care planning, promote independence in the community, improve

quality, rebalance long-term services and supports (LTSS) to strengthen and promote the community-based systems, eliminate cost shifting between Medicare and Medicaid, and achieve cost savings for the State and Federal government through improvements in care and coordination. Illinois' care coordination project provides a strong foundation for this Demonstration and demonstrates a commitment from the State to improve the care of beneficiaries. Illinois has one of the highest rates of potentially avoidable hospital admissions among Medicare-Medicaid beneficiaries nationally<sup>1</sup>. Illinois also has one of the highest proportions of spending on institutional services compared to home and community-based services (HCBS).<sup>2</sup> CMS and the State expect this model of integrated care and financing to, among other things, reduce avoidable hospital admissions, improve quality of care and reduce health disparities, meet both health and functional needs of Enrollees, and improve transitions between care settings. Meeting beneficiary needs, including the ability to self-direct care and live independently in the community, are central goals of this Demonstration.

The Demonstration will evaluate the effect of an integrated service delivery and payment model on serving both community and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency, and oversight standards. Contract management will focus on performance measurement and continuous quality improvement. Except as otherwise specified in this MOU or applicable Medicaid Waiver standards and conditions, Demonstration 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 Demonstration Plans, the State, and CMS.

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

CMS and the State will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid Enrollees, utilizing a simplified and unified set of rules, as detailed in the sections below. Flexibilities will be coupled with specific beneficiary

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1 Center for Strategic Planning, Policy and Data Analysis Group Policy Insight Report: Dual Eligibles and Potentially Avoidable Hospitalizations.

[http://www.cms.gov/reports/downloads/Segal\\_Policy\\_Insight\\_Report\\_Duals\\_PAH\\_June\\_2011.pdf](http://www.cms.gov/reports/downloads/Segal_Policy_Insight_Report_Duals_PAH_June_2011.pdf).

2 Centers for Medicare & Medicaid Services: Patient Protection and Affordable Care Act Section 10202 State Balancing Incentive Payments Program Initial Announcement.

<http://www.cms.gov/smdl/downloads/Final-BIPP-Application.pdf>.

safeguards that are included in this MOU and will be in the Three-way Contract. Demonstration Plans will have full accountability for managing the capitated payment to best meet the needs of Enrollees according to Care Plans developed by Enrollees, their caregivers, and interdisciplinary care teams using a person-centered planning process. CMS and the State expect Demonstration Plans to achieve savings through better-integrated and coordinated care. Subject to CMS and State oversight, Demonstration 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 Enrollee's wishes, needs, and Care Plan.

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

## **II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING**

This document details the principles under which CMS and Illinois 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 Demonstration Plans setting forth the terms and conditions of the Demonstration and initiate the Demonstration. Further detail about Demonstration Plan responsibilities will be included in and appended to the Three-way Contract.

Following the signing of this MOU and prior to the implementation of the Demonstration, the State and CMS will ultimately enter into Three-way Contracts with selected Demonstration Plans, which will have also met the Medicare components of the Plan selection process, including submission of a successful Capitated Financial Alignment Application, and adherence to any annual contract renewal requirements and guidance updates.

## **III. DEMONSTRATION DESIGN / OPERATIONAL PLAN**

### ***A. DEMONSTRATION AUTHORITY***

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

- 1. Medicare Authority:** The Medicare elements of the initiative shall operate according to existing Medicare Parts C and D laws and regulation, as amended or modified, except to the extent these requirements are waived or modified as provided for in Appendix 4. As a term and condition of the Demonstration, Plans will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act, and 42 CFR §422 and 423, and applicable sub-regulatory guidance, as amended from time to time, except to the extent specified in this MOU, including Appendix 4 and, for waivers of sub-regulatory guidance, the Three-way Contract.
- 2. Medicaid Authority:** The Medicaid elements of the Demonstration shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, including but not limited to all requirements of the 1915(c) waivers for those Enrollees in a 1915(c) waiver, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the Demonstration, the State and Demonstration Plans will be required to comply with Medicaid managed care requirements under Title XIX of the Social Security Act and 42 CFR 438 et. seq., other applicable regulations, and applicable sub-regulatory guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5 and, for waivers of sub-regulatory guidance, the Three-way Contract. The State will add concurrent authority to the relevant 1915(c) programs via amendments due no later than July 1, 2013.

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

- 1. Demonstration Plan Procurement Document:** The State issued a request for proposals (RFP) that, consistent with applicable State law and regulations, included purchasing specifications that reflect the integration of Medicare and Medicaid payment and benefits. As articulated in January 25, 2012 and March 29, 2012 guidance from CMS, Demonstration Plans are also required to submit a Capitated Financial Alignment Demonstration application to CMS and meet all of the Medicare components of the plan selection process.
- 2. Demonstration Plan Selection:** CMS and the State, through a plan selection and procurement process, selected entities that will be eligible to contract with CMS and the State. CMS and the State shall contract with qualified Demonstration Plans on a selective basis. The State announced the awardees pending approval of this MOU. See Appendix 7 for more information on the plan selection process.
- 3. Medicare Waiver Approval:** CMS approval of Medicare Waivers is reflected in Appendix 4. CMS reserves the right to withdraw waivers or expenditure authorities at any time it

determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XVIII. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Social Security Act, afford the State a reasonable opportunity to request a reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section III.L of this MOU. If a waiver or expenditure authority is withdrawn, federal financial participation (FFP) is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including Covered Services and administrative costs of disenrolling participants.

- 4. Medicaid Waiver and/or Medicaid State Plan Approval:** Appendix 5 discusses the Medicaid authorities associated with the Demonstration. Implementation of this Demonstration is contingent upon the State submitting all documentation necessary to demonstrate compliance with the Medicaid requirements under 42 CFR Parts 438 and 441 for the enrollment of the Demonstration population into managed care. This includes the submission of a State Plan amendment under Section 1932(a)(1)(A)(ii) of the Social Security Act at least 90 days prior to implementation. Delays in submission may delay the implementation of the Demonstration. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities for the purpose of this Demonstration would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Social Security Act, afford the State an opportunity to request a reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section III.L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including Covered Services and administrative costs of disenrolling participants.
- 5. Readiness Review:** CMS and the State shall conduct a Readiness Review of each selected Demonstration Plan. Prior to the Three-way Contract execution, both CMS and the State must agree that a Demonstration Plan has satisfied all readiness requirements. CMS and the State will collaborate in the design and implementation of the Readiness Review process and requirements. This Readiness Review shall include an evaluation of the capacity of each potential Demonstration Plan and its ability to meet all Demonstration requirements, including having an adequate network that addresses the full range of beneficiary needs and the capacity to uphold all beneficiary safeguards and protections.

- 6. Coordination with other Illinois Programs:** Prior to the date of effective enrollment, CMS and the State will review the implementation of Service Package II of the Illinois Medicaid Integrated Care Program (ICP) in an effort to build on lessons learned and improve the roll-out of the Demonstration. For the benefit of both the ICP Service Package II roll-out and the Demonstration, the Demonstration will not be implemented prior to a full quarter of ICP Phase II implementation.
- 7. Three-way Contract:** CMS and the State shall develop a single Three-way Contract and contract negotiation process that both Parties agree is administratively effective and ensures coordinated and comprehensive program operation, enforcement, monitoring, and oversight.

### ***C. ENROLLMENT***

#### **1. Eligible Populations:**

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; and
- Enrolled in the Medicaid Aid to the Aged, Blind, and Disabled (AABD) category of assistance.

Eligible populations include:

- Beneficiaries who meet all other Demonstration criteria and are in the following Medicaid 1915(c) waivers:
  - Persons who are Elderly;
  - Persons with Disabilities;
  - Persons with HIV/AIDS;
  - Persons with Brain Injury and
  - Persons residing in Supportive Living Facilities.
- Individuals with End Stage Renal Disease (ESRD) at the time of enrollment.

The following populations will be excluded from enrollment:

- Individuals under the age of 21;
- Individuals receiving developmental disability institutional services or who participate in the HCBS waiver for Adults with Developmental Disabilities;
- The Medicaid Spend-down population;
- Beneficiaries in the Illinois Medicaid Breast and Cervical Cancer program;
- Individuals enrolled in partial benefit programs; and



- Individuals enrolled in both Medicare and Medicaid who have Comprehensive Third Party Insurance.

Medicare-Medicaid beneficiaries who are in Medicare fee-for-service and meet the eligibility criteria above will be eligible for Passive Enrollment beginning January 1, 2014, unless they elect to opt out of the Demonstration, as discussed in C.2 below. Those beneficiaries who are enrolled in a Medicare Advantage plan that is operated by the same parent organization that operates a Demonstration Plan will also be eligible for Passive Enrollment into the Demonstration Plan operated by the same parent organization beginning January 1, 2014. Eligible beneficiaries enrolled in a Medicare Advantage plan that is operated by a parent organization that is not offering a Demonstration Plan may enroll into the Demonstration if they elect to disenroll from their current Medicare Advantage plan.

- 2. Enrollment and Disenrollment Processes:** Eligible individuals will be notified of their right to select among contracted Demonstration Plans. No earlier than 90 days prior to October 1, 2013, eligible individuals will have the opportunity to opt into the Demonstration to begin receiving services on October 1, 2013. Beginning January 1, 2014 and on a monthly basis, if no active choice has been made, enrollment for eligible beneficiaries (as described above in C.1.) into a Demonstration Plan may be conducted using a seamless, Passive Enrollment process that provides the opportunity for Enrollees to make a voluntary choice to enroll or disenroll from the Demonstration Plan on a monthly basis. Enrollees will receive sufficient notice of and information on Passive Enrollment no fewer than 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. Disenrollment from Demonstration Plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month in which they disenroll.

CMS and the State will monitor Enrollments and Disenrollments for both evaluation purposes and for the purpose of identifying any inappropriate or illegal marketing practices. As part of this analysis, CMS and the State will monitor any unusual shifts in Enrollment by individuals identified for Passive Enrollment into a particular Demonstration 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 issue corrective action. Any illegal marketing practices will be referred to appropriate agencies for investigation.

As mutually agreed upon, CMS and the State will utilize an independent, third party entity to facilitate enrollment into the Demonstration Plans. Demonstration Plan enrollments,

including transfers between Demonstration Plans, and Disenrollments shall become effective on the same day for both Medicare and Medicaid, as discussed above and in greater detail in Appendix 7. For those who lose Medicaid eligibility during the month, coverage and FFP will continue through the end of that month. See Appendix 7 for a more detailed discussion on timing of Enrollments and Disenrollments.

3. **Uniform Enrollment/Disenrollment Documents:** CMS and the State shall develop uniform Enrollment and Disenrollment forms and other documents.
4. **Outreach and Education:** Demonstration 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 the State shall work with Demonstration Plans to develop a single identification card that can be used to access all care needs.
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). 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 shared Medicare savings under those initiatives.

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

1. **Demonstration Plan Service Capacity:** CMS and the State shall contract with Demonstration Plans that demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid Covered Services to Enrollees, in accordance with this MOU, CMS guidance, and the Three-way Contract. Medicare covered benefits shall be provided in accordance with 42 CFR §422 and 42 CFR §423 et seq. Medicaid covered benefits shall be provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments, 1915(c) waiver authorities, and in accordance with the requirements specified in this MOU. CMS and the State may choose to allow for greater flexibility in offering additional benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, the State, and Demonstration Plans will ensure that beneficiaries have access to an adequate network of medical, pharmacy, behavioral health, and LTSS providers that are appropriate and capable of addressing the needs of this diverse population, as described in more detail in Appendix 7.

2. **Demonstration Plan Risk Arrangements:** CMS and the State shall require each Demonstration Plan to provide a detailed description of its risk arrangements with providers under subcontract with the Demonstration Plan. This description shall be made available to Demonstration 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 and non-medical Covered Services to Enrollees.
3. **Demonstration Plan Financial Solvency Arrangements:** CMS and the State have established a standard for all Demonstration Plans, as articulated in Appendix 7.

***E. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE***

1. **Choice of Plans and Providers:** As referenced in section C.2, Enrollees will maintain their choice of Demonstration Plans and may exercise that choice at any time. If a choice to enroll in a Demonstration Plan is made by the 12<sup>th</sup> of the month, Enrollment will be effective the first calendar day of the following month. Enrollment requests, including requests to change among Demonstration Plans received after the 12<sup>th</sup> of the month will be effectuated the first calendar day of the second month following the request. CMS and the State will monitor input received by the Ombudsman and Demonstration Plans about the time between beneficiary Enrollment requests and the effective date of enrollment. After the first year of the Demonstration, or when the State updates its eligibility systems, the State and CMS will also revisit the timeline for processing enrollments and, if necessary, will shorten the time period between the beneficiary's Enrollment request and effective date of enrollment. All Disenrollments will be effective the first day of the month after the choice is made. A Disenrollment request is any action that terminates the Enrollee's enrollment in the Demonstration, and includes, for example, the right to choose a Medicare Advantage Plan, to receive care through Medicare Fee-For-Service (FFS) and a Prescription Drug Plan, and to receive Medicaid services in accordance with the State's approved State Plan and any approved waiver programs.
2. **Continuity of Care:** CMS and the State will require Demonstration Plans to ensure that Enrollees continue to have access to medically necessary items, services, prescription drugs, and medical, behavioral health, and LTSS providers for the transition period as specified in Appendix 7. Within the 180-day transition period, Demonstration Plans will advise in writing beneficiaries and providers that they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, Demonstration Plans must also contact providers not already members of their network with information on becoming credentialed

as in-network providers. Medicare Part D transition rules and rights will continue as provided for in current law and regulation.

- 3. Enrollment Assistance and Options Counseling:** As referenced in section C.2 and Appendix 7, Medicare-Medicaid Enrollees may access independent enrollment assistance and options counseling offered by the State's Independent Client Enrollment Services to help them make an enrollment decision that best meets their needs. In Illinois, Aging and Disability Resource Networks (ADRN)s serve as a point-of-entry to the options counseling program, ensuring that beneficiaries are informed of their health care options. Under this Demonstration, the State will provide ADRNs with information about Demonstration Plans so that the ADRNs can inform beneficiaries about all of their enrollment options. CMS may provide additional support for ADRNs who are eligible for a funding opportunity released by CMS for eligible State Health Insurance Assistance Programs (SHIPs)/ADRN)s.
- 4. Ombudsman:** The State intends to support an independent Ombudsman outside of the State Medicaid agency to advocate and investigate on behalf of Illinois' Demonstration Enrollees, including home and community based care and nursing facility-based recipients, to safeguard due process, and to serve as the early and consistent means of identifying systematic problems with the Demonstration. Aside from the independent Ombudsman, Illinois Medicaid also currently operates a hotline open to all Medicaid members, including Medicare-Medicaid Enrollees. CMS will support Ombudsman training on the Demonstration and its objectives, and CMS and the State will provide ongoing technical assistance to the Ombudsman. The Ombudsman will support individual advocacy and independent systematic oversight for the Demonstration, with a focus on compliance with principles of community integration, independent living, and person-centered care in the home and community based care context. The Ombudsman will be responsible for gathering and reporting data on Ombudsman activities to the State and CMS via the Contract Management Team described in Appendix 7 of this MOU.
- 5. Person-Centered, Appropriate Care:** CMS, the State, and Demonstration Plans shall ensure that all medically necessary, covered benefits are provided to Enrollees in a manner that is sensitive to the individual's functional and cognitive needs, language, and culture, allows for involvement of the Enrollee and caregivers, and is in an appropriate care setting. CMS, the State, and Demonstration Plans shall ensure that care is person-centered and can accommodate and support self-direction. Demonstration Plans shall also ensure that Enrollees have the option to receive long-term services and supports (LTSS) in the least restrictive setting when appropriate, with a preference for the home and the community, and in accordance with the Enrollee's wishes and Care Plan.

- 6. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and the State expect Demonstration Plan and provider compliance with the ADA and Civil Rights Act of 1964 to promote the success of the Demonstration and will support better health outcomes for Enrollees. In particular, CMS and the State recognize that successful, person-centered care requires physical access to buildings, services, and equipment, and flexibility in scheduling and processes. The State and CMS will require Demonstration Plans to contract with providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their Enrollees. The State and CMS also recognize that access includes effective communication. The State and CMS will require health plans and their providers to communicate with their Enrollees in a manner that accommodates their individual needs, including providing interpreters for those who are deaf or hard of hearing or who do not speak English and accommodations for Enrollees with cognitive limitations. Also, CMS and the State recognize the importance of staff training on accessibility and accommodation, independent living and recovery models, cultural competency, and wellness philosophies. CMS and the State will continue to work with stakeholders, including Enrollees, to further develop learning opportunities, monitoring mechanisms, and quality measures to promote compliance by Demonstration Plans and their providers with all requirements of the ADA. Finally, CMS and the State are committed to compliance with the application of the *Olmstead* decision and agree to ensure that Demonstration Plans provide Enrollees with LTSS in care settings appropriate to their needs consistent with Covered Services.
- 7. Enrollee Communications:** CMS and the State agree that Enrollee and prospective Enrollee materials, in all forms, shall require prior approval by CMS and the State unless CMS and the State agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and the State. CMS and the State will also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or State approval. All materials shall be integrated and include, but not be limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable to the Enrollees and prospective Enrollees in the Demonstration Plans and their caregivers. This includes individuals with disabilities, including, but not limited to, those with cognitive and functional limitations and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard providing the greatest access to individuals with disabilities or limited English proficiency will apply.

- 8. Beneficiary Participation on Governing and Advisory Boards:** CMS and the State shall require Demonstration Plans to obtain meaningful beneficiary input on issues of Demonstration management and Enrollee care. Demonstration plans must establish an independent Demonstration Plan beneficiary advisory committee. Throughout the operation of the Demonstration, Demonstration Plans will be required to meet quarterly with the beneficiary advisory committee. The Demonstration Plan must also assure that the beneficiary advisory committee composition reflects the diversity of the Demonstration population including Enrollees, caregivers, and local representation from key community stakeholders such as faith-based organizations, advocacy groups, and other community-based organizations. The State will maintain its website<sup>3</sup> to provide updates on the Demonstration and have ongoing, quarterly stakeholder meetings through forums such as the Medicaid Advisory Committee (MAC), the MAC Care Coordination Subcommittee, or the Seniors and Persons with Disabilities (SPD) stakeholder group.
- 9. Demonstration Plan Customer Service Representatives:** CMS and the State shall require Demonstration Plans to employ or contract with sufficient numbers of customer service representatives who shall answer all inquiries and respond to Enrollee complaints and concerns in a timely manner. In addition, CMS and the State shall employ or contract with sufficient call center and customer service representatives to address Enrollee questions and concerns. Demonstration Plans, CMS, and the State shall work to assure the language and cultural competency of customer service representatives to adequately meet the needs of the Enrollee population. All services must be culturally and linguistically appropriate and accessible. More detailed information about customer service requirements is included in Appendix 7.
- 10. Privacy and Security:** CMS and the State shall require all Demonstration Plans to ensure privacy and security of Enrollee health records and provide for access by Enrollees to such records.
- 11. Integrated Appeals and Grievances:** As referenced in section F and Appendix 7, Enrollees will have access to an integrated Appeals and Grievance process.
- 12. Limited Cost Sharing:** Demonstration Plans will not charge Medicare Parts C or D premiums, nor assess any cost sharing for Medicare Parts A and B services. For drugs and pharmacy products, including those covered by both Medicare Part D and the State Medicaid agency, Demonstration Plans will be permitted to charge co-pays to individuals currently eligible to make such payments. Co-pays charged by Demonstration Plans for Part D drugs

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<sup>3</sup> <http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx>.

must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy, although plans may elect to reduce this cost sharing for all Enrollees as a way of testing whether reducing Enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the Demonstration.

For Medicaid services beyond the pharmacy cost sharing described here, Demonstration Plans will not charge cost sharing to Enrollees above levels established under the Medicaid State Plan. Demonstration Plans are free to waive Medicaid cost sharing requirements.

- 13. No Balance Billing:** No Enrollee may be balance billed by any provider for any reason for Covered Services or Flexible Benefits.

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

- 1. Demonstration Plan Grievances and Internal Appeals Processes:** CMS and the State agree to develop a unified set of requirements for Demonstration Plan Grievances and internal appeals processes that incorporate relevant Medicare Advantage and Medicaid managed care/appeals requirements to create a more beneficiary friendly and easily navigable system. All Demonstration Plan Grievances and Internal Appeals procedures shall be subject to the review and prior approval of CMS and the State. Medicare Part D appeals and grievances will continue to be managed by CMS under existing Part D rules, and Medicaid non-Part D pharmacy appeals will be managed by the State. CMS and the State will work to continue to coordinate grievances and appeals for all services.
- 2. External Appeals Processes:** CMS and the State agree to utilize a streamlined Appeals process that will conform to both Medicare and Medicaid requirements, to create a more beneficiary friendly and easily navigable system. Protocols will be developed to assure coordinated access to the appeals mechanism. This process and these protocols are discussed in further detail in Appendix 7. Medicare Part D appeals and grievances will continue to be managed by CMS under existing Part D rules.

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

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

These activities shall include but not be limited to:

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

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

- The State and CMS will each retain, yet coordinate, current responsibilities toward the beneficiary such that beneficiaries maintain access to their benefits across both programs.
- CMS and the State will leverage existing protocols (e.g. in responding to beneficiary complaints, conducting account management, and analyzing enrollment data) to identify and solve beneficiary access problems in real-time.
- Oversight will be coordinated and subject to a unified set of requirements. CMS-State Contract Management Teams, as described in Appendix 7, will be established. Oversight will build on areas of expertise and capacity of the State and CMS.
- Oversight of the Demonstration Plans and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and the Illinois Medicaid program.



- Medicare Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the State. Demonstration Plans will be included in all existing Medicare Advantage and Part D oversight activities, including, but not limited to, data-driven monitoring, secret shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and audits.
  - CMS and the State will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poor performers from the Demonstration, leveraging existing CMS tools, such as the Complaints Tracking Module or the Medicare Part D Critical Incidence Reporting System, and existing State oversight and tracking tools. Standards for removal on the grounds of poor performance, including continuous failure to meet quality and performance thresholds, will be articulated in the Three-way Contract.
- 3. Consolidated Reporting Requirements:** CMS and the State shall define and specify in the Three-way Contract a Consolidated Reporting Process for Demonstration 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 Demonstration Plan's performance. Demonstration Plans will be required to meet the encounter reporting requirements that are established for the Demonstration.
- 4. Accept and Process Data:** CMS, or its designated agent(s), and the State, or its designated agent(s), shall accept and process uniform, person-level Enrollee Data for the purposes of program eligibility, payment, and evaluation. Submission of data to the State and CMS must comply with all relevant Federal and State laws and regulations, including, but not limited to, regulations related to HIPAA and to electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation. CMS and the State shall streamline data submissions for Demonstration Plans wherever practicable.

## ***H. QUALITY MANAGEMENT***

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

2. **External Quality Reviews:** CMS and the State shall coordinate the Demonstration Plan external quality reviews conducted by the Quality Improvement Organization (QIO) and EQRO.
3. **Determination of Applicable Quality Measures:** CMS and the State shall determine applicable quality measures and monitor the Demonstration Plans' performance on those measures. These measures are articulated in Appendix 7.

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

1. **Rates and Financial Terms:** For each calendar year of the Demonstration, before rates are offered to Demonstration 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 Demonstration Plans for the Medicare Parts A/B and Part D components of the rate. The State will make a payment to the Demonstration Plans for the Medicaid component of the rate, as more fully detailed in Appendix 6.

#### ***J. EVALUATION***

1. **Evaluation Data to be Collected:** CMS and the State have developed processes and protocols, which will be further detailed in the Three-way Contract, for collecting or ensuring the Demonstration Plans or their contractors collect and report to CMS and the State the data needed for the CMS external evaluation, detailed below.
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 look at changes in person-level health outcomes, experience of care, and costs by sub-population(s), and changes in patterns of primary, acute, behavioral health, and LTSS use and expenditures, using principles of rapid-cycle evaluation and feedback. Key

aspects and administrative features of the Demonstration, including but not limited to enrollment, marketing, and grievances and appeals will also be examined per qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives and seek to isolate the effect of this Demonstration as appropriate.

The State will collaborate with CMS or its designated agent during all monitoring and evaluation activities. The State and Demonstration 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. The State and Demonstration Plans will submit both historical data relevant to the evaluation, including Medicaid statistical information systems (MSIS) data from the years immediately preceding the Demonstration and data generated during the Demonstration period.

#### ***K. EXTENSION OF AGREEMENT***

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

#### ***L. MODIFICATION OR TERMINATION OF MOU***

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

- A. **Limitations of MOU:** This MOU is not intended to and does not create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the State, the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person. Nothing in this MOU may be construed to obligate the Parties to any current or future expenditure of resources or from modifying the Medicare and Medicaid programs as allowed under the respective federal laws and regulations. This MOU does not obligate any funds by either of the Parties. Each party acknowledges that it is entering into this MOU under its own authority.
- B. **Modification:** Either CMS or the State may seek to modify or amend the MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act, such as ensuring the Demonstration is improving the quality of care without

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

**C. Termination:** The parties may terminate this MOU under the following circumstances:

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

If the Demonstration is terminated as set forth above, CMS shall provide the 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.

**D. Demonstration Phase-Out.** Termination at the end of the Demonstration must follow these procedures:

- a. Notification – Unless CMS and the State agree to extend the Demonstration, the State must submit a draft phase-out plan to CMS no less than five months before the end date of this MOU. Prior to submitting the draft phase-out plan, the State must publish on its website the draft phase-out plan for a 30-day public comment period. The State shall summarize comments received and share such summary with CMS. Once the phase-out plan is agreed to by CMS, the phase-out activities must begin within 14 days.
- b. Phase-out Plan Requirements – The State must include, at a minimum, in its phase-out plan the process by which it will notify affected Enrollees, the content of said notices, including information on the beneficiary's appeal rights, and if applicable, the process by which the State will conduct administrative reviews of Medicaid

eligibility for the affected beneficiaries and ensure ongoing coverage for eligible individuals, including plans for making an appropriate referral for enrollment of all Enrollees in a Medicare Part D Plan, as well as any community outreach activities. In addition, such plan must include any ongoing Demonstration Plan and State responsibilities .

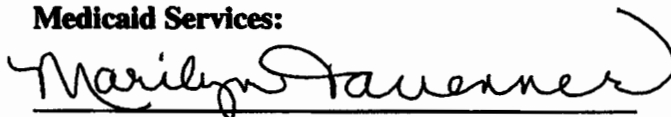
- c. Phase-out Procedures – The State must comply with all notice requirements found in 42 CFR §431.206, 431.210, and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration Enrollees as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. If applicable, the State must conduct administrative renewals for all affected 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, February 22, 2013, through the end of the Demonstration period, December 31, 2016. Additionally, the terms of this MOU shall continue to apply to the State and Demonstration Plans as they implement associated phase-out activities beyond the end of the Demonstration period.

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

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



Marilyn Tavenner  
Acting Administrator, CMS

FEB 22 2013

(Date)

**Illinois**



Julie Hamos  
Director, State of Illinois  
Illinois Department of Healthcare and Family Services

2/22/13

(Date)

## **Appendix 1: Definitions**

**Action** – (i) The denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure to respond to an Appeal in a timely manner, or (vi) solely with respect to a Demonstration Plan that is the only contractor serving a rural area, the denial of an Enrollee’s request to obtain services outside of the contracting area.

**Appeals** – A request for review of a decision as described in Appendix 7 with respect to an Action.

**Care Coordinator** – An employee or delegated subcontractor of the Demonstration Plan who provides Care Management, and together with an Enrollee and care team, establishes a Care Plan for the Enrollee and, through interaction with network providers, ensures the Enrollee receives necessary services.

**Care Management** - Services that assist Enrollees in gaining access to needed services, including medical, social, educational and other services, regardless of the funding source for the services. Care Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet an Enrollee’s needs across the continuum of care.

**Care Plan** – An Enrollee-centered, goal-oriented, culturally relevant, and logical, written plan of care with a service plan component, if necessary, that assures that the Enrollee receives, to the extent applicable, medical, medically-related, social, behavioral, and necessary Covered Services, including long-term services and supports, in a supportive, effective, efficient, timely and cost-effective manner that emphasizes prevention and continuity of care.

**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.

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

**Comprehensive Third Party Insurance** - As defined by the State’s HFS Bureau of Collections, major medical coverage that at least includes physician and hospital services.

**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 beneficiary experiences with health care.

**Contract Management Team** - A group of CMS and HFS representatives responsible for overseeing the Three-way Contract.

**Covered Services** - The set of Medicare and Medicaid services the Demonstration Plans are required to offer.

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

**Demonstration Plan** - A managed care organization that enters into a Three-way Contract with CMS and the State to provide Covered Services and any chosen flexible benefits and be accountable for providing integrated care to Medicare-Medicaid Enrollees.

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

**Enrollee** – A Medicare-Medicaid Enrollee who is enrolled with a Demonstration Plan. “Enrollee” shall include the guardian where the Enrollee is an adult for whom a guardian has been named; provided, however, that the Demonstration Plan is not obligated to cover services for a guardian who is not otherwise eligible as an Enrollee.

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

**Enrollee Communications** - Materials designed to communicate to Enrollees Covered Services and flexible benefits, policies, processes and/or Enrollee rights. This includes pre-enrollment, post-enrollment, and operational materials.

**Flexible Benefits** – Benefits Demonstration Plans may choose to offer outside of the required Covered Services. Flexible Benefits will not be considered in the development of the capitation rate.

**Grievance** - An expression of dissatisfaction by an Enrollee, including complaints, about any matter other than a matter that is properly the subject of an Appeal.

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



**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.

**HFS** - The Illinois Department of Healthcare and Family Services and any successor agency.

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

**Medically Necessary Services** - (per Medicare) A service, supply, or medicine that is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y.

(per Illinois) a service, supply or medicine that is appropriate, covered by the State, and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with the Demonstration Plan's guidelines, policies or procedures based on applicable standards of care and as approved by HFS if necessary, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

Demonstration Plans will be required to provide services in a way that preserves all protections to the Enrollee provided by Medicare and the Illinois Medicaid program. Where there is overlap between Medicare and Medicaid, coverage and rules will be delineated in the Three-way Contract.

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

**Medicare-Medicaid Enrollees** - For the purposes of this Demonstration, individuals who are entitled to Medicare Part A and enrolled in Medicare Parts B and D and receive full benefits under the Illinois Medicaid State Plan, and otherwise meet eligibility criteria for the Demonstration.

**Medicaid** - The program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

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

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

**Medicaid Waiver** - Generally, a waiver of existing law authorized under section 1115(a), 1115A, or 1915 of the Social Security Act as approved by the Secretary of Health and Human

Services or his/her designee.

**Parties** - CMS and the State of Illinois

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

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

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

**Quality Improvement Organization (QIO)** – As set forth in Section 1152 of the Social Security Act and 42 CFR Part 476, an organization under contract with the Centers for Medicare & Medicaid Services to perform utilization and quality control peer review in the Medicare program or an organization designated as QIO-like by the Centers for Medicare & Medicaid Services. The QIO or QIO-like entity provides quality assurance and utilization review in fee-for-service settings.

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

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

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

**State** – The State of Illinois. State may also be referred to as “HFS”.

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

**Three-way Contract** - The participation agreement that CMS and HFS enter into with a Demonstration Plan specifying the terms and conditions pursuant to which a Demonstration Plan may participate in this Demonstration.

## 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 Illinois 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 LTSS.	Page 3, 9, 13, 37-54 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.	Page 13 – 17 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,	Page 21 – 22

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	consumer organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model.	
	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>	State has identified protections (e.g. enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary's needs. At a minimum, States will be required to:	
	· Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model (e.g. participation on Demonstration Plan governing boards and/or establishment of beneficiary advisory boards).	Page 22-23 and addendum

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	· 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.	Page 12, 25, and addendum
	· Ensure privacy of Enrollee health records and provide for access by Enrollees to such records.	Page 25
	· Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community.	Page 13 – 14, 17 and 24
	· 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.	Page 18, 24 – 25
	· Ensure an adequate and appropriate provider network, as detailed below.	Page 11 – 12, 23, and addendum
	· Ensure that beneficiaries are meaningfully informed about their care options.	Page 16 – 17 and 24

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	· Ensure access to grievance and appeals rights under Medicare and/or Medicaid.	
	· <i>For Capitated Model</i> , this includes development of a unified set of requirements for Demonstration Plan complaints and internal appeals processes.	Page 12, 25
<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.	Page 27-28, 29 – 30 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.	Page 11, 23 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 LTSS, utilization, etc.), in order to promote beneficiaries receiving high quality care and for purposes of the evaluation.	Page 26 – 28, 33 - 36 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:	
	· Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models;	Page 27
	· Description of any changes to the State Plan that would affect Medicare-Medicaid Enrollees during this three year period (e.g. payment rate changes, benefit design, addition or expiration of waivers, etc.); and	Addendum



Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
	· State supplemental payments to providers (e.g. Disproportionate Share Hospital payments, Upper Payment Limit payments) during the three-year period.	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.	Page 7 – 10
<b>Expected Savings</b>	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	Page 28 - 29
<b>Public Notice</b>	State has provided sufficient public notice, including:	
	· At least a 30-day public notice process and comment period;	Page 1
	· At least two public meetings prior to submission of a proposal; and	Page 5, 21 – 22 and Addendum
	· Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals.	Page 21

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
<b>Implementation</b>	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation:	
	· Meaningful stakeholder engagement.	Page 21 – 22
	· Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments.	Page 32 and Addendum
	· Receipt of any necessary State legislative or budget authority.	N/A
	· Joint procurement process (for capitated models only).	Page 8
	· Beneficiary outreach/notification of enrollment processes, etc.	Page 9 - 10

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

This Demonstration will be implemented in two regions (service areas) of the State: the greater Chicago region and central Illinois. Below are the counties that will be included in each service area:

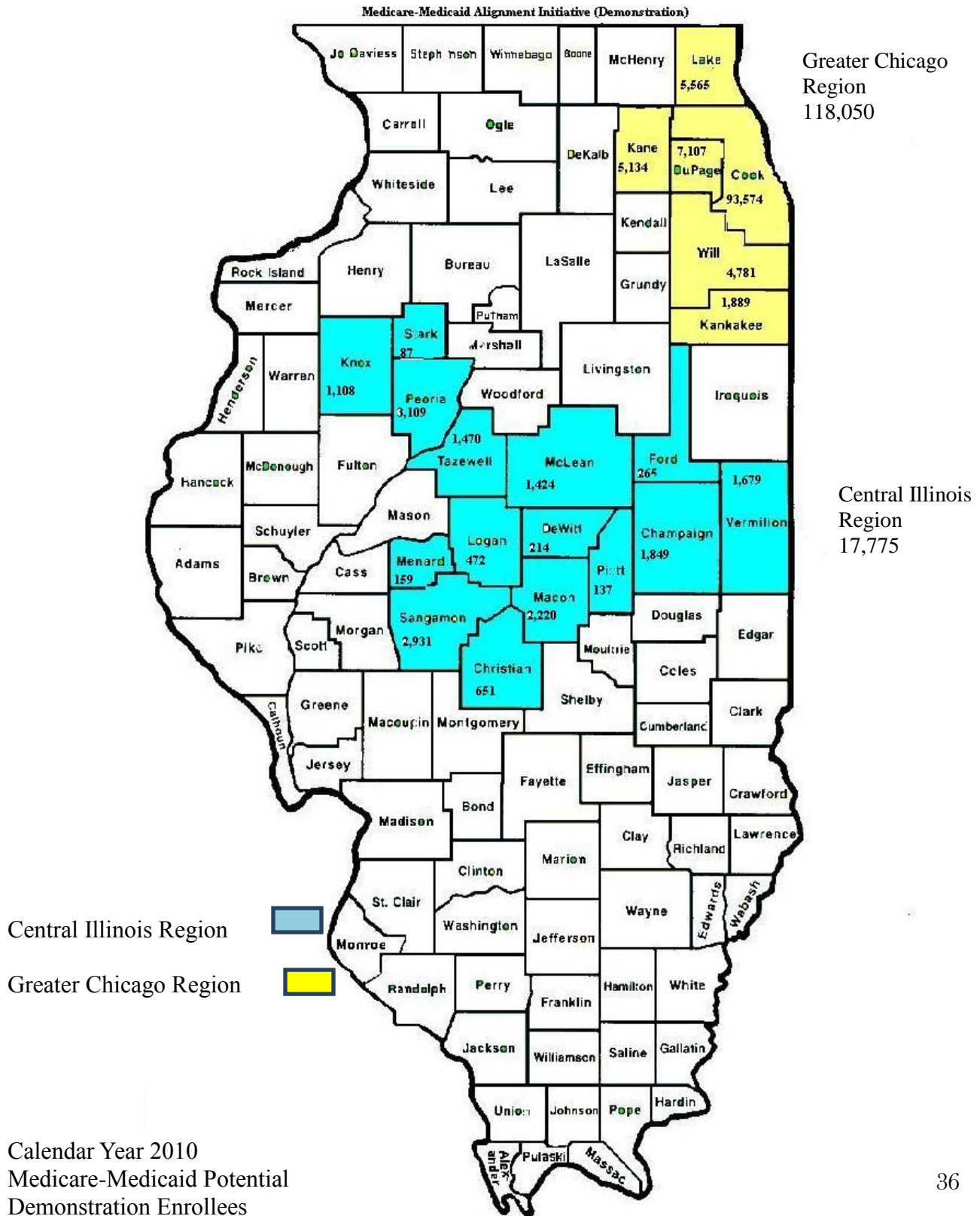
#### **Greater Chicago Service Area:**

Cook	DuPage
Lake	Will
Kane	Kankakee

#### **Central Illinois Service Area:**

Knox	Macon
Peoria	Christian
Tazewell	Piatt
McLean	Champaign
Logan	Vermilion
DeWitt	Ford
Sangamon	Menard
	Stark

Figure 1: Map of Demonstration Service Areas



## **Appendix 4: Medicare Authorities and Waivers**

Medicare provisions described below are waived as necessary to allow for implementation of the Demonstration. Except as waived, Medicare Advantage and Medicare Part D provide the authority and statutory and regulatory framework for the operation of the Demonstration to the extent that Medicare (versus Medicaid) authority applies. Unless waived, all applicable statutory and regulatory requirements of the Medicare program for Medicare Advantage plans that provide qualified Medicare Part D prescription coverage, including Medicare Parts A, B, C, and D shall apply to Demonstration Plans and their sponsoring organizations for the Demonstration period beginning 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 Contract.

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 §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." Section 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 §422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in Demonstration Plans to Medicare-Medicaid Enrollees who are ages 21 and over, including beneficiaries who may have ESRD, excluding individuals receiving developmental disability institutional services or who participate in the HCBS waiver for Adults with Developmental Disabilities, the Spend-down population, the Illinois Breast and Cervical Cancer program, individuals enrolled in partial benefit programs, and those with comprehensive third party insurance, 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 §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 and Appendix 6, which differs as to the method for calculating payment amounts and does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under Sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.

- The provisions regarding deemed approval of marketing materials in Sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 CFR §422.2266 and §423.2266, with respect to marketing and Enrollee communications materials in categories of materials that CMS and the State have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and the State have agreed to approval.
- Sections 1852 (f) and (g) and implementing regulations at 42 CFR §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 §423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the LIS be greater than \$0, to permit Demonstration Plans to reduce Medicare 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, regulation, and policy statement, not expressly waived in this list, shall apply to the Medicare-Medicaid Alignment Initiative Demonstration project beginning 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 Contract.

This Demonstration and the additional authority referenced below are contingent upon submission and approval of all documentation necessary to demonstrate compliance with the Medicaid requirements under 42 CFR Parts 438 and 441 for enrollment of the Demonstration population into managed care, including, but not limited to the submission of concurrent authority to the relevant 1915(c) programs via the State's next amendments due no later than July 1, 2013 and the submission of State Plan authority under 1932(a)(1)(A)(ii). The State must submit the State Plan authority at least 90 days prior to the implementation of the Demonstration. The State must meet all requirements of the State Plan and any approved Medicaid Waiver as expressed in the terms of those authority documents, including, but not limited to, all financial, quality, reporting and monitoring requirements of the waiver, and State financing contained in the State's waiver must be in compliance with Federal requirements. This MOU does not indicate or guarantee CMS approval of any necessary authority for managed care under 42 CFR Parts 438 and 441.

Assessment of actuarial soundness under 42 CFR §438.6, in the context of this Demonstration, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration.

### **1115A Medicaid Waivers**

Under the authority of Section 1115A of the Social Security Act (the Act), the following waivers of State Plan requirements contained in section 1902 and 1903 of the Act are granted to enable the State to carry out the Demonstration. These authorities shall be in addition to those in the State Plan and 1915(c) waivers.

**Provisions Related to Contract Requirements - Section 1903(m)(2)(A)(iii) (as implemented in 42 CFR 438.6)**

Waiver of contract requirement rules at 42 CFR 438.6(a), insofar as its provisions are inconsistent with methods used for prior approval under this Demonstration.



## **Appendix 6: Payments to Demonstration Plans**

CMS and the State of Illinois will enter into a joint rate-setting process based on the following principles:

- (1) Medicare and Medicaid will each contribute to the total capitation payment consistent with baseline spending contributions;
- (2) Demonstration savings percentages assume that Demonstration Plans are responsible for the full range of Covered Services and flexible benefits covered under the Demonstration;
- (3) Aggregate savings percentages will be applied equally to the Medicaid and Medicare A/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. (Note: rate updates will take place on January 1<sup>st</sup> of each calendar year (CY), with changes to savings percentages and quality withholds applicable on a Demonstration Year basis.)

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

<b>Demonstration Year</b>	<b>Calendar Dates</b>
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 under the Demonstration**

	<b>Medicare A/B</b>	<b>Medicare D</b>	<b>Medicaid</b>
<b>2013 Baseline costs for the purposes of setting payment rates</b>	Blend of Medicare Advantage payments and Medicare standardized FFS payments weighted by where Medicare-Medicaid Enrollees	National average monthly bid amount (NAMBA) will be used as the baseline for the direct subsidy portion of	Historical State data. Trend rates developed by State actuaries based on State Plan and HCBS waiver services, with
Medicare baseline			

	<b>Medicare A/B</b>	<b>Medicare D</b>	<b>Medicaid</b>
<p>spending will be established prospectively on a year-by-year basis for each demonstration county.</p> <p>Medicaid baseline spending amounts shall be set up front and will be applied in future years unless more recent historical data are available and/or CMS' actuaries determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.</p>	<p>who meet the criteria and who are expected to transition into the demonstration are enrolled in the prior year. Baseline costs will be calculated as a per member per month standardized cost.</p>	<p>Medicare Part D spending.</p> <p>Note that additional costs associated with LIS payments, reinsurance payments, and risk-sharing payments are also included in the baseline and will be factored into Demonstration Plan payments, as appropriate, but these amounts are subject to reconciliation consistent with Medicare Part D reconciliation rules.</p>	<p>oversight from CMS contractor and staff.</p>
<b>Responsible for producing data</b>	CMS	CMS	State Medicaid agency, validated by CMS
<b>Savings percentages</b>	Year 1: 1% Year 2: 3% Year 3: 5%	Not Applicable	Year 1: 1% Year 2: 3% Year 3: 5%
<b>Risk adjustment</b>	Medicare Advantage CMS-HCC Model	Medicare Part D RxHCC Model	Rate Cell Structure
<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>Other Payment Provisions</b>	Medical Loss Ratio (MLR)	Existing Medicare Part D processes will apply	MLR

## **I. Underlying Rate Structure for Medicaid Components of the Rates**

The rating categories to be utilized in the Medicare-Medicaid Alignment Initiative are described below.

The proposed rate cells for the Demonstration are stratified by age (21-64 and 65+), geographic service area (Greater Chicago and Central Illinois), and setting-of-care as follows:

- Nursing Facility (NF). The NF rate cell will be paid for individuals residing in a NF on the first of the month in which the payment is made. The exception to this is the first 3 months upon transition from a qualifying waiver in which case the payment will be based on the Waiver rate cell for this interim period.
- Waiver. The Waiver rate cell will be paid for individuals enrolled in a qualifying HCBS waiver as of the first of the month in which the payment is made. The exception to this is the first 3 months upon transition from a NF to a qualifying waiver.
- Waiver Plus. The Waiver Plus rate cell will be paid for individuals moving from the NF to a qualifying waiver for the first 3 months of transition.
- Community. The Community rate cell will be paid for individuals who do not meet the state's nursing home level of care criteria and do not reside in a NF or qualify for an HCBS waiver.

The rate cell structure was developed to align the payment with risk while incentivizing movement from the nursing facility to home and community based care. The method to accomplish this includes both incentives and penalties. The incentive includes an enhanced payment rate for a period of time following movement from the nursing facility. The penalty includes payment at the lower waiver rate for a period of time in cases where an individual moves from waiver to nursing facility.

## **II. Baseline spending and payment rates for target population in the Demonstration area.**

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

### **A. Medicaid:**

- a. Prior to implementation of the Demonstration, the State and its actuaries will be responsible for establishing the baseline spending for Medicaid services that will be included under the Demonstration using the most recent data available. The

baseline will take into account historic costs, and will be trended forward to the Demonstration period.

- b. The State and its actuaries will provide the estimated baseline spending and underlying data for each year of the Demonstration at the beginning of the Demonstration period to the CMS contracted actuary, who will validate the estimate of projected costs in Medicaid (absent the Demonstration).
- c. Medicaid payment rates will be determined by applying the annual savings percentages (see section III and IV) to the baseline spending amounts.
- d. The State will combine counties into larger regions. See Appendix 3 for a Map of the Demonstration service areas. Payment rates will be determined per Demonstration service area.
- e. Except for updates based on more recent historical data, updates to the Medicaid baseline will not be allowable unless CMS determines the update would result in a substantial change to the baseline necessary to calculate accurate payment rates for the Demonstration.

B. Medicare Part A/B:

- a. CMS will develop baseline spending (costs absent the Demonstration) and payment rates for Medicare A and B services using estimates of what Medicare would have spent on behalf of the Medicare-Medicaid Enrollees absent the Demonstration.
- b. The Medicare baseline rate for A/B services will be a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.
- c. Medicare A/B payment rates will be determined by applying the annual savings percentages (see section III and IV) to the baseline spending amounts.
- d. Both baseline spending and payment rates under the Demonstration for Medicare A/B services will be calculated as PMPM standardized amounts for each county participating in the State's Demonstration for each year. Beneficiary risk scores will be applied to the standardized payment rates at the time of payment.

- e. Depending on the definition of the Demonstration-eligible group, CMS may require the 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.
- f. 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.
- g. CMS annually applies a coding intensity adjustment factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original FFS Medicare programs. The adjustment for 2013 is 3.41%. The majority of new Demonstration Plan Enrollees will come from Medicare FFS, and during the calendar year of initial enrollment, risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the Demonstration 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 coding intensity adjustment reflective of the projected enrollment patterns. After calendar year 2014, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Demonstration Plan Enrollees.

C. Medicare Part D:

The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Medicare Part D sponsors. The CY 2013 Part D NAMBA is \$79.64.

**III. Aggregate savings percentages under the Demonstration.**

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

B. The savings percentages under this Demonstration will be as follows:

- a. Year 1: 1%
- b. Year 2: 3%
- c. Year 3: 5%

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

#### **IV. Application of aggregate savings percentages to each component of the integrated rate.**

The aggregate savings percentages identified above will be applied to the Medicare A/B and Medicaid components of the rate. The Medicaid savings percentages may vary by rating category but will equal the aggregate savings percentages identified above. Changes to the savings percentages under section III of Appendix 6 would only occur if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration.

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

#### **V. Risk adjustment methodology.**

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

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

- A. Under the Demonstration, both payors will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to Demonstration Plans' performance consistent with established quality thresholds. These

thresholds are based on a combination of certain core quality withhold measures (across all Demonstrations), as well as State-specified quality measures.

**B. Withhold Measures in Demonstration Year One.**

- a. The quality withhold will be 1% in Demonstration Year One. Figure 6-3 below identifies withhold measures for Demonstration Year One. Together, these will be utilized as the basis for the 1% withhold. Additional detail regarding the agreed upon measures will be included in the Three-way Contract.
- b. Because Demonstration Year One crosses calendar years, Demonstration Plans will be evaluated to determine whether they have met required quality withhold requirements at the end of both CY 2013 and CY 2014. The determination in CY 2013 will be based solely on those measures that can appropriately be calculated based on the actual enrollment volume during CY 2013. Consistent with such evaluations, the withheld amounts will be repaid separately for each CY.

**Figure 6-3: Quality Withhold Measures for Demonstration Year One<sup>1</sup>**

<b>Domain</b>	<b>Measure</b>	<b>Source</b>	<b>CMS Core Withhold Measure</b>	<b>State Specified Withhold Measure</b>
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of Enrollees stratified to medium or high risk with a completed comprehensive assessment within 90 days of enrollment.	CMS/State defined process measure	X	
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with the Three-way Contract requirements.	CMS/State defined process measure	X	
Customer Service (for CY 2014 only)	Percent of best possible score the Demonstration Plan earned on how easy it is to get information and help when needed.	AHRQ/CAHPS	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Withhold Measure
	<ul style="list-style-type: none"> <li>In the last six months, how often did your health plan's customer service give you the information or help you needed?</li> <li>In the last six months, how often did your health plan's customer service treat you with courtesy and respect?</li> <li>In the last six months, how often were the forms for your health plan easy to fill out?</li> </ul>			
Getting Appointments and Care Quickly (for CY 2014 only)	<p>Percent of best possible score the Demonstration Plan earned on how quickly members get appointments and care</p> <ul style="list-style-type: none"> <li>In the last six 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 six months, not counting the times when you needed care right away, how often did you get an</li> </ul>	AHRQ/CAHPS	X	



Domain	Measure	Source	CMS Core Withhold Measure	State Specified Withhold Measure
	<p>appointment for your health care at a doctor's office or clinic as soon as you thought you needed?</p> <ul style="list-style-type: none"> <li>In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?</li> </ul>			
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	Demonstration Plan has established a work plan and identified individual in its organization who is responsible for ADA compliance related to this Demonstration	CMS/State defined process measure		X

C. Withhold Measures in Demonstration Years Two and Three – The quality withhold will increase to 2% in Demonstration Year Two and 3% in Demonstration Year Three. Figure 6-4 below identifies the quality withhold measures for Demonstration Years Two and Three. Additional detail regarding the agreed upon measures will be included in the Three-way Contract.

**Figure 6-4: Quality Withhold Measures for Demonstration Years Two and Three**

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Withhold Measure
Plan all-cause readmissions	Percent of members discharged from a hospital stay who were	NCQA/HEDIS	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Withhold Measure
	readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.			
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 six 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/HEDIS HOS	X	
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	
Part D medication adherence for oral diabetes medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	
Transition of	Report number of members	State		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Withhold Measure
Members from LTC to Waiver Services	moving from: institutional care to waiver services. (Exclude institutional stays $\leq$ 90 days)			
Long Term Care Residents – Prevalence of Pressure Ulcers (PPU)	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).	State		X

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

## VII. Payments to Demonstration Plans.

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

### **VIII. Evaluate and pay participating health plans relative to quality withhold requirements.**

- A. CMS and the State will evaluate plan performance according to the specified metrics required in order to earn back the quality withhold for a given year. CMS and the State will share information as needed to determine whether quality requirements have been met and calculate final payments to each Demonstration Plan from each payor.
- B. Whether or not each Demonstration Plan has met the quality requirements in a given year will be made public, as will relevant quality scores of Demonstration Plans in years two and three.

### **IX. Medical Loss Ratio, Reconciliation, and Rate Review**

- A. **Medical Loss Ratio:** Beginning in calendar year 2014, Demonstration Plans will be required each year to meet a Target Medical Loss Ratio (TMLR) threshold of 85 percent, which regulates the minimum amount of revenue that must be used for expenses either directly related to medical claims or care coordination.

If the Medical Loss Ratio (MLR) calculated annually is less than the TMLR, the Demonstration Plan shall remit to the State and CMS an amount equal to the difference between the calculated MLR and the TMLR (expressed as a percentage) multiplied by the revenue received during the coverage year. Any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs.

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

- B. **Cost Reconciliation:** Cost reconciliation under Medicare Part D will continue as is under the Demonstration. CMS will monitor Part D costs closely on an ongoing basis. Any material increase in Part D costs relative to the baseline may be factored into future Demonstration Year savings percentages.
- C. **Rate Review Process:** CMS and the State will review Demonstration Plan financial reports, encounter data, and other information to assess the ongoing financial stability of the Demonstration Plans and the appropriateness of capitation payments. At any point, the State may request that CMS staff review documentation from specific Demonstration Plans to assess financing issues.

In the event that two or more Demonstration Plans show MLRs below 85%, or in the

event that two or more Demonstration Plans show annual losses exceeding 5%, CMS will convene the following parties, or their designees, to assess the factors resulting in the payment or loss and, as warranted, evaluate the payment parameters, including the respective projected baselines, savings percentages, and risk adjustment methodology: (1) CMS participants: Administrator, Chief Actuary or his/her designee, Director of the Center for Medicare, Director of the Center for Medicaid and CHIP Services, Director of the Medicare-Medicaid Coordination Office; (2) Office of Management and Budget participants: Medicare Branch Chief, Medicaid Branch Chief; (3) State participants: Medicaid Director or his/her designee and actuarial consultant. These parties will review available data, as applicable, including data on enrollment, utilization patterns, health plan expenditures, and risk adjustment to assess the appropriateness of capitation rates and identify any potential prospective adjustments that would ensure the rate-setting process is meeting the objective of Medicare and Medicaid jointly financing the costs and sharing in the savings.

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

- A. Rates will be updated using a similar process for each calendar year. Changes to the baseline outside of the annual Medicare Advantage rate announcement would occur only if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in enrollment assumptions; major changes in Federal law and/or State law or policy; and changes in coding intensity.
- B. If Congress acts to delay or replace the Sustainable Growth Rate (SGR) formula used to adjust Medicare physician payment rates, CMS will adjust the Medicare baseline for beneficiaries who otherwise would have been enrolled in Original FFS Medicare to reflect the revised current law physician payment rates. If Congress applies changes retroactively after the SGR cuts are scheduled to go into effect, CMS will adjust the rates retroactively as well.

If other State or federal 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 annual rate development process.

- C. 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 A/B baselines.

## **Appendix 7: Demonstration Parameters**

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

The following sections explain details of the Demonstration design, implementation and evaluation. Where waivers from current Medicare and Medicaid requirements are required, such waivers are indicated in Appendices 4 and 5.

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

HFS is the single state agency for the Medicaid program. The HFS Director directly oversees the agency that will be involved with implementing and monitoring the Demonstration. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across HFS as described below.

Illinois' Administrator of the Division of Medical Programs (Medicaid Director) reports directly to the Director of HFS and will oversee the Demonstration through his or her Deputy Administrator of Medical Programs. The Deputy Administrator of Medical Programs will report directly to the Medicaid Director on all aspects of the Demonstration. The Bureau of Managed Care within the Division of Medical Programs will oversee the selected Demonstration Plans, with dedicated program management staff taking on daily responsibilities. HFS recently hired additional staff charged with analyzing current policies and procedures to develop enhanced monitoring for the Demonstration.

### **II. Plan or Qualified Entity Selection**

The State, in consultation with CMS, issued a Request for Proposals (RFP) that included the State requirements to become a Demonstration Plan under this Demonstration.

The State issued the RFP in May 2012 and selected Demonstration Plans in November 2012. Illinois selected those organizations that best met the criteria established by HFS for a truly integrated care delivery system. The State's RFP and a list of selected plans are available at the following website:

<http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx>.

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

Demonstration Plans that sign a Three-way Contract must, as a condition of that contract, also pass a CMS- and State-sponsored Readiness Review.

### **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 Enrollment and Disenrollment-related transactions, including transfers between Demonstration Plans, will be processed through the Illinois Client Enrollment Services (CES). The State or its vendor will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third party CMS designates to receive such transactions. CMS will also submit a file to the State identifying individuals who have elected to enroll in another type of available Medicare coverage. The State or its designated contractor will share enrollment and disenrollment transactions with Demonstration Plans.
- c. Uniform Enrollment and Disenrollment Letter and Forms - Letters and forms will be agreed to by both CMS and the State. Over-the-phone Enrollment through the CES is the primary method of Enrollment. Beneficiaries may only receive a paper Enrollment form by requesting one from the CES.
- d. Enrollment Effective Date(s) - All enrollment effective dates are prospective. Beneficiary-elected enrollments are effective the first day of the month following a beneficiary's request to enroll, so long as the request is received by the 12<sup>th</sup> of the month. Enrollment requests, including requests to change among Demonstration Plans, received after the 12<sup>th</sup> of the month will be effectuated the first of the second month following the request. Passive Enrollment is effective not sooner than 60 days after beneficiary notification. CMS and the State will monitor input received by the Ombudsman and Demonstration Plans about the time between the beneficiary's Enrollment request and the effective date of Enrollment. After the first year of the Demonstration, or when the State updates its eligibility systems, the State and CMS will also revisit the timeline for



processing enrollments and, if necessary, will shorten the time period between the beneficiary's Enrollment request and the effective date of enrollment.

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

- i. Demonstration Plans will be required to accept opt-in enrollments no earlier than 90 days prior to the initial effective date of October 1, 2013, and Demonstration Plans must begin providing coverage for those enrolled individuals on October 1, 2013. Each Demonstration Plan's ability to accept opt-in enrollments, however, is contingent upon successfully passing the Readiness Review. The earliest effective date for Passive Enrollment will be January 1, 2014 as discussed below in d.ii.
  1. CMS will provide an initial notice of the Demonstration opt-in enrollment period to all Demonstration eligible beneficiaries no earlier than 90 days prior to the start of the opt-in enrollment period.
  2. The effective dates for opt-in and Passive Enrollment are subject to Demonstration Plans meeting CMS and State requirements, including Demonstration Plans' capacity to accept new Enrollees.
- ii. The State will conduct monthly Passive Enrollments for those eligible beneficiaries who have not made a Demonstration Plan selection for effective enrollment beginning January 1, 2014 or otherwise opted out of the Demonstration.
  1. During October 1, 2013 to December 31, 2013, CMS and the State will monitor each Demonstration Plans' ability to manage the opt-in enrollments. Dependent on each Demonstration Plan's capacity, as determined by its ability to manage the opt-in enrollments and the prior month's Passive Enrollments (once applicable), the State will passively enroll a number of beneficiaries into Demonstration Plans that takes into consideration the number of opt-in Enrollments and the opt-out rate for each Demonstration Plan. Furthermore:
    - a. In the Greater Chicago service area, the Passive Enrollment phase-in will not exceed 5,000 beneficiaries per month per Demonstration Plan and will occur over at least a 6-month

period. However, the goal of the Passive Enrollment phase-in is to limit the number of beneficiaries assigned to each Demonstration Plan on a monthly basis without extending the phase-in beyond 6 months unless required to by the 5,000 monthly cap; and

- b. In the Central Illinois service area, the Passive Enrollment phase-in will occur over a 6 month period and will not exceed 3,000 beneficiaries per month per Demonstration Plan.
  2. The State will provide notice of Passive Enrollments at least 60 days and no more than 90 days prior to the effective date of a Passive Enrollment period, and will accept opt-out requests prior to the effective date of enrollment.
  3. The 60-day notice will include the name of the Demonstration Plan in which the beneficiary would be enrolled unless he/she selects another Demonstration Plan or indicates the option to opt out of the Demonstration.
  4. At least thirty days prior to the enrollment effective dates above, the State will send a second notice to beneficiaries who have not responded to the initial notice or opted in. The CES may choose to call beneficiaries in addition to sending a notice, if appropriate. The State will proceed with Passive Enrollment into the identified Demonstration Plan for beneficiaries who do not make a different choice.
- iii. 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 Demonstration Plan. For example, those reassigned to a new PDP effective January 1, 2013, will be eligible for Passive Enrollment into a Demonstration Plan effective January 1, 2014, provided the individual meets the requirements of this Demonstration.
  - iv. The State and CMS must agree in writing to any changes to the enrollment effective dates. CMS will provide identifying information to the State about

beneficiaries that CMS anticipates will be reassigned for a January 1 of the following year effective date, no later than 120 days prior to the date of the first Passive Enrollment period.

- v. Beneficiaries who do not opt out of the Demonstration, and who are enrolled in a Medicare Advantage plan that is operated by the same parent organization that operates a Demonstration Plan, will be eligible for Passive Enrollment into the parent organization's Demonstration Plan effective January 1, 2014. Eligible beneficiaries enrolled in a Medicare Advantage plan that is operated by a parent organization that is not offering a Demonstration Plan may enroll into the Demonstration if they elect to disenroll from their current Medicare Advantage plan.
- e. Disenrollment Effective Date(s) – Disenrollments are effective the first of the month following the request to opt-out of the Demonstration. The CES will also accept cancellations of opt-in enrollment requests, where the beneficiary submits an enrollment request but then cancels the enrollment prior to the effective date.
- f. Upon CMS' or the State's written determination that the Demonstration will not be renewed, no enrollments will be accepted within six months of the end of the Demonstration.
- g. Passive Enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto- and facilitated enrollment for individuals with the Medicare Part D LIS.
- h. The State will develop an "intelligent assignment" algorithm for Passive Enrollment (e.g. that prioritizes continuity of providers and/or services). The algorithm will consider beneficiaries' previous managed care enrollment and historic provider utilization.
- i. The State or its Client Enrollment Services (CES) will provide customer service and options counseling, including mechanisms to counsel beneficiaries notified of Passive Enrollment. The CES will also receive and communicate beneficiary choice of opt-outs to CMS's contractor, who will communicate the choice to CMS via transactions to CMS' MARx system. Beneficiaries will also be provided a notice upon completion of the opt-out process. Medicare resources, including 1-800-Medicare, will remain available to Medicare beneficiaries that disenroll from the Demonstration. Beneficiary requests made to 1-800-Medicare for Enrollment, changes among Demonstration Plans, or Disenrollment (when possible) will be referred to the State or its designated CES.

- j. The State or its vendor will provide notices, as approved by CMS, to ensure complete and accurate information is provided in concert with other Medicare communications, such as Medicare & You and Medicare Plan Finder. CMS may also send a notice to beneficiaries and will coordinate such notice with any State notice(s).
- k. Enrollment data in State and CMS systems will be reconciled on a timely basis to prevent discrepancies between such systems.

#### **IV. Delivery System Requirements**

- a. Requirements for Medical Homes – Demonstration Plans must operate networks from which an Enrollee can choose a provider that acts as a medical home. There will be a focus on Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), PCP-centered medical groups, and private practice PCP offices. Medical homes will provide evidence-based primary care services, acute illness care, behavioral health care (where appropriate), chronic health condition management, and referrals for specialty care and LTSS. Medical homes will be supported by health information technology (HIT) and be a part of the interdisciplinary care team (care team) to assist in coordinating care across the full spectrum of available services, including behavioral health care, and managing transitions between levels of care. Not all primary care offices are ready or capable of operating as true medical homes. However, Demonstration Plans will be required to have a process in place to facilitate medical homes advancing towards National Committee for Quality Assurance (NCQA) certification and will be required to provide financial incentives to providers that achieve NCQA medical home certification.
- b. Requirements for Integrated Primary Care and Behavioral Health Care – Demonstration Plans shall offer integrated primary and behavioral health care services, as appropriate, within Demonstration Plan networks with an emphasis on co-location. Demonstration Plans are required to support and encourage the use of integration and co-location of physical and behavioral health through mechanisms such as the placement of a behavioral health clinician in a primary care setting, the placement of a primary care clinician in a behavioral health practice, the exchange of data between physical and behavioral health care providers serving Enrollees, or an alternative arrangement.

The State plans to enforce this requirement by methods such as: 1) including the Demonstration Plan's approved approach to integration of physical and behavioral health in its Three-way Contract with the State and CMS; or 2)

ensuring the Plan has the necessary contractual agreements in place between providers to integrate these services during Readiness Review.

c. Requirements for Enrollee Assessments and Stratification –

- i. Demonstration Plans will have a health risk questionnaire (health screening) and will administer it to all new Enrollees within 60 days after enrollment. The health screening will collect information about the Enrollee’s medical, psychosocial, functional, and cognitive needs, and medical and behavioral health (including substance abuse) history. As discussed below, Plans will use the information, along with predictive modeling, to guide the administration of a comprehensive health risk and/or a behavioral health risk assessment (comprehensive assessment).
- ii. Plans will supplement the initial health screening with predictive modeling and surveillance data to stratify Enrollees to the appropriate level of intervention. Enrollees will be stratified into three levels: low-, moderate-, and high-risk. Those Enrollees stratified to moderate- or high-risk levels will receive a further comprehensive assessment within 90 days after enrollment. The comprehensive assessment will be inclusive of the HCBS service plan assessment, when applicable. If a comprehensive assessment is not required for an Enrollee in an HCBS waiver, the service plan assessment must be completed within 90 days after enrollment. Demonstration Plans have the option of completing the comprehensive assessment in place of the health screening within 90 days after enrollment. Demonstration Plans will be required to stratify no less than 5% of Enrollees as high-risk. Demonstration Plans will be required to stratify no less than 20% of Enrollees to moderate- and high-risk levels combined.
- iii. Demonstration Plans will analyze predictive modeling reports and other surveillance data for all Enrollees monthly to identify risk level changes. As risk levels change, reassessments will be completed as necessary and Care Plans updated. Service plan reassessments will be completed within the required timeframes under the appropriate 1915(c) waivers, at least annually.
- iv. Demonstration Plans will review Care Plans of Enrollees at high-risk at least every thirty (30) days, and Enrollees at moderate-risk at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. Care Plans and interventions will be updated as needed. At a minimum, Demonstration Plans will complete reassessment annually for all Enrollees or as dictated under the 1915(c) waiver; eligibility determinations for 1915(c)

waivers will not be the responsibility of the Demonstration Plans. In addition, Demonstration Plans will complete a face-to-face reassessment for individuals receiving HCBS waiver services or residing in nursing facilities each time there is a significant change in the Enrollee's condition or the Enrollee requests reassessment.

- d. Requirements for Care Management – Demonstration Plans will offer Care Management services to all Enrollees based on their risk-level to ensure effective linkages and coordination between the medical home and other providers and services and to coordinate the full range of medical and social supports, as needed, both within and outside the Demonstration Plan. All Enrollees will be assigned a Care Coordinator and a care team.

As stated in section c(ii) above, Enrollees shall be assigned to one of three levels – low, moderate, or high-risk. The intensity of Care Management services will depend on an Enrollee's risk level. For Enrollees stratified as low-risk, Demonstration Plans will provide prevention and wellness messaging and condition-specific education materials. For Enrollees stratified as moderate-risk, Demonstration Plans will provide Care Management services dedicated to problem-solving interventions. For Enrollees stratified as high-risk, Demonstration Plans will provide intensive Care Management.

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

- i. Requirements for an Interdisciplinary Care Team (care team) – Every Enrollee must have access to and input in the development of an interdisciplinary care team led by a Care Coordinator. The care team will be person-centered: built on the Enrollee's specific preferences and needs and with his or her input, delivering services with transparency, individualization, respect, linguistic and Cultural Competence, and dignity. Care teams will:
  - 1. Be led by a Care Coordinator who is accountable for coordination of all benefits and services the Enrollee may need. Care Coordinators will have prescribed caseload limits that vary based on risk-level (see section d(iv)). Where the Care Coordinator is not also the service coordinator, the service coordinator will be incorporated into the care team;

2. Support providers in medical homes, assist in assuring integration of services and coordination of care across the spectrum of the healthcare system, and help provide Care Management for Enrollees;
  3. Assure appropriate and efficient care transitions including discharge planning;
  4. Assess the physical, social, and behavioral risks and needs of each Enrollee;
  5. Provide medication management;
  6. Provide Enrollee health education on complex clinical conditions and wellness programs;
  7. Assure integration of primary, specialty, behavioral health, LTSS, and referrals to community-based resources, as appropriate;
  8. Maintain frequent contact with the Enrollee through various methods including face-to-face visits, email, and telephone options, as appropriate to the Enrollee's needs and risk-level. For Enrollees stratified to high-risk, a member of the care team must engage in face-to-face contact with the Enrollee at least once every 90 days or as specified in the HCBS waiver if more frequent and applicable; and
  9. Assist in the development of a person-centered Care Plan within 90 days after enrollment; and
  10. Assist in the implementation and monitoring of the person-centered Care Plan.
- ii. Care Coordinator Responsibilities: The Care Coordinator will lead the care team and will be responsible for leading the provision of Care Management services, as determined by an Enrollee's needs and preferences.
  - iii. Care Coordinator Qualifications and Training: Care Coordinators must have the qualifications and training appropriate to the needs of the Enrollee, and each Demonstration Plan must establish policies for appropriate assignment of Care Coordinators. For example, Enrollees with higher-level needs could be assigned Care Coordinators with clinical backgrounds such as registered

nurses, licensed clinical social workers, rehabilitation specialists, or other relevant clinical backgrounds. Care Coordinators for Enrollees with higher-level needs may also have community-based experience working with the elderly, persons with disabilities, including developmental disabilities, and person-centered planning approaches. Enrollees identified to have low levels of risk and/or needs may be assigned Care Coordinators with non-clinical backgrounds, such as counselors or peer support counselors.

For Enrollees in HCBS waivers, either the Care Coordinator or another member of the care team must meet the qualifications and training requirements as specified in Illinois administrative code.

Specific educational and training requirements will be detailed in the Three-way Contracts, but at a minimum, training topics will include person-centered planning processes, cultural and disability competencies, compliance with the Americans with Disabilities Act, and independent living and recovery.

- iv. Care Coordinator Caseloads: Demonstration Plans must include a sufficient number of Care Coordinators with the background and training to serve low, moderate, and high-risk Enrollees, based on an analysis of the population to be served.

Care Coordinators assigned to Enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set, taking into account the risk-level of the Enrollee. Demonstration Plans will provide CMS and the State with its methodology for assigning weights to Enrollees with varying risk levels for prior approval and assessment during Readiness Review. In addition, caseloads of Care Coordinators shall not exceed the following standards:

1. High Risk Enrollees. Enrollees identified as needing intensive Care Management services – 1:75
2. Moderate Risk Enrollees. Enrollees identified as needing supportive Care Management services – 1:150
3. Low-Risk Enrollees. Enrollees identified as needing prevention and wellness – 1:600



4. For Enrollees in the Persons with Brain Injury waiver or the Persons with HIV/AIDS waiver, the caseloads shall not exceed 1:30.
- v. Care Management for Enrollees Receiving HCBS waiver services - Demonstration Plans will be required to provide the full range of care coordination including HCBS waiver service planning, connecting Enrollees with local community services, and coordinating referrals for other non-Covered Services, such as supportive housing and other social services, to maximize opportunities for independence in the community.
- vi. Care Plan Requirements – The Care Plan must be developed within 90 days of enrollment, be updated as necessary at least annually for all Enrollees or as specified in the HCBS waiver, and:
  1. Incorporate an Enrollee’s medical, behavioral health, LTSS, social, and functional needs;
  2. Include identifiable goals to address the Enrollee’s needs and preferences and to facilitate monitoring of an Enrollee’s progress and evolving service needs;
  3. Include, in the development, implementation, and ongoing assessment of the Care Plan, an opportunity for Enrollee participation and an opportunity for input from the PCP, other providers, a legal representative, and the Enrollee’s family and/or caregiver if appropriate; and
  4. Include a HCBS service plan, if appropriate:
    - a. For beneficiaries receiving HCBS waiver services, responsibilities regarding development of the HCBS waiver service plan (service plan) component of the Care Plan may differ depending on whether an Enrollee is already receiving HCBS waiver services at the time of enrollment in the Demonstration (existing HCBS eligible) or is determined newly eligible for HCBS waiver services after enrollment in the Demonstration (newly HCBS eligible).
      - i. For those newly HCBS-eligible Enrollees, the Demonstration Plan will be involved in service plan development from the moment the Enrollee is

determined eligible for services. The Demonstration Plans will be responsible for HCBS waiver service planning, including the development, implementation, and monitoring of the service plan, and updating the service plan when an Enrollee's needs change. The Demonstration Plan Care Coordinator will coordinate HCBS waiver service planning with the Enrollee and the care team. Demonstration Plans will not be responsible for eligibility determinations for 1915(c) waivers.

- ii. For existing HCBS-eligible Enrollees, the Demonstration Plans will maintain the existing service plan for at least an 180-day transition period unless changed with the consent and input of the Enrollee and only after completion of a comprehensive assessment. These service plans will be transmitted to Demonstration Plans prior to the effective date of enrollment. The Demonstration Plan Care Coordinator will coordinate the process for changing or updating the HCBS waiver service plan, as appropriate, with the Enrollee and the care team.
- e. Requirements for Self-Direction – Demonstration Plans will support Enrollees in directing their own care and Care Plan development. Furthermore, Enrollee self-direction is a component of the HCBS waivers operated by the Division of Rehabilitation Services under the State's Home Services Program (the three waivers that have participant direction are: the Persons with Disabilities waiver; the Persons with HIV/AIDS waiver; and the Persons with Brain Injury waiver). Under these waivers, Enrollees will serve as co-employer of personal assistants, and Demonstration Plans will be responsible for supporting Enrollees in their role as co-employers. Demonstration Plans must assure that Care Coordinators or another member of the care team are properly trained and have the skills and resources to be able to train Enrollees in employing their own personal assistants.
- f. Requirements for Care Transitions – Because Demonstration Plans will be required to assure integration of primary, specialty, behavioral health, LTSS, monitor transitions between levels of care, and facilitate discharge planning, Demonstration Plans will be required to operate a SNFist program. The SNFist

program must be designed to improve health outcomes among nursing home residents, particularly those with high rates of hospitalization. A SNFist program may include an adequate network of providers that are part of a coordinated group working together and specializing in medical care for the population residing in nursing homes. The SNFist program may also include visiting onsite care by the SNFist in the nursing home to provide constant monitoring of Enrollee health status and continual updates to the Enrollee Care Plan, as appropriate, or an alternative structure. Demonstration Plans may operate a hospitalist program as well to improve care transitions. Demonstration Plans that proposed a hospitalist program through their RFP response will be required to operate one under the Three-way Contract.

- g. Requirements for Demonstration Monitoring and Continuous Improvement –
  - i. Monitoring – CMS and the State will work intensively with Demonstration Plans prior to implementation and will closely monitor them following implementation. Key areas of oversight will include provider networks, claims payment, service authorization and delivery, participant direction, critical incident reporting and follow-up, and data transfers. Other monitoring activities will include reviews of Enrollee Care Plans, service authorizations, and services received to ensure that Plans are providing services agreed to by the Enrollee in the plan of care.
  - ii. Continuous Improvement - Performance will be monitored throughout the operation of the Demonstration and measured according to the quality metrics specified in Section XI.h below. The State, CMS, and Demonstration Plans will ensure continual improvement to the operation of the Demonstration through monitoring of compliance with performance measures. Other monitoring activities will include Demonstration Plan beneficiary advisory committees and quarterly stakeholder meetings held by the State.

The State will also establish an independent Ombudsman outside of the State Medicaid agency and the State and CMS will respond to the appropriate inquiries from this entity to improve the functioning of the Demonstration.
- h. Requirements Regarding the *Colbert* and *Williams* Consent Decrees – The Demonstration will serve as a vehicle for implementation of the *Colbert* Consent Decree for those class members who are dually eligible for Medicare and Medicaid. Working in conjunction with the State and other State contractors, Demonstration Plans will be responsible for assessing an Enrollee’s readiness for

and providing the Enrollee with options for transition to the community. Enrollees transitioning to the community will have access to non-Medicaid services provided outside of the Demonstration Plan that are required under the Consent Decree, such as housing subsidies, and Demonstration Plans will be responsible for coordinating with the entities responsible for these services. For those Enrollees who choose to transition to the community, and are enrolled in the Demonstration, Demonstration Plans will designate a *Colbert* transition administrator. The *Colbert* transition administrator will serve as the point-of-contact between the Demonstration Plan and other entities involved, such as other State agencies or State contractors, in providing the necessary services required under the *Colbert* Consent Decree. Demonstration Plans will be responsible for heightened monitoring as the individual adjusts to living in the community. The Three-way Contracts may include additional Demonstration Plan responsibilities related to the *Colbert* Consent Decree. Demonstration Plans will also be responsible for ensuring Enrollees who are *Williams* class members have access to all Medicare and Medicaid services required by the service plan developed by the Enrollee's *Williams* provider unless a modification is agreed to by the Enrollee and the Enrollee's *Williams* provider.

- i. Requirements for Network Adequacy – State Medicaid standards shall be utilized for LTSS, behavioral health services where Medicare is not primary, and prescription drugs that Medicaid covers and are excluded from Medicare Part D, and Medicare standards shall be utilized for Medicare prescription drugs and for other services for which Medicare is primary. Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to State Medicaid standards, so long as the State can show that such standards are at least as stringent and beneficiary friendly as Medicare standards.
  - i. LTSS standards – Unless the State approves an exception, for the first year of the demonstration (October 1, 2013 – December 31, 2014) Demonstration Plans will be required to offer contracts to all nursing facilities and supportive living facilities, as well as any willing LTSS provider in the service area that renders such Covered Services so long as such provider meets all applicable State and federal requirements for participation in the Medicaid program and meets the qualifications of the applicable HCBS waiver.

After the first year of the Demonstration, Demonstration Plans may establish quality standards and may contract with only those providers that meet such

standards, provided that all of the contracting providers are informed of any such quality standards no later than 90 days after the start of the first year of the Demonstration and that the State has given prior approval of the quality standards. Any such quality standards that are not established within 90 days after the start of the Demonstration must be in effect for 12 months before the Demonstration Plan may terminate a contract of a provider based on a failure to meet such quality standards. The State may grant exceptions to these contracting requirements for reasons other than failure to meet the quality standards. The Demonstration Plan must transition beneficiaries, or have a plan to transition beneficiaries, to new providers prior to terminating the contracts. The following provider specific standards also apply:

1. For Nursing Facilities (NFs) and Supportive Living Facilities (SLFs), Demonstration Plans must maintain the adequacy of its provider network within each county of the service area provided that each provider meets all applicable State and federal requirements for participation in the Medicaid Program.
2. For providers of each of the Covered Services listed below under a HCBS waiver, within each county in the service area, Demonstration Plans must enter into and maintain contracts with a set of providers that provided at least eighty percent (80%) of the fee-for-service services during CY 2012. For counties where there is more than one provider of Covered Services, Demonstration Plans shall enter into contracts with at least two of such providers, even if one served more than eighty percent (80%) of the current clients. HCBS services subject to this standard include:
  - Adult Day Care
  - Homemaker
  - Day Habilitation (BI waiver)
  - Supported Employment (BI waiver)
  - Home Delivered Meals
  - Home Health Aides
  - Nursing Services
  - Occupational Therapy
  - Speech Therapy
  - Physical Therapy

3. The following requirements apply for the remaining HCBS waiver services:

- Environmental Modifications: Demonstration Plans will be monitored to ensure that necessary environmental modifications are made within 90 days after the Demonstration Plan becomes aware of the need.
- Personal Assistants: The State is not dictating a network adequacy requirement, as personal assistants are hired at the discretion and choice of the beneficiary. However, Demonstration Plans are required to assist Enrollees in locating potential personal assistants as necessary.
- Personal Emergency Response System: Demonstration Plans must contract with at least two providers that serve the service area.

For any Covered Services for which Medicare requires a more rigorous network adequacy standard than described above, including time, distance, and/or minimum number of providers or facilities, the Demonstration Plan must meet the Medicare requirements.

- ii. Medicare network standards account for the type of service area (e.g. rural, urban, suburban, etc.), travel time, and minimum number of the type of providers, as well as distance in certain circumstances. The State and CMS may grant exceptions to these general rules to account for patterns of care for Medicare-Medicaid Enrollees but will not do so in a manner that will dilute access to care for Enrollees. Networks will be subject to confirmation through Readiness Reviews.
- j. Solvency— Demonstration Plans will be required to meet Solvency requirements, consistent with 42 CFR §438.116, §422.400, and §422.504(a)(14), and 215 Illinois Compiled Statutes (ILCS), 125/2-2; and
- k. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts - Demonstration Plans will be required to adhere to managed care standards at 42 CFR 438.214 and 42 CFR 422.204, and to credential and recredential providers in accordance with NCQA credentialing standards as well as credentialing and recredentialing guidelines as defined by the ILCS (410 ILCS 517) and further defined by the Illinois Administrative Code (77Ill. Adm. Code

965). State Operating Agencies will be responsible for approval and authorization of waiver service providers.

## **V. Benefits**

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

(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.

(per the State): a service, supply or medicine that is appropriate, covered by the State, and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Demonstration Plan's guidelines, policies or procedures based on applicable standards of care and as approved by HFS if necessary, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

Demonstration Plans will be required to provide services in a way that preserves all protections to the Enrollee provided by Medicare and the Illinois Medicaid program. Where there is overlap between Medicare and Medicaid, coverage and rules will be delineated in the Three-way Contract.

- b. Flexible Benefits – Demonstration Plans will have discretion to use the capitated payment to offer flexible benefits, as specified in the Enrollee's Care Plan, as appropriate to address the Enrollee's needs.
- c. 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 Demonstration Plan, but will obtain the hospice service through the Medicare FFS benefit and the Demonstration Plan would no longer receive Medicare Part C payment for that Enrollee. Medicare hospice services and hospice drugs and all other Original Medicare services would be paid for under Medicare fee-for-service. Demonstration 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 Demonstration Plans. Demonstration Plans would continue to receive Medicare Part D payment for all non-hospice covered drugs.

- d. Continuity of Care – Demonstration Plans will be required to offer a 180-day transition period in which Enrollees may maintain a current course of treatment with a provider who is currently out of the Demonstration Plan’s network. The 180-day transition period is applicable to all providers, including behavioral health providers and providers of LTSS. Out-of-network PCPs and specialists providing an ongoing course of treatment will be offered Single Case Agreements to continue to care for that Enrollee beyond the 180 days if they remain outside the network.
  - i. Demonstration Plans may choose to transition Enrollees to a network PCP earlier than 180 days only if:
    - 1. The Enrollee is assigned to a medical home that is capable of serving his/her needs appropriately;
    - 2. A health screening and/or a comprehensive assessment, if necessary, is complete;
    - 3. The Plan consulted with the new medical home and determined that the medical home is accessible, competent, and can appropriately meet the Enrollee’s needs;
    - 4. A transition care plan is in place (to be updated and agreed to with the new PCP, as necessary); and
    - 5. The Enrollee agrees to the transition prior to the expiration of the 180-day transition period.
  - ii. Demonstration Plans may choose to transition Enrollees to a network specialist or LTSS provider earlier than 180 days only if:
    - 1. A health screening and/or a comprehensive assessment, if necessary, is complete;
    - 2. A transition care plan is in place (to be updated and agreed to with the new provider, as necessary); and
    - 3. The Enrollee agrees to the transition prior to the expiration of the 180-day transition period.
- e. With the exception of Part D drugs, which are required to follow all Part D transition requirements, all prior approvals for drugs, therapies, or other services existing in Medicare or Medicaid at the time of enrollment will be honored for



180 days after enrollment and will not be terminated at the end of 180 days without advance notice to the Enrollee and transition to other services, if needed.

- f. Out of Network Reimbursement Rules - Plans must reimburse an out-of-network provider of emergent or urgent care, as defined by 42 CFR 424.101 and 42 CFR 405.400 respectively, at the Medicare or Medicaid FFS rate applicable for that service. Where this service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Balance billing protections will still apply under this scenario.

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

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

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

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

(3) Factors: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the Demonstration Plan application. The factors for each element will

be scored using a system from zero to four, where four is the highest score for a factor. Demonstration Plans are required to provide a response that addresses every factor within each of the eleven elements. The scores for each factor within a specific element are totaled to provide the overall score for that element out of a total of 160 possible points. Demonstration Plans must achieve a minimum score of 70% to meet the CMS approval standard.

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

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

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

**VII. Prescription Drugs** – the integrated formulary must include any Medicaid-covered drugs that are excluded by Medicare Part D. Demonstration 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 Demonstration Plan. Each Demonstration 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.

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

a. Integrated/Unified Appeals Process:

i. Appeal time frames - Enrollees, their authorized representatives, including providers who are authorized by the Enrollee, will have:

1. 60 calendar days from the date of notice of Action to file a Demonstration Plan Appeal;
2. 30 calendar days from the Demonstration Plan's notice of disposition (i.e., resolution) to request a State Fair Hearing for Medicaid-only services; and
3. 30 calendar days from the notice of the right to a State Fair Hearing following the Independent Review Entity's (IRE) adverse disposition (i.e., resolution) to request a State Fair Hearing for Medicare-Medicaid overlapping services. The Enrollee will receive notice of his or her right to request a State fair hearing from his or her Demonstration Plan and/or the State.

ii. Appeal levels -

1. All initial Appeal requests will be filed with the Demonstration Plan in accordance with applicable laws and regulations. The State will review all Demonstration Plan Appeal process policies and procedures to ensure consistency with Medicaid-required timelines.
2. Appeals for Medicare A and B services will be automatically forwarded to the Medicare Part C Independent Review Entity (IRE) if the Demonstration Plan upholds its initial denial.
3. For Medicaid-only benefits, if the resolution following the Demonstration Plan Appeal process is not wholly in favor of the Enrollee, such Enrollee or their authorized representative may request a State Fair Hearing.

4. For services in which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies, but excluding Medicare Part D), these services will be defined in a unified way in the Three-way Contract and as required Demonstration Plan benefits. If the resolution following the Demonstration Plan Appeal process is not wholly in favor of the Enrollee, the Appeal related to these services will be forwarded to the IRE by the Demonstration Plan. If the resolution of the IRE is not wholly in favor of the Enrollee, the Enrollee or their authorized representative may then request a State Fair Hearing and/or file a request for hearing with an Administrative Law Judge. Any determination in favor of the Enrollee will require payment by the Demonstration Plan for the service or item in question.

iii. Appeal resolution time frames –

1. All initial Appeals must be resolved by the Demonstration Plan within 15 business days of their submission for Standard Appeals and within 24 hours of their submission for Expedited Appeals.
2. For Medicare services automatically forwarded to the IRE, the IRE must notify the Enrollee of an expedited decision within 72 hours, a pre-service decision within 30 calendar days and a payment decision within 60 calendar days.
3. For Medicaid-only services appealed to a State Fair Hearing, Standard Appeals will be resolved within 90 calendar days of the filing of an Appeal with the Demonstration Plan, not including the number of days the Enrollee took to subsequently file for a State Fair Hearing, and Expedited Appeals will be resolved within 3 business days from the filing of an Appeal with the State Fair Hearing Agency.
4. For Medicare-Medicaid overlap services, if the Enrollee requests a State Fair Hearing for his or her Medicaid benefits, Standard Appeals will be resolved within 90 calendar days of the Demonstration Plan's notice of Disposition, not including the number of days the Enrollee took to file for a State Fair Hearing, and Expedited Appeals will be resolved within 3 business days from the filing of an Appeal with the State Fair Hearing Agency.

iv. Continuation of Benefits Pending an Appeal-

1. All Medicare Parts A and B, and non-Part D benefits will be required to be provided pending the resolution of the Demonstration Plan Appeal process. This means that such benefits will continue to be provided by providers to Enrollees, and that Demonstration Plans must continue to pay providers for providing such services pending the resolution of the Demonstration Plan Appeal process.
2. For Medicaid-only service and Medicare-Medicaid overlap service Appeals: If the request for an Appeal is filed with the Demonstration Plan within 10 calendar days of the notice of Action, services will be required to be provided pending the resolution of the Demonstration Plan Appeal process.
3. Following the Demonstration Plan Appeal process, if resolution at the Demonstration Plan level, is not wholly in favor of the Enrollee:
  - a. For Medicaid-only services, if the Enrollee files an Appeal with the State Fair Hearing Agency within 10 calendar days of the notice of disposition from the Demonstration Plan, services will be required to be provided and paid for pending the resolution of the State Fair Hearing Appeal process.
  - b. For appeals of Medicare-Medicaid overlap services, the Appeals will be forwarded to the IRE as discussed in IX.a.ii.4, and services will be required to be provided and paid for pending the resolution. If the resolution of the IRE is not wholly in favor of the Enrollee, services will be required to be provided and paid for pending resolution of the State Fair Hearing Appeal process, if the Enrollee files an Appeal with the State Fair Hearing Agency within 10 calendar days of the notice of disposition from the IRE.
- v. Integrated Notice - Demonstration Plan Enrollees will be notified of all applicable Demonstration, Medicare, and Medicaid Appeal and State Fair Hearing rights through a single notice jointly developed by the State and CMS.

## **X. Demonstration Plan Marketing, Outreach, and Education Activity**

As indicated in the CMS “Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation rates and Medicare Advantage and Part D Payment Policies and Final Call Letter” released on April 2, 2012, CMS Medicare Marketing Guidelines do not apply to 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 Demonstration Plans – Demonstration Plans will be subject to rules governing their marketing and Enrollee communications as specified under section 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., 438.10; §438.104; and the Medicare Marketing Guidelines (Chapter Two of the Medicare Managed Care Manual and Chapter Three of the Prescription Drug Benefit Manual). The following exceptions apply:
  - i. Demonstration Plans will not be allowed to market directly to individual potential Enrollees. Instead, Demonstration Plans may participate in group marketing events, provide general audience materials (such as general circulation brochures and media and billboard advertisements), and provide responses to beneficiary-initiated requests for Demonstration Plan information. As stated in this appendix, Demonstration Plans must refer all potential Enrollees to the CES for enrollment. The State reserves the right to develop predetermined marketing scripts for Demonstration Plan staff, subject to CMS review and approval. All processing of enrollments and disenrollments will occur as stated in this appendix.
- b. The Demonstration Plan shall not:
  - i. Provide cash, gifts, prizes, or other monetary rebates to induce enrollment.
  - ii. Seek to influence a potential Enrollee’s enrollment with a Demonstration Plan in conjunction with the sale of any other insurance.
  - iii. Induce providers or employees of CMS, Department of Human Services or HFS to reveal confidential information regarding Enrollees or otherwise use such confidential information in a fraudulent manner; or

- iv. Threaten, coerce, or make untruthful or misleading statements to Potential Enrollees or Enrollees regarding the merits of enrollment with a Demonstration Plan or any other Plan.
- c. Review and Approval of Marketing and Enrollee Communications – Demonstration 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. Demonstration 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 the State may agree to defer to one or the other party for review of certain types of marketing and Enrollee communications, as agreed in advance by both parties. Demonstration Plans must submit all marketing and Enrollee communication materials, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.
- d. Permissible Start Date for Demonstration Plan Marketing Activity – Demonstration Plans may begin marketing activity, as limited in Section X, no earlier than 90 days prior to the effective date of enrollment for the contract year.
- e. Minimum Required Marketing and Enrollee Communications Materials – At a minimum, Demonstration Plans will provide current and prospective Enrollees the following materials. These materials will be subject to the same rules regarding content and timing of beneficiary receipt as applicable under section 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; §438.10; §438.104; and the Medicare Marketing Guidelines (Chapter Two of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual).
  - i. An Evidence of Coverage (EOC) document that includes information about all State-covered and plan-covered supplemental benefits, in addition to the required Medicare benefits information.
  - ii. An Annual Notice of Change (ANOC) summarizing all major changes to the plan's covered benefits from one contract year to the next, starting in the second year of the Demonstration.
  - iii. Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the Demonstration Plan and Enrollee rights, as well as the benefits offered under the Demonstration Plan, including cost sharing, applicable conditions and limitations, and any other conditions associated

with receipt or use of benefits. Demonstration Plans will use a Demonstration-specific SB.

- iv. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits.
  - v. A comprehensive, integrated formulary that includes outpatient prescription drugs covered under Medicare, Medicaid, or as Demonstration Plan-covered additional benefits.
  - vi. A single identification (ID) card for accessing all covered services under the plan.
  - vii. All Medicare Part D required notices, with the exception of the LIS Rider and the creditable coverage notices, required under Chapter 4 of the Prescription Drug Benefit Manual, and the late enrollment penalty notice requirements required under Chapter 4 of the Prescription Drug Benefit Manual.
- f. Notification of Formulary Changes – The requirement at 42 CFR §423.120(b)(5) that Demonstration Plans provide at least 60 days advance notice regarding Medicare Part D formulary changes also applies to Demonstration Plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits.

## **XI. Administration and Oversight**

- a. Oversight Framework
  - i. Under the Demonstration, there will be a CMS-State Contract Management Team that will ensure access, quality, program integrity, compliance with applicable laws, including but not limited to the Emergency Medical Treatment and Active Labor Act (EMTALA) and the ADA, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and the State will require Demonstration Plans to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. Demonstration Plans must have policies and procedures in place to identify and address fraud, waste, and abuse at both the Demonstration Plan and the third-party levels in the delivery of Demonstration benefits, including prescription drugs, medical care, behavioral health, and LTSS. In addition, all



Medicare Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to Demonstration Plans by CMS in the same way they are currently applied for PDP sponsors and Medicare Advantage organizations.

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

b. The Contract Management Team

- i. Structure - The Contract Management Team will include representatives from CMS and the State, authorized and empowered to represent CMS and the State about aspects of the Three-way Contract. Generally, the CMS members of the team will include the State Lead from the Medicare-Medicaid Coordination Office (MMCO), Regional Office Lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The precise makeup will include individuals who are knowledgeable about the full range of services and supports utilized by the target population, particularly LTSS.
- 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 of data will be detailed in the Three-way Contract:
  1. Quality (including HEDIS); core measures are articulated in Section h below
  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. Medicare Part C and Part D reporting requirements, as applicable
  9. All required 1915(c) waiver reporting
- c. Day-to-Day Oversight and Coordination – The Contract Management Team will be responsible for day-to-day monitoring of each Demonstration Plan. These responsibilities include, but are not limited to:
- i. Monitoring compliance with the terms of the Three-way Contract, including issuance of joint notices of non-compliance/enforcement;
  - ii. Coordination of periodic audits and surveys of the Demonstration Plans;
  - iii. Receipt and response to complaints;
  - iv. Reviewing reports from and responses to the Ombudsman;
  - v. Reviewing direct stakeholder input on both plan-specific and systematic performance;
  - vi. Regular meetings with each Demonstration Plan;
  - vii. Coordination of requests for assistance from Demonstration Plans, and assignment of appropriate State and CMS staff to provide technical assistance;
  - viii. Coordinating review of marketing materials and procedures; and
  - ix. Coordinating review of grievance and appeals data, procedures, and materials.
- d. Centralized, Program-Wide Monitoring, Surveillance, Compliance, and Enforcement

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

Demonstration Plan contracts will be treated in the same manner, which includes analysis of their performance based on CMS internal data, active collection of additional information, and CMS issuance of compliance notices where

applicable. The 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. Emergency/ Urgent Situations

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

f. Demonstration Plan Call Center Requirements

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

i. Demonstration Plans shall operate:

1. Enrollee Services Telephone Line: Demonstration Plans will be required to establish a toll-free telephone number, available twenty-four hours, seven days a week, for Enrollees to access medical professionals, either to the Demonstration Plan directly or to the PCPs, for consultation to obtain medical care.
- ii. Operators must be available in sufficient numbers to support Enrollees.
- iii. All Demonstration Plan sponsors' call centers must have interpreter services available to call center personnel to answer questions from non-English speaking and limited English proficient individuals. Interpretation services must be available free-of-charge to Enrollees in all non-English languages spoken by beneficiaries.
- iv. TTY services or comparable services must be available for people who are deaf or hard of hearing.
- v. Demonstration Plans must ensure that customer service department representatives shall, upon request, make available to Enrollees and potential Enrollees information including, but not limited to, the following:

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

g. Data System Specifications, Reporting Requirements, and Interoperability

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

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

h. Unified Quality Metrics and Reporting

Demonstration Plans and other qualified entities will be required to report HEDIS, HOS, and CAHPS data, as well as measures related to behavioral health, care coordination/transitions, and LTSS. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS plus any additional Medicaid measures identified by the State. All existing Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures. The initial combined set of core metrics is described below in Figure 7-1. The State and CMS are continuing to explore quality measures and the list below will be further refined and specified, including any specifications that may be different between the State measure and the CMS measure, 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.

Demonstration Plans must submit data consistent with requirements established by CMS and/or the State as further described below and in the Three-way Contract. Demonstration Plans will also be subject to monitoring efforts consistent with the requirements of Medicare Advantage and Part D.

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

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Antidepressant medication management	Percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X	X
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. <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>	NCQA/HEDIS	X	X
Follow-up After Hospitalization for Mental Illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health	NCQA/HEDIS	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	practitioner.			
Screening for Clinical Depression and Follow-up	Percentage of patients ages 18 years and older screened for clinical depression using a tool and follow-up plan documented.	CMS	X	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	
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. <ul style="list-style-type: none"> <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> <li>In the last 6 months, how often were the forms for your health plan easy to fill out?</li> </ul>	AHRQ/CAHPS	X	
Consumer Governance Board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements.	CMS	X	
SNP1: Complex Case Management	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: Care Plan Element H: Informing and Educating Practitioners Element I: Satisfaction with Case Management Element J: Analyzing Effectiveness/Identifying Opportunities Element K: Implementing Interventions and Follow-up Evaluation	NCQA/ HEDIS	X	
SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members.  Element A: Coordination of Benefits for Dual Eligible Members Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) Element D: Service Coordination Element E: Network Adequacy Assessment	NCQA/ HEDIS	X	
Care Transition Record Transmitted to Health Care Professional	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	X	
Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented	NCQA/HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions.  Element A: Managing Transitions Element B: Supporting Members through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E: Analyzing Transitions Element F: Reducing Transitions	NCQA/HEDIS	X	
CAHPS, various settings including: -Health Plan plus supplemental items/questions, including:  -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home	Depends on Survey	AHRQ/CAHPS	X	X
Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the drug plan's pharmacy help desk.	CMS Call Center data	X	
Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number.	CMS Call Center data	X	
Part D Appeals Auto-Forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions.  This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: $[(\text{Total number of cases auto-forwarded to the IRE}) / (\text{Average Medicare Part D enrollment})] * 10,000$ .	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: $[(\text{Number of cases upheld}) / (\text{Total number of cases reviewed})] * 100$ .	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: $[(\text{Total number of complaints logged into the CTM for the drug plan regarding any issues}) / (\text{Average Contract enrollment})] * 1,000 * 30 / (\text{Number of Days in Period})$ .	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	CMS Administrative data	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	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.			
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 State	X	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 State	X	X
Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication	CMS PDE data	X	
Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data State	X	X
Plan Makes Timely Decisions about Appeals	Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage.	IRE	X	
Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	IRE	X	
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.	CMS Call Center data	X	
Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed State	X	X
Risk assessments	Percent of Enrollees stratified to medium or high risk with a completed comprehensive assessment within 90 days of enrollment.	CMS/State defined process measure	X	X



Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Care Plans	Percent of members with Care Plans by specified timeframe	CMS/State defined process measure	X	
Real time hospital admission notifications	Percent of hospital admission notifications occurring within specified timeframe	CMS/State defined process measure	X	
Risk stratification based on LTSS or other factors	Percent of risk stratifications using BH/LTSS data/indicators	CMS/State defined process measure	X	
Discharge follow-up	Percent of members with specified timeframe between discharge to first follow-up visit	CMS/State defined process measure State	X	X
Self-direction	Percent of Care Coordinators that have undergone State-based training for supporting self-direction under the Demonstration	CMS/State defined process measure	X	
Care for Older Adults – Medication Review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/ HEDIS	X	
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	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 State / CAHPS	X	X
Plan All-Cause Readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
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	
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	CMS  Beneficiary database	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems			
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2013.	CMS	X	
Getting Information From Drug Plan	The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost.  -In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? -In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? -In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? -In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?	AHRQ/CAHPS	X	
Rating of Drug Plan	The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs.  -Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	AHRQ/CAHPS	X	
Documentation of care goals	Percent of enrollees with documented discussions of care goals	CMS/State defined process measure	X	X
Ensuring physical access to buildings, services and equipment	Demonstration Plan has established a work plan and identified individual in its organization who is responsible for ADA compliance related to this Demonstration	CMS/State defined process measure	X	X
Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists	AHRQ/CAHPS	X	
Getting Care Quickly	Composite of access to urgent care	AHRQ/CAHPS	X	
Health Status/Function Status	Percent of members who report their health as excellent	AHRQ/CAHPS	X	
Getting Needed Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan.  -In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? -In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	AHRQ/CAHPS	X	
Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.  • In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
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	X
Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received.  Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	AHRQ/CAHPS	X	X
Overall Rating of Plan	Percent of best possible score the plan earned from plan members who rated the overall plan.  • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	AHRQ/CAHPS	X	
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	
Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X	X
Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X	X
Cervical Cancer Screening	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.	NCQA/HEDIS		X
Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for —bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS State	X	X
Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	CMS HOS	X	
Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS State / CAHPS	X	X
Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS	X	X
Management of Urinary Incontinence in Older Adults	<b>Discussing:</b> Members who reported having a problem with urine leakage in the past six months and who discussed their urine leakage problem with their current practitioner. <b>Receiving Treatment:</b> Members who reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem.	State MCO/Survey		X
Annual Dental visit	Percentage of members 19-20 and 21 years of age and older who had at least one dental visit during the measurement year.	State		X
Dental ER Visit	The number of dental emergency room visits during	State		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	the measurement year per 1000 members.			
Ambulatory Care	Emergency Department visits per 1,000 Enrollees.	NCQA/HEDIS		X
Ambulatory Care follow-up with a Provider within 14 Days of Emergency Department (ED) Visit	Follow-up with any provider within 14 days following Emergency Department visit.	State		X
Inpatient Utilization-General Hospital/Acute Care	Utilization of acute inpatient care and services, per 1,000 Enrollees, in the following categories: Total inpatient, Surgery, Medicine and Maternity.	NCQA/HEDIS		X
Mental Health Utilization	Percentage of members receiving the following mental health services during the measurement year, per 1,000 Enrollees: Any service, Inpatient, Outpatient or ED, and Intensive outpatient or partial hospitalization.	NCQA/HEDIS		X
Ambulatory Care Follow-up with a Provider within 14 days of Inpatient Discharge	Ambulatory care follow-up visit within 14 days of having an inpatient hospital stay.	State		X
Inpatient Hospital 30-day Readmission Rate	Inpatient Hospital readmission for the same discharge diagnosis within 30 days after having an initial inpatient hospital stay.	State		
	1. Acute inpatient facility (IHR)	State		X
	2. Inpatient mental hospital (IMR)	State		X
Long Term Care– Urinary Tract Infection Admission Rate	LTC hospital utilization due to urinary tract infections.	State		X
Long Term Care– Bacterial Pneumonia Admission Rate	LTC hospital utilization due to bacterial pneumonia.	HSAG/State		X
Annual Monitoring for Patients on Persistent Medications (MPM)	Percentage of members who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the agent during the measurement year. Report on each of the following rates: ACE/ARB, Digoxin, Diuretics, Anticonvulsants and Total.	NCQA/HEDIS		X
Adherence to Appropriate Medications for Individuals Diagnosed with Psychoses and Bi-Polar Disorders (PBD)	Percentage of members diagnosed with psychoses and bi-polar disorders who maintained medication adherence at 6 months and 12 months.	State		X
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Percentage of member's age 19 – 64 years with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	NCQA/HEDIS		X
Adult BMI Assessment	Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.	NCQA/HEDIS		X
Transition of members between Community, Waiver and LTC Services	Report number of members moving from: institutional care to waiver services, community to waiver services community to institutional care and waiver services to institutional care. (Exclude institutional stays ≤ 90 days)	State		X
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	The percentage of members who were hospitalized with AMI and who received persistent beta-blocker treatment for six months after discharge	NCQA/HEDIS		X
Pharmacotherapy Management of COPD Exacerbation	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter and who were dispensed appropriate medications.			
	1) Dispensed a systemic corticosteroid within 14 days of the event	NCQA/HEDIS		X
	2) Dispensed a bronchodilator within 30 days of the event	NCQA/HEDIS		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Use of Spirometry testing in the Assessment and Diagnosis of COPD	The percentage of members 40 years old or older with a new diagnosis or newly active COPD, and who received appropriate Spirometry testing to confirm the diagnosis.	NCQA/HEDIS		X
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Percentage of members with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.	NCQA/HEDIS		X
Diabetes Monitoring for People With Diabetes and Schizophrenia	Percentage of members with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NCQA/HEDIS		X
Aspirin Use and Discussion (ASP)	<b>Aspirin Use.</b> A rolling average represents the percentage of members who are currently taking aspirin. Includes the following in the denominator: Women ages 55-79 with at least 2 risk factors for heart disease, Men ages 45-64 with at least one risk factor for heart disease and Men ages 65-79 regardless of risk factors. <b>Discussing Aspirin Risks and Benefits.</b> A rolling average represents the percentage of members who discussed the risks and benefits of using aspirin with a doctor or other health provider. Includes the following in the denominator: Women ages 55-79 and men ages 45-79.	State MCO/Survey		X
Participant Outcomes and Status Measures (POSM) Quality of Life Survey	Program participant perception of quality of life. Purposes: 1) help determine quality of life measures that should be considered in developing service plans; 2) determine if quality of life improvements are reported by participants over time; and, 3) assist in identifying areas in need of quality improvement.	State MCO/Survey		X
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Percentage of members with schizophrenia and cardiovascular disease, who had a LDL-C test during the measurement year.	NCQA/HEDIS		X
Glaucoma Screening in Older Adults	Percentage of members age 40 – 59, 60 – 64, 65 years and older and Total who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions	NCQA/HEDIS		X
Severe Mental Illness (SMI)	Recovery-oriented measures for persons with SMI receiving Mental Health Services.			
	1. Stability in Family and Living Conditions	State DHS/Provider		X
	2. Return to or Stay in School	State DHS/Provider		X
	3. Criminal/Juvenile Justice involvement	State DHS/Provider		X
	4. Employment Status	State DHS/Provider		X

## XII. Stakeholder Engagement

The State and CMS will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. This will be accomplished through an ongoing process of public meetings and monitoring individual and provider experiences through a variety of means, including surveys, focus groups, website updates, and data analysis. In addition, the State will require that Demonstration 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.

### **XIII. Evaluation**

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

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

The evaluator will design a State-specific evaluation plan for the Illinois Demonstration and will also conduct a meta-analysis that will look at the State Demonstrations overall. A mixed methods approach will be used to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative analyses will consist of tracking changes in selected utilization, cost, and quality measures over the course of the Demonstration; evaluating the impact of the Demonstration on cost, quality, and utilization measures; and calculating savings attributable to the Demonstration. The evaluator will use a comparison group for the impact analysis. The comparison group methodology will be detailed in the State-specific evaluation plan. Quarterly reports will provide rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit State-specific annual reports that incorporate qualitative and quantitative findings to date and will submit a final evaluation report at the end of the Demonstration.

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

Demonstration 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. The State will also maintain, or develop in conjunction with CMS, the capability to track grievances and appeals data electronically from its Demonstration Plans. The State will also develop the capability to identify and track beneficiaries receiving care coordination, including the frequency and manner of care coordination contacts.