

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of Rhode Island

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

**Medicare-Medicaid Alignment Integrated Care Initiative
Demonstration**

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I. STATEMENT OF INITIATIVE

The Centers for Medicare & Medicaid Services (CMS) and the State of Rhode Island (RI) Executive Office of Health and Human Services (EOHHS) will establish a Federal-State partnership to implement the Medicare-Medicaid Alignment Integrated Care Initiative Demonstration (“ICI Demonstration” or “Demonstration”) to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Beneficiaries”). The Federal-State partnership will include a Three-way Contract between CMS, the State, and one or more Medicare-Medicaid Plans (MMPs) that will provide integrated benefits to those Medicare-Medicaid Beneficiaries who reside in the targeted geographic area(s) and who choose to participate (Enrollees).

The Demonstration will begin no sooner than December 1, 2015 and continue until December 31, 2018, unless terminated pursuant to Section L or continued pursuant to Section K of this Memorandum of Understanding (MOU). Meeting Enrollee needs, including the ability to self-direct care and perform self-care, and live independently in the community, are central goals of this Demonstration. In meeting such needs, the ICI Demonstration will seek to test an innovative payment and service delivery model to alleviate fragmentation; improve coordination of services for Medicare-Medicaid Beneficiaries; enhance quality of care; reduce costs for both the State and the Federal government; meet Enrollees’ health and functional needs; improve transitions among care settings; and reduce health disparities. CMS and the State expect MMP and provider implementation of the independent living and recovery philosophy, wellness principles, and cultural competence to contribute to achieving these goals. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

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

The ICI Demonstration will be implemented as part of the State’s broader Integrated Care Initiative, which aims to achieve improved health and well-being, and better health care, at lower costs for a segment of Rhode Island’s Medicaid-only and Medicare-Medicaid Beneficiaries. In 2013, under Phase I of the Integrated Care Initiative, the State introduced an enhanced Primary Care Case Management model called Connect Care Choice Community Partners (CCCCP) and a Medicaid health plan model called the Rhody Health Options (RHO) program, available to Medicaid-only and Medicare-Medicaid Beneficiaries under the Rhode Island Comprehensive Section 1115(a) demonstration. The one health plan participating in the RHO program is also the

only current prospective MMP for the ICI Demonstration.

The ICI Demonstration is part of Phase II of the Integrated Care Initiative, and will require at least one MMP to provide both Medicare and Medicaid benefits to ICI Demonstration Enrollees, with the exception of certain developmental disability and other services (outlined in Appendix 7) that are also carved out of Phase I. These services will continue to be provided to ICI Demonstration Enrollees via the fee-for-service (FFS) system and will not be covered by the capitated rate. The individuals who receive those services will be eligible for Demonstration enrollment. CMS and the State may seek to bring these services into the ICI Demonstration in the future.

Medicare-Medicaid Beneficiaries will have the choice to opt out of the ICI Demonstration. For Medicaid benefits, individuals who opt out of the ICI Demonstration may enroll in or remain in RHO or any other Medicaid program that may be available to Medicare-Medicaid Beneficiaries for Medicaid services only. For Medicare benefits, individuals who opt out of the ICI Demonstration will have the choice to enroll in a Medicare Advantage plan, or receive FFS Medicare and enroll in a Prescription Drug Plan (PDP). Medicare-Medicaid Beneficiaries eligible for the ICI Demonstration may also be eligible to enroll in the Program of All-Inclusive Care for the Elderly (PACE), if they choose not to enroll in the Demonstration. Outreach and enrollment notices for the ICI Demonstration will inform Medicare-Medicaid Beneficiaries of all enrollment options.

CMS and the State shall jointly select and monitor the MMPs. CMS and the State will implement the ICI Demonstration under Medicare Parts C and D and demonstration authority for Medicare, and State Plan and Rhode Island Comprehensive Section 1115(a) demonstration authority for Medicaid, as described in Section III.A and detailed in Appendices 4 and 5.

Consistent with the goals of the State's Comprehensive Section 1115(a) demonstration and the Integrated Care Initiative, key goals of the ICI Demonstration include:

- Enhancing person-centered care;
- Improving and maintaining Enrollee quality of life and care;
- Developing an integrated system of care and coordination of services;
- Increasing the proportion of individuals successfully residing in a community setting;
- Reducing long-term care costs by providing person-centered care in the most appropriate and cost-effective setting;

- Decreasing avoidable hospitalizations, emergency room utilization and reducing nursing facility admissions and length of stay;
- Evaluating the effect of an integrated care and payment model on Medicare-Medicaid Beneficiaries who receive care and supports in the community and in institutions; and
- Promoting Alternative Payment Arrangements as a means to transform the delivery of high quality and cost-effective care within CMS requirements.

The Demonstration will evaluate the effect of an integrated care and payment model on both community-based and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency, and oversight standards as well as requirements. Contract management, which will be jointly accomplished by the State and CMS, will focus on performance measurement and continuous quality improvement. Except as otherwise specified in this MOU, applicable Medicaid waiver or Section 1115(a) demonstration standards and conditions, State Plan Amendments, or the Three-way Contract, MMPs will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as ICI Demonstration-specific and evaluation requirements, as will be further specified in the Three-way Contract to be executed among each MMP, the State, and CMS.

As part of this Demonstration, CMS and the State will implement a new Medicare and Medicaid payment methodology designed to support MMPs in serving Medicare-Medicaid Beneficiaries enrolled in the Demonstration, and will further encourage MMPs to utilize Alternative Payment Arrangements to support delivery system transformation. 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 Beneficiaries, utilizing a simplified and unified set of rules where feasible. Flexibilities will be coupled with specific Enrollee safeguards and will be included in this MOU and the Three-way Contract. MMPs will have full accountability for managing the capitated payment to best meet the needs of Enrollees. Interdisciplinary Care Plans for Enrollees eligible for Long-term Services and Supports (LTSS) or otherwise determined to be high-risk will be developed by Enrollees, their caregivers, and Interdisciplinary Care Team, using a person-centered planning process. CMS and the State expect MMPs to achieve savings through better integrated and coordinated care. Subject to CMS and State oversight, MMPs will have significant flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to or means to avoid high-cost services if indicated by

the Enrollees' wishes, needs, and Interdisciplinary 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.

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document details the principles under which CMS and the State plan to implement and operate the Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration. The parties will execute a Three-way Contract with MMPs setting forth the terms and conditions of the Demonstration. Further detail about MMP 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 a Three-way Contract with one or more selected plans, which will have also met the Medicare components of the plan selection process, including submission of a successful Capitated Financial Alignment Demonstration Application to CMS, and adherence to any annual contract renewal requirements and guidance updates, as specified in Appendix 7. The Three-way Contract will include the additional operational and technical requirements pertinent to the implementation of the Demonstration.

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 Contract, as well as those activities the parties intend to conduct prior to entering into the Three-way Contract and initiating the Demonstration. This section and any appendices referenced herein are not intended to create contractual or other legal rights between the parties.

- 1. Medicare Authority:** The Medicare elements of the initiative shall operate according to existing Medicare Parts C and D laws and regulations, as amended or modified, except to the extent these requirements are waived or modified as provided for in Appendix 4. As a term and condition of the initiative, MMPs 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 Parts 422 and 423, and applicable sub-regulatory guidance, as amended from time to time, except to the extent specified in this MOU, including Appendix 4 and, for waivers of sub-regulatory guidance, the Three-way Contract.

- 2. Medicaid Authority:** The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, including but not limited to all requirements of the Rhode Island Comprehensive Section 1115(a) demonstration applicable to ICI Demonstration Enrollees, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the initiative, MMPs will be required to comply with Medicaid managed care requirements under Title XIX of the Social Security Act and 42 CFR Part 438 et. seq., and applicable sub-regulatory guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5 and, for waivers of sub-regulatory guidance, the Three-way Contract.

B. CONTRACTING PROCESS

- 1. MMP Procurement Document:** MMPs are required to meet the following requirements:
- Achieve a final score of 70 or higher on the Model of Care section of the CMS Capitated Financial Alignment Demonstration application;
 - Successfully respond to the State procurement;
 - Participate in and acceptably complete an ICI Demonstration readiness review that will be jointly conducted by CMS and the State; and
 - Enter into a Three-way Contract with CMS and the State.

As articulated in the January 13, 2014 guidance from CMS, MMPs are also required to submit a Capitated Financial Alignment Demonstration application to CMS and meet all of the Medicare components of the MMP selection process.

All applicable Medicare Advantage/Part D requirements and Medicaid managed care requirements will apply, unless otherwise waived, as specified by CMS and the State herein or in the Three-way Contract.

- 2. MMP Selection:** The State and CMS will review applications for MMPs, in accordance with the requirements outlined in Appendix 7, and will determine which applications satisfy all ICI Demonstration requirements and can be selected to serve as MMPs for the Demonstration.

The State's 2013 Rhody Health Options procurement included requirements for plans to serve as MMPs. The current RHO health plan, already providing Medicaid benefits to Medicaid-only and Medicare-Medicaid beneficiaries under Phase I of the ICI, will be

required to meet all CMS requirements for the ICI Demonstration; however it will not be required to respond to an additional State procurement. The State conducted a procurement in 2014 to seek additional RHO health plans eligible to serve as MMPs under the ICI Demonstration. New plans that wished to participate in the ICI Demonstration, but did not participate in Phase I, were also required to apply to provide integrated benefits to Medicaid-only beneficiaries who are eligible for LTSS.

- 3. Medicare Waiver Approval:** CMS approval of Medicare waivers is reflected in Appendix 4. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XVIII. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Social Security Act, afford the State a reasonable opportunity to request reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section III.L of this MOU. If a waiver or expenditure authority is withdrawn, Federal financial participation (FFP) is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling Enrollees.
- 4. Medicaid Waiver Approval:** CMS approval of any new Medicaid waivers pursuant to the Rhode Island Comprehensive Section 1115(a) demonstration or Title XIX of the Social Security Act authority and processes is reflected in Appendix 5. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities 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 hearing to appeal CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section III.L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling Enrollees.
- 5. Readiness Review:** CMS and the State, either directly or with MMP support, shall conduct a readiness review of each selected MMP. Following the signing of the Three-way Contract, CMS and the State must agree that an MMP has passed readiness prior to that MMP

accepting any enrollment. 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 MMP and its ability to meet all program requirements, including having an adequate network that addresses the full range of Enrollee needs, and the capacity to uphold all Enrollee safeguards and protections. CMS and the State will conduct a readiness review of the enrollment systems, staffing capacity, and processes and their ability to meet enrollment requirements.

- 6. 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 ICI Demonstration will be available to individuals who meet the following criteria:

- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits, including: long-term nursing facility residents; individuals with intellectual and developmental disabilities; individuals with Serious and Persistent Mental Illness; individuals eligible for LTSS in the community; individuals residing in the community without LTSS needs; and individuals with End Stage Renal Disease (ESRD) at the time of enrollment; and
- Age 21 or greater at the time of eligibility determination.

The following populations are not eligible for the ICI Demonstration:

- Medicare beneficiaries who are not eligible for full Medicaid benefits, including Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualifying Individuals (QIs);
- Individuals who are eligible for “partial” Medicare: benefits (Part A only or Part B/D only);
- Individuals who are required to “spend down” income in order to meet Medicaid eligibility requirements, and who are not eligible for LTSS;
- Individuals residing at Tavares, Eleanor Slater, or out-of state hospitals;
- Individuals eligible for the Medicaid buy-in for workers with disabilities and meet a nursing facility level of care (in Rhode Island this is called The Sherlock Plan);

- Individuals who are in hospice on the effective enrollment date. Enrollees who elect hospice care while enrolled in an MMP can remain in the MMP; and
- Individuals who reside out of state (e.g., an individual who is admitted to an out-of-state nursing facility).

The following individuals may elect to enroll and participate in the Demonstration, but will not be passively enrolled:

- Individuals with active comprehensive commercial or other coverage, including employer, union, or TRICARE coverage; and
- Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE). These individuals may enroll in the Demonstration if they choose to disenroll from PACE.

Those beneficiaries who are enrolled in a Medicare Advantage plan that is operated by the same parent organization that operates an MMP will also be eligible for passive enrollment into the MMP operated by the same parent organization. Eligible beneficiaries enrolled in a Medicare Advantage plan that is operated by a parent organization that is not offering an MMP will not be passively enrolled. They may enroll in the ICI Demonstration if they elect to disenroll from their current Medicare Advantage plan.

- 2. Enrollment and Disenrollment Processes:** MMPs will begin to accept opt-in enrollments among those individuals eligible for the ICI Demonstration no sooner than September 1, 2015 for coverage starting no sooner than December 1, 2015. Enrollment requests received through the 10th day of the month will take effect on the first day of the following calendar month. Enrollment requests received on the 11th day of the month or later will take effect on the first day of the second month after the request was submitted.

When no active choice has been made, enrollment for eligible beneficiaries (as described above in Section III.C.1) 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 MMP on a monthly basis. Individuals who are eligible for the Demonstration and who are enrolled in a plan for Medicaid benefits that is operated by the same parent organization as the MMP may be passively enrolled into that same plan under the ICI Demonstration, with the opportunity to opt-out until the last day of the month, as further detailed in Appendix 7. Passive enrollments will commence no sooner than three months after the Demonstration begins.

Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted MMPs (if applicable) no fewer than sixty (60) calendar days prior to the effective date of enrollment and will further have the opportunity to opt out of the Demonstration prior to the enrollment effective date, as detailed in Appendix 7. MMP enrollments, including enrollment from one MMP to a different MMP (if applicable), and opt outs, shall become effective on the same day for both Medicare and Medicaid.

Disenrollment from MMPs and enrollment transfers from one MMP to a different MMP (if applicable), 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. All disenrollments will be effective the first day of the month after the choice is made. A disenrollment request, either voluntary or involuntary, is any action that terminates the Enrollee's enrollment in the ICI Demonstration, and includes, for example, the right to choose a Medicare Advantage Plan, to receive care through Medicare FFS and a Prescription Drug Plan (PDP), and to receive Medicaid services in accordance with the State's approved State Plan, Section 1115(a) demonstration, and any approved waiver programs.

As mutually agreed upon, and as discussed further in Appendix 7 and the Three-way Contract, CMS and the State will utilize an independent third party entity (Enrollment Counselor) to facilitate all enrollments into the MMPs and to provide unbiased enrollment counseling.

CMS and the State will monitor input received by the Ombudsman, Enrollment Counselor, and MMPs about the time between beneficiary enrollment requests and the effective date of enrollment. For those who lose Medicaid eligibility during the month, coverage and Federal financial participation will continue through the end of that month.

CMS and the State will monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations, and CMS policies, for the 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 MMP to a Medicare Advantage plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS and the State may discontinue

further passive enrollment into an MMP and implement corrective action as appropriate. Any illegal marketing practices will be referred to appropriate agencies for investigation.

CMS and the State will also monitor any enrollments or disenrollments based on beneficiary health needs. Any MMPs under the same parent company as any Medicaid managed care plan for which the State has terminated or suspended enrollment and marketing activities related to the Medicaid managed care plan are not permitted to conduct enrollment or marketing activities related to the MMP until the Medicaid managed care plan deficiencies are resolved or may be disqualified from the Demonstration. Per January 13, 2014 guidance from CMS, any MMP will be ineligible to participate if it is under sanction as described in 42 CFR Part 422.750 and 42 CFR Part 423.750 at the time CMS and the State seek to execute the Three-way Contract. Also as articulated in the January 13, 2014 guidance from CMS, any MMP that is an outlier in the CMS past performance analysis for Contract Year (CY) 2014 and/or has a Consistently Low Performing Icon on the Medicare Plan Finder will be ineligible to receive passive enrollment until it is no longer considered by CMS to be a past performance outlier and/or no longer has a Consistently Low Performing Icon on Medicare Plan Finder.

- 3. Uniform Enrollment/Disenrollment Documents:** CMS and the State shall develop uniform enrollment and disenrollment forms and other documents.
- 4. Outreach and Education:** MMP outreach and marketing materials will be subject to a single set of marketing rules defined by CMS and the State, as further detailed in Appendix 7.
- 5. Single Identification Card:** CMS and the State shall work with MMPs to develop a single identification card that can be used to access all care needs, as further detailed in Appendix 7.
- 6. Interaction with other Demonstrations:** To best ensure continuity of Enrollee care and provider relationships, CMS will work with the State to address Enrollee or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). An Enrollee enrolled in the Demonstration will not be enrolled in, nor have costs attributed to, 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. MMP Service Capacity:** CMS and the State shall contract with MMPs that demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered items and services to Enrollees, in accordance with this MOU and the access and adequacy standards outlined in Appendix 7, CMS guidance, and the Three-way Contract. Medicare covered benefits shall be provided in accordance with 42 CFR Part 422 and 42 CFR Part 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, and the Rhode Island Comprehensive Section 1115(a) demonstration, and in accordance with 42 CFR Part 438 and the requirements specified by the Three-way Contract and this MOU. In accordance with the Three-way Contract and this MOU, CMS and the State may choose to allow for greater flexibility in offering additional benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, the State, and MMPs will ensure that Enrollees have access to an adequate network of medical, drug, behavioral health, and community-based or facility-based LTSS providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.
- 2. MMP Risk Arrangements:** CMS and the State shall require each MMP to provide a detailed description of its risk arrangements with providers under subcontract with the MMP. This description shall be made available to 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 services to Enrollees.
- 3. MMP Financial Solvency Arrangements:** CMS and the State have established a standard for all MMPs, as articulated in Appendix 7.

E. ENROLLEE PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

- 1. Choice of Plans and Providers:** As referenced in Section III.C.2, Enrollees will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. This includes but is not limited to the right to choose 1) another MMP (if available), 2) an RHO plan, or any other Medicaid program that may be available to Medicare-Medicaid Beneficiaries, for Medicaid benefits only, plus Medicare Advantage or FFS Medicare and a PDP, or 3) the PACE program.
- 2. Continuity of Care:** CMS and the State will require MMPs to ensure that individuals continue to have access to medically necessary items, services, prescription and non-prescription drugs, and medical, behavioral health, and community-based and facility-based

LTSS providers for the transition period as specified in Appendix 7. In addition, during the transition MMPs will advise Enrollees and providers if and when they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, and as appropriate, MMPs must also contact providers who are not already members of their network with information on becoming credentialed as in-network providers. Part D transition rules and rights will continue as provided for in current law and regulation.

- 3. Enrollment Assistance and Options Counseling:** As referenced in Section III.C.2 and Appendix 7, the State will provide Medicaid-Medicare Beneficiaries with independent non-biased enrollment counseling to help them make an enrollment decision that best meets their needs. The State will work with the independent Enrollment Counselor and the Ombudsman program to ensure ongoing outreach, education and support to individuals eligible for the ICI Demonstration.
- 4. Enrollee Ombudsman Program:** The State is creating a new Enrollee Ombudsman program. The Ombudsman, subject to funding from CMS, will help Enrollees and their caregivers access needed care and will support individual advocacy and independent systematic oversight for the ICI Demonstration, as described in Appendix 7 of this MOU.
- 5. Person-Centered, Appropriate Care:** CMS, the State, and MMPs shall ensure that all Medicaid and Medicare Medically Necessary covered benefits are provided to Enrollees and are provided in a manner that is sensitive to the Enrollee's functional and cognitive needs, language and culture, allows for involvement of the Enrollee and caregivers, and is in a care setting appropriate to the Enrollee's needs, with a preference for the home and the community. CMS, the State, and MMPs shall ensure that care is person-centered and can accommodate and support self-direction. MMPs shall also ensure that Medically Necessary covered services are provided to Enrollees, in the least restrictive community-based setting and in accordance with the Enrollee's wishes and Interdisciplinary Care Plan.
- 6. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and the State expect MMP and provider compliance with the ADA and the Civil Rights Act of 1964 to promote the success of the MMP model and support better health outcomes for MMP 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 MMPs 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 MMPs and their providers to communicate with their Enrollees in a manner that accommodates their individual needs,

including providing interpreters for those who are deaf or hard of hearing, accommodations for Enrollees with cognitive limitations, and interpreters for those who do not speak English. Also, CMS and the State recognize the importance of staff training on accessibility and accommodation, independent living and recovery models, cultural competency, and wellness philosophies. CMS and the State will continue to work with stakeholders, including Enrollees, to further develop learning opportunities, monitoring mechanisms, and quality measures to ensure that MMPs and their providers comply with all requirements of the ADA. Finally, CMS and the State are committed to compliance with the ADA, including application of the Supreme Court's *Olmstead* decision, and agree to ensure, through ongoing surveys and readiness and implementation monitoring, that MMPs provide for Enrollees' long-term services and supports in care settings appropriate to their needs.

- 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 some of which may be required to be used and some of which may be used at the option of the plan but, in either instance, 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 (i.e., no more than a 6th grade reading level) to the Enrollees that will be enrolled in the MMPs, 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. Enrollee Participation on Governing and Advisory Boards:** As part of the Three-way Contract, CMS and the State shall require MMPs to obtain Enrollee and community input on issues of program management and Enrollee care through a range of approaches. MMPs must establish at least one Enrollee Advisory Committee (EAC) that meets quarterly and is open to all Enrollees. EAC members and the Enrollee Ombuds staff will be invited to participate in the State's ongoing stakeholder process. MMPs must also establish a process for that EAC to provide input to the MMPs. Each MMP must demonstrate that the EAC composition reflects the diversity of the ICI Demonstration Enrollee population, and participation of individuals

with disabilities, within the governance structure of the MMP. MMPs will also be encouraged to include Enrollee representation on their boards of directors. The State will maintain additional processes for ongoing stakeholder participation and public comment, as discussed in Appendix 7.

- 9. MMP Customer Service Representatives:** CMS and the State shall require MMPs to employ or contract with sufficient numbers of customer service representatives who shall answer all inquiries and respond to Enrollee complaints and concerns. In addition, CMS and the State shall themselves employ or contract with sufficient call center and customer service representatives to address Enrollee questions and concerns. In Rhode Island, this will be done through contracts with the Enrollment Counselor and the Enrollee Ombudsman program. MMPs, 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 MMPs to ensure privacy and security of Enrollee health records and provide for access by Enrollees to such records. These requirements shall be specified in the Three-way Contract.
- 11. Limited Cost Sharing:** MMPs will not charge Medicare Part C or D premiums, nor assess any cost sharing for Medicare Parts A and B services, and may choose not to assess any cost sharing for Part D services. For drugs and pharmacy products covered by Medicare Part D, MMPs will be permitted to charge co-pays to individuals currently eligible to make such payments consistent with co-pays applicable for Medicare drugs. Co-pays charged by MMPs for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy, although MMPs 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, with the exception of “applied income” for LTSS, the MMPs will not assess any cost sharing to Enrollees. For Medicaid LTSS, the individual must contribute his or her applied income, after allowable deductions. That applied income is paid to the provider as the individual’s contribution to the cost of care.
- 12. No Balance Billing:** No Enrollee may be balance billed by any provider for any reason for covered services.

F. APPEALS AND GRIEVANCES

1. **MMP Grievances and Internal Appeals Processes:** CMS and the State agree to utilize a unified set of requirements for MMP grievances and internal appeals processes that incorporate relevant Medicare Advantage and Medicaid managed care requirements, to create a more Enrollee-friendly and easily navigable system. This is discussed in further detail in Appendix 7 and will be specified in the Three-way Contract. All MMP 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 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 items and 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. **MMP Contract Management:** As more fully discussed in Appendix 7, CMS and the State agree to designate representatives to serve on a CMS-State Contract Management Team which shall conduct MMP 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, and 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 MMPs' fiscal operations and financial solvency, conducting program integrity studies to monitor fraud, waste, and abuse as may be agreed upon by CMS and the State, and ensuring that MMPs take corrective action, as appropriate.
- Reviewing and analyzing reports on MMPs' network adequacy, including the MMPs' ongoing efforts to replenish their networks and to continually enroll qualified providers.
- Reviewing any other applicable ratings and measures.
- Reviewing reports from the Enrollee Ombudsman program.
- Reviewing direct stakeholder input on both MMP-specific and systematic performance.
- Responding to and investigating Enrollee complaints and quality of care issues.

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

- The State and CMS will each retain, yet coordinate, current responsibilities toward the Enrollee such that Enrollees maintain access to their benefits across both programs.
- CMS and the State will leverage existing protocols (for example, in responding to Enrollee complaints, conducting account management, and analyzing enrollment data) to identify and solve Enrollee access problems in real time.
- Oversight will be coordinated and subject to a unified set of requirements. Oversight will build on areas of expertise and capacity of the State and CMS, leveraging the CMS-State Contract Management Team, as described in Appendix 7.
- Oversight of the MMPs and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and the Rhode Island Comprehensive Section 1115(a) demonstration.
- Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the State. MMPs will be included in all existing Medicare Advantage and Part D oversight activities, including (but not limited to) data-driven monitoring, secret shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and possibly audits.
- Oversight will also include, but is not limited to, a focus on fraud, waste, and abuse.
- CMS and the State will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poor performers from

the program, leveraging existing CMS tools, such as the Complaints Tracking Module or the Part D Critical Incidence Reporting System, and existing State oversight and tracking tools. Standards for removal on the grounds of poor performance will be articulated in the Three-way Contract.

3. **Consolidated Reporting Requirements:** CMS and the State shall define and specify in the Three-way Contract a Consolidated Reporting Process for MMPs 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 MMP's performance. MMPs 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 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. This is discussed in more detail in Appendix 7. CMS and the State shall streamline data submissions for MMPs wherever practicable.

H. QUALITY MANAGEMENT

1. **Quality Management and Monitoring:** As a model conducted under the authority of Section 1115A of the Social Security Act, the Demonstration and independent evaluation will include and assess quality measures designed to ensure Enrollees are receiving 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 the Medicare Advantage, Part D, the Rhode Island Comprehensive Section 1115(a) demonstration, and the State's Medicaid managed care program 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 MMP external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).

3. **Determination of Applicable Quality Standards:** CMS and the State shall determine applicable quality standards and monitor the MMPs' compliance with those standards. These standards are articulated in Appendix 7 and the Three-way Contract.

I. FINANCING AND PAYMENT

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

J. EVALUATION

1. **Evaluation Data to be Collected:** CMS and the State have developed processes and protocols, as specified in Appendix 7 and as will be further detailed in the Three-way Contract, for collecting or ensuring the MMPs or their contractors collect and report to CMS and the State the data needed for evaluation.
2. **Monitoring and Evaluation:** CMS will fund an external evaluation. The Demonstration will be evaluated in accordance with Section 1115A(b)(4) of the Social Security Act. As further detailed in Appendix 7, CMS or its contractor will measure, monitor, and evaluate the overall impact of the Demonstration including the impacts on program expenditures and service utilization changes, including monitoring any shifting of services between medical and non-medical services. The evaluation will include changes in person-level health outcomes, experience of care, and costs by sub-population(s), and changes in patterns of primary, acute, behavioral health, and long-term care and support services use and expenditures, using principles of rapid-cycle evaluation and feedback. Key aspects and administrative features of the Demonstration, including but not limited to enrollment, marketing, and appeals and grievances, will also be examined per qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives, and 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 MMPs

will submit all data required for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements listed in the Three-way Contract with MMPs. The State and MMPs will submit both historical data relevant to the evaluation, including MSIS data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

K. EXTENSION OF AGREEMENT

The 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 and 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.

- 1. Limitations of MOU:** This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person. Nothing in this MOU may be construed to obligate the parties to any current or future expenditure of resources. This MOU does not obligate any funds by either of the parties. Each party acknowledges that it is entering into this MOU under its own authority.
- 2. Modification:** Either CMS or the State may seek to modify or amend this MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any material modification shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.
- 3. Termination:** CMS and the State may terminate this MOU under the following circumstances:

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

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

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

- a. Notification – Unless CMS and the State agree to extend the Demonstration, the State must submit a draft phase-out plan to CMS no less than five months before the end date of this MOU. After CMS review, 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 how Enrollee appeal rights will continue to operate during the phase-out and any MMP transition), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected Enrollees and ensure ongoing coverage for eligible individuals, including plans for enrollment of all Enrollees in a Part D plan, as well as any community outreach activities. In addition, such plan must include any ongoing MMP and State responsibilities and close-out costs.

- c. Phase-out Procedures – The State must comply with all notice requirements found in 42 CFR Parts 431.206, 431.210, and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Enrollees as outlined in 42 CFR Parts 431.220 and 431.221. If an Enrollee requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR Part 431.230. If applicable, the State must conduct administrative renewals for all affected Enrollees in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.
- d. FFP – If the Demonstration is terminated by either party or any relevant waivers are suspended or withdrawn by CMS, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including covered services and administrative costs of disenrolling Enrollees.

M. SIGNATURES

This MOU is effective on the date of the signatures below through the end of the Demonstration period, December 31, 2018. Additionally, the terms of this MOU shall continue to apply to the State and MMPs as they implement associated phase-out activities beyond the end of the Demonstration period.

In Witness Whereof, CMS and the State of Rhode Island 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:



Andrew M. Slavitt

Acting Administrator, Centers for Medicare & Medicaid Services

7/28/15
(Date)

State of Rhode Island, Executive Office of Health and Human Services:



Elizabeth Roberts

Secretary, Rhode Island Executive Office of Health and Human Services

7/21/15
(Date)

APPENDICES

- Appendix 1: Definitions
- Appendix 2: CMS Standards and Conditions Checklist and Supporting State Documentation
- Appendix 3: Details of State Demonstration Area
- Appendix 4: Medicare Authorities and Waivers
- Appendix 5: Medicaid Authorities and Waivers
- Appendix 6: Payments to MMPs
- Appendix 7: Demonstration Parameters

Appendix 1: Definitions

Action – A denial or a limited authorization of a requested item or service or a reduction, suspension, or termination of a previously authorized item or service; denial, in whole or in part, of payment for an item or service; failure to provide items or services in a timely manner; determination that a requested service is not a covered benefit (does not include requests for items or services that are paid for fee-for-service outside the MMP); or failure to make a grievance determination within required timeframes.

Alternative Payment Arrangements – Methods of payment that are not solely based on fee-for-service reimbursements, and may include, but shall not be limited to, bundled payments, global payments, and shared savings arrangements. Alternative Payment Arrangements may include fee-for-service payments, which are settled or reconciled with a bundled or global payment.

Appeal – A request by an Enrollee, or a provider on behalf of an Enrollee, for review of an Action.

Care Coordinator – An individual who is responsible for managing all activities performed by the Interdisciplinary Care Team for Enrollees who are not receiving LTSS and are otherwise not identified as being at high-risk.

Care Management – A set of individualized, person-centered, goal-oriented, culturally relevant services to assure that an Enrollee receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care Management emphasizes prevention, continuity, and coordination, that support linkages across the full continuum of Medicare and Medicaid covered services based on individual Enrollee strength-based needs and preferences. Care Management services will assist Enrollees to obtain needed medical, behavioral health, prescription and non-prescription drugs, community-based or facility-based LTSS, social, educational, psychosocial, financial and other services in support of the Interdisciplinary Care Plan or general Enrollee goals, irrespective of whether the needed services are covered under the capitation payment to the MMPs under this Demonstration. Care Management services are planned and provided based on opportunities to deliver quality-based outcomes such as: improved/maintained functional status, improved/maintained clinical status, enhanced quality of life, Enrollee satisfaction, adherence to the Interdisciplinary Care Plan, improved Enrollee safety, cost savings, wellness, and Enrollee autonomy. Care Management services include supports available to all Enrollees, at the level needed to effectively support each Enrollee.

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

CMS – The Centers for Medicare and Medicaid Services.

Community Transition Plan – A comprehensive plan that is created for Enrollees who have been identified as able to safely transition from a nursing facility to a community setting. Enrollees will be assigned a Transitions Care Manager (TCM). The TCM will participate in discharge planning meetings, develop an Interdisciplinary Care Plan, facilitate referrals to community providers, conduct a home safety evaluation, and follow the Enrollee upon discharge, including a face-to-face home visit within 24 hours of the discharge.

Comprehensive Functional Needs Assessment (CFNA) – A multidimensional, interdisciplinary process to determine actionable risk factors and Enrollees' strength-based needs and preferences based on their medical, psychological, and functional capabilities. The CFNA is the basis of Enrollee-specific coordinated and integrated Interdisciplinary Care Plans. The CFNA requires Enrollee input (with family and/or caregiver input provided as appropriate and with Enrollee consent) and multi-disciplinary input from providers who serve the Enrollee. A CFNA must include information regarding, but not limited to: Enrollee-centered needs; strength-based preferences; functional, medical and behavioral health status; self-care skills; medical history; social supports; psychosocial needs; and other elements of the Enrollee's needs to obtain deep and broad information for the purpose of creating an Interdisciplinary Care Plan.

Connect Care Choice Community Partners (CCCCP) – CCCCCP is an enhanced Primary Care Case Management model under the Rhode Island Integrated Care Initiative. CCCCCP offers a community health team to those individuals who are actively engaged with a RI EOHHS-certified Patient Centered Medical Home practice. The CCCCCP model encompasses primary care/nurse case management teams and co-located behavioral health to provide quality focused and holistic care to beneficiaries. CCCCCP is designed to achieve and preserve access to primary, preventive, behavioral health, and specialty care that allows the individual to remain well and independent in the community and decrease unnecessary acute episodes of care.

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

Contract – Also referred to as the Three-way Contract, this is the participation agreement that CMS and the State have with an MMP specifying the terms and conditions pursuant to which a participating MMP may participate in this Demonstration.

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

Covered Services – The set of services that MMPs are required to offer under the Demonstration.

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

Discharge Opportunity Assessment – A comprehensive assessment, administered in-person by a clinical professional, of an Enrollee’s desire and ability to be safely discharged from a nursing facility into a community setting.

Enrollee – Individuals enrolled in an MMP, including the duration of any month in which their eligibility for the Demonstration ends.

Enrollee Communications – Materials designed to communicate to Enrollees MMP benefits, policies, processes and/or Enrollee rights.

Enrollee Ombudsman Program – An independent, conflict-free entity, planned with support from a grant from CMS that has not yet been awarded, under RI EOHHS that will assist Enrollees in accessing their care, understanding and exercising their rights and responsibilities, and appealing adverse decisions made by their MMPs. The Enrollee Ombudsman will be accessible to all Enrollees by telephone and, where appropriate, in-person, including support from community-based organizations. The Enrollee Ombudsman will provide advice, information, referral and assistance in accessing benefits and assistance in navigating MMPs, providers, or RI EOHHS. The Enrollee Ombudsman may participate in MMP Enrollee Advisory

Committee activities.

Enrollment – The processes by which an individual who is eligible for the Demonstration is enrolled in a MMP.

Enrollment Counselor – An independent entity contracted with the State, which is responsible for processing all enrollment and disenrollment transactions. The Enrollment Counselor will provide unbiased education to Enrollees on MMPs and other potential enrollment choices, and ensure ongoing customer service related to outreach, education, and support for individuals eligible for the Demonstration. The Enrollment Counselor will incorporate the option of PACE enrollment into its scripts and protocols.

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

External Grievance – A grievance that is filed with CMS and/or the State.

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

Long-Term Services and Supports (LTSS) – A range of medical, social, or rehabilitation services a person needs over months or years in order to improve or maintain function or health, which are provided in the community or in a long-term care facility such as a nursing facility.

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

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

Health Outcomes Survey (HOS) – Enrollee survey used by the Centers for Medicare &

Medicaid Services to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

Intensive Care Management (ICM) – Intensive Care Management services are available to Enrollees eligible for LTSS, and to individuals who are not eligible for LTSS and are designated as being at high-risk based on a Comprehensive Functional Needs Assessment performed by the MMP. ICM services consist of (1) care coordination and management performed by a Lead Care Manager, (2) an Interdisciplinary Care Plan, (3) an Interdisciplinary Care Team, (4) coordination of Medicare and Medicaid services, and monitoring of Interdisciplinary Care Plans, (5) management of care transitions, and (6) analyzing ICM effectiveness and appropriateness, and Enrollee outcomes.

Interdisciplinary Care Plan (ICP) – The Interdisciplinary Care Plan is a written plan developed for Enrollees eligible for LTSS or otherwise determined to be at high risk. The ICP is developed in collaboration with the Enrollee; the Enrollee’s family, guardian or other caregivers; primary care provider (PCP); and/or other Interdisciplinary Care Team or other providers involved with the Enrollee and with the Enrollee’s consent, that delineates the activities to be undertaken to address key issues of risk for the Enrollee across the full care continuum. The ICP will include a written description of Enrollee-specific health care goals to be achieved and the amount, duration, and scope of the covered services to be provided to achieve such goals. The ICP shall include all services covered under the ICI Demonstration, as well as any non-covered services, with an emphasis on care management and informal supports necessary to support the Enrollee’s health care goals and effectiveness of the covered services in a culturally and linguistically person-centered manner. ICP effectiveness is monitored through reassessment and ongoing Interdisciplinary Care Team determination as to whether the health care goals are being met.

Integrated Care Initiative (ICI) – The Rhode Island Integrated Care Initiative integrates the provision of primary care, acute care, behavioral health care, and long-term services and supports for Medicaid-only individuals and Medicare-Medicaid Beneficiaries through Care Management strategies focused on the person’s needs. The ICI will be coordinated with the Rhode Island Money Follows the Person (MFP) program, “Rhode to Home.” The State has developed three models for integrating care under the ICI: (1) the CCCCP enhanced Primary Care Case Management model based on a FFS reimbursement approach, (2) a capitated model that includes both this Demonstration and the Rhody Health Options program, and (3) the PACE model, if there is available capacity to serve new members. Phase I of the ICI includes the provision of

Medicaid-covered benefits to Medicaid-only adults eligible for LTSS, and to all full-benefit Medicare-Medicaid Beneficiaries except for those individuals who are specifically excluded from the ICI or choose to opt out. Under Phase II of the ICI, Medicare-Medicaid Beneficiaries who enroll in the ICI Demonstration will receive Medicare and Medicaid benefits from a Rhode Health Options plan serving as an MMP. As under Phase I, certain developmental disability services, as well as a limited number of other services, will continue to be funded and managed under the FFS system. CMS and EOHHS may seek to include these services in the ICI (including the Demonstration) at a later point in time. The ICI Demonstration under Phase II shall be governed through a Three-way Contract between CMS, the State and the MMP.

Interdisciplinary Care Team (ICT) – A team of professionals and para-professionals that collaborate, in person and/or through other means, with Enrollees to develop and implement an Interdisciplinary Care Plan that meets Enrollees’ medical, behavioral, LTSS, and social needs. The ICT will be developed by the MMP (and under the direction of the Lead Care Manager for Enrollees eligible for LTSS or determined to be at high risk). The ICT includes the Enrollee and, with the Enrollee’s consent, may include but is not limited to the Enrollee’s family, guardian, and/or other caregiver; physicians; physician assistants; LTSS providers; nurses; specialists; pharmacists; behavioral health specialists; social workers; and peer supports appropriate for the Enrollee’s medical diagnoses and health condition, co-morbidities, and community support needs.

Lead Care Manager (LCM) – An appropriately qualified professional who is the MMP’s designated accountable point of contact for each Enrollee’s Intensive Care Management services, for Enrollees eligible for LTSS, or Enrollees not eligible for LTSS and determined to be at high risk based on the results of a Comprehensive Functional Needs Assessment performed by the MMP. The LCM is the primary individual responsible for implementing all responsibilities associated with the delivery of Intensive Care Management services. LCM responsibilities include: (1) conducting a Comprehensive Functional Needs Assessment when sufficient information is available to designate a LCM prior to that Assessment, (2) leading development of an Interdisciplinary Care Plan, (3) overseeing creation of an Interdisciplinary Care Team, (4) implementing and coordinating Medicare and Medicaid services, and monitoring of Interdisciplinary Care Plans, (5) management of care transitions, and (6) analyzing Intensive Care Management effectiveness and appropriateness, and Enrollee outcomes.

Medically Necessary Services – Services must be delivered in a way that preserves all protections to the Enrollee provided by Medicare and Rhode Island Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to

improve the functioning of a malformed body member, or otherwise Medically Necessary under 42 U.S.C. 1395y. In accordance with Medicaid law and regulations, and per Rhode Island Medicaid, the term “Medical Necessity,” “Medically Necessary,” or “Medically Necessary Service” means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition including such services necessary to prevent a detrimental change in either medical or mental health status. Medically Necessary Services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the Enrollee or service provider.

Medicare-Medicaid Beneficiaries – 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 Medicaid benefits under the Rhode Island Medicaid State Plan.

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

Medicare-Medicaid Plan (MMP) – A health plan under contract with CMS and the State to provide fully integrated Medicare and Medicaid benefits under the ICI Demonstration. The MMP integrates the provision of primary care, acute care, behavioral health care, and LTSS and supports through Care Management strategies focused on the person’s needs.

Medicaid-only Beneficiaries – For the purposes of this ICI Demonstration, individuals who are entitled to full Medicaid benefits but are not eligible for Medicare.

Medicaid – The program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof, including the Rhode Island Comprehensive Section 1115(a) demonstration.

Medicaid Waiver – Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act. A Section 1115(a) waiver is also referred to as a demonstration.

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

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

Social Security Act.

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

Passive Enrollment – An enrollment process through which an eligible individual is enrolled by the State (or its vendor) into an MMP, when not affirmatively electing one, following a minimum 60-day advance notification that includes the plan selection and the opportunity to select a different MMP, if applicable; make another enrollment decision; or opt out of the Demonstration prior to the effective date.

Peer Navigator – An individual who provides services to meet the needs of Enrollees who require assistance and peer mentoring to facilitate access to community services. Typically a trained para-professional who is responsible for helping Enrollees navigate the delivery system across their local communities.

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

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

Quality Improvement Organization (QIO) – A statewide organization that contracts with CMS to evaluate the appropriateness, effectiveness, and quality of care provided to Medicare Enrollees.

Readiness Review – Prior to entering into a Three-way Contract with the State and CMS, each MMP selected to participate in the ICI Demonstration will undergo a readiness review. The readiness review will evaluate each MMP'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 Medically Necessary Services. CMS and the State will use the results to inform their decision of whether the MMP 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 MMP's headquarters.

Rhode Island Executive Office of Health and Human Services (RI EOHHS) – The agency responsible for administering the Medicaid program in the State of Rhode Island, and responsible for implementation and oversight of the Demonstration.

Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) – The Department responsible for assuring access to quality services and supports for Rhode Islanders with developmental disabilities, mental health and substance abuse issues, and chronic long-term medical and psychiatric conditions; and for advancing the State's mission to address and erase the stigma attached to these disabilities as well as planning for the development of new services and prevention activities.

Self-Direction (also Consumer Direction) – The ability of an Enrollee to direct his/her own services through a consumer-directed personal assistance option.

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.

State – The State of Rhode Island (also "RI EOHHS").

Wellness Assessment – An assessment that is conducted for Enrollees residing in nursing facilities who do not want and/or are not able to transition safely to a community setting. This assessment can be conducted via phone or in person with a nursing facility resident, family member, or nursing home clinical staff member, as appropriate.

Wellness Plan – A long-term plan, informed by the Wellness Assessment, developed to help Enrollees residing in nursing facilities stay healthy in the nursing facility setting. The Wellness Plan will coordinate with all other clinical plans of care at the nursing facility, and will supplement where necessary.

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

Standard/ Condition	Standard/Condition Description	
Integration of Benefits	Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services.	pp. 6-9, 11-12, 18-21, 23, 31-32, Addendum
Care Model	Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.	pp. 14-19, Addendum
Stakeholder Engagement	State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss proposed model with relevant stakeholders. Stakeholders include, but are not limited to, Enrollees and their families, consumer organizations, Enrollee advocates, providers, and plans that are relevant to the proposed population and care model.	pp. 26-27, Appendix A, Appendix C

	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 Enrollees (and their representatives) of the changes related to this initiative.	pp. 26, 30
Enrollee Protections	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure Enrollee health and safety and Enrollee access to high quality health and supportive services necessary to meet the Enrollee's needs. At a minimum, States will be required to:	
	· Establish meaningful Enrollee input processes which may include Enrollee participation in development and oversight of the model (e.g., participation on MMP governing boards and/or establishment of Enrollee advisory boards).	pp. 22, 30, 37
	· Develop, in conjunction with CMS, uniform/integrated Enrollee materials that are accessible and understandable to the Enrollees who will be enrolled in the plans, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency.	pp. 30, 39
	· Ensure privacy of Enrollee health records and provide for access by Enrollees to such records.	pp. 30, 38
	· Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community.	pp. 14, 17-19, 29-30

	· Ensure access to services in a manner that is sensitive to the Enrollee’s language and culture, including customer service representatives that are able to answer Enrollee questions and respond to complaints/concerns appropriately.	pp. 30, 39
	· Ensure an adequate and appropriate provider network, as detailed below.	pp. 13-14, 29, Addendum
	· Ensure that Enrollees are meaningfully informed about their care options.	pp. 14-20, 29-30
	· Ensure access to grievance and appeals rights under Medicare and/or Medicaid.	
	o <i>For Capitated Model</i> , this includes development of a unified set of requirements for MMP complaints and internal appeals processes.	pp. 21, 29
State Capacity	State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of MMPs, and the capacity to receive and/or analyze Medicare data.	pp. 35-37, Addendum
Network Adequacy	The Demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.	pp. 13-14, 29, Addendum

Measurement/ Reporting	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality and cost outcomes for the target population. These metrics may include, but are not limited to Enrollee experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote Enrollees receiving high quality care and for purposes of the evaluation.	pp. 9-10, 33-37
Data	State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:	
	· Enrollee level expenditure data and covered benefits for the most recently available three years, including available encounter data in capitated models;	pp. 33-36, Addendum
	· Description of any changes to the State Plan that would affect Enrollees during this three-year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and	pp. 33-36, Addendum
	· State supplemental payments to providers (e.g., DSH, UPL) during the three-year period.	pp. 33-36, Addendum
Enrollment	State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting Enrollee education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.	pp. 10-12, 19
Expected Savings	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	pp. 13, 35

Public Notice	State has provided sufficient public notice, including:	
	· At least a 30-day public notice process and comment period;	pp. 27-28
	· At least two public meetings prior to submission of a proposal; and	p. 27
	· Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals.	p. 27
Implementation	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation:	
	· Meaningful stakeholder engagement.	pp. 30, 37
	· Submission and approval of any necessary Medicaid waiver applications and/or State Plan Amendments.	pp. 20, 22-25, 31
	· Receipt of any necessary State legislative or budget authority.	pp. 38-39
	· Joint procurement process (for capitated models only).	pp. 7, 13, 38
	· Enrollee outreach/notification of enrollment processes, etc.	pp. 19-20

Appendix 3: Details of State Demonstration Area

The Demonstration area consists of the entire State of Rhode Island.

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 MMPs and their sponsoring organizations for the Demonstration period beginning no earlier than December 1, 2015 through December 31, 2018, 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 Section 1315a(b)(2)(B) that the Center for Medicare and Medicaid Innovation is permitted to test is "[a]llowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals." §1315a(b)(2)(B)(x). Section 1315a(d)(1) provides that "The Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) [of the Social Security Act] as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b)."

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

- Section 1851(a), (c), (e), and (g) of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in MMPs to Medicare-Medicaid Enrollees who are age 21 or older, including Medicare-Medicaid Enrollees who may have End-Stage Renal Disease, and excluding beneficiaries who may meet exclusion criteria specified in Section III.C.1, and (2) the passive enrollment process provided for under the Demonstration.

- Sections 1853, 1854, 1857(e), 1860D-11, 1860D-13, 1860D-14, and 1860D-15 of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subparts F and G, and Part 423, Subparts F and G, only insofar as such provisions are inconsistent with the methodology for determining payments, medical loss ratios and Enrollee liability under the Demonstration as specified in this MOU, including Appendix 6, which differs as to the method for calculating payment amounts and medical loss ratio requirements, and does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under Sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.
- The provisions regarding deemed approval of marketing materials in Sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 CFR Part 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.
- Section 1860D-14(a)(1)(D) and implementing regulations at 42 CFR Part 423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the low-income subsidy be greater than \$0, to permit MMPs to reduce Part D cost sharing below the levels required under Section 1860D-14(a)(1)(D)(ii) and (iii).

Appendix 5: Medicaid Authorities and Waivers

All requirements of the Medicaid program expressed in law and regulation, not expressly waived in this list, shall apply to the Demonstration beginning no earlier than December 1, 2015 through December 31, 2018, 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.

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

Assessment of actuarial soundness under 42 CFR Part 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, waivers of State Plan requirements contained in Section 1902 and 1903 of the Social Security Act may be granted to enable the State of Rhode Island (State) to carry out the Demonstration. These authorities would be in addition to those in the State Plan and the existing Rhode Island Comprehensive Section 1115(a) demonstration. No additional waivers of Medicaid authority under Section 1115A of the Social Security Act are required for this Demonstration, or conferred via this Appendix.

Appendix 6: Payments to MMPS

CMS and the State of Rhode Island (RI) Executive Office of Health and Human Services (EOHHS) will enter into a joint rate-setting process based on the following principles:

1. Medicare and Medicaid will each contribute to the total capitation payment consistent with projected baseline spending contributions, as described below;
2. Demonstration savings percentages assume that MMPs are responsible for providing Enrollees with the full range of Covered Services and Flexible Benefits under the Demonstration;
3. Aggregate savings percentages will be applied equally to the Medicaid and Medicare Parts A and B components; and
4. Both CMS and EOHHS will contribute to the methodologies used to develop their respective components of the overall blended rate as summarized in Figure 6-2 and further described below.

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

Figure 6-1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1	No sooner than December 1, 2015 – December 31, 2016
2	January 1, 2017 – December 31, 2017
3	January 1, 2018 – December 31, 2018

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

Rate Element	Medicare Parts A and B	Medicare Part D	Medicaid
<p>2014 Baseline costs for the purposes of setting payment rates</p> <p>Medicare baseline spending will be established prospectively on a calendar year basis for each Demonstration county.</p> <p>Medicaid baseline spending amounts will be set up front and will be applied in future years unless more recent historical data are available and/or CMS' actuaries and EOHHS determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.</p>	Blend of Medicare Advantage payments and Medicare standardized Fee-For-Service (FFS) weighted by where Medicare Medicaid Enrollees who meet the criteria and who are expected to transition into the Demonstration are enrolled in the prior year. Baseline costs will be calculated as a per member per month (PMPM) standardized cost.	<p>National average monthly bid amount (NAMBA) will be used as the baseline for the direct subsidy portion of Part D spending.</p> <p>Note that additional costs associated with LIS payments, reinsurance payments, and risk-sharing are included in the Part D baseline for the purposes of tracking and evaluating Part D costs but not for the purposes of setting payment rates. These amounts will be factored into plan payments, but these amounts are subject to reconciliation consistent with Part D reconciliation rules.</p>	Blend of Medicaid capitation rates and historical State FFS data, with base data and trend rates developed by State actuaries, subject to CMS review.
Responsible for producing data	CMS	CMS	EOHHS and its contractors, validated by CMS
Savings percentages	Demonstration Year 1: 1% Demonstration Year 2: 1.25% Demonstration Year 3: 3%*	Not Applicable	Demonstration Year 1: 1% Demonstration Year 2: 1.25% Demonstration Year 3: 3%*
Risk adjustment	Medicare Advantage CMS-HCC Model	Medicare Part D RxHCC Model	Rate Cell Structure with risk adjustment using methodology described in section IV below
Quality withhold	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3%	Not Applied	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3%
Other Payment Provisions	Minimum Medical Loss Ratio (MLR), risk corridors.	Existing Medicare Part D Processes will apply	Minimum Medical Loss Ratio (MLR), risk corridors.

* Except as otherwise provided for in Section IX.C

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

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

A. Medicaid:

- i. There are several data sources that contribute to the development of the Medicaid component of the rate for Demonstration Year 1. These sources include the capitation payments and risk/gain share adjustments in the Rho Health Options (RHO) program, care coordination payments in the existing Connect Care Choice Community Partners (CCCCP) program, and comparable fee-for-service (FFS) expenditures for beneficiaries not enrolled in RHO or CCCCCP.
- ii. Prior to implementation of the Demonstration, EOHHS 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, including expenses in the RHO and CCCCCP programs, i.e. “Phase 1” of the Integrated Care Initiative (capitation rates, risk/gain share payments, encounter data, and FFS expenditures). The baseline will take into account historic payments, and will be trended forward to the Demonstration period.
- iii. 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, and inclusive of the RHO and CCCCCP programs, as applicable).

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

B. Medicare Parts A/B:

- i. CMS will develop baseline spending (costs absent the Demonstration) and payment rates for Medicare A and B services using estimates of what Medicare would have spent on behalf of the Enrollees absent the Demonstration.
- ii. The Medicare baseline rate for A/B services will be a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

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

accurate payment rate for such month. Such update may take place retroactively, as needed.

- iii. Medicare A/B payment rates will be determined by applying the annual savings percentages (see Sections II and III) to the baseline spending amounts.
- iv. Both baseline spending and payment rates under the Demonstration for Medicare A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized payment rates at the time of payment.
- v. CMS may require EOHHS to provide a data file for Enrollees who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline spending. CMS will specify the format and layout of the file.
- vi. The Medicare portion of the baseline will be updated annually consistent with the annual Fee-For-Service (FFS) estimates and benchmarks released each year with the annual Medicare Advantage rate announcement.
- vii. CMS annually applies a coding intensity adjustment factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service (FFS) Medicare programs. The adjustment for 2015 is 5.16% and the adjustment for 2016 is 5.41%. The majority of new Demonstration Enrollees will come from Medicare FFS, and 2015 and 2016 MMP risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the MMPs themselves. In calendar years 2015 and 2016, CMS will apply an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis. In CY 2017, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration Enrollees; this will

apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in CY 2017 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2016. After calendar year 2017, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Enrollees.

C. Medicare Part D:

- i. 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.
- ii. The CY 2015 Medicare Part D NAMBA is \$70.18.

II. Aggregate Savings Percentages Under the Demonstration

- A. Both Parties agree that there is reasonable expectation for achieving savings while paying MMPs capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to Enrollee needs. The savings percentages will be:
 - i. Demonstration Year 1: 1%
 - ii. Demonstration Year 2: 1.25%
 - iii. Demonstration Year 3: 3%, except as otherwise provided for in Section IX.C
- B. The savings percentages will be calculated and applied based on Demonstration Years. Rate updates will take place on January 1st of each calendar year.

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

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

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

IV. Rate Structure for the Medicaid Component of the Rates

A. The Medicaid component will employ the rating categories described below:

Figure 6-3: Medicaid Component Rating Categories

Rating Category	Rating Category Description
1*	Enrollees eligible to receive community or facility-based long-term services and supports (LTSS)
2	Enrollees residing in the community who are not eligible to receive LTSS
3	Enrollees with Severe and Persistent Mental Illness (SPMI)
4	Enrollees with Intellectual/Developmental Disabilities (I/DD)

*The Medicaid component for rating category 1 will be a blended rate that includes Enrollees eligible for community-based and facility-based LTSS, and will reflect transition assumptions between the two LTSS settings.

- B. The rate setting methodology for the Medicaid component will be the same methodology used to set the capitation rates for RHO. To develop RHO PMPM capitation rates for each rating category, EOHHS developed medical and LTSS expense PMPM estimates for the rate year by projecting the selected base period (SFY 2013) PMPMs for each target population forward using selected trend factors. Baseline medical expenses and trend factors will be updated using historical claims experience incurred prior to the Demonstration. There will be no adjustments for age or gender. Rates are statewide. A detailed description of the rate development is presented in the rate book that accompanied the Letter of Intent (the State MMP procurement vehicle) and its exhibits, (see LOI # 7548793 at www.purchasing.ri.gov).

V. Risk Adjustment Methodology for Medicare Components of the Rates

- A. The Medicare A/B Demonstration county rate will be risk adjusted based on the risk profile of each enrolled beneficiary. Except as specified in Section I.B.vii, the existing CMS-HCC and CMS-HCC ESRD risk adjustment methodologies will be utilized for the Demonstration.
- B. The Medicare Part D national average bid will be risk-adjusted in accordance with existing Part D RxHCC methodology.

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

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

- B. Withhold Measures in Demonstration Year 1:

- i. Figure 6-4 below identifies core withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for the 1% withhold. Additional detail regarding the agreed upon measures will be included in the Three-way Contract, and the methodology for calculating quality withhold payments will be described in future technical guidance.
- ii. Because Demonstration Year 1 crosses calendar/contract years, MMPs will be evaluated to determine whether they have met required quality withhold requirements at the end of both CY 2015 and CY 2016. The determination in CY 2015 will be based solely on those measures that can be appropriately calculated based on actual enrollment volume during CY 2015. Consistent with such evaluations, the withheld amounts will be repaid separately for each CY.

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

Domain	Measure	Source	CMS Core Withhold Measure
Assessments	Percent of Enrollees with initial assessments completed within 90 days of enrollment.	CMS-defined Process Measure	X
Consumer Governance Board	Establishment of consumer advisory board or consumer inclusion on governance board, consistent with contract requirements	CMS-defined Process Measure	X
Customer Service	Percent of the best possible score the MMP earned on how easy it is for members to get information and help from the plan when needed: <ul style="list-style-type: none"> • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? 	AHRQ/CAHPS	X

Domain	Measure	Source	CMS Core Withhold Measure
	<ul style="list-style-type: none"> In the last 6 months how, often were the forms for your health plan easy to fill out? 		
Encounter Data	Encounter data submitted timely in compliance with contract requirements.	CMS-defined Process Measure	X
Getting Appointments and Care Quickly	<p>Percent of best possible score the MMP earned on how quickly members get appointments and care:</p> <ul style="list-style-type: none"> In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? 	CAHPS	X
Nursing Facility Diversion	<p>Reporting of the number of nursing home certifiable Enrollees who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Enrollees who lived outside the NF during the previous year.</p> <p><u>Nursing Facility Diversion Rate:</u> <u>Numerator:</u> Of those Enrollees in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year.</p> <p><u>Denominator:</u> Nursing home certifiable Enrollees enrolled in a</p>	State-specified measure	

Domain	Measure	Source	CMS Core Withhold Measure
	<p>plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months.</p> <p><u>Exclusions:</u> Any nursing home certifiable Enrollee with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.</p>		
Out-of-plan Services	Reporting of the number of Enrollee discharges from, and placements into, residential settings involving out-of-plan services, including residential services for Enrollees with intellectual and developmental disabilities (I/DD).	State-specified Measure	
Person-Centered Care Plan	Percent of Enrollees with care plans within required timeframes.	CMS/State defined process measure	X

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

C. Withhold Measures in Demonstration Years 2 and 3

- i. The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3 and will be based on performance on the core Demonstration and EOHHS-specified measures. Figure 6-5 below identifies the quality withhold measures for Demonstration Years 2 and 3.

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

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Annual Flu Vaccine	Percent of Enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Controlling Blood Pressure	Percentage of Enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	
Follow-up After Hospitalization for Mental Illness	Percentage of discharges for Enrollees 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Part D Medication Adherence for Oral Diabetes Medications	Percent of Enrollees 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	
Plan All-Cause Hospital Readmissions	Percent of Enrollees discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Reducing the Risk of Falling	Percent of Enrollees with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Screening for Clinical Depression and	Percentage of Enrollees ages 21 years and older screened for	CMS	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Follow-up Care	clinical depression using a standardized tool and follow-up plan documented.			
Care for Older Adults – Medication Review	Percent of Enrollees 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 Enrollees 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 Enrollees who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS		X
Care for Older Adults – Advance Care Plan	Percent of Enrollees who had an advance care plan during the measurement year.	NCQA/HEDIS		X
Nursing Facility Diversion	<p>Reporting of the number of nursing home certifiable Enrollees who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Enrollees who lived outside the NF during the previous year.</p> <p><u>Nursing Facility Diversion Rate:</u> <u>Numerator:</u> Of those Enrollees in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year.</p>	State-specified Measure		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
	<p><u>Denominator</u>: Nursing home certifiable Enrollees enrolled in a plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months.</p> <p><u>Exclusions</u>: Any nursing home certifiable Enrollee with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.</p>			
Nursing Facility Transitions	The number of members who successfully transitioned from a nursing facility to the community.	State-specified process measure		X

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

- ii. Additional detail regarding the agreed upon measures will be specified in the Three-way Contract, and the methodology for calculating quality withhold payments will be described in future technical guidance. Metrics applicable to individuals younger than 21 based on technical specifications may be modified to reflect the ICI Demonstration target population.

VII. Payments to MMPs

- A. Not later than the fifth day of the month, CMS will make separate monthly, risk-adjusted payments to the MMPs for the Medicare Parts A/B and Part D components of the rate, based on standardized Demonstration payment rates. Medicare Parts A/B and Part D payments will be subject to the same payment adjustments that are made for

payments to Medicare Advantage and Part D plans, including but not limited to adjustments for user fees and Medicare Secondary Payer adjustment factors.

- B. Not later than the fifth day of the month, EOHHS will make a payment to the MMPs for the Medicaid component of the rate.
- C. The capitated payment from CMS and EOHHS is intended to be adequate to support access to and utilization of Covered Services, according to Enrollees' Interdisciplinary Care Plans. CMS and EOHHS will jointly monitor access to care and overall financial viability of MMPs accordingly.

VIII. Evaluate and Pay MMPs Relative to Quality Withhold Requirements

- A. CMS and EOHHS will evaluate MMP performance according to the specified metrics required in order to earn back the quality withhold for a given year. CMS and EOHHS will share information as needed to determine whether quality requirements have been met and calculate final payments to each MMP from each payer.
- B. Whether or not each MMP has met the quality requirements in a given year will be made public, as will relevant quality scores of MMPs in Demonstration Years 2 and 3.

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

- A. Minimum Medical Loss Ratio: Each MMP will be required each year to meet a minimum Medical Loss Ratio (MLR) threshold which regulates the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments after final risk adjustment) that must be used for expenses either directly related to medical claims or those which are related to the care and quality of care for Enrollees. MLRs will be reported based on 42 CFR §§ 422.2400 et seq. and §§ 423.2400 et seq., with some possible exceptions including, but not limited to, the treatment of care management expenses, subcapitated payments, and "in lieu of" services, where appropriate for the Demonstration.

- i. If an MMP has an MLR below 85% of the joint Medicare and Medicaid payment to the MMPs, the MMP must remit the amount by which the 85% threshold exceeds the MMP's actual MLR multiplied by the total applicable revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicare and Medicaid programs on a percent of premium basis.
 - ii. The Three-way Contract will include additional specifications on the MLR. To the maximum extent possible, the methodology for calculating the MLR will conform to prevailing regulatory requirements applicable to the other products offered by organizations operating MMPs.
- 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: In the event that one or more MMPs experience annual losses in Demonstration Year 1 exceeding 3% of revenue in the aggregate of all regions in which the MMP participates, the savings percentage for Demonstration Year 3 will be reduced to 1.5%. Revenue will include Medicare A/B revenue and Medicaid revenue, including any reconciliation and risk adjustment. Annual losses will be calculated as if the MMP had received the full quality withhold payment and any other offsets, as defined in the Three-way Contract.

CMS and EOHHS will review MMP financial reports, encounter data, and other information to assess the ongoing financial stability of the MMPs and the appropriateness of capitation payments. At any point, the State may request CMS review of documentation from specific MMPs 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. Risk Mitigation Strategies

Risk corridors will be established to account for possible enrollment bias and to protect MMPs and payors against uncertainty in rate setting that could result in either overpayment or underpayment until actual Demonstration experience is available.

- A. The Demonstration will use a tiered MMP-level symmetrical risk corridor to include the combined Medicare A/B and Medicaid components.
- B. The risk corridors will be reconciled after application of any risk adjustment methodologies (e.g. CMS-HCC). Risk corridors will be reconciled as if all MMPs had received the full quality withhold payment.
- C. Process for collecting cost information. CMS and EOHHS will evaluate encounter data, cost data, and MMP financial reports to determine MMP incurred costs of services.
- D. Risk corridor share: The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the capitated payments, not including Part D, except as described below:
 - i. Prior to risk corridor calculations, CMS will analyze FFS Medicare expenditures relative to the risk adjusted county FFS rates for the population enrolled in the Demonstration to calculate a ratio of the risk-adjusted Medicare FFS county rates to Medicare FFS costs (“Rate-to-FFS Ratio”). One ratio will be calculated for the entire Demonstration area.
 - ii. If that analysis shows a Rate-to-FFS Ratio for the entire Demonstration area between 0.98 and 1.02, the maximum Medicare payment/recoupment will equal 2% of the risk-adjusted Medicare baseline in DY1, 1.5% of the risk-adjusted

Medicare baseline in DY2, and 1% of the risk-adjusted Medicare baseline in DY3.

- iii. If the analysis shows a Rate-to-FFS Ratio greater than 1.02 and there are plan losses, Medicare participation in the risk corridor will be limited to 1% of the risk-adjusted Medicare baseline in each year.
- iv. If the analysis shows a Rate-to-FFS Ratio less than 0.98 and there are plan losses, Medicare participation in the risk corridor settlement will be adjusted. First, Medicare will make payment to the MMP of the lesser of the Medicare amount necessary to bring the Rate-to-FFS Ratio to 0.98 or the total plan losses. For Medicare, participation in the risk corridor bands will be capped at 2% of the risk-adjusted Medicare baseline in DY1, 1.5% of the risk-adjusted Medicare baseline in DY2, and 1% of the risk-adjusted Medicare baseline in DY3; in such scenarios, the risk-adjusted Medicare baseline will be adjusted to incorporate the payment associated with the Rate-to-FFS Ratio analysis.
- v. If the analysis shows a Rate-to-FFS Ratio less than 0.98 and there are plan gains, Medicare recoupment in the risk corridor will be limited to 1% of the risk-adjusted Medicare baseline in each year.
- vi. If the analysis shows a Rate-to-FFS Ratio for the risk adjustment model greater than 1.02 and there are plan gains, Medicare participation in the risk corridor will be adjusted. First, Medicare will recoup from the MMP the lesser of the Medicare amount necessary to bring the Rate-to-FFS Ratio to 1.02 or the total plan gains. For any remaining gains after that recoupment, the risk corridor bands in Section X.E will apply. Medicare recoupment under the risk corridor bands will be capped at 2% of the risk-adjusted Medicare baseline in DY1, 1.5% of the risk-adjusted Medicare baseline in DY2, and 1% of the risk-adjusted Medicare baseline in

DY3; in such scenarios, the Medicare baseline will be adjusted to incorporate the recoupment associated with the Rate-to-FFS Ratio analysis.

- vii. In instances in which risk corridor payments exceed a Medicare maximum, all remaining payments once Medicare has reached its maximum obligation shall be treated as Medicaid expenditures eligible for FMAP.

E. Risk corridor tiers: CMS and EOHHS will use the following bands to address potential MMP gains/losses.

i. Demonstration Year 1:

- a. Greater than 5% gain/loss, MMPs would bear 10% of the risk/reward; EOHHS and CMS would share in the other 90% as described in Section X.D, above.
- b. Between 1.5% and 5% gain/loss, MMPs would bear 30% of the risk/reward; EOHHS and CMS would share in the other 70% as described in Section X.D, above.
- c. Between 0 and 1.5% gain/loss, MMPs would bear 100% of the risk/reward.

ii. Demonstration Year 2:

- a. Greater than 6% gain/loss, MMPs would bear 10% of the risk/reward; EOHHS and CMS would share in the other 90% as described in Section X.D, above.
- b. Between 2% and 6% gain/loss, MMPs would bear 30% of the risk/reward; EOHHS and CMS would share in the other 70% as described in Section X.D, above.
- c. Between 0 and 2% gain/loss, MMPs would bear 100% of the risk/reward.

iii. Demonstration Year 3:

- a. Greater than 7% gain/loss, MMPs would bear 100% of the risk/reward.
- b. Between 2.5% and 7% gain/loss, MMPs would bear 30% of the risk/reward; EOHHS and CMS would share in the other 70% as described in Section X.D, above.

- c. Between 0 and 2.5% gain/loss, MMPs would bear 100% of the risk/reward.
- iv. The following expenses will be excluded for purposes of the gain/loss calculations:
 - a. Provider pay-for-performance incentive arrangements that were not approved by CMS/EOHHS; and
 - b. Provider pay-for-performance incentives that exceed EOHHS approved levels, in accordance with EOHHS issued “Guidelines for Provider Pay-for Performance.”
- v. Offsets for the purposes of the gain/loss calculations include:
 - a. All Third Party Liability (TPL) collections by the MMP, including those pursuant to subrogation (EOHHS and CMS reserve the right to alter the process for subrogation collections at a future date);
 - b. Reinsurance recoveries made to the MMP;
 - c. Drug rebates received or receivable for drugs provided to Enrollees during the Demonstration; and
 - d. Other payments as determined jointly by EOHHS and CMS.
- vi. As part of the Three-way Contract, both Parties intend to develop an approach to considering MMP administrative costs to ensure that CMS and the State do not share in any MMP losses related to inefficient administrative spending or booking profit margins as an administrative cost, as part of any applicable risk corridor settlement.
- vii. The Three-way Contract will include additional specifications on the risk corridors. To the maximum extent possible, the methodology for calculating any risk corridor payments will conform to prevailing regulatory requirements applicable to the other products offered by organizations operating MMPs. In the event the MMP qualifies to make both a risk corridor payment to CMS and the State, as well as an MLR remittance, the risk corridor calculation will be net of any MLR remittances.

- F. Interim and final settlement amounts shall be calculated for each Demonstration Year; however, any Demonstration Year 1 payment will be contingent upon MMP participation in Demonstration Year 2, and any Demonstration Year 2 payment will be contingent upon MMP participation in Demonstration Year 3, unless otherwise permitted by EOHHS and CMS.
- G. Cost reconciliation under Part D will continue as-is under the Demonstration. CMS will monitor Part D costs closely on an ongoing basis. Any material increase in Part D costs relative to the baseline may be factored into future Demonstration Year savings percentages.

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

- A. Rates will be updated using a similar process for each calendar year. Changes to the Medicare baselines (and therefore the corresponding payment rate) outside of the annual Medicare Advantage rate announcement would occur only if and when CMS and the State determine the change is necessary to calculate accurate payment rates for the Demonstration. For changes solely affecting the Medicare program baseline, CMS will consult with the State prior to making any adjustment, but State concurrence will not be required. Changes may be based on the following factors: shifts in enrollment assumptions; major changes or discrepancies in Federal law and/or State policy compared to the assumptions about Federal law and/or State law or policy used in the development of baseline estimates; and changes in coding intensity. CMS and/or the State will make changes to baseline estimates after identification of the need for such changes, and changes will be applied, if necessary on a retrospective basis, to effectuate accurate payment rates for each month.
- B. Changes to the savings percentages would occur if and when CMS and the State jointly determine that changes in Medicare Part D spending have resulted in materially higher

or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

- C. If there are major changes to the CMS-HCC methodology for Medicare-Medicaid Enrollees, CMS, in consultation with the State, will revisit the appropriateness of the “Rate-to-FFS-Ratio” methodology described in Section X.
- D. If other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and the State to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

Appendix 7: Demonstration Parameters

The purpose of this Appendix is to describe the parameters that will govern this Federal-State partnership; the parameters are based upon those articulated by CMS in its January 9, 2013 and March 29, 2012 Health Plan Management System (HPMS) guidance. CMS and the State have further negotiated these parameters, as specified below.

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

I. State of Rhode Island Delegation of Administrative Authority and Operational Roles and Responsibilities

The Rhode Island (RI) Executive Office of Health and Human Services (EOHHS) is the single State agency that administers the Medicaid program. The Medicaid Director oversees Medicaid operations and will be involved with implementing and monitoring the ICI Demonstration. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across RI EOHHS as described below.

All responsibility for development of the ICI Demonstration model and implementation plan rests with the Medicaid Director, who will chair the ICI Management Team. The Medicaid Director will serve as the main point of contact for the Medicare-Medicaid Coordination Office at CMS regarding CMS/Rhode Island collaboration in the ICI Demonstration. In addition to State staff, the State will use contractors for certain tasks including rate development, data analysis, demonstration evaluation, quality assurance, and other functions.

II. Plan or Qualified Entity Selection

The State, in consultation with CMS, developed an application process that includes the State and CMS requirements to become an MMP under this Demonstration. The State and CMS will engage in a joint selection process that will take into account previous performance in Medicare and Medicaid, and ensure that bidders have met CMS' requirements, as specified in this MOU.

The State, in consultation with CMS, issued a Letter of Interest (LOI) that included the State

requirements to become an MMP under this Demonstration. The State issued the LOI in February 2013 and selected one MMP in June 2013. The LOI is available at the following website: http://www.ohhs.ri.gov/documents/documents13_2ndQ/7461245_RHO.pdf. The State issued a new LOI in spring 2014, completed in summer 2014, to seek additional MMPs through this process.

All MMP applicants are also required to meet the Medicare components of the plan selection process, including submission of a successful Capitated Financial Alignment Demonstration application to CMS. Successful applicants are required to adhere to any annual contract renewal requirements and guidance updates.

MMP selections are contingent on the selected entities passing a CMS and State-sponsored readiness review. Upon final selection, the State and CMS will ultimately enter into a Three-way Contract with selected plans.

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

III. State Level Enrollment Operations Requirements

- A. Eligible Populations/Excluded Populations: As described in the body of the MOU, Section III.C.1.
- B. Enrollment and Disenrollment Processes: Enrollment and disenrollment transactions will be processed through the State Enrollment Counselor, consistent with the enrollment effective date requirements outlined in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. RI EOHHS (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 RI EOHHS identifying individuals who have elected to disenroll from a MMP, opt out of passive enrollment, or have enrolled in, or have selected another type of, available Medicare coverage that is not an MMP. RI EOHHS will share enrollment, disenrollment, and opt-out transactions with contracted MMPs.
- C. Uniform Enrollment / Disenrollment and Opt-Out Letter and Forms: Letters and forms will be made available to stakeholders by both CMS and the State.
- D. Enrollment Effective Date(s): All enrollment effective dates are prospective. Enrollee-elected enrollments are effective the first calendar day of the month

following the initial receipt of a beneficiary's request to enroll, so long as the request is received by the 10th of the month. Enrollment requests received after the 10th of the month will be effectuated the first day of the second month following the request.

- E. Passive enrollment is effective not sooner than 60 calendar days after beneficiary notification of the right to select an MMP. All disenrollment requests will be effective the first day of the month following a beneficiary's request to disenroll from the Demonstration.
- F. Disenrollment Effective Date(s): Requests to disenroll from an MMP, opt out, or enroll in a different MMP (if applicable) will be effective the first day of the month following receipt of the request.
- G. Opt-in Enrollments: MMPs will be required to accept opt-in enrollments for eligible individuals no earlier than 90 calendar days prior to the first effective enrollment date, and begin providing coverage for opt-in Enrollees no earlier than December 1, 2015.
- H. Phased Enrollment: The State will utilize a phased approach to enrollment which will enable CMS and the State to assess an MMP's ability to serve a subset of Enrollees before receiving a larger volume of beneficiaries who are passively enrolled.
 - i. The State's enrollment strategy will begin with an opt-in only enrollment period for at least the first two months of the Demonstration.
 - ii. Following the opt-in only period, the State will conduct at least four separate waves of passive enrollment as follows:
 - a. Wave 1: The tentative effective enrollment date for the first wave of passive enrollment is no earlier than February 1, 2016, or two months after the first opt-in effective enrollment date, and may include individuals who are eligible for LTSS benefits in the community.
 - b. Wave 2: The tentative effective enrollment date for the second wave of passive enrollment is no earlier than March 1, 2016, or at least three months after the first opt-in effective enrollment date, and may include individuals who are using nursing facility-based LTSS.

- c. Wave 3: The tentative effective enrollment date for the third wave of passive enrollment is no earlier than April 1, 2016, or at least four months after the first opt-in effective enrollment date, and may include individuals not eligible for LTSS.
 - d. Wave 4: The tentative effective enrollment date for the fourth wave of passive enrollment is no earlier than May 1, 2016 or at least five months after the first opt-in effective enrollment date and may include individuals with serious and persistent mental illness.
- I. Beneficiary Notification: The State will send notices to individuals eligible to opt in to the ICI Demonstration prior to the first effective enrollment date. In addition:
 - i. The State will provide notice of the option to select an MMP at least 60 calendar days prior to the effective date of each wave of passive enrollment and will accept opt-out requests through the last day of the month prior to the effective date of enrollment. This notice will explain the Enrollee's options, including the option to decline passive enrollment into the MMP, or once enrolled, to request prospective disenrollment from the Demonstration.
 - ii. Thirty calendar days prior to each passive enrollment effective date, a second notice will be provided to Enrollees who have not responded to the initial notice. The notice will include the name of the MMP into which the Enrollee would be enrolled unless he/she selects another plan or opts out of the ICI Demonstration. Rhode Island will proceed with passive enrollment into the identified MMP for Enrollees who do not make a different choice.
 - iii. Any time an individual requests to opt out of passive enrollment or disenroll from the Demonstration, the State will send a letter confirming the opt-out and providing information on the benefits available to the Enrollee once they have opted out or disenrolled.
- J. Medicare Reassignment: Enrollees who otherwise are included in Medicare reassignment effective January 1 of a given year either from their current Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP, will not be eligible for passive enrollment that same year. For example: those reassigned to a new PDP effective

January 1, 2015, will be eligible for passive enrollment into an MMP effective no earlier than January 1, 2016.

- K. Enrollment Effective Dates: The State and CMS must agree in writing to any changes to the enrollment effective dates.
- L. No enrollments will be accepted within 6 months of the end of the Demonstration.
- M. Passive enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto-assignment for individuals with the Part D Low Income Subsidy.
- N. “Intelligent Assignment” Algorithm: 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 Enrollees’ previous Medicaid managed care enrollment and historic provider utilization.
- O. Customer Service: The State will provide customer service, including mechanisms to counsel Enrollees notified of passive enrollment and to receive and communicate Enrollee choice of opt out to CMS on a daily basis via transactions to CMS’ MARx system. Medicare resources, including 1-800-Medicare, will remain resources for Medicare Enrollees; calls related to ICI Demonstration enrollment will be referred to the State’s Enrollment Counselor for customer service and enrollment support.
- P. CMS and the State will jointly approve all Demonstration enrollment notices to ensure complete and accurate information is provided in concert with other Medicare communications, such as the Medicare & You handbook. CMS may also send a jointly-approved notice to individuals, and will coordinate such notice with any State notice(s).
- Q. State and CMS systems will be reconciled on a timely basis to resolve discrepancies between systems.
- R. PACE Information: The State will ensure that the PACE program is known to eligible individuals as an integrated program alternative to the ICI Demonstration, within the geographic area where PACE is offered. The option of PACE enrollment will be specified in outreach and educational materials about the ICI Demonstration and will be incorporated into the Enrollment Counselor scripts and protocols consistent with geographic limitations.

IV. State Level Delivery System Requirements

- A. Requirements for Care Management and Care Coordination: MMPs will offer Care Management services to all Enrollees as needed to support health and wellness, ensure effective linkages and coordination between the primary care provider (PCP) and other providers and services, and to coordinate the full range of medical and behavioral health services, preventive services, medications, LTSS, social supports, and enhanced benefits as needed, both within and outside the MMP. Care Management services include both Intensive Care Management (ICM) for Enrollees who are eligible for LTSS and other high-risk Enrollees who may benefit from such services, and Care Coordination services for individuals with more limited needs. All Care Management services will be person-centered and will be delivered to Enrollees according to their strength-based needs and preferences. Enrollees will be encouraged to participate in decision making with respect to their care.

MMPs shall have effective systems, policies, procedures and practices in place to identify Enrollees in need of Care Management services, including an early warning system and procedures that foster proactive identification of high-risk Enrollees and to further identify Enrollees' emerging needs. A determination of which Enrollees are at high risk will be made by the MMP as a result of its predictive modeling results, Initial Health Screen or Comprehensive Functional Needs Assessment, and/or State-established minimum required determinants of health status, as described below. Enrollees who are determined to be at high-risk and eligible for ICM may include, but not be limited to, individuals with complex medical conditions and/or social support needs that may lead to: the need for high-cost services; deterioration in health status; or, institutionalization.

- i. The objectives of the ICI Demonstration Care Management model are to:
 - a. Ensure delivery of integrated care based on an Interdisciplinary Care Plan (ICP) in collaboration with community-based providers, with appropriate incentives to maximize quality and cost-effectiveness;
 - b. Offer person-centered, strength-based supports that empower Enrollees to participate in the care delivery process;
 - c. Increase the proportion of individuals successfully residing in a community setting;

- d. Ensure that needed services identified through the assessment processes are obtained and that any existing gaps or barriers to necessary services are eliminated with a focus in transitions in care and the integration of physical and behavioral health, and that MMPs create payment incentives to achieve this goal, among others;
 - e. Facilitate access to timely, appropriate, accessible and quality primary, acute, behavioral health, LTSS, and community support services;
 - f. Assist Enrollees in achieving an optimal level of wellness and function by facilitating timely and appropriate health care service delivery and Enrollee self-advocacy and self-management;
 - g. Evaluate and continuously improve the quality and effectiveness of the Care Management program, including the use of payment incentives;
 - h. Tailor successful evidenced-based practices to meet the needs of Enrollees; and
 - i. Maximize the use of technology to improve access to care and provision of care while reducing cost.
- ii. Among other outcomes, ICI Care Management efforts will seek to:
- a. Achieve cost-effectiveness while improving or maintaining the level of quality by using payment incentives among other tools;
 - b. Maintain Enrollees in the least intensive setting possible with a focus on community-based resources; and
 - c. Implement payment, measurement and incentive strategies that decrease avoidable hospitalizations and emergency room utilization, and reduce nursing home admissions and lengths of stay.
- iii. Routine Care Coordination for Low- and Moderate-risk Enrollees: Upon initial enrollment, Enrollees who reside in the community and are not eligible for LTSS, and have not otherwise been determined to be high risk, will receive a telephonic Initial Health Screen (IHS) to risk stratify them into a low-, moderate-, or high-risk category. Those who stratify as high-risk will then receive an in-person Comprehensive Functional Needs

Assessment, described in Section IV.b.ii. Care Coordination for individuals at low and moderate risk will include, but is not limited to:

- a. Routine support from Enrollee Services within the MMP. The Enrollee can contact Enrollee Services as needed to obtain telephonic support (e.g. referrals to community-based services, identification of specialists, assistance arranging services). Enrollee Services will facilitate contact with Care Management services as requested or needed by the Enrollee;
- b. Wellness services, provided and documented by the PCP at least annually in the Enrollee medical record;
- c. Health and wellness information will be shared with the ICT as appropriate, including the Enrollee, a caregiver if desired by the Enrollee, the PCP, and any other relevant providers as determined by the PCP or the Enrollee;
- d. Peer Navigator services, to the extent that MMP Care Management staff determines such supports to be necessary and beneficial. Low-risk Enrollees will be eligible to receive Peer Navigator services, based on need, as periodic support to identify additional needs and supports and to follow through on referrals and community-based services;
- e. Targeted support from MMP Care Management or Enrollee Services staff, to be designated by the MMP at the time the Enrollee is identified as being in need of support;
- f. A CFNA, in the event that the Enrollee experiences a change in health status or social supports, as described in Section IV.b.iii.a. The provision of a CFNA may be triggered by: predictive modeling data; a self- or other referral regarding the Enrollee's needs; or contact with MMP staff that indicates the potential for increased risk such that the Enrollee may qualify for ICM services;
- g. Home safety checks as needed by an Initial Health Screen or CFNA; and
- h. In-home services, as needed.

- iv. Intensive Care Management (ICM) for High-risk Enrollees: ICM will be available to Enrollees eligible for LTSS, or who are determined to be high-risk via the IHS and CFNA or other sources. ICM will include a set of high-touch, person-centered care management activities requiring direct interaction with the Enrollee and ICT; data collection, analysis, interpretation, and communication of data to the ICT; and monitoring and quality assurance of ICM activities. Specific ICM services will include, but are not limited to:
 - a. Person-centered Care Management and coordination from a Lead Care Manager with physical and/or behavioral health expertise, as described in Section IV.C., based on the Enrollees' strength-based preferences and needs;
 - b. Creation of a comprehensive Interdisciplinary Care Plan (ICP), as described in Section IV.F. The ICP will be shared with and updated by the ICT, and will include ongoing monitoring and revisions to the ICP to continuously improve the health and well-being of the Enrollee until such time that ICM services are not needed;
 - c. Coordination of a range of home and community-based services as needed, including but not limited to Peer Navigator services, to the extent that MMP care management staff determines such supports to be necessary and beneficial;
 - d. For Enrollees with intellectual and developmental disabilities (I/DD) who are receiving out-of-plan services excluded from the capitation rates, coordination of those out-of-plan services as part of the ICP;
 - e. Home safety checks as determined by a CFNA; and
 - f. Payment incentives by the MMP to support ICM goals and objectives.
- v. Coordination with Medicaid Health Homes: Enrollees may be eligible to receive Health Home services if they meet State-specified criteria and an approved Health Home operates in the Demonstration county. Enrollees who receive Care Management from a Health Home will have their needs coordinated by the Health Home for the condition(s) qualifying those Enrollees for Health Home services (e.g. an SPMI Health Home would continue to coordinate SPMI services). The MMP Lead Care Manager will

be required to coordinate with the Health Home for both Health Home and MMP services. The Health Home care manager will be a member of the Interdisciplinary Care Team, and any Health Home care plan will be integrated into the Interdisciplinary Care Plan developed by the MMP.

MMPs and Health Homes will ensure there are no gaps or duplication in services provided to Enrollees. The Three-way Contract will further specify the responsibilities of the MMPs and the expectation of the Health Homes to support and coordinate MMP and Health Home services.

- B. Requirements for Assessment: The assessment process consists of two main components: Initial Health Screens for Enrollees who are not eligible for LTSS, and Comprehensive Functional Needs Assessments for Enrollees who are eligible for LTSS or who are otherwise determined to be high-risk. Both types of assessment are informed by and result in risk profiling.
- i. Initial Health Screen (IHS): Each MMP will develop an IHS, which EOHHS will review and approve. During the first six months of the ICI Demonstration, MMPs will be required to administer a telephonic IHS within one hundred-eighty (180) calendar days of effective enrollment to all Enrollees who are not eligible for LTSS or otherwise determined to be high-risk. After the first six months of the Demonstration, MMPs must administer the IHS within forty-five (45) calendar days of effective enrollment for non-LTSS Enrollees not otherwise determined to be high-risk. The MMP will re-administer the IHS for an Enrollee based on the Enrollee's condition or needs, including as indicated by predictive modeling or provider- or self-referral. If the Enrollee or caregiver requests an IHS, it must be completed within fifteen (15) calendar days of the request.
 - a. At a minimum, the IHS shall include:
 - 1. Complete demographic information including, but not limited to household information including mailing address, and phone number; the Enrollee's preferred language; age/date of birth; and living arrangement (lives alone, lives with family, etc.) and current residence status (community or facility-based);
 - 2. Strength-based needs and preferences;

3. Self-reported health status;
 4. Emergency room utilization in the last six months;
 5. History of hospitalizations in the last year;
 6. Presence of co-morbid chronic conditions;
 7. Availability of an informal caregiver;
 8. Prior nursing facility admissions;
 9. Ability to perform activities of daily living (ADLs); and
 10. Perceived risks (e.g. of falls).
- b. The MMP will stratify each Enrollee who receives the IHS as being low-, moderate-, or high-risk. The State will identify minimum required determinants of high-risk status that may include, but are not limited to, three or more emergency department visits in the prior six month period, a hospital re-admission within 60 calendar days prior to enrollment, loss of an informal caregiver in the prior six-month period, potential loss of housing, and indication of an unstable chronic disease process in the six months prior to the IHS.
- c. The MMP will incorporate the results of the IHS into the Enrollee's ICP as applicable, and will distribute the revised ICP to appropriate ICT members including, but not limited to, Enrollees and their caregivers. IHS results for low-risk enrollees will be distributed to the PCP as appropriate.
- ii. Comprehensive Functional Needs Assessment (CFNA): For Enrollees eligible for LTSS, and Enrollees not eligible for LTSS but determined to be at high risk based on the IHS or other sources, the MMP will perform a CFNA within the timeframes described in Section IV.B.ii.b. MMPs will leverage existing MDS data when conducting an assessment of the needs of individuals who are eligible for LTSS and are residing in a nursing facility.

- a. MMPs shall develop and submit to EOHHS a CFNA tool and scoring methodology, subject to EOHHS review and approval, to identify high-risk Enrollees who require ICM services. MMPs shall develop a Discharge Opportunity Assessment and Wellness Assessment for individuals who reside in a nursing facility as described in Section IV.B.iv, below.
- b. MMPs shall ensure the completion of a CFNA for the following Enrollees, within the following timeframes:
 1. Non-LTSS High-risk: Enrollees living in the community who are not eligible for LTSS and who are determined by the MMP based on the IHS or via predictive modeling activities to be high-risk Enrollees will receive an in-person CFNA in their homes (with Enrollee consent). Throughout the Demonstration, the CFNA must be completed no later than fifteen (15) days after IHS completion. Reassessments will be conducted by phone or in-person at least annually, or sooner if required based on the Enrollee's condition or needs or the circumstances described in Section IV.B.iii.a.
 2. Community LTSS: Enrollees who are eligible for LTSS and who reside in the community will receive an in-person CNFA in their homes (with Enrollee consent). During the first six months of the Demonstration, for Enrollees eligible for community-based LTSS who were not enrolled in an RHO plan (or other Medicaid managed care plan operated by the MMP parent organization) immediately prior to the Demonstration, the CFNA will be completed no later than one hundred-eighty (180) calendar days after the effective enrollment date. After the first six months of the Demonstration, the CFNA must be completed no later than fifteen (15) calendar days after the effective enrollment date. Reassessments will be conducted in-person, or by phone if needed or requested by the Enrollee, at least every ninety (90) calendar days, or sooner if required based on the Enrollee's condition or needs or the circumstances described in Section IV.B.iii.a.
 3. Previous RHO: For Enrollees eligible for LTSS who were enrolled in an RHO plan (or other Medicaid managed care plan operated by

the MMP parent organization) immediately prior to the Demonstration, the previous assessment conducted by the RHO plan will be shared with the ICT within thirty (30) days of ICI Demonstration enrollment. If the RHO assessment was completed within the 180 calendar days prior to MMP enrollment, the Enrollee will be reassessed according to the applicable timeframe for that Enrollee, using the RHO assessment date as the starting point.

4. For all Enrollees described above in Sections IV.B.ii.b.1 through IV.B.ii.b.3, the MMP will further be required to ensure the conduct of an in-person re-assessment within fifteen (15) calendar days of identifying a significant change in the Enrollee's condition or needs or the circumstances described in Section IV.B.iii.a, with the exception of hospitalizations. Following a hospitalization, reassessments will be conducted within five (5) days of discharge.
- c. At a minimum, a CFNA for community-based high-risk individuals must include, but not be limited to, an assessment of:
1. Enrollee strength-based preferences and needs for care delivery, housing, caregiver involvement and other key factors as they relate to care;
 2. Self-reported health status;
 3. Utilization history for emergency room services, inpatient services, community-based LTSS, and nursing facility services within the last 18 months;
 4. Medical and behavioral health history including all chronic conditions and history of exacerbations within the prior 12 months;
 5. Medications and medication management needs;
 6. Mental health screening and history including, but not limited to, cognitive functioning;

7. Alcohol, tobacco, and other drug use;
 8. Ability to perform Activities of Daily Living (ADLs);
 9. Fall risks, home safety evaluation, home modifications needed;
 10. Advance directives;
 11. Cultural and linguistic preferences;
 12. Evaluation of visual and hearing needs and preferences;
 13. Caregiver resources and involvement;
 14. Informal and community support systems;
 15. Nutritional status and availability of appropriate food based on the Enrollee's medical needs and preferences;
 16. Housing, social service, legal needs;
 17. Potential to avoid institutional care (e.g. housing status, availability of an informal caregiver);
 18. Interest in vocational rehabilitation, employment, or volunteer work; and
 19. Barriers to meeting goals or complying with the ICP.
- d. The CFNA, including reassessments, will be administered by a licensed clinician.
- iii. Comprehensive Re-assessment: MMPs will be required to ensure the completion of comprehensive re-assessments on an ongoing basis for Enrollees eligible for community-based LTSS and high-risk non-LTSS Enrollees using the timelines listed in Section IV.B.ii.b. The comprehensive re-assessment will have the same content as the initial CFNA and must be fully updated at the time of re-assessment.

- a. Changes in the Enrollee's condition or needs that may warrant a comprehensive re-assessment include, but may not be limited to: hospitalization; significant changes in medication; change in, or loss of, a caregiver; medical, psychosocial or behavioral health crisis; excessive emergency department utilization; other major changes in the Enrollee's psychosocial, medical, behavioral condition; or major changes in caregivers or housing.
 - b. MMPs will incorporate the results of the comprehensive re-assessment into the Enrollees' ICPs, and will distribute the revised ICPs to appropriate ICT members including, but not limited to, Enrollees and their caregivers.
- iv. Facility-based LTSS: At least quarterly, the MMP shall identify nursing facility residents who may have the desire and/or opportunity to return to the community, based on methods including but not limited to self- or provider referral, MDS results, and predictive modeling. MMPs shall develop a Discharge Opportunity Assessment for those individuals. The Discharge Opportunity Assessment shall be conducted within thirty (30) days of Enrollee identification or referral.
 - a. The Discharge Opportunity Assessment may include, but not be limited to data regarding:
 - 1. Whether the Enrollee wishes to return to a community-based residence;
 - 2. The Enrollee's MDS score;
 - 3. Whether the Enrollee has been in the nursing facility for 90 days or more;
 - 4. Whether the Enrollee has a home in the community; and
 - 5. Whether the Enrollee has an informal caregiver to assist at a community-based residence.
 - b. For Enrollees residing in nursing facilities who are found to have the desire and/or opportunity to return to the community, the MMP shall ensure the development of a person-centered Community Transition Plan designed to support community reintegration. Such Enrollees will

also be assigned a Transitions Care Manager (TCM). The TCM will participate in discharge planning meetings, develop a plan of care, facilitate referrals to community providers, conduct a home safety evaluation, and follow the Enrollee upon discharge, including a face-to-face home visit within 24 hours of the discharge. The Community Transition Plan shall include, but is not limited to:

1. Identification of community supports;
 2. Availability of housing;
 3. Safety assessment of residence;
 4. Identification of home modification needs; and
 5. Identification of DME needs.
- c. For Enrollees in nursing facilities who do not desire to return to the community, the MMP shall ensure the completion of a Wellness Assessment in the facility using MDS and other existing data to the greatest extent possible and appropriate. The Wellness Assessment shall be completed within one hundred-twenty (120) days of enrollment, and will inform development of a Wellness Plan (see Section IV.G). Reassessments will be conducted based on the Enrollee's condition or needs, or the circumstances described in Section IV.B.iii.a. The Wellness Assessment will include, but is not limited to:
1. Enrollee strength-based preferences and needs for care delivery, housing, caregiver involvement, and other key factors as they relate to care;
 2. Health status;
 3. Utilization history for inpatient services and other acute care needs within the last 18 months;
 4. Medical and behavioral health history;
 5. Mental health screening and history, including but not limited to depression and cognitive functioning;

6. Ability to perform ADLs;
7. Fall risks;
8. Advance directives;
9. Cultural and linguistic preferences;
10. Evaluation of visual and hearing needs and preferences;
11. Nutritional status; and
12. Barriers to meeting goals or complying with the Wellness Plan.

- C. Requirements for Lead Care Managers: The MMP will assign an LCM to each Enrollee who is eligible for community LTSS or who is determined to be at high risk for poor health outcomes and/or high costs associated with health care delivery. Such Enrollees will be eligible to receive ICM services.

For Enrollees with a primarily medical condition(s), a qualified individual with physical health expertise shall be designated as the LCM. For individuals with a primary mental illness or substance use disorder, a qualified individual with behavioral health expertise shall be designated as the LCM. Regardless of whether the primary expertise of the LCM is in physical or behavioral health, all ICM is intended to be holistic and person-centered, and not restricted to solely physical or behavioral health. When necessary, the MMP will make physical health Care Management resources available to the primary behavioral health LCMs, and vice versa, to meet the comprehensive needs of Enrollees. The MMP shall establish the role and responsibilities of each type of LCM.

The MMP will maintain policies and procedures for assigning LCMs to manage the delivery of ICM services in a manner that ensures that Enrollees are served by the staff best qualified to meet their needs. In the event that Enrollees wish to select different LCMs, the MMP shall help them do so. The MMP is expected to leverage existing care management supports that may already be in place. These supports may include a nurse care manager in a primary care practice where the Enrollee receives primary care.

- i. The LCM will:

- a. Conduct the CFNA (to the extent that the MMP has sufficient information to assign an LCM with appropriate expertise to an Enrollee prior to full CFNA results) and fully incorporate such results into the Enrollee's ICP. If the MMP does not have sufficient information to assign an LCM to an Enrollee prior to the CFNA, a qualified LCM will perform the CFNA and another LCM with expertise more relevant to the Enrollee's needs may be assigned after the CFNA is completed;
- b. Discuss the Enrollee's desired treatment results and outcomes;
- c. Oversee creation of the ICT with appropriate participants, reflecting both in- and out-of-plan services, as appropriate;
- d. Convene a telephonic or in-person meeting of the ICT, if appropriate and necessary, to discuss Enrollee needs and preferences;
- e. Hold in-person or telephonic ICT meeting(s) on an as needed basis, including any time an Enrollee experiences a significant change in condition (e.g. hospitalization or loss of caregiver) and qualifies for ICM;
- f. Use all relevant information from the CFNA, Enrollee and family input, and other data to create a comprehensive, multidisciplinary ICP;
- g. Develop and implement the ICP in collaboration with the ICT;
- h. Share the ICP with the Enrollee, the Enrollee's family and/or caregiver (with Enrollee consent), and appropriate members of the ICT;
- i. Coordinate service delivery among all providers associated with the Enrollee's care, including but not limited to providers of medical, LTSS, and behavioral health services; including providers or out-of-plan services, as described in Section V.D;
- j. Follow up with providers to obtain necessary test and treatment results, or other information about the Enrollee's health status;
- k. Provide or link Enrollees to self-management and disease management education, with a focus on self-care;

- l. Review and update the ICP periodically as needed, assessing progress toward achieving Enrollee-centered goals and outcomes, and making appropriate revisions in collaboration with the Enrollee and the Enrollee's providers as the Enrollee's condition and needs change;
 - m. Provide information and engage in discussion with Enrollees to help inform decisions about use of medical resources, including the emergency room; and
 - n. Make referrals for services and assist providers in obtaining the necessary authorization to provide services, including access to alternative therapies.
- ii. All LCMs will receive training on interdisciplinary care coordination and key LCM responsibilities.
 - iii. Minimum qualifications and experience required for LCMs, including those with behavioral health expertise, will be included in the Three-way Contract.
- D. Requirements for Care Coordinators and Care Management Staff for Low- and Moderate-risk Non-LTSS Enrollees: The MMP will make Care Coordinators and/or Care Management staff available to Enrollees who are not eligible for LTSS and are not otherwise designated as being high-risk.
- i. Care Coordinators and/or other Care Management staff will:
 - a. Support provider level staff to the greatest degree possible to incorporate Care Management activities at the practice level;
 - b. Build on and improve the State's medical home model;
 - c. Ensure the IHS is conducted and that data from the IHS, and other sources as appropriate, are conveyed to the PCP in order to deliver preventive services, if appropriate;
 - d. Be available to educate Enrollees on prevention, wellness, and self-care as needed and desired by the Enrollees; and
 - e. Facilitate referrals to appropriate services, as needed.

- ii. In addition, as necessary and appropriate based on the Enrollee's needs, Care Coordinators and/or other Care Management staff will:
 - a. Coordinate service delivery among providers associated with the Enrollee's care, including but not limited to providers of medical, LTSS, and behavioral health services as needed, and including both in- and out-of-plan services;
 - b. Provide or link Enrollees to self-management and disease management education, with a focus on self-care as needed;
 - c. Make referrals for in- and out-of-plan services and assist providers in obtaining the necessary authorization to provide services, including access to alternative therapies as necessary and appropriate;
 - d. Provide Member Services support to link Enrollees who do not receive LTSS to necessary Care Management resources within the MMP;
 - e. Address changes in condition and arrange for a CFNA based on the terms in Section IV.B.ii of this MOU, when needed as a result of a change in the Enrollee's condition, and refer Enrollees for ICM services when appropriate;
 - f. Arrange home safety checks for the Enrollee, when indicated by the IHS;
 - g. Make available all relevant information to support the delivery of integrated care at the practice level;
 - h. Promote the sharing of data and information with providers through tools that include, but are not limited to, shared medical records, secure messaging, health information exchange and other techniques to support care integration; and
 - i. Provide other support as appropriate.
- iii. Minimum qualifications and experience required for Care Coordinators or other Care Management staff will be included in the Three-way Contract.

- E. Requirements for the Interdisciplinary Care Team: The MMP shall ensure assembly of an ICT for each Enrollee based on the Enrollee's person-centered needs.
- i. The MMP will utilize the ICT to:
 - a. Serve as a communication hub to coordinate services across the full continuum of care, including but not limited to primary, specialty, behavioral health, LTSS, and other services, and including both in-plan and out-of-plan services;
 - b. Support transitions from hospital or nursing facility to community, under the direction of the LCM, as applicable;
 - c. Collaborate across all physical, behavioral, and social support disciplines with attention to coordinated provision of Enrollee education and self-management support; behavior change techniques and motivational interviewing practices when delivering services to Enrollees; medication management; coordination of community-based services and supports; referrals, as desired by the Enrollee and as appropriate, to end-of-life services and supports; and changes in the Enrollee's condition when additional multidisciplinary planning is necessary and potentially beneficial;
 - d. Promote the delivery of Care Management services in an integrated fashion at the practice level; and
 - e. Promote the use of performance data at the individual and the population-based level to promote incentives to improve care delivery.
 - ii. For Enrollees eligible for LTSS or determined to be high-risk, the LCM shall oversee development of the ICT. The ICT shall include the Enrollee, the LCM, and the PCP. Additional individuals, including but not limited to the following, may be included as appropriate and applicable:
 - a. Family members and/or caregivers;
 - b. Behavioral health specialist;
 - c. Peer Navigator;

- d. Pharmacist;
 - e. Physical, occupational and/or speech therapists;
 - f. LTSS providers;
 - g. Health Home care manager, if applicable; and
 - h. Other key medical specialists or human service providers.
- iii. For Enrollees not eligible for LTSS and not otherwise determined to be high-risk, the ICT shall include individuals based on the Enrollee's needs and preferences, and as applicable, including but not limited to:
- a. The Enrollee;
 - b. Family members and/or caregivers;
 - c. PCP;
 - d. Health Home care manager, if applicable; and
 - e. Behavioral health specialist if appropriate.
- F. Requirements for the Interdisciplinary Care Plan (ICP): The MMP will ensure development of an appropriate ICP for each Enrollee eligible for community LTSS or determined to be at high risk (including Enrollees newly determined to be at high risk). The ICP must be developed within five (5) calendar days of completion of the CFNA, or sooner, based on Enrollee needs. The ICP must be modified, if necessary, within five (5) days after a hospitalization. The MMP will:
- i. Comprehensively document within the ICP the needs and interventions identified by the ICT and CFNA, including medical, behavioral health, LTSS, Health Home services and/or care plans, and other critical needs (e.g. legal or housing), and including both services covered by the MMP (i.e. included in the capitated rate) and out-of-plan services. At minimum, the ICP will include but not be limited to:
 - a. Short- and long-term goals and expected outcomes and measures including timelines for achievement of goals, including reference to

any goals, outcomes, and measures listed in other clinical care plans the Enrollee may have outside of the MMP;

- b. Barriers to service delivery and strategies to address such barriers;
- c. Measures taken to reduce risks without restricting the Enrollee's autonomy to undertake risks to achieve goals;
- d. Medical, behavioral, and psychosocial support needs and ICM interventions, including but not limited to:
 - 1. Integrated interventions that incorporate medical, behavioral health, LTSS, social service, and community living support needs;
 - 2. Plans for known or anticipated care transitions;
 - 3. Disease management/chronic condition management including, but not limited to, self-management and education;
 - 4. Prevention and wellness goals and strategies;
 - 5. Home safety needs, issues, and interventions;
 - 6. Availability of informal support systems, including factors that put the Enrollee's informal supports at risk;
 - 7. Specific person(s) and/or any provider agency responsible for delivering LTSS, including back-up plans to the extent possible;
 - 8. Self-directed services and supports;
 - 9. Advanced care planning, if desired by the beneficiary;
 - 10. Other needed interventions (e.g. housing, legal, recreational);
 - 11. Signatures (or other indications of consent, where applicable) of all people with responsibility for ICP implementation, including the

Enrollee and the Enrollee's designee, if applicable and with the Enrollee's consent, and a timeline for Enrollee and/or LCM ICP review signifying ICP acceptance and an intention to follow the ICP; and

12. Emergency after-hours backup plan that ensures that an informal caregiver is available, if needed, from a contracted agency in person 24 hours per day, seven days per week. Such emergency situations include but are not limited to: significant change in Enrollee condition, unexpected caregiver absence, fire, or flood.
- ii. Distribute copies of the original ICP and ICP updates to the Enrollee, the Enrollee's family or caregiver, and providers, as appropriate and with Enrollee consent. For Enrollees who were in a Rhody Health Options plan (or other Medicaid managed care plan operated by the MMP parent organization) immediately prior to the Demonstration and who enroll in an MMP not operated by the individual's previous plan, the MMP must obtain the current care plan from the previous plan.
 - iii. Develop the ICP with an emphasis on leveraging existing caregivers and services and avoiding duplication with existing resources, including but not limited to sources of Care Management outside of the MMP.
 - iv. Write the ICP in a culturally and linguistically appropriate manner that enhances the Enrollee's health literacy while considering the Enrollee's overall capacity to learn and be self-directed. Goals must be documented in the first person.
 - v. Ensure that the ICP considers processes and strategies for resolving conflict or disagreement within the ICM and care coordination processes. The MMP must maintain clear conflict of interest guidelines for all ICM participants, as well as a method for the Enrollee to request ICP revision. Enrollees must be informed by the MMP of their rights and the process to appeal the denial, termination, or reduction of a service.
- G. Requirements for the Wellness Plan: The MMP will develop an appropriate Wellness Plan for Enrollees receiving facility-based LTSS who do not desire and/or are not able to return to the community. The Wellness Plan must be developed within fifteen (15) calendar days of completion of the Wellness

Assessment, or sooner, based on Enrollee needs. The Wellness Plan must be modified, if necessary, within five (5) days after a hospitalization. At minimum, the Wellness Plan will include but not be limited to:

- i. Short- and long-term goals and expected outcomes and measures including timelines for achievement of goals, including reference to any goals, outcomes, and measures listed in other clinical care plans the Enrollee may have outside of the MMP;
- ii. Barriers to service delivery and strategies to address such barriers;
- iii. Measures taken to reduce risks without restricting the Enrollee's autonomy to undertake risks to achieve goals;
- iv. Medical, behavioral, and psychosocial support needs, including but not limited to:
 - a. Plans for known or anticipated care transitions;
 - b. Prevention and wellness goals and strategies;
 - c. Advanced care planning, if desired by the beneficiary; and
 - d. ADL needs, goals, and strategies.

H. Requirements for Peer Navigators: Some Enrollees may require Peer Navigator assistance in accessing support services or coordinating non-medical care, or benefit from a "peer mentoring" relationship. Peer Navigator responsibilities to support such needs include assisting Enrollees in making appointments, transportations, follow-up, and services. The responsibilities of these Peer Navigators (with oversight by the LCM, as applicable) may include:

- i. Participating in Peer Navigator training administered by the MMP;
- ii. Assisting with making appointments for health care services;
- iii. Canceling scheduled appointments if necessary;
- iv. Assisting with transportation needs;
- v. Following up with Enrollees and providers to assure that appointments are kept;

- vi. Rescheduling missed appointments;
- vii. Linking Enrollees to alternatives to facility-based medical care, including the emergency room, when appropriate and desired by the Enrollee;
- viii. Assisting Enrollees to access both formal and informal community-based support services such as child care, housing, employment, and social services;
- ix. Assisting Enrollees to deal with non-medical emergencies and crises;
- x. Assisting Enrollees in meeting ICP goals, objectives, and activities;
- xi. Providing emotional support to Enrollees, when needed; and
- xii. Serving as a role model in guiding the Enrollee to practice responsible health behavior.

I. Requirements for Predictive Modeling: The State shall require MMPs to utilize predictive modeling software to stratify Enrollees for whom claims history exists into low-, moderate-, and high-risk categories. At a minimum, MMPs will utilize predictive modeling software that uses claims data and evidence-based algorithms to categorize Enrollees. Such software will further identify Enrollees at risk for poor health outcomes who may benefit from Care Management services. With regard to predictive modeling data, MMPs will be required to:

- i. Use predictive modeling data, to identify Enrollees' changing needs on an ongoing basis, where claims history is available. MMPs must stratify Enrollees' needs based on acuity as well as risk for hospitalization or nursing facility placement.
- ii. Include a thorough analysis of claims data, encounter data, and/or data from other systems over a one-year period in predictive modeling activities, where a full year of claims data exists for an Enrollee. Where one year of data does not exist, the MMP will determine whether and how to conduct predictive modeling activities.
- iii. At least monthly, conduct a data "sweep" and subsequent analysis of claims data for new and existing Enrollees to identify Enrollees at risk of poor health outcomes who may benefit from Care Management services.

- iv. Review predictive modeling data and any other available information for each Enrollee not eligible for LTSS to determine if an in-person CFNA is needed and in what timeframe, as described in Section IV.B.ii.
- J. Requirements for Additional Data Analysis: In addition to predictive modeling activities, MMPs will be required to analyze Enrollee risk and potential needs based upon all available information, including IHS and CFNA results, encounter data, hospital discharge summaries, provider referrals and referrals of all types (including Enrollee self-referral), data collected through utilization management processes, and Enrollee and caregiver input. MMPs will be required to:
- i. Utilize all available data, including information gathered via the full range of applicable assessment activities, to identify and plan for each Enrollee's person-centered needs and to inform development of an appropriate ICP, where applicable.
 - ii. Review referrals and any other available information for each Enrollee not eligible for LTSS to determine if an in-person CFNA is needed and in what timeframe, as described in Section IV.B.ii.
- K. Network Adequacy: The following standards will be used for access to all covered services except in the event that Medicaid or Medicare standards are more stringent and would provide for increased access to providers. Each MMP's provider network must meet the existing applicable Medicare and Medicaid provider network requirements. State Medicaid standards shall be utilized for community-based and facility-based LTSS, as described below, or for other services for which Medicaid is exclusive, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more favorable to the Enrollee (i.e., offer broader coverage). Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to the more favorable to the Enrollee (i.e., offer broader coverage) of the applicable Medicare and Medicaid standards.

MMPs shall ensure they maintain a network of providers that is sufficient in number, mix and geographic distribution to meet the complex and diverse needs of the anticipated number of Enrollees in the service area. Networks will be subject to confirmation through readiness reviews and regular examination on an ongoing basis.

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

Additionally, the provider network must meet all of the following requirements:

- i. **Twenty-four Hour Coverage:** The MMP will provide coverage, either directly or through its PCPs, to Enrollees on a twenty four (24) hours per day, seven (7) days per week basis. If PCPs are to provide such coverage, the MMP will have a back-up plan for instances where the PCP is not available. The MMP will also have written policies and procedures describing how Enrollees and providers can contact the MMP to receive instructions for treatment of an emergent or urgent medical problem.
- ii. **Travel Time:** The MMP will make available to every Enrollee a PCP whose office is located within the maximum timeframes outlined in the Medicare Advantage standards, currently: in Providence county, ten (10) minutes or less driving time from the Enrollee's home; and in all other counties, fifteen (15) minutes or less. Enrollees may, at their discretion, select PCPs located farther from their homes.
- iii. **Access Standards for Long-Term Care Providers:** The MMP shall ensure that home and community-based services are available twenty-four (24) hours per day, seven (7) days per week. The required services must be in place within five (5) days of determination of an Enrollee's need. Nursing facilities shall be located within ten (10) miles of an Enrollee's address of record, unless the Enrollee selects a nursing facility farther than 10 miles. Assisted living facilities, adult day care service centers and other community-based LTSS agencies shall be located within twenty (20) minutes driving time of the Enrollee's address of record, unless the Enrollee selects a provider located more than 20 minutes driving time of the Enrollee's address of record.

L. **Solvency:** MMPs will be required to meet solvency requirements:

- i. Consistent with section 1903 (m) of the Social Security Act, and regulations found at 42 CFR § 422.402¹, and 42 CFR § 438.116; and
 - ii. MMPs will be required to meet solvency requirements established in the Three-way Contract.
- M. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts: MMPs must adhere to managed care standards at 42 CFR Part 438.214 and 42 CFR Part 422.204, and must be accredited by NCQA and follow NCQA procedural requirements for standards for credentialing and re-credentialing. In order to minimize administrative burdens on MMPs and providers, MMPs must employ a single, uniform provider credentialing application that will be developed with the input from MMPs and stakeholders, meet Medicare contracting requirements, and be approved by the State.
- N. Enrollee Ombudsman Program: The State will make available to Enrollees an independent, conflict-free entity to serve as Enrollee Ombudsman based on a grant proposal submitted to CMS. The requirements for the Enrollee Ombudsman will be outlined in the Three-way Contract, as well as in the Special Terms and Conditions if a grant is awarded. The requirements for MMP cooperation with the Enrollee Ombudsman will be outlined in the Three-way Contract.

The Enrollee Ombudsman will provide Enrollees assistance in accessing their care, understanding and exercising their rights and responsibilities, and in appealing adverse decisions made by their MMP. The Enrollee Ombudsman will be accessible to all Enrollees by telephone and, where appropriate, in person. The Enrollee Ombudsman will provide advice, information, referral and assistance in accessing benefits and in navigating the MMPs, providers, or RI EOHHS. Ombudsman assistance will be available to Enrollees free of charge. The Enrollee Ombudsman may participate in MMP Enrollee Advisory Committee activities. The Enrollee Ombudsman will be required to regularly report on its work to the State and CMS. MMPs will be required to notify Enrollees of the availability of the Enrollee Ombudsman in materials including, but not limited to, enrollment materials, annual notice of grievance and appeal procedures, and all written notices of denial, reduction or termination of a service.

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

RI EOHHS will employ and contract with staff to manage the Enrollee Ombudsman program. The Enrollee Ombudsman program will deliver services to Enrollees under contract with local community-based organizations. RI EOHHS will oversee the delivery of all Enrollee Ombudsman program services and the State will provide ongoing technical assistance to the Enrollee Ombudsman program. CMS will support training for the Enrollee Ombudsman program and its contracted community-based organizations on the ICI Demonstration and its objectives.

V. Benefits

- A. Medical Necessity Determinations – Medically necessary items and services are defined in Appendix 1 for both Medicare and Medicaid covered services. Where there is overlap between Medicare and Medicaid benefits, the standard that provides more extensive coverage shall apply; the benefits will maintain coverage to at least the extent provided by Medicare and RI EOHHS as outlined in both State and Federal rules. MMPs will be required to abide by the more generous of the applicable Medicare, RI EOHHS, or the combined Medicare-Medicaid standard.
- i. All care must be provided in accordance and compliance with the ADA, as specified by the *Olmstead* decision.
 - ii. The MMP must cover all services as outlined in the Three-way Contract and in the State and Federal guidance and may not impose more stringent coverage rules unless explicitly authorized by the Three-way Contract.
 - iii. As a term and condition of this Demonstration, the MMPs will be required to provide all medically necessary Medicare Parts A, B, and D and Medicaid State Plan and 1115(a) demonstration items and services, except as specified in Section V.D below. The Planned ICI Demonstration services will be updated to address any changes due to State Plan Amendments or changes to Rhode Island’s Section 1115(a) demonstration.
- B. Supplemental Benefits – The State and CMS may consider adding certain supplemental benefits to the required ICI Demonstration benefit package in Demonstration Years 2 and 3. These services may include the following:
- i. Integrated pain management program;

- ii. Screening, Brief Intervention and Referral to Treatment (SBIRT); and
 - iii. Non-medical transportation.
- C. Flexible Benefits – MMPs will have discretion to use the capitated payment to offer Flexible Benefits, as specified in the Enrollee’s ICP, as appropriate to address the Enrollee’s needs. The MMPs will have the flexibility to cover items or services that are not traditionally included as Medicare or Medicaid covered services but that are necessary and appropriate for the Enrollee and are covered as cost-effective alternative services.
- D. Out-of-plan Benefits – The following benefits will be available to Enrollees through the Medicaid fee-for-service (FFS) delivery system and not through the MMP benefit package. These services are currently out-of-plan benefits in RHO. MMPs will be required to refer to and coordinate these services as appropriate, and to include in their contracts with PCP, behavioral health, LTSS, and other relevant providers the requirement to coordinate with in-plan and out-of-plan services. The State will also issue a provider communication prior to Demonstration implementation describing the MMP requirement and provider expectation to coordinate both in-plan and out-of-plan services for Enrollees. The State will monitor the coordination and provision of out-of-plan services. Additional detail will be provided in the Three-way Contract. The State will also monitor claims throughout the Demonstration to ensure appropriate payment and non-payment for out-of-plan benefits. CMS and EOHHS may seek to include these services in the ICI Demonstration at a later point in time.
- i. Dental services;
 - ii. HIV Medical and Non-Medical Case Management;
 - iii. Non-emergency transportation services (non-emergency transportation is coordinated by the MMPs, including with the State’s contracted transportation broker);
 - iv. Residential services for Enrollees with I/DD, including less than 24-hour support, 24-hour support, shared living arrangements, environmental accessibility modifications to the home and/or vehicle, electronic devices allowing Enrollees to obtain help in an emergency, and specialized equipment and supplies (e.g. items necessary for Enrollees to improve their daily living or communication needs);

- v. Day/employment supports for Enrollees with I/DD; and
 - vi. Family supports for Enrollees with I/DD, including respite services, homemaker services, personal care services, environmental accessibility modifications to the home and/or vehicle, electronic devices allowing Enrollees to obtain help in an emergency, and specialized equipment and supplies (e.g. items necessary for Enrollees to improve their daily living or communication needs).
- E. Election of Medicare Hospice Benefit – As in Medicare Advantage, if, after enrollment, an Enrollee elects to receive the Medicare hospice benefit, the Enrollee will remain in the MMP, but will obtain the hospice service through the Medicare FFS benefit and the MMP would no longer receive Medicare Part C payment for that Enrollee. Medicare hospice services and all other Original Medicare services would be paid for under Medicare FFS. MMPs 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 MMPs. MMPs would continue to receive Medicare Part D payment, for which no changes would occur. Medicaid services and payments for hospice Enrollees must comply with the ICI Demonstration 1115(a) demonstration requirements.
- F. Continuity of Care – For all items and services other than nursing facility services and non-Part D prescription drugs, MMPs must allow Enrollees to maintain current providers and service levels at the time of enrollment for at least six months after enrollment, or until an IHS (for Enrollees determined to be low or moderate risk) or CFNA and ICP have been completed by the MMP, whichever is later. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR Part 438.404 and 42 CFR Part 422.568 which clearly articulate the Enrollee’s right to file an Appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the Appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the Appeal. The continuity of care period for non-Part D prescription drugs shall be 90 days. Part D transition rules and rights will continue as provided for in current law and regulation. Individuals in nursing facilities at the time of Demonstration implementation may remain in the facility for the duration of the Demonstration as long as they continue to meet RI EOHHS criteria for nursing facility care, unless they or their families prefer to move to a different nursing facility or return to the community.

- i. MMPs are required to provide or arrange for all covered Medically Necessary Services provided by the Three-way Contract, whether by subcontract or by single-case agreement in order to meet the needs of the Enrollee.

During the continuity of care period, change from the existing provider can only occur in the following circumstances:

- a. The Enrollee requests a change;
 - b. The IHS and/or CFNA and ICP are complete, and the Enrollee agrees to the change;
 - c. The provider chooses to discontinue providing services to an Enrollee as currently allowed by Medicare or Medicaid; or
 - d. The MMP, CMS, or the State identifies provider performance issues that affect an Enrollee's health and welfare, including but not limited to exclusion of that provider from the Medicare and/or Medicaid program.
- ii. During the continuity of care period, MMPs will maintain Enrollees' current providers at no less than the Medicare or Medicaid FFS rate and honor prior authorizations issued by RI EOHHS, its contracted managed care entities, and Medicare.
- G. Out-of-Network Reimbursement Rules – MMPs must cover emergent or urgent services provided by out-of-network providers and may authorize other out-of-network services to promote access to continuity of care. For services that are part of the traditional Medicare benefit package, MMPs will be required to pay non-contracting providers at least the lesser of the providers' charges or the Medicare FFS payment amounts, for all settings and types of care for authorized out-of-network services. For nursing facility services that are part of the traditional Medicaid benefit package, MMPs will be required to pay non-contracting providers a rate similar to the Medicaid FFS rate.
- H. Under the Demonstration, skilled nursing level care may be provided in a long-term care facility without a preceding acute care inpatient stay for individuals

enrolled in the ICI Demonstration, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.

- I. For Enrollees residing in nursing facilities who wish to move to the community, the MMP will comply with the “Nursing Home Transition Including Rhode to Home” guidelines issued by RI EOHHS regarding nursing facility transitions. The MMP ensures that all community supports, including housing, are in place prior to the Enrollee’s transition, and providers are knowledgeable and prepared to support the Enrollee, including interface and coordination with and among clinical services and community-based LTSS.

VI. Model of Care

All MMPs (in partnership with contracted providers) will be required to implement an evidence-based Model of Care (MOC) meeting all CMS MOC standards for Special Needs Plans (SNP). CMS’ MMP MOC approval process is 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:

- A. Standard: The standard is defined as an MOC that has achieved a score of 70 percent or greater based on NCQA’s scoring methodology.
- B. Elements: The MOC has 11 clinical and non-clinical elements, as identified below, and each element will have a score that will be totaled and used to determine the final overall score. The 11 MOC elements are listed below:
 - Description of the Plan-specific Target Population;
 - Measurable Goals;
 - Staff Structure and Care Management Goals;
 - Interdisciplinary Care Team;
 - Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
 - MOC Training for Personnel and Provider Network;
 - Health Risk Assessment;
 - Individualized Care Plan;
 - Integrated Communication Network;
 - Care Management for the Most Vulnerable Subpopulations; and

- Performance and Health Outcomes Measurement.

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

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

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

MMPs will be permitted to cure problems with their MOC submissions after their initial submissions. MMPs with MOCs scoring below 70 percent 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, prospective MMPs with MOCs that do not meet CMS' standards for approval will not be eligible for selection as MMPs.

VII. Prescription and Select Non-Prescription Drugs

The integrated formulary must include any Medicaid-covered drugs that are excluded by Medicare Part D and covered under the ICI Demonstration. MMPs 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 MMP. Each MMP must track, report, and resolve its grievances or re-route improperly-filed grievance requests to the coverage decision or appeals processes, as appropriate. MMPs 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 MMP must have mechanisms in place to track and report all Appeals. Other than Medicare Part D appeals, which shall continue to be adjudicated under processes set forth at 42 CFR Part 423, Subpart M unchanged, the following is the baseline for a unified Medicare-Medicaid Appeals process:

A. Appeals Process:

- i. Appeal time frames - Enrollees, their appointed representatives, and their providers (for Medicare services) will have:
 - a. Ninety (90) calendar days from the date of denial notice to file an MMP Appeal.
 - b. Thirty (30) calendar days from the MMP's notice of disposition (i.e. resolution) to request a State Fair Hearing for Medicaid-only services; and
 - c. Thirty (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 under the process described in Section IX.B.iii, below. The Enrollee will receive notice from his/her MMP of the Enrollee's right to request a State Fair Hearing through the State Fair Hearing agency.

- B. Appeal levels: Initial Appeals must be filed with the MMP. The filing of an internal Appeal and exhaustion of the MMP internal Appeals process is a prerequisite to an external appeal to Medicare or Medicaid.
- i. Subsequent Appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE) if the plan upholds its initial denial.
 - ii. For Medicaid-only benefits, if the resolution following the MMP Appeal process is not wholly in favor of the Enrollee, such Enrollee or his/her authorized representative may request a State Fair Hearing.
 - iii. Services for which Medicare and Medicaid overlap (including home health, durable medical equipment and skilled therapies, but excluding Medicare Part D) will be defined in a unified way in the Three-way Contract as required MMP benefits. If the resolution following the MMP Appeal process is not wholly in favor of the Enrollee, the Appeal related to these services will be forwarded to the IRE by the MMP. If the Enrollee disagrees with the outcome of any part of the MMP decision, the Enrollee or his/her 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 MMP for the service or item in question.

C. Appeal resolution time frames:

The MMP shall resolve Appeals consistent with 42 C.F.R. § 422.560 et seq. and 42 C.F.R. § 438.408. All initial, MMP-level Appeals must be resolved and Enrollees notified by the MMP as expeditiously as the Enrollee's condition requires, but always within the following timeframes. This excludes Part D Appeals, which will be resolved in accordance with existing rules.

- i. Appeals requiring expedited review: The MMP must give prompt oral notice of the denial and a written notice within two (2) calendar days when the MMP determines, or a treating provider who serves the Enrollee indicates, that application of the time frames for a standard Appeal could seriously jeopardize the Enrollee's life, health, or ability to maintain or regain maximum function.

- ii. Other medical care: All MMP-level Appeals must be resolved as expeditiously as the Enrollee's condition requires, but always within thirty (30) calendar days of the initial request for standard Appeals. The MMP may extend the timeframe by up to 14 calendar days, per 42 C.F.R. § 422.590(a) and 42 C.F.R. § 438.408(c), if the Enrollee requests the extension or if the MMP justifies a need for additional information and how the delay is in the interest of the Enrollee. This excludes Part D appeals, which will be resolved in accordance with existing rules.
- iii. Non-medical care: If the Appeal involves a problem other than access to medical care (e.g. claims payment disputes), the MMP must decide on the Appeal within thirty (30) calendar days of all necessary information being received by the MMP. The MMP must make all efforts to obtain all necessary information within 30 calendar days of receiving the Appeal.
- iv. External Appeals filed or auto-forwarded to the Medicare IRE shall be resolved under the current Medicare Appeal timelines.
- v. For Medicaid-only services appealed to a State Fair Hearing, Standard Appeals will be resolved within ninety (90) calendar days of the filing of an Appeal with the MMP, not including the number of days the Enrollee took to file for a State Fair Hearing; or three (3) business days for expedited requests, pursuant to 42 CFR 438.408(b) and (c), and 431.244(f).
- vi. For Medicare-Medicaid overlap services, if the Enrollee requests a State Fair Hearing for his/her Medicaid benefits, standard Appeals will be resolved within ninety (90) calendar days of the date the Enrollee filed the Appeal with the MMP, not including the number of days the Enrollee took to file for a State Fair Hearing; or 72 hours for expedited requests.
- vii. Continuation of Benefits Pending an Appeal:
 - a. All Medicare Parts A and B, and non-Part D benefits will be required to be provided pending the resolution of the MMP Appeal process. This means that such benefits will continue to be provided by providers to Enrollees, and those MMPs must continue to pay providers for providing such services pending the resolution of the MMP Appeal process. This right to aid pending an Appeal currently exists in Medicaid, but is generally not currently available in

Medicare. Existing Medicaid rules concerning benefits pending an Appeal will not change.

- b. For Medicaid-only service and Medicare-Medicaid overlap service Appeals: If the request for an Appeal is filed with the MMP within 10 calendar days of the Notice of Action or prior to the date of the action, services will be required to be provided pending the resolution of the MMP Appeal process.
- c. Following the MMP Appeal process, if resolution at the MMP level is not wholly in favor of the Enrollee:
 - 1. 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 MMP or prior to the date of the Action, services will be required to be provided and paid for pending the resolution of the State Fair Hearing Appeal process;
 - 2. For appeals of Medicare-Medicaid overlap services, if the resolution of the Medicare IRE is not wholly in favor of the Enrollee, and the Enrollee files an Appeal with the State Fair Hearing Agency within 10 calendar days of the IRE's decision notice, services will be required to be provided and paid for pending resolution of the State Fair Hearing Appeal process.
- D. Integrated Notice: MMP Enrollees will be notified of all applicable Demonstration, Medicare Appeal, Medicaid Appeal, and State Fair Hearing rights – including whether an individual may receive benefits pending the Appeal – through a single notice jointly developed by the State and CMS.
- E. In the case of a decision where both the State Fair Hearing and the IRE issue a ruling, the MMP shall be bound by the ruling that is most favorable to the Enrollee.

X. MMP 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 marketing

done by State governments and marketing 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 MMPs – MMPs 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., 438.104; and the Medicare Marketing Guidelines. The State and CMS will work to develop a single consolidated set of marketing rules and requirements and the Three-way Contract will require MMPs to comply with any unified set of rules and requirements that are developed. The following exceptions apply:
 - i. MMPs may not market directly to individuals on a one-on-one basis but may provide responses to Enrollee-initiated requests for information and/or enrollment. MMPs may participate in group marketing events and provide general audience materials (such as general circulation brochures and media and billboard advertisements).
 - ii. CMS and the State will develop a process to mitigate Enrollee shifting from MMPs to other plans operated by the same parent company. At a minimum, the Three-way Contract will identify procedures to provide additional education to Enrollees that are considering opting out of an MMP for a non-MMP that may be offered by the same corporate parent. Enrollee choices regarding enrollment will be honored by CMS and the State.
- B. Review and Approval of Marketing and Enrollee Communications – MMPs must receive prior approval of all marketing and Enrollee communications materials by CMS and/or the State in categories of materials that CMS or the State requires to be prospectively reviewed. In accordance with State rules, the State will conduct prospective review of certain Enrollee communication materials. MMP 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. MMPs must

submit all marketing and Enrollee communication materials, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

- C. Permissible Start Date for MMP Marketing Activity – MMPs may begin marketing activity, as limited in Sections X.A and X.B above, no earlier than 90 calendar days prior to the effective date of enrollment for the contract year.
- D. CMS and the State will work together to educate individuals about their MMP options. CMS and the State will work together to develop single, consolidated notices and marketing materials for use in the ICI Demonstration. The Three-way Contract will specify that the MMPs will be required to use any notices, materials, or other documents that the State and CMS make mandatory.
- E. The State’s independent Enrollment Counselor will be responsible for educating Enrollees on all potential plan choices through a variety of mechanisms. Outreach and educational activities may include letters, outreach events, and/or outbound telephone calls and will take into account the prevalence of cognitive impairments, mental illness, limited English proficiency, and low functional literacy.
- F. Minimum Required Marketing and Enrollee Communications Materials – At a minimum, MMPs will provide current and prospective Enrollees the following materials. These materials will be subject to the same rules regarding content and timing of Enrollee receipt as applicable under section 1851(h) of the Social Security Act; 42 CFR §422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, and 423.2260 et. seq.; and the Medicare Marketing Guidelines.
 - i. An Evidence of Coverage (EOC) document that includes information about all State-covered and MMP-covered additional benefits, in addition to the required Medicare benefits information. Additional content will be required by the State, e.g.: eligibility requirements for ICI Demonstration enrollment; excluded services; Enrollee rights and responsibilities; services requiring prior authorization; self-referral services; explanation that the MMP ID card replaces the Medicare and Medicaid cards; assessment and care planning processes; access and network adequacy requirements; how to access services; how to choose providers; how to access emergency care; the availability of self-directed services and how to begin self-directing services; the right to disenroll from the Demonstration and the procedure for disenrolling; Appeal and Grievance

rights and processes; non-discrimination requirements; information on Enrollees' right to execute advance directives; how to contact the State call center for any concerns; how to contact the Enrollee Ombudsman for any assistance; how to access additional information in alternative formats or languages; how to access the MMP provider directory; the name of the MMP's parent company and any DBA (Doing Business As) that may be used; toll-free Enrollee services and care management and nurse advice 24-hour service lines; and any other content required by State or Federal regulation.

- ii. An Annual Notice of Change (ANOC) summarizing all major changes to the MMP's covered benefits from one contract year to the next, starting in the second year of the Demonstration.
 - iii. A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the MMP, as well as the benefits offered under the MMP, including co-payments, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. MMPs will use a Demonstration-specific SB.
 - iv. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits. This directory must be available on the MMP website, and provided in paper upon request.
 - v. A comprehensive integrated formulary that includes outpatient prescription drugs covered under Medicare, Medicaid, or as MMP-covered additional benefits.
 - vi. A single identification (ID) card for accessing all covered services under the MMP.
 - vii. All Medicare Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.
- G. Notification of Formulary Changes – The requirement at 42 CFR Part 423.120(b)(5) that MMPs provide at least 60-day advance notice regarding Part D formulary changes also applies to MMPs 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 Emergency Medical Treatment and Active Labor Act (EMTALA) and ADA, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and the State will require MMPs to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. MMPs must have policies and procedures in place to identify and address fraud, waste, and abuse at both the plan and the third-party levels in the delivery of ICI Demonstration benefits, including prescription drugs, medical care, behavioral health, and community-based and facility-based LTSS. In addition, all Medicare Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to MMPs by CMS in the same way they are currently applied for Prescription Drug Plan (PDP) sponsors and Medicare Advantage organizations.
- ii. 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 long-term services and supports.

- ii. Reporting: Data reporting to CMS and the State will be coordinated and unified to the extent possible. Specific reporting requirements and processes for the following areas will be detailed in the Three-way Contract.
 - a. Quality (including HEDIS): Core measures are articulated in Section XI.H, below;
 - b. Rebalancing from Institutional to HCBS Settings;
 - c. Utilization;
 - d. Encounter Reporting;
 - e. Enrollee Satisfaction (including CAHPS);
 - f. Complaints and Appeals;
 - g. Enrollment/Disenrollment Rates;
 - h. Part C and Part D Reporting Requirements;
 - i. All required 1115(a) and 1915(c) waiver reporting; and
 - j. Enrollee Ombudsman.

C. Day-to-day Oversight and Coordination

- i. The Contract Management Team will be responsible for monitoring of each MMP. These responsibilities include, but are not limited to:
 - a. Monitoring compliance with reporting requirements;
 - b. Monitoring compliance with the terms of the Three-way Contract, including issuance of joint notices of non-compliance/enforcement;

- c. Coordination of periodic audits and surveys of the MMP;
- d. Receipt and response to complaints;
- e. Reviewing reports from the Enrollee Ombudsman and coordinating with the Ombudsman as necessary;
- f. Reviewing direct stakeholder input on both plan-specific and systematic performance;
- g. Regular meetings with each MMP;
- h. Coordination of requests for assistance from MMPs and assignment of appropriate State and CMS staff to provide technical assistance;
- i. Coordinating review of marketing materials and procedures; and
- j. 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. ICI Demonstration MMP contracts will be included in these activities, just as all Medicare Advantage and Part D organizations will be included. Demonstration contracts will be treated in the same manner, which includes analysis of their performance based on CMS internal data, active collection of additional information, and CMS issuance of compliance notices, where applicable. The State and Contract Management Team will be informed about these activities and copied on notices but will not take an active part in these ongoing projects or activities.

E. 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. MMP Call Center Requirements

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

- i. MMPs shall operate a toll-free Enrollee services telephone line call center. The line will be available nationwide for a minimum of 8am to 8pm Eastern Time, seven days per week.
- ii. Customer service representatives must be available in sufficient numbers to support Enrollees and meet CMS and State-specified standards.
- iii. MMPs shall have interpreter services available to call center personnel to answer questions from non-English speaking and limited English proficient current and prospective Enrollees. Oral interpretation services must be available free-of-charge to all current and prospective Enrollees in all non-English languages spoken by Enrollees.
- iv. MMPs must ensure that customer service representatives shall, upon request, make available to Enrollees and potential Enrollees information including, but not limited to, the following:
 - a. The identity, locations, qualifications, and availability of providers;
 - b. Enrollees' rights and responsibilities;
 - c. The procedures available to an Enrollee and/or provider(s) to challenge or appeal the failure of the MMP to provide a requested service and to appeal any adverse Actions (denials);
 - d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;
 - e. How to access the Enrollee Ombudsman, the State Enrollee Call Center, and 1-800-Medicare;

- f. Information on all MMP covered services and other available services or resources (e.g., State agency services) either directly or through referral or authorization; and
- g. The procedures for an Enrollee to change MMPs if applicable, or to opt out of the ICI 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; and
- vi. Data Exchange among CMS, State of Rhode Island Providers and MMPs, and Health Insurance Exchanges.

H. Unified Quality Metrics and Reporting

MMPs will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, Enrollee/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report Medicare HEDIS, HOS, and CAHPS data, as well as measures related to long-term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements plus any additional Medicaid measures identified by the State. All existing Medicare Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures.

A combined set of core metrics is described below in Table 7-B; more detail on the measures will be provided in the Three-way Contract. CMS and the State will

utilize the reported measures in the combined set of core metrics for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and to allow quality to be evaluated and compared with other plans in the model. A subset of these measures will also be used for calculating the quality withhold payment as addressed in Section VI of Appendix 6 in this MOU.

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

Table 7-B: Core Quality Measures under the ICI Demonstration

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
1. Antidepressant Medication Management	Percentage of Enrollees 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X	
2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	<p>The percentage of adolescent and adult Enrollees with a new episode of alcohol or other drug (AOD) dependence who received the following.</p> <ul style="list-style-type: none"> • Initiation of AOD Treatment. The percentage of Enrollees who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of Enrollees who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. 	NCQA/HEDIS	X	
3. Follow-up After Hospitalization for Mental Illness	Percentage of discharges for Enrollees 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
4. Screening for Clinical Depression and Follow-up Care	Percentage of Enrollees ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
5. SNP 1: Complex Case Management	<p>The organization coordinates services for Enrollees with complex conditions and helps them access needed resources.</p> <p>Element A: Identifying Members for Case Management</p> <p>Element B: Access to Case Management</p> <p>Element C: Case Management Systems</p> <p>Element D: Frequency of Member Identification</p> <p>Element E: Providing Members with Information</p> <p>Element F: Case Management Assessment Process</p> <p>Element G: Individualized Care Plan</p> <p>Element H: Informing and Educating Practitioners</p> <p>Element I: Satisfaction with Case Management</p> <p>Element J: Analyzing Effectiveness/Identifying Opportunities</p> <p>Element K: Implementing Interventions and Follow-up Evaluation.</p>	NCQA/SNP Structure & Process Measures	X	
6. SNP 6: Coordination of Medicare and Medicaid Benefits	<p>The organization coordinates Medicare and Medicaid benefits and services for Enrollee.</p> <p>Element A: Coordination of Benefits for Dual Eligible</p>	NCQA/ SNP Structure & Process Measures	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	Enrollees 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			
7. Care Transition Record Transmitted to Health Care Professional	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	X	
8. Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS	X	
9. SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions Element B: Supporting Enrollee through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E; Analyzing Transitions Element F: Reducing Transitions	NCQA/SNP Structure & Process Measures	X	
10. CAHPS, Health Plan plus	The percent of the best possible score that the plan earned on how easy it is for Enrollees to get information from their plan	AHRQ/CAHPS and dependent on	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
supplemental items/questions Getting Information From Drug Plan	about prescription drug coverage and cost. A. 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? B. 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? C. In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? D. 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?	survey		
11. CAHPS, Rating of Plan for Coverage of Prescription Drugs	The percent of the best possible score that the plan earned from Enrollees who rated the plan for its coverage of prescription drugs. <ul style="list-style-type: none"> • Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs? 	AHRQ/CAHPS and dependent on survey	X	
12. CAHPS, Getting Needed	The percent of best possible score that the plan earned on how easy it is for Enrollees to get the prescription drugs and	AHRQ/CAHPS and dependent on	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Prescription and Non-Prescription Drugs	<p>non-prescription drugs they need using the plan.</p> <p>A. In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed?</p> <p>B. In the last six months, how often was it easy to use your health plan to fill a prescription or obtain a non-prescription drug at a local pharmacy?</p>	survey		
13. CAHPS, Getting Needed Care	<p>Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.</p> <p>A. In the last 6 months, how often was it easy to get appointments with specialists?</p> <p>B. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?</p>	AHRQ/CAHPS and dependent on survey	X	
14. CAHPS, Getting Appointments and Care Quickly	<p>Percent of best possible score the plan earned on how quickly Enrollees can get appointments and care.</p> <p>A. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?</p> <p>B. 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?</p> <p>C. In the last 6 months, how often did you see the person you</p>	AHRQ/CAHPS and dependent on survey	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	came to see within 15 minutes of your appointment time?			
15. CAHPS, Overall Rating of Health Care Quality	<p>Percent of best possible score the plan earned from Enrollees who rated the overall health care received.</p> <ul style="list-style-type: none"> 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 and dependent on survey	X	
16. CAHPS, Overall Rating of Plan	<p>Percent of best possible score the plan earned from Enrollees who rated the overall plan.</p> <ul style="list-style-type: none"> 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 your health plan? 	AHRQ/CAHPS and dependent on survey	X	
17. Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the plan’s pharmacy help desk.	CMS Call Center data	X	
18. 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 Enrollees who called the plan’s customer service phone number.	CMS Call Center data	X	
19. Part D Appeals Auto-Forward	How often the plan did not meet Medicare’s deadlines for timely appeals decisions.	IRE	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	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: $[(\text{Total number of cases auto-forwarded to the IRE}) / (\text{Average Medicare Part D enrollment})] * 10,000$.			
20. Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 calendar days of receipt of a completed enrollment request.	Medicare Advantage Prescription Drug System (MARx)	X	
21. 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	
22. Part D Enrollee Access and Performance Problems	To check on whether Enrollees are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan Enrollees directly. A higher score is better, as it means Medicare found fewer problems.	CMS Administrative data	X	
23. Part D Enrollee Choosing to Leave the Plan	The percent of Enrollees who chose to leave the plan in 2013.	CMS Medicare Enrollee Database Suite of	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
		Systems		
24. 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	
25. Part D High Risk Medication	The percent of the Enrollees who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X	
26. Part D Diabetes Treatment	Percentage of Medicare Part D Enrollees who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X	
27. Part D Medication Adherence for Oral Diabetes Medications	Percent of Enrollees 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	
28. Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of Enrollees 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	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
29. Part D Medication Adherence for Cholesterol (Statins)	Percent of Enrollees with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
30. Plan Makes Timely Decisions about Appeals	Percent of Enrollees who got a timely (per timelines in Section IX) response when they made a written appeal to the plan about a decision to refuse payment or coverage.	IRE	X	
31. Part D Appeals Upheld	<p>How often an independent reviewer agrees with the plan's decision to deny or say no to an Enrollee's Part D appeal.</p> <p>This measure is defined as the percent of IRE confirmations of upholding the plans' Part D decisions. This is calculated as: [(Number of Part D cases upheld) / (Total number of Part D cases reviewed)] * 100.</p>	IRE	X	
32. Non-Part D Appeals Upheld	<p>How often a Hearing Officer agrees with the plan's non-Part D decision to deny or say no to an Enrollee's non-Part D appeal.</p> <p>This measure is defined as the percent of ICI Administrative Hearing Unit confirmations of upholding the plans' decisions. This is calculated as: [(Number of non-Part D cases upheld) / (Total number of non-Part D cases reviewed)] * 100.</p>	IRE	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
33. 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 Enrollees who called the plan’s customer service phone number.	CMS Call Center data	X	
34. Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X	
35. Enrollee Governance Board	Establishment of Enrollee advisory board or inclusion of Enrollee on governance board consistent with contract requirements.	CMS/State defined process measure	X	
36. Customer Service	<p>Percent of best possible score the plan earned on how easy it is to get information and help when needed.</p> <p>A. In the last 6 months, how often did your health plan’s customer service give you the information or help you needed?</p> <p>B. In the last 6 months, how often did your health plan’s customer service treat you with courtesy and respect?</p> <p>C. In the last 6 months, how often were the forms for your health plan easy to fill out?</p>	AHRQ/CAHPS	X	
37. Assessments	Percentage of Enrollees with initial assessments completed within required timeframes.	CMS/State defined process measure	X	
38. Person-Centered	Percent of Enrollees with care plans within required	CMS/State defined	X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Care Plan	timeframes.	process measure		
39. Documentation of Care Goals	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure	X	
40. Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure	X	
41. Discharge follow-up	Percent of Enrollees with specified timeframe between discharge to first follow-up visit.	CMS/State defined process measure	X	
42. Care for Older Adults – Medication Review	Percent of Enrollees 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	
43. Care for Older Adults – Functional Status Assessment	Percent of Enrollees 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	
44. Care for Older Adults – Pain Screening	Percent of Enrollees who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS	X	
45. Diabetes Care – Eye Exam	Percent of Enrollees with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS	X	
46. Diabetes Care – Kidney Disease Monitoring	Percent of Enrollees with diabetes that had a kidney function test during the year.	NCQA/HEDIS	X	
47. Diabetes Care –	Percent of Enrollees with diabetes who had an A-1-C lab test	NCQA/HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Blood Sugar Controlled	during the year that showed their average blood sugar is under control.			
48. Rheumatoid Arthritis Management	Percent of Enrollees with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS	X	
49. Reducing the Risk of Falling	Percent of Enrollees with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
50. Plan All-Cause Readmissions	Percent of Enrollees discharged from a hospital stay who was 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	
51. Controlling Blood Pressure	Percentage of Enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	
52. Comprehensive medication review	Percentage of Enrollees who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA) Part D Reporting Data	X	
53. Complaints about the Plan	How many complaints Medicare received about the health plan. Rate of complaints about the plan per 1,000 Enrollees. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
54. Enrollee Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan Enrollee directly. A higher score is better, as it means Medicare found fewer problems.	CMS Enrollee database	X	
55. Enrollees Choosing to Leave the Plan	The percent of Enrollees who chose to leave the plan in 2014.	CMS	X	
56. Breast Cancer Screening	Percent of female Enrollees aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X	
57. Colorectal Cancer Screening	Percent of Enrollees aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X	
58. Cardiovascular Care – Cholesterol Screening	Percent of Enrollees with heart disease who have had a test for —badl (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
59. Diabetes Care – Cholesterol Screening	Percent of Enrollees with diabetes who have had a test for —badl (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
60. Annual Flu Vaccine	Percent of Enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	X	
61. Improving or Maintaining Mental Health	Percent of all Enrollees whose mental health was the same or better than expected after two years.	CMS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
		HOS		
62. Monitoring Physical Activity	Percent of senior Enrollees who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS	X	
63. Access to Primary Care Doctor Visits	Percent of all Enrollees who saw their primary care doctor during the year.	HEDIS	X	
64. Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X	
65. Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS	X	
66. Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS	X	
67. Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X	
68. Health Status/Function Status	Percent of Enrollees who report their health as excellent.	AHRQ/CAHPS	X	
69. 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	
70. Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measures	X	
71. Care for Older Adults – Advance	Percent of Enrollees who had an advance care plan during the measurement year.	NCQA/HEDIS		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Care Plan				
72. Percent of Residents Experiencing One or More Falls with a Major Injury	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	NQF/CMS		X
73. Long Term Care Overall Balance Measure	<p>Reporting of the number of Enrollees who did not reside in a nursing facility (NF) as a proportion of the total number of Enrollees in a plan.</p> <p><u>Numerator:</u> Of those Enrollees in the denominator, those who did not reside for more than 100 continuous days in a NF during the current measurement year.</p> <p><u>Denominator:</u> Enrollees in a plan eleven out of twelve months during the current measurement year.</p> <p><u>Exclusions:</u> Any Enrollee with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.</p>	State-specified measure		X
74. Nursing Facility Diversion	Reporting of the number of nursing home certifiable Enrollees who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing	State-specified measure		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	<p>home certifiable Enrollees who lived outside the NF during the previous year.</p> <p><u>Nursing Facility Diversion Rate:</u> <u>Numerator:</u> Of those Enrollees in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year.</p> <p><u>Denominator:</u> Nursing home certifiable Enrollees enrolled in a plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months.</p> <p><u>Exclusions:</u> Any nursing home certifiable Enrollee with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.</p>			
75. Nursing Facility Transitions	The number of members who successfully transitioned from a nursing facility to the community.	State-specified process measure		X
76. Antipsychotic Use in Persons with Dementia	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.	Pharmacy Quality Alliance (NQF 2111)		X
77. CAHPS Shared Decision Making	<p>Percentage of members who reported “Definitely Yes”)</p> <p>Q10: In the last 6 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?</p>	<p>NQCA</p> <p>NQF Endorsed (0007)</p>		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	Q11: In the last 6months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice you thought was best for you?			
78. Out-of-plan Services	Reporting of the number of Enrollee discharges from, and placements into, residential settings involving out-of-plan services, including residential services for Enrollees with intellectual and developmental disabilities (I/DD).	State-specified Measure		

XII. Stakeholder Engagement

The State will continue to engage with and incorporate feedback from stakeholders, including Enrollees, during the implementation and operational phases of the Demonstration. This will be accomplished through an ongoing process of public meetings, and monitoring Enrollee and provider experiences through a variety of means, including focused meetings, surveys, website updates, and data analysis. The State is currently creating a calendar of stakeholder meetings that will occur over the next several months, and will post the schedule online. In addition, the State will require that MMPs develop meaningful Enrollee input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to Enrollees. The State will also develop consumer notices and related materials about the ICI Demonstration that are easily understood (i.e., no more than a 6th grade reading level) by persons with limited English proficiency and low functional literacy, and will translate materials into prevalent languages as determined by CMS and the State.

XIII. Evaluation

- A. CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the Financial Alignment models, including the ICI Demonstration, on Enrollee experience of care, quality, utilization, and cost. The evaluator will also explore how the ICI Demonstration operates, how it transforms and evolves over time, and Enrollees' perspectives and experiences. The key issues targeted by the evaluation will include (but are not limited to):
 - i. Enrollee health status and outcomes;
 - ii. Quality of care provided across care settings;
 - iii. Enrollee access to and utilization of care across care settings;
 - iv. Enrollee satisfaction and experience;
 - v. Administrative and systems changes and efficiencies;
 - vi. Long-term care rebalancing effectiveness; and
 - vii. Overall costs or savings for Medicare and Medicaid.
- B. The evaluator will design a State-specific evaluation plan for the ICI 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. Quarterly reports will provide rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit Rhode Island-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

- C. The State is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. The State and MMPs 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 collect data on Care Management and coordination, including identification of beneficiaries who receive Care Management, frequency of contacts, and classification into risk tiers. The State will also track beneficiaries eligible for the Demonstration, including which beneficiaries choose to enroll, disenroll from, or opt out of passive enrollment into the Demonstration, enabling the evaluation to identify differences in outcomes for these groups.

The State will need to provide information including but not limited to the following on a quarterly basis to CMS and/or the evaluator:

- i. Beneficiary-level data identifying beneficiaries eligible and enrolled in the demonstration:
 - a. Medicare Beneficiary Claim Account Number (HICN);
 - b. MSIS number;
 - c. Social Security Number;
 - d. CMS Beneficiary Link Key;
 - e. Person First and Last Name, Birthdate, and Zip code;
 - f. Eligibility identification flag - Coded 0 if not identified as eligible for the Demonstration, 1 if identified as eligible for the Demonstration using

- criteria available in claims or other administrative data, and 2 if identified by criteria from non-administrative data sources;
- g. Monthly eligibility indicator - Each monthly eligibility flag variable would be coded 1 if eligible, and zero if not; and
 - h. Monthly enrollment indicator - Each monthly enrollment flag variable would be coded 1 if enrolled in the Demonstration, and zero if not.
- ii. Summary level data for the State Data Reporting System, including but not limited to:
- a. The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries not eligible for the Demonstration (e.g., individuals under the age of 21, individuals receiving hospice care at the time of enrollment, etc.);
 - b. The number of beneficiaries enrolled in the Demonstration;
 - c. The number of beneficiaries who opt out of passive enrollment into the Demonstration;
 - d. The number of beneficiaries who disenroll from the Demonstration; and
 - e. The number of MMPs participating in the Demonstration.
- D. The State will ensure that the evaluator at least annually receives information indicating the primary care provider of record for each Enrollee. The State will also have the capability to track beneficiary-level data on grievances and appeals that identify the MMP and providers involved.