

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of Texas

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

Texas Dual Eligibles Integrated Care Demonstration Project

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I. STATEMENT OF INITIATIVE

The Centers for Medicare & Medicaid Services (CMS) and the State of Texas Health and Human Services Commission (HHSC) will establish a federal-state partnership to implement the Texas Dual Eligibles Integrated Care Demonstration (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees). The federal-state partnership will include a three-way contract with managed care plans that will provide integrated benefits to Medicare-Medicaid enrollees in the targeted geographic areas. The Demonstration will begin no sooner than March 1, 2015 and continue until December 31, 2018, unless continued pursuant to sections K and L or terminated pursuant to section L of this Memorandum of Understanding (MOU). The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation, improve coordination of services, and enhance quality of care for Medicare-Medicaid enrollees, and reduce costs for both the State and the Federal Government.

The population that will be eligible to participate in the Demonstration is limited to full benefit Medicare-Medicaid enrollees who are age 21 or older. Section C.1 below provides more information on eligibility for the Demonstration.

Under this initiative, these managed care plans, called STAR+PLUS (State of Texas Access Reform Plus) Medicare-Medicaid Plans (MMPs) in Texas, 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 STAR+PLUS MMPs will ensure that beneficiaries have access to an adequate network of medical, behavioral health, and supportive services.

CMS and the State shall jointly select and monitor the STAR+PLUS MMPs. CMS will implement this initiative under demonstration authority for Medicare and demonstration or State Plan or waiver authority for Medicaid as described in section III.A and detailed in Appendices 4 and 5.

Key objectives of the initiative are to improve the beneficiary experience in accessing services, deliver person-centered care, promote independence in the community, improve the quality of services, eliminate cost shifting between Medicare and Medicaid, and achieve cost savings for the State and Federal Government through improvements in care coordination. This initiative builds on the foundation of Texas' STAR+PLUS Medicaid managed care program for individuals with disabilities or who are age 65 or older, which has allowed the state to be innovative in the service delivery model this population uses to access health care across the

state. Many of the same performance checks and quality programs operating under the STAR+PLUS program will continue to apply to enrollees in this Demonstration in addition to Demonstration-specific quality withholds and performance measures collected. Enrollees in this Demonstration will also benefit from a new initiative being developed for STAR+PLUS to improve the quality of care in nursing facilities and reduce avoidable hospitalizations, scheduled to start March 2015.

The initiative aims to integrate the current, fragmented model of care for Medicare-Medicaid beneficiaries by creating a single point of accountability for the delivery, coordination, and management of Medicare and Medicaid services, including primary, preventive, acute, specialty, and behavioral health services, long-term services and supports (LTSS), and pharmacy products. Currently, only 8% of STAR+PLUS members are enrolled in both a Medicare Advantage plan and a STAR+PLUS MCO that are operated by the same organization. Under this demonstration, dually eligible STAR+PLUS members will have the opportunity to have all their Medicare and Medicaid services coordinated by the same plan. CMS and the State expect this model of integrated care and financing to, among other things, improve quality of care and reduce health disparities, meet both health and functional needs of enrollees, and improve transitions between care settings. Meeting beneficiary needs, including the ability to self-direct services, be involved in one's care, and live independently in the community, are central goals of this initiative. CMS and the State expect that STAR+PLUS MMPs' and providers' implementation of the independent living and recovery philosophy, wellness principles, and cultural competence will contribute to achieving these goals.

The initiative will test the effect of an integrated care and payment model on serving both community and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency, and oversight standards. Contract management will focus on performance measurement and continuous quality improvement. Except as otherwise specified in this MOU, STAR+PLUS MMPs will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as program-specific and evaluation requirements, as will be further specified in a three-way contract to be executed among the STAR+PLUS MMPs, the State, and CMS.

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

CMS and the State will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees, utilizing a simplified and unified set of rules, as detailed in the sections below. Flexibilities will be coupled with specific beneficiary safeguards and will be included in this MOU and the three-way contract. STAR+PLUS MMPs will have full accountability for managing the capitated payment to best meet the needs of enrollees according to Plans of Care developed by enrollees, their caregivers, and their Service Coordination Teams using a person-centered planning process. CMS and the State expect STAR+PLUS MMPs to achieve savings through better integrated and coordinated care. Subject to CMS and state oversight, STAR+PLUS 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' preferences and goals, needs, and Plan of Care.

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

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document details the principles under which CMS and Texas plan to implement and operate the aforementioned Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute a three-way contract with STAR+PLUS MMPs that sets forth the terms and conditions of the Demonstration and initiate the Demonstration. Further detail about STAR+PLUS MMPs' 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 enter into three-way contracts with selected plans, which will have also met the Medicare components of the plan selection process, including submission of a successful Capitated Financial Alignment Application to CMS, and adherence to any annual contract renewal requirements and guidance updates, as specified in Appendix 7. These three-way contracts 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 CMS and the State intend to incorporate into the three-way contracts, as well as those activities CMS and the State intend to conduct prior to entering into the three-way contracts and initiating the Demonstration. This section and any appendices referenced herein are not intended to create contractual or other legal rights between the parties.

1. **Medicare Authority:** The Medicare elements of the initiative shall operate according to existing Medicare Parts C and D laws and 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, STAR+PLUS 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 §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.

1. **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 Texas Health Care Transformation and Quality Improvement Program (THTQIP) section 1115(a) demonstration, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the initiative, STAR+PLUS MMPs will be required to comply with Medicaid managed care requirements under Title XIX and 42 CFR §438 et. seq., unless waived by the state's existing THTQIP section 1115(a) demonstration, and applicable sub-regulatory guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5, the THTQIP section 1115(a) demonstration program, and, for waivers of sub-regulatory guidance, the three-way contract.

B. CONTRACTING PROCESS

1. **STAR+PLUS MMP Selection:** Texas will leverage its existing STAR+PLUS MCO contracts to allow plans to participate in the Demonstration as MMPs. STAR+PLUS MMP participation in Texas' Demonstration will be limited to existing STAR+PLUS MCO contractors that were selected through the procurement process that was completed in 2011.
2. **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 L of this MOU. If a waiver or expenditure authority is withdrawn, federal financial participation (FFP) is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.

- 3. Medicaid Waiver and/or Medicaid State Plan Approval:** CMS approval of any new Medicaid waivers pursuant to sections 1115(a), 1115A, or 1915 of the Social Security Act authority and processes is reflected in Appendix 5. CMS reserves the right to withdraw or terminate 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 L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.
- 4. Readiness Review:** CMS and the State, either directly or with contractor support, shall conduct a readiness review of each selected STAR+PLUS MMP. Following the signing of the three-way contract, CMS and the State must agree that a STAR+PLUS MMP has passed readiness prior to that plan 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 STAR+PLUS MMP and its ability to meet all Demonstration requirements, including having an adequate network that addresses the full range of beneficiary needs, and the capacity to uphold all beneficiary safeguards and protections.
- 5. Three-way Contract:** CMS and the State shall develop a single three-way contract and contract negotiation process that both parties agree is administratively effective and

ensures coordinated and comprehensive program operation, enforcement, monitoring, and oversight.

C. ENROLLMENT

1. Eligible Populations:

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

- Age 21 or older at the time of enrollment;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits;
- Required to receive their Medicaid benefits through the STAR+PLUS program as further outlined in the state's existing THTQIP section 1115(a) demonstration. Generally, these are individuals who are age 21 or older who:
 - have a physical disability or a mental disability and qualify for SSI, or
 - qualify for Medicaid because they receive Home and Community Based Services (HCBS) STAR+PLUS Waiver services; and
- Reside in one of the Demonstration counties listed in Appendix 3.

Dually eligible individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions (ICF/IIDs) or receiving services through the following section 1915(c) waivers will be excluded from the Demonstration:

- Community Living Assistance and Support Services (CLASS)
- Deaf Blind with Multiple Disabilities Program (DBMD)
- Home and Community-based Services (HSC)
- Texas Home Living Program (TxHmL)

The following populations will be excluded from passive enrollment in the Demonstration but may elect to enroll under the following circumstances:

- Individuals enrolled in a Medicare Advantage plan not operated by the same parent organization that operates a STAR+PLUS MMP and who meet the eligibility criteria for the Demonstration may enroll in a STAR+PLUS MMP if they elect to disenroll from their existing plan;
- Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE) who meet the eligibility criteria for the Demonstration may enroll in if they disenroll from that program; and
- Eligible individuals participating in the CMS Independence at Home (IAH) demonstration may enroll in the Demonstration if they disenroll from IAH.

2. Enrollment and Disenrollment Processes: Under this Demonstration, enrollment for eligible beneficiaries into a STAR+PLUS MMP may be conducted – when no active choice has otherwise been made – using a seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the STAR+PLUS MMP at any time. Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted STAR+PLUS MMPs no fewer than 60 days prior to the effective date of enrollment, and will have the opportunity to opt-out until the last day of the month prior to the effective date of enrollment, as further detailed in Appendix 7. Disenrollment from STAR+PLUS MMPs and enrollment from one STAR+PLUS MMP to a different STAR+PLUS MMP 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. As mutually agreed upon, and as discussed further in Appendix 7 and the three-way contract, CMS and the State will utilize a third party entity, independent of the STAR+PLUS MMP, to facilitate all enrollment into the STAR+PLUS MMPs. STAR+PLUS MMP enrollments, including enrollment from one STAR+PLUS MMP to a different STAR+PLUS MMP, and opt-outs shall become effective on the same day for both Medicare and Medicaid. For those who lose Medicaid eligibility during the month, coverage and FFP 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 purposes 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 STAR+PLUS MMP to a Medicare Advantage plan either operated by the same parent organization or by another organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS and the State may discontinue further passive enrollment into a STAR+PLUS MMP. Any inappropriate or illegal marketing practices will be referred to appropriate agencies for investigation.

- 3. Uniform Enrollment/Disenrollment Documents:** CMS and the State shall develop uniform enrollment and disenrollment forms and other documents.
- 4. Outreach and Education:** STAR+PLUS MMP outreach and marketing materials will be subject to a single set of marketing rules by CMS and the State, as further detailed in Appendix 7.

5. **Single Identification Card:** CMS and the State shall work with STAR+PLUS MMPs to develop a single identification card that can be used to access all covered services and flexible benefits, as further detailed in Appendix 7.
6. **Interaction with other Demonstrations:** To best ensure continuity of beneficiary care and provider relationships, CMS will work with the State to address beneficiary or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). A beneficiary enrolled in the Demonstration will not be enrolled in nor have costs attributed to, an ACO or any other shared savings initiative or demonstration for the purposes of calculating shared Medicare savings under those initiatives.

D. DELIVERY SYSTEMS AND BENEFITS

1. **STAR+PLUS MMP Service Capacity:** CMS and the State shall contract with STAR+PLUS MMPs that demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to enrollees, in accordance with this MOU, CMS guidance, and the three-way contract. Medicare covered benefits shall be provided in accordance with 42 CFR §422 and 42 CFR §423 et seq. Medicaid covered benefits shall be provided in accordance with 42 CFR §438, unless waived by the state's existing THTQIP section 1115(a) demonstration, and with the requirements in the approved Medicaid State Plan, including any applicable State Plan amendments and/or section 1115(a) demonstrations, and in accordance with the requirements specified by the Texas Uniform Managed Care Contract, STAR+PLUS Expansion Contract, 1 TAC Chapter § 353, STAR+PLUS handbook, and Uniform Managed Care Manual, 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 flexible benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, the State, and STAR+PLUS MMPs will ensure that beneficiaries have access to an adequate network of medical, behavioral health, pharmacy, and LTSS providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.
2. **STAR+PLUS MMP Risk Arrangements:** CMS and the State shall require each STAR+PLUS MMP to provide a detailed description of its risk arrangements with providers under subcontract with the plan. 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 or non-medical services to enrollees.

- 3. STAR+PLUS MMP Financial Solvency Arrangements:** CMS and the State, through the Texas Department of Insurance (TDI), have established a financial solvency standard for all STAR+PLUS MMPs, as articulated in Appendix 7.

E. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

- 1. Choice of Plans and Providers:** As referenced in section C.2, Medicare-Medicaid beneficiaries will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose a different STAR+PLUS MMP, a Medicare Advantage plan, to receive care through Original Medicare and a Prescription Drug Plan (PDP), and to receive Medicaid services in accordance with the State's approved State Plan services and any approved section 1115(a) demonstration and/or 1915(b) waiver.
- 2. Continuity of Care:** CMS and the State will require STAR+PLUS MMPs to ensure that enrollees continue to have access to medically necessary items, services, and providers for the transition period as specified in Appendix 7. In addition, STAR+PLUS MMPs will advise enrollees in writing when they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, and as appropriate, STAR+PLUS MMPs must also contact providers not already members of their network with information on becoming credentialed as in-network providers. Medicare Part D transition rules and rights will continue as provided for in current law and regulation.
- 3. Enrollment Assistance and Options Counseling:** As referenced in section C.2 and Appendix 7, the State will provide Medicare-Medicaid beneficiaries with enrollment options counseling and assistance, independent of the STAR+PLUS MMPs, to help them make an enrollment decision that best meets their needs. The Texas Department of Aging and Disability Services (DADS) will work with HHSC, the Texas State Health Insurance Assistance Program (SHIP), Aging and Disability Resource Centers (ADRCs), the enrollment broker, and other local partners to ensure ongoing outreach, education, and support to beneficiaries eligible for the Demonstration.
- 4. Ombudsman:** Created by the 78th Texas Legislature, the HHSC's Office of the Ombudsman assists the public when the agency's normal complaint process cannot or does not satisfactorily resolve the issue. The Office of the Ombudsman:
 - Conducts independent reviews of complaints on behalf of all enrollees
 - Ensures policies and practices are consistent with the goals of the Texas HHSC

- Ensures individuals are treated fairly, respectfully and with dignity
- Makes referrals to other agencies as appropriate
- Performs informal dispute resolution reviews for certain long-term care facilities

The Ombudsman will support individual advocacy and provide the State and CMS with feedback on MMP performance issues encountered during their individual advocacy work, with a focus on compliance with principles of community integration, independent living, and person-centered care in the HCBS context. The Ombudsman will be responsible for gathering and reporting data to the State and CMS via the Contract Management Team described in Appendix 7 of this MOU. CMS will support Ombudsman training on the Demonstration and its objectives, and CMS, the Administration for Community Living (ACL), and the State will provide ongoing technical assistance to the Ombudsman.

- 5. Person-Centered, Appropriate Care:** CMS, the State, and STAR+PLUS MMPs shall ensure that all medically necessary, covered benefits are provided to enrollees 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 in decision-making, and is in a setting appropriate to the enrollee's needs. CMS, the State, and STAR+PLUS MMPs shall ensure that care is person-centered and can accommodate and support self-direction. STAR+PLUS MMPs shall also ensure that medically necessary, covered services are provided to enrollees in the least restrictive community setting, with a preference for the home and the community, and in accordance with the enrollee's preferences and goals and Plan of Care.
- 6. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and the State expect STAR+PLUS MMPs and providers to comply with the ADA and the Civil Rights Act of 1964 to promote the success of the Demonstration and to support better health outcomes for enrollees. In particular, CMS and the State recognize that successful person-centered care requires physical access to buildings, services, and equipment and flexibility in scheduling and processes. The State and CMS will require that STAR+PLUS MMPs 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 STAR+PLUS 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 Demonstration enrollees, to further develop learning opportunities, monitoring mechanisms, and quality measures to ensure that STAR+PLUS 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 that, through ongoing surveys and readiness and implementation monitoring, STAR+PLUS MMPs provide for enrollees' LTSS in settings appropriate to their needs and preferences.

- 7. Enrollee Communications:** 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 or the State. CMS and the State will also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or State approval. All materials shall be integrated and include, but not be limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, coverage (claims or service) denials, complaints (including grievances), internal (plan-level) appeals, external appeals (e.g., State Fair Hearing or Office of Medicare Hearings and Appeals Administrative Law Judge hearings), and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable to the beneficiaries that will be enrolled in the STAR+PLUS 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, and those with low functional literacy, 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 STAR+PLUS MMPs to obtain enrollee and community input on issues of Demonstration management and enrollee services through a range of approaches. Each STAR+PLUS MMP must establish at least one enrollee advisory committee and a process for that committee to provide input to the plan's governing board. Each STAR+PLUS MMP must also demonstrate that the advisory committee composition reflects the diversity of the Demonstration enrollee population, and participation of individuals with disabilities, including enrollees, within the governance structure of the STAR+PLUS MMP. The State will maintain additional processes for ongoing stakeholder participation and public comment, including through stakeholder and enrollee participation in the Promoting Independence Advisory Committee, the Quality Improvement Advisory Committee, STAR+PLUS stakeholder meetings, STAR+PLUS Quality Council, Medicaid

Managed Care Advisory Committee, and other various advisory and stakeholder meetings devoted to services for Medicare-Medicaid enrollees.

- 9. STAR+PLUS MMP Customer Service Representatives:** CMS and the State shall require STAR+PLUS 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. STAR+PLUS 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 customer 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 that all STAR+PLUS MMPs ensure privacy and security of enrollee health records and provide for access by enrollees to such records as specified in the three-way contract.
- 11. Integrated Appeals and Grievances:** As referenced in section F and Appendix 7, Medicare-Medicaid enrollees will have access to an integrated appeals and grievance process.
- 12. Limited Cost Sharing:** STAR+PLUS MMPs will not charge Medicare Parts C or D premiums, nor assess any cost sharing for Medicare Parts A and B services. For drugs and pharmacy products covered by Medicare Part D, plans will be permitted to charge co-pays to individuals currently eligible to make such payments. Co-pays charged by STAR+PLUS MMPs for Medicare 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 (LIS), although STAR+PLUS 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. STAR+PLUS MMPs will not assess any cost sharing for Medicaid services.
- 13. No Balance Billing:** No enrollee may be balance billed by any provider for any reason for Demonstration covered services or flexible benefits.

F. INTEGRATED APPEALS AND GRIEVANCES

- 1. STAR+PLUS MMP Grievances and Internal Appeals Processes:** CMS and the State agree to utilize a unified set of requirements for grievances and internal appeals processes

that incorporate relevant Medicare Advantage and Medicaid managed care requirements, to create a more beneficiary-friendly and easily navigable system, which is discussed in further detail in Appendix 7 and will be specified in the three-way contract. All STAR+PLUS 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 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 grievances and appeals will continue to be managed under existing rules.

G. ADMINISTRATION AND REPORTING

- 1. STAR+PLUS 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 contract management activities related to ensuring access to services, quality, program integrity, and program compliance as well as monitoring program costs and STAR+PLUS MMP financial results.

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 withholds or other purposes related to the Demonstration.
- 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 STAR+PLUS MMPs' fiscal operations and TDI's assessment of financial solvency, reviewing program integrity studies to monitor fraud, waste, and abuse as may be agreed upon by CMS and the State, and ensuring that STAR+PLUS MMPs take corrective action, as appropriate.

- Reviewing and analyzing reports on STAR+PLUS MMPs' network adequacy, including plans' ongoing efforts to replenish their networks and to continually enroll qualified providers.
- Reviewing any other applicable ratings and measures.
- Reviewing reports from the Ombudsman.
- Reviewing direct stakeholder input on both plan-specific and systematic performance.
- Responding to and investigating beneficiary complaints and quality of care issues.

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

- The State and CMS will each retain, yet coordinate, current responsibilities toward enrollees such that enrollees maintain access to their benefits across both Medicare and Medicaid.
- CMS and the State will leverage existing protocols (for example, in responding to enrollees complaints, conducting account management, and analyzing enrollment data) to identify and solve enrollees' access problems in real-time.
- Oversight will be coordinated and subject to a unified set of requirements. A CMS-State Contract Management Team, as described in Appendix 7, will be established. Oversight will build on areas of expertise and capacity of the State and CMS.
- Oversight of the STAR+PLUS MMPs and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and the State's THTQIP section 1115(a) demonstration. Roles and responsibilities of the State and CMS will be further detailed in the three-way contract.
- Medicare Part D and Medicare Advantage oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the State. STAR+PLUS 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.
- CMS and the State will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poor performing providers from the program, leveraging existing CMS tools, such as the Complaints Tracking Module or the Medicare Part D Critical Incidence Reporting System, and

existing State oversight and tracking tools. Standards for removal on the grounds of poor performance 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 STAR+PLUS 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 STAR+PLUS MMP's performance. STAR+PLUS 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 the Health Insurance Portability and Accountability Act (HIPAA) of 1996 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 STAR+PLUS 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 beneficiaries are receiving high quality care. In addition, CMS and the State shall conduct a joint comprehensive performance and quality monitoring process that is at least as rigorous as Medicare Advantage, Medicare Prescription Drug, and Medicaid managed care requirements, including the state's existing THTQIP section 1115(a). 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 STAR+PLUS MMP's external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).
- 3. Determination of Applicable Quality Measures:** CMS and the State shall determine applicable quality measures and monitor the STAR+PLUS MMPs' compliance with those measures. These measures 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 STAR+PLUS MMPs, CMS shall disclose to 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 STAR+PLUS MMPs for the Medicare Parts A/B and Part D components of the rate. The State will make a payment to the STAR+PLUS MMPs for the Medicaid component of the rate, as more fully detailed in Appendix 6. These separate payments, in total, constitute an effective blended capitation payment to cover the combination of all Medicare and Medicaid services required for the Demonstration.

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 STAR+PLUS 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, and LTSS use and expenditures, using principles of rapid-cycle evaluation and feedback. Key aspects and administrative features of the Demonstration, including but not limited to enrollment, marketing, and appeals and grievances will also be examined per qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives and 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 STAR+PLUS 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. The State and STAR+PLUS 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 Medicaid State Plan, waiver, or state law or statutory changes that may have an impact on the Demonstration.

- 1. Limitations of MOU:** This MOU is not intended to, and does not, create any right or benefit, substantive, contractual, or procedural, enforceable at law or in equity, by any party against the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person, or against the state of Texas, its instrumentalities, officers, employees, contractors or any other agent of the state. 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, amend, or extend the duration of 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 of care and reducing spending. Any material modification, including extension, shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration. At the end of each Demonstration Year, the Director of the Medicare-Medicaid Coordination Office (MMCO) will meet with the State Medicaid Director to discuss the performance of all STAR+PLUS MMPs. These parties will review available data, as applicable, including data on enrollment, utilization patterns, health plan expenditures, and risk adjustment to assess whether the STAR+PLUS MMPs are meeting the objectives of CMS and the State for this Demonstration, including cost savings. Together, the State and CMS will determine the need

to take any performance improvement steps, and will discuss opportunities for extending the Demonstration for an additional year, subject to section 1115A of the Social Security Act.

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

If the Demonstration is terminated as set forth above, CMS shall provide the State with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Demonstration enrollees, and, to the extent that timing permits, adheres to the phase-out plan requirements detailed below. All enrollees must be successfully enrolled in a Medicare 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 Demonstration. Prior to submitting the draft phase-out plan, the State must publish on its website the draft phase-out plan for a 30-day public comment period. The State shall summarize comments received and share such summary with CMS. Both parties must agree to phase-out activities and implement such activities within 14 days of CMS approval of such agreement.
 - 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 beneficiary appeal rights will continue to operate during the phase-out and any plan 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 Medicare Part D plan, as well as any community outreach activities. In addition, such plan must include any ongoing STAR+PLUS MMPs and State responsibilities and close-out costs.

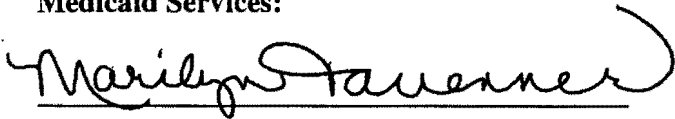
- c. Phase-out Procedures - The State must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration enrollees as outlined in 42 CFR §431.220 and §431.221. If a Demonstration enrollee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

M. SIGNATURES

This MOU is effective on this day forward May 23, 2014 through the end of the Demonstration period. Additionally, the terms of this MOU shall continue to apply to the State and STAR+PLUS MMPs as they implement associated phase-out activities beyond the end of the Demonstration period.

In witness whereof, CMS and the State of Texas 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:

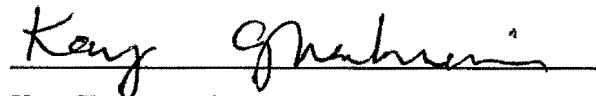


MAY 23 2014

Marilyn Tavenner
Administrator

May 23, 2014

State of Texas, Health and Human Services Commission:



05/23/14

Kay Ghahremani
State Medicaid Director

May 23, 2014

Appendix 1: Definitions

Adverse Action - consistent with 42 CFR §438.400, is a coverage decision by the STAR+PLUS MMP, subcontractor, service provider, the State, or other authorized entities, that constitutes a denial or limited authorization of a service authorization request, including the type or level of service; or reduction, suspension, or termination of a previously authorized service; or failure to provide services in a timely manner; or denial in whole or in part of a payment for a covered service for an enrolled member; or failure by the STAR+PLUS MMP to render a decision within the required timeframes; or the denial of an enrollee's request to exercise his or her right under 42 CFR §438.52(b)(2)(ii) to obtain services outside of the network.

Allowable Expenses - all expenses related to the provision of covered services for enrollees that are incurred during the Demonstration Year, are not reimbursable or recovered from another source, and that conform to requirements of HHSC's Cost Principles, as referenced in the three-way contract. For the purposes of calculating the Experience Rebate, allowable expenses does not include costs attributed to Medicare Part D. The determination of the allowability of expenses reported on the Financial Statistical Report (FSR) is subject to routine annual audit by HHSC or its agents.

Appeal - an enrollee's request for review of an Adverse Action taken by a STAR+PLUS MMP related to items or services. In accordance with 42 CFR 438.400, a Medicaid-based appeal is defined as a request for review of an Adverse Action, as defined herein. An appeal is an enrollee's challenge to an Adverse Action regarding services, benefits, and reimbursement provided by the STAR+PLUS MMP or its service providers.

Behavioral Health Services - covered services for the treatment of mental, emotional, or chemical dependency disorders.

Care Management - a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet an enrollee's needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost effective, and positive outcomes.

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

CMS - the Centers for Medicare & Medicaid Services.

Community-Based Long Term Services and Supports (LTSS) - services provided to STAR+PLUS enrollees in their home or other community-based settings necessary to provide assistance with activities of daily living to allow the enrollee to remain in the most integrated setting possible. Community-Based LTSS includes services available to all STAR+PLUS

enrollees, which include Personal Assistance Services (PAS) and Day Activity and Health Services (DAHS), as well as those services available only to STAR+PLUS enrollees who qualify for HCBS STAR+PLUS Waiver services.

Comprehensive Health Risk Assessment - upon enrollment in the STAR+PLUS MMP, all enrollees shall receive, and be an active participant in, a comprehensive health risk assessment, to be completed no later than 90 days from the individual's enrollment in the STAR+PLUS MMP. Assessment domains will include, but not be limited to, physical and behavioral health, social needs, functional status, wellness and prevention domains, caregiver status and capabilities, as well as the enrollees' preferences, strengths, and goals. Relevant and comprehensive data sources, including the enrollee, providers, and family/caregivers, as appropriate, shall be used by the STAR+PLUS MMPs. Results of the assessment will be used to confirm the appropriate risk stratification level for the enrollee and as the basis for developing the Plan of Care.

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

Contract Management Team - a group of CMS and State representatives responsible for overseeing the three-way contracts.

Covered Services - the set of services offered by the STAR+PLUS MMPs.

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.

DADS - the Texas Department of Aging and Disability Services.

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

Enrollment - the processes by which an individual who is eligible for the Demonstration is enrolled in a STAR+PLUS MMP.

Experience Rebate - the portion of the MMP's Net Income Before Taxes, if any, that is returned to the State in accordance with requirements in the three-way contract. The State will remit to CMS a share of the rebate as described in Appendix 6 of this MOU.

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 members.

Financial Management Service Agency (FMSA) - an organization that assists the enrollee or his/her legally authorized representative (LAR) in hiring or retaining HCBS service providers in accordance with qualifications and other requirements. The FMSA enters into service agreements with each of the enrollee's service providers before issuing payment. A FMSA is not responsible for providing case management services to the individual. The FMSA must obtain employer-agent status and perform all responsibilities as required by the Internal Revenue Service and other appropriate government agencies.

Financial Statistical Report (FSR) - a report designed by HHSC, and submitted to HHSC by the MMP in accordance with three-way contract requirements. The FSR is a form of modified income statement, subject to audit, and contains revenue, cost, and other data, as defined by the three-way contract. Not all incurred expenses may be included in the FSR. The FSR will include revenue, cost, and other data broken out for Demonstration enrollees separate from individuals served by other Texas Medicaid programs. [Note that the present STAR+PLUS FSR template may be modified to reflect any changes in line items to better reflect both Medicaid and Medicare items.]

Flexible Benefits - additional services for coverage beyond covered services, which may be actual health care services, benefits, or positive incentives that HHSC and CMS determines will promote healthy lifestyles and improve health outcomes among enrollees. Flexible benefits that promote healthy lifestyles may target specific weight loss, smoking cessation, or other programs approved by HHSC and CMS. Also called "value added services."

Grievance - In accordance with 42 CFR §438.400, grievance means an expression of dissatisfaction about any matter other than an "adverse action." A grievance is filed and decided at the STAR+PLUS 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). Also called a "complaint."

Health and Human Services Commission (HHSC) - the administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code, or its designee, including, but not limited to, the Health and Human Services agencies.

Health Outcomes Survey (HOS) - beneficiary survey used by CMS 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.

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

Home and Community-Based Services (HCBS) STAR+PLUS Waiver - the Texas HHSC program that provides HCBS to aged and disabled Medicaid beneficiaries as cost-effective alternatives to institutional care in nursing homes. Enrollees who qualify for the HCBS STAR+PLUS Waiver (SPW) are eligible to receive the HCBS component of the THTQIP section 1115(a) demonstration. Covered waiver services include: personal attendant services (including three service delivery options: 1) self-directed; 2) agency model, self-directed; and 3) agency model); in-home or out-of-home respite services; nursing services (in home); emergency response services; home delivered meals; minor home modifications; adaptive aids and medical equipment; medical supplies not otherwise available under the Texas Medicaid State Plan or THTQIP section 1115(a) demonstration; physical, occupational, and speech therapy; day activity health services; adult foster care; assisted living; limited transition assistance services; and cognitive rehabilitation therapy, supported employment, and employment assistance.

Individual Service Plan (ISP) - A person-centered plan developed for enrollees eligible for HCBS STAR+PLUS Waiver services by the Service Coordinator and incorporated into the enrollee's Plan of Care. Service planning includes: 1) determining the individual's needs; 2) determining service levels; 3) maintaining costs and cost ceilings; 4) reviewing services; and 5) obtaining approval for planned services. For enrollees seeking or needing the HCBS STAR+PLUS Waiver services, the STAR+PLUS MMPs must use the MN/LOC Assessment Instrument, as amended or modified, to assess enrollees and to supply current medical information for Medical Necessity determinations. For each enrollee receiving HCBS STAR+PLUS Waiver Services, the MMP must also complete the Individual Service Plan (ISP) form. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be completed on an annual basis and the end date or expiration date does not change. Both of these forms (MN/LOC Assessment Instrument and ISP form) must be completed annually at reassessment.

Legally Authorized Representative (LAR) - a person authorized by state or federal law to act on behalf of an HCBS STAR+PLUS Waiver enrollee, including a parent, guardian, managing conservator of a minor, organization, or the guardian of an adult.

Long Term Services and Supports (LTSS) - services to meet an individual's health or personal care needs over an extended period of time and may include nursing, assistance with bathing, toileting, dressing, eating, meal preparation, relief for caregivers, home modifications and repairs, transportation, adaptive aids, services at licensed facilities, and nutrition services such as home-delivered meals or meals at senior centers. LTSS are provided predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

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

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

Medically Necessary Services - services must be provided in a way that provides all protections to covered individuals provided by Medicare and Texas 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.
- (per HHSC) In accordance with Medicaid law and regulations, and per HHSC, services must be covered in accordance with clinical coverage guidelines specified in Texas Administrative Code (T.A.C.) Section 353.2., a service, supply, or medicine that is appropriate, covered by the State, and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with the STAR+PLUS MMP's guidelines, policies or procedures based on applicable standards of care and as approved by HHSC if necessary, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

STAR+PLUS MMPs will be required to provide services in a way that preserves all protections to the enrollee provided by Medicare and the Texas Medicaid program. Where there is overlap between Medicare and Medicaid, coverage and rules will be delineated in the three-way contract.

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.

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

Medicare-Medicaid Enrollee - for the purposes of this Demonstration, individuals who are enrolled in Medicare Parts A, B and D and Medicaid and no other comprehensive private or public health coverage. See also "enrollee."

Net Income Before Taxes - an aggregate excess of Revenues over Allowable Expenses.

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

Parties - parties to the three-way contracts, including CMS, the State of Texas, and the STAR+PLUS MMPs.

Passive Enrollment - an enrollment process through which an eligible beneficiary is enrolled by the State (or its vendor) into a STAR+PLUS MMP, when not otherwise affirmatively electing one, following a minimum 60-day notice that includes the plan selection and the opportunity to select a different STAR+PLUS MMP, decline enrollment into a STAR+PLUS MMP, or opt out

of the Demonstration prior to the effective date of coverage.

Plan of Care - a person-centered care plan that addresses acute care and LTSS will be developed for all enrollees by the STAR+PLUS MMP Service Coordinator with the enrollee, his/her family supports, as appropriate, and providers. The Plan of Care will contain the enrollee's health history; a summary of current, short-term, and long-term health and social needs, concerns, and goals; and a list of required services, their frequency, and a description of who will provide such services. Continuous monitoring of the Plan of Care will occur, and any gaps in services, including any necessary revisions to the plan, will be addressed in an integrated manner by the STAR+PLUS MMP. For enrollees eligible for HCBS waiver services, the enrollee's ISP will be incorporated into the Plan of Care.

Pre-Tax Income - see Net Income Before Taxes.

Privacy - requirements established in HIPAA, and implementing regulations, Medicaid regulations, including 42 CFR §431.300 through §431.307, as well as relevant Texas 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 beneficiaries.

Readiness Review - prior to entering into a three-way contract with the State and CMS, each STAR+PLUS MMP selected to participate in the Demonstration will undergo a readiness review. The readiness review will evaluate each STAR+PLUS 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 STAR+PLUS 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 STAR+PLUS MMP's headquarters.

Revenue - all revenue received by the MMP pursuant to this three-way contract, excluding Medicare Part D revenues and including retroactive adjustments made by HHSC and/or CMS. Revenue includes any funds earned on Medicaid or Medicare managed care funds such as investment income and earned interest. Revenue excludes any reinsurance recoveries, which shall be shown as a contra-cost, or reported offset to reinsurance expense. Revenues are reported at gross, and are not netted for any reinsurance premiums paid.

Service Coordination - a specialized care management service that is performed by a Service Coordinator that includes but is not limited to: 1) identification of needs, including physical and behavioral health services, and LTSS, 2) development of a Plan of Care to address those identified needs; 3) assistance to ensure timely and coordinated access to an array of providers and covered services; 4) attention to addressing unique needs of enrollees; 5) coordination of covered services with non-capitated services (e.g. non-emergency transportation), as necessary

and appropriate; and 6) includes, for enrollees who have been determined STAR+PLUS HCBS eligible, the development of an ISP with the enrollee, family members, as appropriate, and providers, as well as authorization of HCBS waiver services.

Service Coordination Team - for each enrollee, the STAR+PLUS MMP will support a Service Coordination Team (referred to hereafter as “the team”), led by a Service Coordinator to ensure the integration of the enrollee’s medical, behavioral health, substance use, LTSS, and social needs. The STAR+PLUS MMP Service Coordinator must work with the enrollee’s primary care provider (PCP) as a team, regardless of whether the PCP is in the MMP’s network during the transition period, to coordinate all STAR+PLUS MMP covered services and any applicable non-capitated services. The team will be person-centered, built on the enrollee’s specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

Service Coordinator - the person with primary responsibility for providing service coordination and care management to STAR+PLUS MMP enrollees. The Service Coordinator leads the Service Coordination Team and must actively collaborate with the enrollee’s specialty care providers, including behavioral health and LTSS service providers, as appropriate.

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

STAR+PLUS - the State of Texas Access Reform (STAR) Plus Medicaid managed care program in which HHSC contracts with managed care organizations to provide, arrange, and coordinate preventive, primary, acute, and LTSS covered services. Those eligible for the STAR+PLUS program include adult persons with disabilities and persons age 65 and over who qualify for Medicaid through the Supplemental Security Income (SSI) program and/or the Medical Assistance Only (MAO) program or meet the functional and income eligibility requirements for STAR+PLUS HCBS Waiver and meet program rules for income and asset levels.

STAR+PLUS MCO - a managed care organization (MCO) contracted by the State to offer covered services under the STAR+PLUS program.

STAR+PLUS MMP - contracted Medicare-Medicaid Plan (MMP) participating in the Demonstration to cover an integrated set of Medicare and Medicaid benefits to Medicare-Medicaid enrollees.

State - the State of Texas.

Texas Department of Insurance (TDI) - regulates the business of insurance in the State of Texas. Tex. Ins. Code 31.002.

Texas Health Care Transformation and Quality Improvement Program (THTQIP) -

section 1115(a) demonstration program under which the STAR+PLUS program operates.

Three-Way Contract - the agreement that CMS and HHSC enters into with STAR+PLUS MMPs specifying the terms and conditions pursuant to which a STAR+PLUS MMP may participate in this Demonstration.

Appendix 2: CMS Standards and Conditions and Supporting State Documentation

To participate in the Demonstration, each State submitted a proposal outlining its approach. The proposal had to meet a set of standards and conditions. The table below crosswalks the standards and conditions to their location in the Texas proposal, submitted in 2012 and posted on the MMCO website. 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	Location in proposal (i.e. page #)
Integration of Benefits	Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and LTSS.	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. 8-9, 11, and 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, beneficiaries and their families, consumer organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model.	pp. 21-22
	State has also established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis for the duration of the Demonstration (i.e., implementation, monitoring and evaluation), including a process for informing beneficiaries (and their representatives) of the changes related to this initiative.	pp. 23-24

Beneficiary Protections	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary’s needs. At a minimum, States will be required to:	
	<ul style="list-style-type: none"> Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model (e.g., participation on STAR+PLUS MMP governing boards and/or establishment of beneficiary advisory boards). 	pp. 23-24
	<ul style="list-style-type: none"> Develop, in conjunction with CMS, uniform/integrated enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency. 	pp. 24-25
	<ul style="list-style-type: none"> Ensure privacy of enrollee health records and provide for access by enrollees to such records. 	p. 29
	<ul style="list-style-type: none"> Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community. 	pp. 15-17, 24, and Addendum
	<ul style="list-style-type: none"> Ensure access to services in a manner that is sensitive to the beneficiary’s language and culture, including customer service representatives that are able to answer enrollee questions and respond to complaints/concerns appropriately. 	pp. 24-25
	<ul style="list-style-type: none"> Ensure an adequate and appropriate provider network, as detailed below. 	pp. 15-16, 25
	<ul style="list-style-type: none"> Ensure that beneficiaries are meaningfully informed about their care options. 	p. 14
	<ul style="list-style-type: none"> Ensure access to grievance and appeals rights under Medicare and/or Medicaid. 	

	<ul style="list-style-type: none"> ○ <i>For Capitated Model</i>, this includes development of a unified set of requirements for STAR+PLUS MMP complaints and internal appeals processes. 	pp. 25-26, Addendum
State Capacity	State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.	pp. 30-32
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.	p. 15-16, 25
Measurement/Reporting	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality and cost outcomes for the target population. These metrics may include, but are not limited to beneficiary experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote beneficiaries receiving high quality care and for purposes of the evaluation.	pp. 15, 28-29
Data	State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:	
	<ul style="list-style-type: none"> • Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models; 	Addendum
	<ul style="list-style-type: none"> • Description of any changes to the State Plan that would affect Medicare-Medicaid enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and 	Addendum
	<ul style="list-style-type: none"> • State supplemental payments to providers (e.g., DSH, UPL) during the three-year period. 	Addendum

Enrollment	State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting beneficiary education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.	p. 11-14
Expected Savings	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	p. 30
Public Notice	State has provided sufficient public notice, including:	
	<ul style="list-style-type: none"> • At least a 30-day public notice process and comment period; 	pp. 21-24
	<ul style="list-style-type: none"> • At least two public meetings prior to submission of a proposal; and 	pp. 21-24
	<ul style="list-style-type: none"> • Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals. 	p. 22
Implementation	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation:	
	<ul style="list-style-type: none"> • Meaningful stakeholder engagement. 	pp. 21-24
	<ul style="list-style-type: none"> • Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments. 	p. 32
	<ul style="list-style-type: none"> • Joint procurement process (for capitated models only). 	p. 4
	<ul style="list-style-type: none"> • Beneficiary outreach/notification of enrollment processes, etc. 	p. 14

Appendix 3: Details of State Demonstration Area

The Demonstration area consists of six counties in Texas: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant. If, before the scheduled start date for this Demonstration, a situation arises wherein beneficiary choice would be limited or quality and/or availability of services would be decreased in any of the Demonstration service areas, and subject to ongoing stakeholder discussions, CMS and the State may change and/or add up to two additional counties to the Demonstration. Any changes to the Demonstration service area may be approved only as long as it does not decrease beneficiary choice, does not increase the overall number of beneficiaries expected to participate in the Demonstration, and furthers the goals of this Demonstration. Any such change would be subject to the Demonstration-specific readiness review process and must be effectuated no later than January 1, 2016.

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 STAR+PLUS MMPs and their sponsoring organizations for the Demonstration period beginning no sooner than March 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 contracts.

Under the authority at section 1115A of the Social Security Act, codified at 42 U.S.C. §1315a, CMMI is authorized to “...test payment and service delivery models ...to determine the effect of applying such models under [Medicare and Medicaid].” 42 U.S.C. §1315a(b)(1). One of the models listed in §1315a(b)(2)(B) that CMMI 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 §422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in STAR+PLUS MMPs to Medicare-Medicaid beneficiaries who are age 21 and older, including beneficiaries who may have ESRD, and (2) the passive enrollment process provided for under the Demonstration.
- Sections 1853, 1854, 1857(e), 1860D-11, 1860D-13, 1860D-14, and 1860D-15 of the Social Security Act, and implementing regulations at 42 CFR §422, Subparts F and G, and §423, Subparts F and G, only insofar as such provisions are inconsistent with

the methodology for determining payments, medical loss ratios (MLR), 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 MLR requirements, and does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.

- The provisions regarding deemed approval of marketing materials in sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 CFR §422.2266 and §423.2266, with respect to marketing and enrollee communications materials in categories of materials that CMS and the State have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and the State have agreed to approval.
- Sections 1852(f) and (g) and implementing regulations at 42 CFR §422, Subpart M, only insofar as such provisions are inconsistent with the grievance and appeals processes provided for under the Demonstration.
- Section 1860D-14(a)(1)(D) and implementing regulations at 42 CFR §423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the LIS be greater than \$0, to permit STAR+PLUS MMPs to reduce Medicare Part D cost sharing below the levels required under section 1860D-14(a)(1)(D)(ii) and (iii).

Appendix 5: Medicaid Authorities and Waivers

All requirements of the Medicaid program expressed in law and regulation, not expressly waived in this list, shall apply to the Demonstration beginning no sooner than March 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 contracts.

This Demonstration and the additional authority referenced below are contingent upon submission and approval of all documentation necessary to demonstrate compliance with the Medicaid requirements under 42 CFR §438 and §441 for enrollment of the Demonstration population into managed care, including, but not limited to the submission of any amendments to the State's 1915(b) NorthSTAR program due no later than 90 days prior to the effective date of implementation for this Demonstration. In order to provide Demonstration enrollees with access to fully integrated services, including behavioral health services, through the STAR+PLUS MMPs, an amendment to carve all Demonstration enrollees out of the NorthSTAR program in Dallas County will require approval by CMS before enrollment may begin in that service area. The State must meet all requirements of any approved Medicaid waiver as expressed in the terms of those authority documents, including, but not limited to, all financial, quality, reporting, and monitoring requirements of the waiver, and State financing contained in the State's waiver must be in compliance with federal requirements. This MOU does not indicate or guarantee CMS approval of any necessary authority for managed care under 42 CFR §438 and §441.

This Demonstration and the additional authority referenced below are also contingent upon CMS approval of an amendment to the state's existing THTQIP section 1115(a) demonstration to make conforming changes to the demonstration's budget neutrality and benefits. The state's current section 1115(a) demonstration expires September 30, 2016, and must be renewed by CMS in order to continue this authority for the duration of this financial alignment Demonstration. The State must meet all requirements of any approved Medicaid waiver authority as expressed in the terms of the THTQIP section 1115(a) demonstration, including, but not limited to, all financial, quality, reporting and monitoring requirements of the THTQIP section 1115(a) demonstration, and State financing contained in the State's THTQIP section 1115(a) demonstration must be in compliance with federal requirements. This MOU does not indicate or guarantee CMS approval of any amendments to the THTQIP section 1115(a) demonstration. If the necessary THTQIP section 1115(a) demonstration authority is approved, Title XIX financial alignment Demonstration savings may not be added to budget neutrality savings under the State's existing THTQIP section 1115(a) demonstration. When Texas' section 1115(a)

demonstration is considered for renewal in 2016 and at the end of the financial alignment Demonstration, CMS' Office of the Actuary will estimate and certify actual Title XIX savings to date under the financial alignment Demonstration attributable to populations and services provided under the THTQIP section 1115(a) demonstration. This amount will be subtracted from the THTQIP section 1115(a) demonstration budget neutrality savings approved for the renewal.

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

1115A Medicaid Waivers

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

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

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

Appendix 6: Payments to STAR+PLUS MMPs

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

1. Medicare and HHSC will each contribute to the total capitation payment consistent with baseline spending contributions;
2. Demonstration savings percentages assume that STAR+PLUS MMPs are responsible for the full range of services covered under the Demonstration;
3. Aggregate savings percentages will be applied equally to the Medicaid and Medicare Parts A/B components; and
4. Both CMS and the State will contribute to the methodologies used to develop their respective components of the overall blended rate as summarized in Table 6-2 and further described below.

Table 6-1 below outlines how the Demonstration Years will be defined for the purposes of this effort.

Table 6-1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1.a	March 1, 2015 – December 31, 2015
1.b	January 1, 2016 – December 31, 2016
2	January 1, 2017 – December 31, 2017
3	January 1, 2018 – December 31, 2018

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

Rate Element	Medicare Parts A/B	Medicare Part D	Medicaid
<p>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>Blend of Medicare Advantage and Medicare standardized FFS payments 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</p>	<p>National average monthly bid amount (NAMBA) will be used as the baseline for the direct subsidy portion of Part D spending.</p> <p>Note that additional costs associated with LIS payments, reinsurance payments, and risk-</p>	<p>Medicaid capitation rates through the THTQIP section 1115(a) demonstration program that would otherwise apply for beneficiaries in the target population but not enrolled in the Demonstration, adjusted to add historical costs for benefits and for</p>

Rate Element	Medicare Parts A/B	Medicare Part D	Medicaid
Medicaid baseline spending amounts shall be set up front and will be applied in future years unless more recent historical data are available and/or CMS' actuaries and the State determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.	per member per month (PMPM) standardized cost.	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.	Medicare cost sharing that are currently not in the underlying Medicaid capitation rates.
Responsible for producing data	CMS	CMS	HHSC
Savings percentages	Demonstration Year 1.a: 1.25% Demonstration Year 1.b: 2.75% Demonstration Year 2: 3.75% Demonstration Year 3: 5.5%	Not Applicable	Demonstration Year 1.b: 1.25% Demonstration Year 1.b: 2.75% Demonstration Year 2: 3.75% Demonstration Year 3: 5.5%
Risk adjustment	Medicare Advantage CMS-HCC Model	Part D RxHCC Model	STAR+PLUS Rating Category Structure as described in section I
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 provisions	STAR+PLUS Experience Rebate process as described in section IX	Existing Part D processes will apply	STAR+PLUS Experience Rebate process as described in section IX.

I. Underlying Rate Structure for Medicaid Components of the Rates

The proposed rating categories for the Medicaid component of the rates in the Demonstration are described below. The Demonstration rating categories will be consistent with those in the STAR+PLUS program, although the STAR+PLUS capitation structure is still subject to future review and approval by CMS. The State and its actuaries will continue to explore the need for additional or differently structured rating categories for the target population in the Demonstration. After signing of this MOU, the State may update these rating categories, subject to CMS review and approval, to maintain consistency with the state’s underlying section 1115(a) demonstration and to promote community-based alternatives to nursing facility placement.

Table 6-3: Proposed Rating Categories

Rating Category	Description
HCBS	<ul style="list-style-type: none"> • Receive state plan services, as well as section 1115(a) HCBS STAR+PLUS Waiver services, and • Elderly or adults with disabilities who qualify for nursing facility level of care, but do not reside in a nursing facility • For the first three months after an enrollee transitions into a nursing facility, the MMP will be paid at the HCBS rate.
Other Community Care (OCC)	<ul style="list-style-type: none"> • Receive state plan services only, and • Do not reside in a nursing facility
Nursing Facility	<ul style="list-style-type: none"> • Receive state plan services only, and • Reside in a nursing facility • For the first three months after an enrollee transitions out of a nursing facility, the MMP will be paid at the nursing facility rate.

The rate cell structure is intended to align the payment with risk while incentivizing home and

community-based care over nursing facility placement through incentives and penalties. The incentive includes an enhanced payment rate for a period of time following movement to or from the nursing facility. The penalty includes payment at the lower HCBS rate for a period of three months in cases where an individual moves from HCBS to nursing facility.

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

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

A. Medicaid:

1. The State and its actuaries have established actuarially sound Medicaid capitation rates for the THTQIP section 1115(a) demonstration that would otherwise apply for beneficiaries in the target population but not enrolled in this Demonstration. These rates, adjusted to add historical costs for benefits and Medicare cost sharing that are currently not in the underlying Medicaid capitation rates, will serve as the baseline Medicaid costs.
2. CMS and its contractors will review the underlying Medicaid data and assumptions used to establish the rates.
3. Upon request throughout the Demonstration, the State and its actuaries will provide the underlying data for THTQIP section 1115(a) demonstration rate calculations to the CMS contracted actuary for review and validation.
4. Medicaid payment rates will be determined by applying annual savings percentages (see section III and IV) to the applicable baseline amounts.
5. The Medicaid portion of the baseline may be updated as described in section X of this Appendix.

B. Medicare Parts A/B:

1. CMS will develop baseline spending (costs absent the Demonstration) and payment rates for Medicare Parts A/B services using estimates of what Medicare would have spent on behalf of the beneficiaries absent the Demonstration.

2. The Medicare baseline rate for Parts A/B services will be a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans. CMS may adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.
3. Medicare Parts A/B payment rates will be determined by applying the applicable savings percentages (see section III and IV) to the baseline spending amounts.
4. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each period. Beneficiary risk scores will be applied to the standardized payment rates at the time of payment.
5. CMS may require the State to provide a data file for beneficiaries who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline spending. CMS will specify the format and layout of the file.
6. The Medicare portion of the baseline will be updated annually consistent with the annual FFS estimates and benchmarks released each year with the annual Medicare Advantage rate announcement.
7. CMS annually applies a coding intensity adjustment factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Medicare FFS programs. As reference, the adjustment for 2015 is 5.16%. The majority of Demonstration enrollees will come from Medicare FFS, and 2015 risk scores for those individuals will be based solely on prior FFS claims. In calendar year 2015, 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 2016, CMS will apply an appropriate coding intensity adjustment reflective of all

Demonstration enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportionate to the anticipated percent of enrollees in CY 2016 with prior Medicare Advantage experience and/or experience in the Demonstration, depending on the Demonstration's enrollment phase-in as of September 30, 2015. After calendar year 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all STAR+PLUS MMP enrollees.

C. Medicare Part D:

The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D NAMBA for the calendar year. CMS will estimate an average monthly prospective payment amount for the LIS and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

The CY 2014 Part D NAMBA is \$75.88. The CY 2015 NAMBA will be announced in August 2014.

III. Aggregate Savings Percentages under the Demonstration

A. Both parties agree that there is reasonable expectation for achieving savings while paying STAR+PLUS MMPs capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to enrollee needs.

B. For the State of Texas, the savings percentages will be:

- Demonstration Year 1.a: 1.25%
- Demonstration Year 1.b: 2.75%
- Demonstration Year 2: 3.75%
- Demonstration Year 3: 5.5%

Updates to the Medicare portion of the capitated rate will take place on January 1st of each calendar year, while updates to the Medicaid portion of the rate will occur at the beginning of the state fiscal year on September 1st. Savings percentages will be calculated and applied based on Demonstration Years.

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

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

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

V. Risk Adjustment Methodology

- A. The Medicare Parts A/B FFS standardized county rate will be risk adjusted based on the risk profile of each enrollee. The existing CMS-HCC risk adjustment methodology will be utilized for the Demonstration.
- B. The Medicare Part D NAMBA will be risk-adjusted in accordance with existing Part D RxHCC methodology.
- C. The Medicaid component will employ the rating categories described in section I of this Appendix, above.

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

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

A workgroup of State staff, external stakeholders, and representatives from the EQRO are developing a comprehensive set of state-specific performance measures on LTSS to be implemented starting in 2015. To date, the following domains have been identified as critical to the delivery of high quality care in LTSS:

- Service coordination
- Assessment
- Service authorization, delivery, and planning, with a focus on the use of person-centered approaches

- Community supports

Additionally, an enrollee’s perception of the quality of his or her care is a vital component of how STAR+PLUS MMP performance should be measured, and as such this perspective will be considered in the development of the final LTSS performance measures. At least two LTSS quality measures, to be selected jointly by the State and CMS, will serve as withhold measures for each Demonstration year. Specific LTSS performance measures to be used in this Demonstration will be included in the three-way contract.

B. Withhold Measures in Demonstration Year One – Table 6-4 below identifies core withhold measures for Demonstration Year One. Together, these will be utilized as the basis for the 1% withhold. Additional detail regarding the agreed upon measures will be included in the three-way contract.

Table 6-4: Quality Withhold Measures for Demonstration Year One

Domain	Measure	Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of enrollees with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X	
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. <ul style="list-style-type: none"> • In the last six months, how often did your health plan’s customer service give you the information or help you needed? • In the last six months, how often did your health plan’s customer service treat you 	AHRQ/CAHPS	X	

	<p>with courtesy and respect?</p> <ul style="list-style-type: none"> In the last six months, how often were the forms for your health plan easy to fill out? 			
Getting Appointments and Care Quickly	<p>Percent of best possible score the plan earned on how quickly enrollees get appointments and care</p> <ul style="list-style-type: none"> In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last six months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time? 	AHRQ/CAHPS	X	
LTSS	TBD LTSS measure (based on ongoing stakeholder process and subject to CMS approval)	State-defined measure		X
LTSS	TBD LTSS measure (based on ongoing stakeholder process and subject to CMS approval)	State-defined measure		X
Annual Plan of Care update	Number/percent of enrollees whose Plan of Care is updated annually before the expiration date.	State-defined measure		X

C. Withhold Measures in Demonstration Years Two and Three – The quality withhold will increase to 2% in Demonstration Year Two and 3% in Demonstration Year Three and will be based on performance on the core Demonstration and State-specified measures. Table 6-5 below identifies the quality withhold measures for Demonstration Years Two and Three.

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

Domain	Measure	Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Plan all-cause readmissions	Percent of enrollees discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for enrollees six years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Screening for clinical depression and follow-up care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	
Reducing the risk of falling	Percent of enrollees with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Controlling blood pressure	Percentage of enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	
Part D medication adherence for oral diabetes medications	Percent of plan 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	X	

LTSS	TBD LTSS measure (based on ongoing stakeholder process and subject to CMS approval)	State-defined measure		X
LTSS	TBD LTSS measure (based on ongoing stakeholder process and subject to CMS approval)	State-defined measure		X
Plan of Care update	Number/percent of enrollees whose Plan of Care is updated annually before the expiration date.	State-defined measure		X

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

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

VII. Payments to STAR+PLUS MMPs

- A. CMS will make separate, monthly, risk-adjusted payments to the STAR+PLUS MMPs for the Medicare Parts A/B and Part D components of the rate, based on standardized Demonstration payment rates. Medicare Parts A/B payments and Part D payments will be subject to the same payment adjustments that are made for payments to Medicare Advantage and Part D plans, including but not limited to adjustments for user fees and Medicare secondary payor adjustment factors.
- B. The State will make a payment to the STAR+PLUS MMPs for the Medicaid component of the rate subject to the rate structure specified in section I.
- C. The capitated payment from CMS and the State is intended to be adequate to support access to and utilization of covered services, according to enrollee Plans of Care. CMS and the State will jointly monitor access to care and overall financial viability of STAR+PLUS MMPs accordingly.

VIII. Evaluate and Pay STAR+PLUS MMPs Relative to Quality Withhold Requirements

- A. CMS and the State will evaluate STAR+PLUS MMPs' performance according to the specified metrics required in order to earn back the quality withhold for a given Demonstration Year. CMS and the State will share information as needed to determine whether quality requirements have been met and calculate final payments to each STAR+PLUS MMP from each payor.

- B. Whether or not each STAR+PLUS MMP has met the quality requirements in a given Demonstration Year will be made public, as will relevant quality results of STAR+PLUS MMPs in Demonstration Years Two and Three.

IX. Risk Mitigation Strategies

- A. **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.
- B. **Rate Review Process:** CMS and the State will review STAR+PLUS MMP financial reports, encounter data, and other information to assess the ongoing financial stability of the STAR+PLUS MMPs and the appropriateness of capitation payments. At any point, the State may request that CMS review documentation from specific plans to assess the appropriateness of capitation rates and identify any potential prospective adjustments that would ensure the rate-setting process is meeting the objective of Medicare and Medicaid jointly financing the costs and sharing in the savings.
- C. **Experience Rebate:** The Demonstration will utilize a one-sided Experience Rebate, similar to that used in Texas' STAR+PLUS program. This is separate from the Rebate currently used in the STAR+PLUS Program; for those groups of STAR+PLUS enrollees that are not part of this Demonstration, the previously existing STAR+PLUS Experience Rebate will continue to apply. The Experience Rebate is designed to limit the profits received by STAR+PLUS MMPs to a reasonable percentage of total revenue, and to encourage use of revenues for services rather than administrative expenses by putting a limit (Admin Cap) on the amount of administrative expenses that can be used to calculate Net Income Before Taxes when determining the Experience Rebate. The Experience Rebate will apply for all Demonstration Years and will include all Medicare A/B and Medicaid eligible costs. The Admin Cap will be introduced in Demonstration Year 2. Additional detail on the Experience Rebate will be included in the three-way contract.

Under this Demonstration, at an appropriate time after the end of each state fiscal year, the STAR+PLUS MMP must pay to the State an Experience Rebate if the STAR+PLUS MMP's Net Income Before Taxes is greater than the percentage set forth of the total Revenue for the period. There will be specified time frames for the payment of the Experience Rebates, and interest will be applied for late payment or inappropriate reporting that ultimately results in delayed payment; further details will be included in the three-way contract. The Experience Rebate will be calculated in accordance with a tiered

rebate method summarized in Table 6-6, below. The State will remit to CMS a share as described below.

Revenue will include capitated payments received by the STAR+PLUS MMP for Medicare A/B services (Medicare A/B Component) and for covered Medicaid services (Medicaid Component). Revenues used in calculating the Experience Rebate reflect capitation rate levels, which include the impact of risk adjustment methodologies and cost reconciliation, if any, as described in Sections V and IX.A, respectively. In calculating the Experience Rebate, Revenues will not be reduced by any quality withhold hereunder, and any such withheld payment will not be an Allowable Expense hereunder. Thus, any payment forfeited under the quality withhold terms will not reduce the Net Income Before Taxes used in the Experience Rebate calculation. The Experience Rebate would be calculated as if the payment had not been withheld.

Rebate amounts collected from STAR+PLUS MMPs will be distributed back to the Medicare and Medicaid programs, with the amount to each payor in proportion to their contributions to the aggregate capitation payments, not including Part D. The share of the rebate attributed to the Medicaid Component will be treated as recoupment of Medicaid expenditures subject to federal matching rules. At the option of CMS and the State, any Experience Rebate payments (along with any associated interest) may be recovered either by requiring the STAR+PLUS MMP to make a payment or by an offset to future capitation payments.

Net Income Before Taxes, as well as Revenues and Allowable Expenses, will be measured through the established Texas Financial Statistical Reporting (FSR) system, and reviewed and confirmed by the State and CMS. Additional factors, such as the Loss Carry Forward or the Admin Cap, that may impact the final amounts used to calculate the percentages below will be described further in the three-way contract. HHSC's standard Cost Principles will apply with respect to the FSR, and MMPs will be subject to standard FSR audits; these aspects will also be further described in the three-way contract.

CMS and the State will use the following graduated tiers to determine STAR+PLUS MMPs' applicable Experience Rebates:

1. The MMP will retain all the Net Income Before Taxes that is equal to or less than 3% of the total Revenues received by the MMP;
2. The State/CMS and the MMP will share that portion of the Net Income Before Taxes that is over 3% and less than or equal to 5% of the total Revenues received by the MMP, with 80% to the MMP and 20% to the State/CMS.

3. The State/CMS and the MMP will share that portion of the Net Income Before Taxes that is over 5% and less than or equal to 7% of the total Revenues received by the MMP, with 60% to the MMP and 40% to the State/CMS.
4. The State/CMS and the MMP will share that portion of the Net Income Before Taxes that is over 7% and less than or equal to 9% of the total Revenues received by the MMP, with 40% to the MMP and 60% to the State/CMS.
5. The State/CMS and the MMP will share that portion of the Net Income Before Taxes that is over 9% and less than or equal to 12% of the total Revenues received by the MMP, with 20% to the MMP and 80% to the State/CMS.
6. The State/CMS will recoup the entire portion of the Net Income Before Taxes that exceeds 12% of the total Revenues received by the MMP.

Table 6-6: Experience Rebate Tiers

Net Income Before Taxes as a % of Revenues	STAR+PLUS MMP Share	Medicare/Texas Share
≤ 3%	100%	0%
>3% and ≤ 5%	80%	20%
>5% and ≤ 7%	60%	40%
>7% and ≤ 9%	40%	60%
>9% and ≤ 12%	20%	80%
>12%	0%	100%

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

- A. Rates will be updated using a similar process for each calendar year. Updates to the Medicare portion of the capitated rate will take place on January 1st of each calendar year, while updates to the Medicaid portion of the rate will occur at the beginning of the state fiscal year, with changes to savings percentages applicable on a Demonstration Year basis. Rate updates for the Medicaid component of the rates will take place at least once each Texas state fiscal year and may be more often as necessary to match adjustments

made to the Medicaid capitation rates in the contracts that support the THTQIP 1115(a) demonstration program that would apply for beneficiaries in the target population who do not enroll in the Demonstration. Adjustments to the Medicaid component of the rates may be done retroactively, if necessary to match the Medicaid baseline rates. Changes to the baseline (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage rate announcement would occur only if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. 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 outside the annual rate update process may be based on the following factors: shifts in enrollment assumptions, major changes in federal law and/or state law or policy compared to assumptions about federal law and/or state law or policy used in the development of baseline estimates, changes in coding intensity. CMS and/or the State will make changes to baseline estimates after the need for such change is identified, 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 Parts A/B baselines, or if and when CMS and the State jointly determine the change is necessary to calculate reasonable, appropriate payment rates for the Demonstration.

Appendix 7: Demonstration Parameters

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

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

I. State of Texas Delegation of Administrative Authority and Operational Roles and Responsibilities

In accordance with 42 CFR, §431.10(e), HHSC is the single state agency for the Medicaid program. The State Medicaid Director oversees Medicaid operations and will be involved with implementing and monitoring the Demonstration. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across HHSC as described below.

Overall responsibility for development of the Demonstration and implementation plan rests with the State Medicaid Director, who will serve as the main point of contact for MMCO at CMS regarding Texas' Demonstration.

II. Plan or Qualified Entity Selection

Texas awarded STAR+PLUS contracts to managed care organizations (MCOs) in August 2011, following a competitive bidding process. As a condition of the procurement, all STAR+PLUS contractors also currently offer Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). STAR+PLUS MMP participation in Texas' Demonstration will be limited to existing STAR+PLUS MCO contractors that were selected through the procurement process that was completed in 2011. The state will leverage these existing contractors for this Demonstration, and all STAR+PLUS MCOs will submit an application to CMS to offer an MMP product.

III. State Level Enrollment and Disenrollment Operations Requirements

- A. Eligible Populations/Excluded Populations - As described in the body of the MOU.
- B. Enrollment, and Disenrollment Processes - All enrollment and disenrollment transactions, including enrollments from one STAR+PLUS MMP to a different

MMP, will be processed through the Texas enrollment broker except those transactions related to non-Demonstration plans participating in Medicare Advantage. HHSC, 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.

- 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. Beneficiary-elected enrollments are effective the first day of the month following the initial receipt of a beneficiary's request to enroll, or the first day of the month following the month in which the beneficiary is eligible, as applicable for an individual beneficiary. Passive enrollment is effective no sooner than 60 days after beneficiary notification of plan selection and the right to select a STAR+PLUS MMP or option to decline passive enrollment.
 - i. STAR+PLUS MMPs will be required to accept opt-in enrollments no earlier than 90 days prior to the initial effective date of March 1, 2015, and with an enrollment effective date of March 1, 2015.

The enrollment effective dates above are subject to STAR+PLUS MMPs meeting CMS and state requirements including plans' capacity to accept new enrollees.

- ii. The State will provide beneficiaries with notice of the option to select a STAR+PLUS MMP at least 60 days prior to the effective date of a passive enrollment period and will accept opt-out requests through the last day of the month prior to the effective date of enrollment and at any time during the Demonstration period on a monthly basis. This notice will explain the beneficiary's options, including the option to opt out of or disenroll from the Demonstration. The notice will also include the name of the STAR+PLUS MMP in which the beneficiary would be enrolled unless he/she selects another plan or chooses to opt-out of the Demonstration.

For the first six months of this Demonstration, CMS and the State will monitor each STAR+PLUS MMPs' ability to manage opt-in and passive enrollments. Dependent on each STAR+PLUS MMP's capacity, as determined by its ability to manage the opt-in enrollments and the prior month's passive enrollments (once applicable), the State will passively enroll a number of beneficiaries into STAR+PLUS MMPs that takes into

consideration the number of opt-in enrollments and the opt-out rate for each STAR+PLUS MMP. Furthermore:

- a. In Harris County, the passive enrollment phase-in will occur over a period of at least six months and will not exceed 5,000 beneficiaries per month per STAR+PLUS MMP; and
 - b. In Bexar, Dallas, El Paso, Hidalgo, and Tarrant counties, the passive enrollment phase-in will occur over a period of at least six months and will not exceed 3,000 beneficiaries per month per STAR+PLUS MMP per county.
- iii. No later than 30 days prior to the enrollment effective dates, a second notice will be provided to beneficiaries who have not made an active choice to either select a STAR+PLUS MMP or opt-out of the Demonstration. The notice will include the name of the STAR+PLUS MMP in which the beneficiary would be enrolled unless he/she selects another plan or chooses to opt-out of the Demonstration. Texas will proceed with passive enrollment into the identified STAR+PLUS MMP for beneficiaries who do not make a different choice, with an effective date of the first day of the month referenced in section D.i, above.
 - iv. Enrollees subject to Medicare reassignment effective January 1, 2015, either from their current (2014) Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Drug Plan (MA-PD) to another PDP, will not be eligible for passive enrollment into this Demonstration during CY 2015. Individuals eligible to be reassigned to a new PDP effective January 1, 2016, and meeting all eligibility criteria for the Demonstration will be eligible for passive enrollment into a STAR+PLUS MMP effective no earlier than January 1, 2016.
 - v. Requests to disenroll from a STAR+PLUS MMP or opt-out of the Demonstration will be accepted at any point after an individual's initial enrollment occurs and are effective on the first day of the month following receipt of the request. Requests to opt-in or disenroll from one STAR+PLUS MMP and enroll in another will be accepted through the 12th of the month for an effective date of coverage the 1st calendar day of the next month. Requests received after the 12th of the month will be processed for an effective date the 1st of the second month following the request. Any time an individual requests to opt-out of passive enrollment or disenrolls from the Demonstration, the State will send a letter

confirming the opt-out and providing information on the Medicaid benefits available to the beneficiary once they have opted out or disenrolled, and contact information to receive more information about Medicare benefits.

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

- E. No enrollments will be accepted within six months of the end of the Demonstration.
- F. Passive enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto and facilitated enrollment for individuals with the Medicare Part D Low Income Subsidy (LIS).
- G. The State will develop an “intelligent assignment” algorithm for passive enrollment that prioritizes continuity of providers and/or services. The algorithm will consider beneficiaries’ previous managed care enrollment and historic provider utilization.
- H. The State will provide customer service, including mechanisms to counsel beneficiaries notified of passive enrollment and to receive and communicate beneficiary choice of opt-out to CMS on a daily basis via transactions to CMS’ MARx system. Beneficiaries will also be provided a notice upon the completion of the opt-out process. Medicare resources, including 1-800-Medicare, will remain a resource for Medicare beneficiaries; calls related to STAR+PLUS MMP enrollment will be referred to the state enrollment broker for customer service and enrollment options counseling and support.
- I. CMS and the State will jointly approve all Demonstration enrollment notices to ensure complete and accurate information is provided in concert with other Medicare communications, such as the Medicare & You handbook. CMS may also send a jointly-approved notice to beneficiaries, and will coordinate such notice with any State notices.
- J. State and CMS enrollment systems will be reconciled on a timely basis to resolve discrepancies between systems.

IV. State Level Delivery System Requirements

A. State Requirements for Care Management - Care management services will be available to all STAR+PLUS MMP enrollees. STAR+PLUS MMPs will be required to address the following components as part of their comprehensive care management programs as outlined below and in the three-way contract. Through the readiness review process, CMS and the State will review STAR+PLUS MMP capacity to deliver care management services.

- i. Risk Stratification: The STAR+PLUS MMPs will develop and implement a risk stratification process that uses a combination of predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information as appropriate that will consider enrollees' physical and behavioral health, substance use, and LTSS needs. The STAR+PLUS MMPs will stratify enrollees into two risk levels, with Level 1 the highest risk and Level 2 moderate and lower risk enrollees.
- ii. Comprehensive Health Risk Assessment: No later than 90 days after the individual's enrollment in the STAR+PLUS MMP, all enrollees shall receive, and be an active participant in, a comprehensive health risk assessment.

Assessment domains will include, but not be limited to, physical and behavioral health, social needs, functional status, wellness and prevention domains, caregiver status and capabilities, as well as the enrollees' preferences, strengths, and goals. Relevant and comprehensive data sources, including the enrollee, providers, and family/caregivers, as appropriate, shall be used by the STAR+PLUS MMP. Results of the assessment will be used to confirm the appropriate risk stratification level for the enrollee and as the basis for developing the Plan of Care. As part of the comprehensive health risk assessment, the STAR+PLUS MMP will also conduct an assessment to determine eligibility for HCBS waiver services if the enrollee has an unmet need for at least one waiver service or if requested by the enrollee.

A reassessment will be completed at least once every 12 months after the initial assessment completion date. A reassessment and/or updates to the Plan of Care (see section A.iii. below) must also be completed when there is a change in the enrollee's health status or needs, a significant health care event, or as requested by the enrollee, his/her caregiver, or his/her provider. Mid-year reassessment and/or updates to the Plan of

Care may be triggered by a hospital admission, transition between care settings, change in functional status, loss of a caregiver, change in diagnosis, or as requested by a member of the Service Coordination Team who observes a change that requires further investigation.

Initial comprehensive assessments and annual reassessments will be completed in person for enrollees stratified to Level 1. Initial comprehensive assessments and annual reassessments may be completed telephonically for enrollees stratified to Level 2 unless an in-person assessment is requested by the enrollee, caregiver, or provider.

All assessments will be conducted by qualified health professionals who possess an appropriate professional scope of practice, licensure, and/or credentials, and are appropriate for responding to or helping enrollees manage their service needs. Examples of health professionals who may complete portions of the assessment include registered nurse (RN), nurse practitioner (NP), licensed vocational nurses (LVNs), physician's assistant (PA), or person with an undergraduate or graduate degree in social work or a related field.

- iii. Plan of Care: For all enrollees, a person-centered Plan of Care will be developed by the STAR+PLUS MMP Service Coordinator, with the enrollee, his/her caregiver and/or family supports, PCP, and other members of the Service Coordination Team (see section A.iv below), that addresses all the health and social needs of the enrollee, as identified in the comprehensive health risk assessment. The Plan of Care will contain the enrollee's health history; a summary of current, short-term, and long-term health and social needs, concerns, and goals; and a list of required services, their frequency, and a description of who will provide such services.

If an enrollee is found to be eligible for HCBS waiver services as a result of the HCBS assessment referenced in section A.ii above, the Service Coordinator will work with the enrollee to develop an Individual Service Plan (ISP). HCBS waiver service planning includes: 1) determining the individual's needs, goals, and preferences; 2) determining service levels; 3) maintaining costs and cost ceilings; 4) reviewing services; and 5) obtaining approval for planned services. The ISP will be incorporated into the enrollee's overall Plan of Care.

Each enrollee's Plan of Care must also include, as applicable and consistent with enrollee preferences, coordination with the enrollee's family and community support systems, including Independent Living Centers, Area Agencies on Aging (AAAs), and Local Authorities, as applicable. The Plan of Care shall be agreed to and signed by the enrollee or the enrollee's LAR to indicate agreement with the plan. The Plan of Care shall allow for financial management services and promote self-determination and may include information about accessing services outside of Demonstration covered services, such as affordable, integrated housing.

For all enrollees, the STAR+PLUS MMP must ensure that the Plan of Care is in place within 90 days of enrollment, or upon receipt of all necessary eligibility information from the State, whichever is later. Continuous monitoring of the Plan of Care will occur, and any gaps in services will be addressed in an integrated manner by the STAR+PLUS MMP, including any necessary revisions to the plan. The Plan of Care expires annually and must be updated each year regardless of any mid-year revisions made based on an enrollee's needs. Each STAR+PLUS MMP is required to conduct an annual reassessment and update the Plan of Care prior to the expiration date. All services under the current Plan of Care would continue in the event of expiration.

- iv. Service Coordination Team: For each enrollee, STAR+PLUS MMPs will support a Service Coordination Team ("the team"), led by a Service Coordinator to ensure the integration of the enrollee's medical, behavioral health, substance use, LTSS, and social needs. Other required members of the team include the enrollee and the enrollee's PCP. Other providers or individuals, including the enrollee's caregiver, may also be team members, as appropriate or by request of the enrollee. Service Coordinators must also actively collaborate with the enrollee's specialty care providers, including behavioral health and LTSS service providers, as appropriate.

The team will be person-centered, built on the enrollee's specific preferences and needs, as identified in the comprehensive risk assessment and outlined in the Plan of Care, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

Members of the team must agree to participate in approved training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the State. This training will include *ADA/Olmstead* requirements. STAR+PLUS MMPs will offer similar trainings to additional members of the team as appropriate.

- v. **Service Coordinators:** STAR+PLUS MMPs must employ Service Coordinators with experience in meeting the needs of individuals with disabilities and vulnerable populations who have chronic or complex conditions. The Service Coordinator must work with the enrollee's PCP and other members of the Service Coordination Team to coordinate all Demonstration covered services and flexible benefits. The Service Coordinator shall be responsible for working with the enrollee and all members of the team to develop a single Plan of Care in which physical and behavioral health, substance abuse, and LTSS service needs are addressed. In addition, during the transition period (see section G below), the Service Coordinator must work with the PCP regardless of whether the PCP is in the STAR+PLUS MMP's network to coordinate all Demonstration covered services and any applicable transition services. The Service Coordinator must ensure that all enrollees stratified to Level 1 must receive a minimum of two in-person service coordination contacts annually and those stratified to Level 2 receive a minimum of one in-person and one telephonic service coordination contact annually.

A Service Coordinator must have an undergraduate and/or graduate degree in social work or a related field, or be an RN, LVN, NP, or a PA. The STAR+PLUS MMP must monitor the Service Coordinator's workload and performance to ensure that he or she is able to perform all necessary functions for enrollees in a timely manner.

- vi. **Self-Direction:** Enrollees may have the opportunity to direct their own services, including both employer and budget authority. Demonstration enrollees will choose a financial management service agency (FMSA) to assist with these activities.

B. Network Adequacy - HHSC standards shall be utilized for LTSS, as described below, or for other services for which Medicaid is the exclusive payor, and

Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more stringent. Home health and durable medical equipment (DME) requirements, as well as any other services for which Medicaid and Medicare coverage may overlap, shall be subject to the more beneficiary-friendly of the applicable Medicare and Medicaid standards.

- i. STAR+PLUS MMPs are required to develop and maintain provider networks adequate to deliver all Demonstration covered services, with an emphasis on the special needs of individuals with chronic conditions and disabilities.
- ii. Each STAR+PLUS MMP network must provide convenient and timely access to care. In addition to meeting Medicare Advantage minimum network requirements, the STAR+PLUS MMP must offer network provider agreements to all Medicaid Significant Traditional Providers (STPs) identified by HHSC to the STAR+PLUS MMPs. STPs also include Local Mental Health Authorities (LMHAs) and behavioral health providers.
 - Nursing facilities: A Nursing Facility must be treated as an STP if it holds a valid certification and license and it contracts with DADS as of September 1, 2013.
 - Other LTSS providers: LTSS providers must be treated as STPs if they are community-based long term care providers that provide a significant level of care to Medicaid clients. STAR+PLUS MMPs must ensure that enrollees have access to at least one LTSS provider of each service type required by HHSC in the network within 75 miles of the enrollee's residence.
 - Behavioral health providers: STAR+PLUS MMPs must ensure that enrollees have access to the following types of behavioral health providers within 75 miles of the enrollee's residence: psychologists and other behavioral health service providers. To ensure accessibility and availability of qualified providers to all enrollees, the provider network must include behavioral health service providers with experience serving special populations including, as applicable, persons with disabilities, the elderly, and cultural or linguistic minorities.

- Personal assistants: The State is not dictating a network adequacy requirement for personal assistants since they are hired at the discretion of the enrollee. However, STAR+PLUS MMPs are required to assist enrollees in locating personal assistants as necessary.
- iii. Providers must not be under sanction or exclusion from the Medicaid and Medicare programs and must have a valid National Provider Identifier (NPI) or Atypical Provider Identifier (API).
 - iv. The STAR+PLUS MMP must ensure its providers and subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the three-way contract.
 - v. Each STAR+PLUS MMP's provider network must be responsive to the linguistic, cultural, and other unique needs of any minority, older, disabled, or other special needs populations served by the STAR+PLUS MMP. This includes the capacity to communicate with enrollees in languages other than English, when necessary, as well as with those who require sign language interpreting.
 - vi. Each STAR+PLUS MMP must enter into written contracts with properly credentialed providers.

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

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

C. Solvency - STAR+PLUS 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 §438.116, §422.400, and §422.504(a)(14); and
- ii. As specified in state law, including maintaining compliance with Texas Department of Insurance rules and other requirements for Medicaid and Medicare managed care organizations.

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

- i. STAR+PLUS MMPs must be consistent with recognized MCO industry standards, such as those provided by NCQA or URAC and relevant state and federal regulations, including 28 TAC §11.1902 and §11.1402(c), relating to provider credentialing and notice. Under this Demonstration, STAR+PLUS MMPs must also adhere to managed care standards at 42 CFR §438.12, 42 CFR §422.204, and 42 CFR §438.214.
- ii. During the initial credentialing process, the MMP and its claim systems must be able to recognize the provider as a network provider no later than 30 calendar days after receiving a complete application requiring expedited credentialing, and no later than 90 calendar days after receiving all other complete applications. The re-credentialing process must occur at least every three years.
- iii. The STAR+PLUS MMP may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. Additionally, if the STAR+PLUS MMP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reasons for its decision.
- iv. The re-credentialing process must take into consideration provider performance data including, but not be limited to, enrollee complaints and appeals, quality of care, and utilization management. STAR+PLUS MMPs must comply with the requirements of Texas Insurance Code Chapter 1452, Subchapter C, regarding expedited credentialing and payment of physicians who have joined medical groups that are already contracted with the STAR+PLUS MMP.

V. Benefits

- A. Medical Necessity Determinations - Medically necessary services will be defined as services:
- i. (per Medicare) that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y.
 - ii. (per HHSC) that must be covered in accordance with clinical coverage guidelines specified in 1 T.A.C. Section 353.2., i.e. a service, supply, or medicine that is appropriate, covered by the State, and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with the STAR+PLUS MMP's guidelines, policies or procedures based on applicable standards of care and as approved by HHSC if necessary, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.
 - iii. Where there is overlap between Medicare and Medicaid benefits, coverage and rules will be delineated in the three-way contract; the benefits will maintain coverage to at least the extent provided by Medicare and Texas Medicaid as outlined in both state and federal rules. STAR+PLUS MMPs will be required to abide by the more generous of the applicable Medicare and HHSC standards.
 - iv. All care must be provided in accordance and compliance with the ADA, as specified by the *Olmstead* decision.

As a term and condition of this Demonstration, in addition to all Medicare Parts A, B, and D, and Medicaid State Plan services, the STAR+PLUS MMPs will be required to provide services as defined in the approved THTQIP section 1115(a) demonstration.

The STAR+PLUS MMP must also provide medically necessary services that are available to those in the STAR+PLUS HCBS waiver (within traditional Medicaid) to those enrollees who meet the additional Medicaid waiver eligibility requirements criteria, as described in the THTQIP section 1115(a) demonstration. The State provides an enriched array of services to beneficiaries who would otherwise qualify for nursing facility care through a HCBS waiver. The enrollee must meet MN/LOC criteria and the cost of the services in the ISP cannot exceed

202% of cost of providing the same services in a nursing facility. The STAR+PLUS MMP must be able to demonstrate that that enrollee has a minimum of one unmet need for at least one STAR+PLUS HCBS Waiver service before the services in the ISP may be authorized by the State.

Under the Demonstration, skilled nursing level care may be provided in a long term care facility without a preceding acute care inpatient stay for individuals enrolled in the Demonstration, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.

- B. NorthSTAR - In order to provide Demonstration enrollees with access to fully integrated services through the STAR+PLUS MMPs, Demonstration enrollees in Dallas County will not access behavioral health services through the NorthSTAR program. Enrollees who choose to disenroll from the Demonstration will continue to have access to NorthSTAR services.
- C. Flexible Benefits - STAR+PLUS MMPs will have discretion to use the capitated payment to offer flexible benefits, as specified in the enrollee's Plan of Care, as appropriate to address the enrollee's health and social needs. The State will permit STAR+PLUS MMPs to propose additional services for coverage. These flexible benefits may be actual health care services and LTSS, benefits, or positive incentives that promote healthy lifestyles and improved health outcomes among enrollees, including weight loss, smoking cessation, or other programs approved by HHSC. On a case-by-case basis, a STAR+PLUS MMP may offer additional benefits that are outside the scope of services to individual enrollees. Case-by-case services may be based on medical necessity, functional necessity, cost-effectiveness, the preferences and goals of the enrollee or the enrollee's family, or the potential for improving the enrollee's health status. These services and benefits cannot increase the cost borne or capitation rates paid during any current contract term or in any subsequent contract term and cannot violate any other state or federal rule or regulation.
- D. Election of Medicare Hospice Benefit - As in Medicare Advantage, if an enrollee elects to receive the Medicare hospice benefit, the enrollee will remain in the STAR+PLUS MMP but will obtain the hospice service through the Medicare FFS benefit, and the STAR+PLUS MMP would no longer receive the Medicare Part C payment for that enrollee. Medicare hospice services and all other Original Medicare services would be paid for under Medicare FFS. STAR+PLUS MMPs and providers of hospice services would be required to coordinate these services with the rest of the enrollee's services, including with Medicaid and Medicare

Part D benefits and any flexible benefits offered under the STAR+PLUS MMP. STAR+PLUS MMPs would continue to receive Medicare Part D payment, for which no changes from current rules would occur. Medicaid services and payments for hospice must comply with underlying Medicaid requirements.

E. Continuity of Care

- i. Any preexisting Plan of Care and/or ISP will remain in place until the STAR+PLUS MMP conducts an initial comprehensive health risk assessment and contacts the enrollee and/or the enrollee's LAR and coordinates updates to the enrollee's Plan of Care.
- ii. The STAR+PLUS MMP must perform an initial comprehensive health risk assessment within 90 days of an individual's enrollment in the STAR+PLUS MMP, as described in section IV.A.ii above.
- iii. STAR+PLUS MMPs must allow enrollees to maintain their current providers and service authorizations at the time of enrollment, except as otherwise specified in this section, for a period of up to 90 days, with further details to be outlined in the three-way contract.
 - a. The STAR+PLUS MMP is also required to ensure that all enrollees who are receiving LTSS, including nursing facility services, at the time of enrollment into the Demonstration receive continued authorization of those services for up to six months after initial enrollment into the Demonstration.
 - b. Exception shall be made for an enrollee who, at the time of enrollment in the STAR+PLUS MMP, has been diagnosed with and is receiving treatment for a terminal illness and remains enrolled in the Demonstration, in which case the STAR+PLUS MMP shall ensure continued access to covered services for nine months from the time of enrollment.

- iv. If, as a result of the comprehensive health risk assessment, the STAR+PLUS MMP proposes modifications to the services outlined in an enrollee's preexisting Plan of Care and/or ISP, the STAR+PLUS MMP must provide written notification about and an opportunity to appeal the proposed modifications no less than 10 days prior to implementation of the enrollee's updated Plan of Care. The enrollee, as well as their representative and/or provider where applicable, shall be entitled to all appeal rights, such as aid pending appeal, if applicable.

VI. Out of Network Reimbursement Rules – During the applicable transition period, STAR+PLUS MMPs are required to provide or arrange for all medically necessary covered services, whether by sub-contract or by single-case agreement, in order to meet the needs of the enrollee. STAR+PLUS MMPs must reimburse an out-of-network provider of emergent or urgent care at the prevailing Medicare or Medicaid FFS rate applicable for that service. The STAR+PLUS MMP must comply with out-of-network provider reimbursement rules as adopted by the State for services for which Medicaid is the primary payor.

VII. Model of Care (MOC) - All STAR+PLUS MMPs (in partnership with contracted providers) will be required to implement an evidence-based MOC having explicit components consistent with the Special Needs Plan (SNP) MOC. CMS' MMP MOC approval process will be based on scoring each of the 11 clinical and non-clinical elements of the MOC. The scoring methodology is divided into three parts: 1) a standard; 2) elements; and 3) factors. These components of the MOC approval methodology are defined below:

- 1) **Standard:** The standard is defined as a MOC that has achieved a score of 70% or greater based on CMS' scoring methodology.
- 2) **Elements:** The MOC has 11 clinical and non-clinical elements, as identified below, and each element will have a score that will be totaled and used to determine the final overall score. The 11 MOC elements are listed below:
 1. Description of the Plan-specific Target Population;
 2. Measurable Goals;
 3. Staff Structure and Care Management Goals;
 4. Interdisciplinary Care Team;
 5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;

6. MOC Training for Personnel and Provider Network;
 7. Health Risk Assessment;
 8. Plan of Care;
 9. Integrated Communication Network;
 10. Care Management for the Most Vulnerable Subpopulations; and
 11. Performance and Health Outcomes Measurement.
- 3) Factors: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the MMP application. The factors for each element will be scored using a system from zero to four, where four is the highest score for a factor. Interested organizations are required to provide a response that addresses every factor within each of the 11 elements. The scores for each factor within a specific element are totaled to provide the overall score for that element out of a total of 160 possible points. Interested organizations must achieve a minimum score of 70% to meet the CMS approval standard.

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

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

STAR+PLUS MMPs will be permitted to cure problems with their MOC submissions after their initial submissions. STAR+PLUS MMPs with MOCs scoring below 70% will have the opportunity to improve their scores based on CMS and State feedback on the elements and factors that need additional work, and regardless of their subsequent passing score, will receive a 1-year approval. At the end of the review process, STAR+PLUS MMPs with MOCs that do not meet CMS' standards for approval will not be eligible for selection as STAR+PLUS MMPs. Any MOC resubmissions by STAR+PLUS MMPs will be in accordance with prevailing CMS requirements.

VIII. Prescription Drugs – Integrated formulary must include any Medicaid-covered drugs that are excluded by Medicare Part D. STAR+PLUS 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.

IX. Grievances – Enrollees shall be entitled to file internal grievances directly with the STAR+PLUS MMP. Each STAR+PLUS MMP must track and resolve its grievances according to applicable Medicare and Medicaid rules, or if appropriate, re-route grievances to the coverage decision or appeals processes. Enrollees may also file a grievance with HHSC if they are not satisfied with the STAR+PLUS MMP’s grievance resolution. Once the enrollee files a grievance with HHSC, HHSC will require the STAR+PLUS MMP to resolve the grievance within 14 days.

X. Appeals – Each STAR+PLUS MMP must have mechanisms in place to track and report all appeals. Other than Medicare Part D appeals, which shall remain unchanged, the following is the approach for an integrated Medicare-Medicaid appeals process:

A. Appeal time frames - Enrollees and/or their authorized representatives, including providers, will have 60 days from the notice of Action to file an appeal with the STAR+PLUS MMP related to denial of Demonstration covered services. The STAR+PLUS MMP must provide for continuation of benefits when an enrollee files an appeal of a reduction or denial of previously authorized services on or before the later of 1) 10 days after the notice of Action, or 2) the intended effective date of the STAR+PLUS MMP’s proposed Action. This right to continuation of benefits must be set out in the notice of Adverse Action.

The enrollee may also appeal to the HHSC Appeals Division for a Fair Hearing within 90 days of the notice of Action.

B. Appeal levels - Enrollees will continue to have full access to the Medicare and Medicaid appeals frameworks for benefit appeals.

i. Initial appeals for Medicaid service actions may be made to the STAR+PLUS MMP. Upheld STAR+PLUS MMP decisions for Medicaid services may be appealed to the HHSC Appeals Division for a Fair Hearing. Enrollees may also appeal directly to the HHSC Appeals Division at any time.

ii. Initial appeals for Medicare Parts A and B service actions will be made to the STAR+PLUS MMP. Sustained decisions regarding Adverse Actions will be auto-forwarded to the Medicare Part C Independent Review Entity (IRE). If the resolution of the IRE is not wholly in favor of the enrollee, the enrollee or

his/her authorized representative may then file a request for hearing with an Office of Medicare Hearings and Appeals Administrative Law Judge.

C. Appeal resolution time frames-

- i. STAR+PLUS MMPs must resolve all appeals regarding standard service denials as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date the appeal is filed in accordance with 42 CFR 422.560 et seq. and 42 CFR 404. STAR+PLUS MMPs must hear an approved request for an expedited appeal and notify the enrollee of the outcome of the expedited appeal within 72 hours. STAR+PLUS MMPs must abide by these timeframes, except that the STAR+PLUS MMP must complete investigation and resolution of an appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one business day after receiving the enrollee's request for expedited appeal. The STAR+PLUS MMP may extend the timeframes from this section by up to 14 calendar days, outside of an expedited appeal request, if—
 - the enrollee requests the extension; or
 - the STAR+PLUS MMP shows (to the satisfaction of the State and/or CMS, upon request) that there is need for additional information and how the delay is in the enrollee's interest.
- ii. If the enrollee appeals a Medicaid service action directly to the HHSC Appeals Division, a decision must be issued by the Fair Hearing body within 90 days from the date the individual filed for the state fair hearing.
- iii. If the enrollee appeals a Medicaid service action to both the STAR+PLUS MMP and the HHSC Appeals Division, the appeal must be resolved by the Fair Hearing within the earlier of 90 days from when the individual requests an appeal of the HHSC Appeals Division, or 90 days from when the individual requests an appeal of the STAR+PLUS MMP, not including the number of days the enrollee took to subsequently file for a state fair hearing, in accordance with 42 CFR §431.244(f)(1)(i).
- iv. The IRE must conduct the appeal as expeditiously as the enrollee's health condition requires and should resolve all Medicare appeals within 30 calendar days and 72 hours for expedited appeals.

D. Continuation of Benefits Pending Appeal –

- i. As provided in 42 CFR §431.211, and §431.230, §420, and §424, continuations of covered Medicaid services will continue to be required when a request is made within the applicable timeframes for making such request. This means that authorized benefits will continue to be provided, and that STAR+PLUS MMPs must continue to pay providers for providing services pending an internal STAR+PLUS MMP appeal or Fair Hearing request. Payments will not be recouped based on the outcome of the appeal for services covered during pending appeals. This right to aid pending an appeal currently exists in Medicaid, but generally is not currently available in Medicare.
 - ii. Continuation of all Medicare Parts A and B and non-Part D benefits will be required to be provided pending internal STAR+PLUS MMP appeals.
 - iii. In the case of a decision where the STAR+PLUS MMP, the HHSC Appeals Division, and the IRE all issue a ruling, the STAR+PLUS MMPs shall be bound by the ruling that is most favorable to the enrollee.
- E. Integrated Notice - Enrollees will be notified of all applicable Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question, developed jointly by the State and CMS.

XI. STAR+PLUS MMPs’ 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 STAR+PLUS MMPs – STAR+PLUS 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 (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual). The following exceptions apply:

- i. STAR+PLUS 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. STAR+PLUS MMPs may participate in group marketing events and provide general audience materials (such as general circulation brochures, and media and billboard advertisements). STAR+PLUS MMPs must refer all potential enrollees to the state enrollment broker for enrollment. The State reserves the right to develop predetermined marketing scripts for STAR+PLUS MMP staff, subject to CMS review and approval. All processing of enrollments and disenrollments will occur as stated in this appendix.
 - ii. CMS and the State will develop a process to mitigate beneficiary shifting from STAR+PLUS 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 a STAR+PLUS MMP for a non-Demonstration plan that may be a part of the same corporate family. Beneficiary choices regarding enrollment will be honored by CMS and the State.
- B. Review and Approval of Marketing and Enrollee Communications – STAR+PLUS MMPs must receive prior approval of all marketing and enrollee communications materials in categories of materials that CMS and/or the State requires to be prospectively reviewed. STAR+PLUS 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. STAR+PLUS 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 STAR+PLUS MMP Marketing Activity – STAR+PLUS MMPs may begin marketing activity, as limited by section A.i above, no earlier than 90 days prior to the effective date of enrollment for the contract year.
- D. Minimum Required Marketing and Enrollee Communications Materials – At a minimum, STAR+PLUS MMPs will provide current and prospective enrollees the following materials. These materials will be subject to the same rules regarding content and timing of beneficiary receipt as applicable under section

1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual).

- i. An Evidence of Coverage (EOC) document that includes information about all State-covered and plan-covered and flexible benefits, in addition to the required Medicare benefits information.
- ii. An Annual Notice of Change (ANOC) summarizing all major changes to the STAR+PLUS 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 STAR+PLUS MMP, as well as the benefits offered under the plan, including co-pays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. STAR+PLUS MMPs will use a Demonstration-specific Summary of Benefits.
- iv. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and flexible benefits.
- v. A comprehensive, integrated formulary that includes Medicare and Medicaid outpatient prescription drugs provided under the STAR+PLUS MMP.
- vi. A single identification card for accessing all covered services under the STAR+PLUS MMP.
- vii. All Medicare Part D required notices, with the exception of the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual, and the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual.

XII. 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 STAR+PLUS MMPs to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse, including applicable requirements under Chapter 531 of Texas Government Code.

STAR+PLUS 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 covered services, including prescription drugs, medical and behavioral health services, and LTSS. In addition, all Medicare Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to STAR+PLUS MMPs by CMS in the same way they are currently applied for Medicare Advantage organizations and Part D sponsors.

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 MMCO, CMS Regional Office Lead from the Consortium for Medicaid and Children’s Health Operations (CMCHO), and an Account Manager from the Consortium for Medicare Health Plans Operations (CMHPO). The precise makeup will include individuals who are knowledgeable about the full range of services and supports utilized by the target population, particularly LTSS.
- ii. Reporting – Data reporting to CMS and the State will be coordinated and unified to the extent possible. Specific reporting requirements and processes for the following areas will be detailed in the three-way contract:

1. Quality (including HEDIS); core measures are articulated in Table 7-1 in this MOU.
2. Rebalancing from institutional to HCBS settings
3. Utilization
4. Encounter reporting
5. Enrollee satisfaction (including CAHPS)
6. Grievances (complaints) and appeals
7. Enrollment/disenrollment rates
8. Medicare Part C and D reporting requirements, as applicable
9. All required THTQIP section 1115(a) demonstration reporting
10. Financial Statistical Reports, and other financial and related reports as specified in the three-way contract
11. Any MMP-specific reporting which may be required by TDI

C. Day-to-Day Oversight and Coordination

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

- i. Monitoring compliance with reporting requirements;
- ii. Monitoring compliance with the terms of the three-way contract, including issuance of joint notices of non-compliance/enforcement;
- iii. Coordination of periodic audits and surveys of the STAR+PLUS MMP;
- iv. Receipt and response to complaints;
- v. Review reports from the Ombudsman;
- vi. Reviewing direct stakeholder input on both plan-specific and systematic performance;
- vii. Regular meetings with each STAR+PLUS MMP;
- viii. Coordination of requests for assistance from contractors, and assignment of appropriate State and CMS staff to provide technical assistance;
- ix. Coordinate review of marketing materials and procedures; and
- x. Coordinate review of grievance and appeals data, procedures, and materials.

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

CMS' central office conducts a wide array of data analyses, monitoring studies, and audits. STAR+PLUS MMP contracts will be included in these activities, just as all Medicare Advantage and Part D organizations will be included. STAR+PLUS MMP 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. STAR+PLUS MMPs Call Center Requirements

STAR+PLUS MMPs will be responsible for implementing the following call center elements for current and prospective enrollees which incorporate current federal regulatory requirements and CMS guidance requirements for Medicare Advantage Plans and Part D plans as well as Demonstration specific requirements:

- i. STAR+PLUS MMPs shall operate a toll-free enrollee services telephone line. The line must be available statewide a minimum of 8 a.m. to 8 p.m. Central Time, seven days a week, and be staffed by customer service representatives except for weekends and federal and state holidays, to be indicated in the three-way contract.
- ii. STAR+PLUS MMPs shall ensure that after hours, on weekends, and on holidays the toll-free enrollee services telephone line is answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in cases of emergency. All recordings must be in English, Spanish, and the languages of other major population groups in the service area. A voice mailbox must be available after hours

for callers to leave messages. Calls received by the automated system must be returned on the next business day.

- iii. Customer service representatives must be available in sufficient numbers to support current and prospective enrollees and meet CMS and State specified standards.
- iv. STAR+PLUS 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.
- v. TTY services or comparable services must be available for people who are deaf or hard of hearing.
- vi. STAR+PLUS MMPs must ensure that customer service representatives shall, upon request, make available to current and prospective 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 STAR+PLUS MMP to provide a requested coverage 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 Ombudsman, the HHSC enrollment broker, and 1-800-Medicare;
 - f. Information on all covered services and flexible benefits or other available resources (e.g., state agency services) either directly or through referral or authorization; and
 - g. The procedures for an enrollee to change MMPs or to opt-out of the Demonstration.

G. Data System Specifications, Reporting Requirements, and Interoperability

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

- i. Data system description and architecture and performance requirements
- ii. Current information system upgrades and development plans and resource commitments necessary for implementation
- iii. Consolidated reporting requirements
- iv. Encounter reporting
- v. Reporting data for evaluation and program integrity
- vi. Data Exchange among CMS, Texas providers, STAR+PLUS MMPs, and the Federally Facilitated Marketplace, as applicable

H. Unified Quality Metrics and Reporting

STAR+PLUS MMPs will be required to report quality measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, LTSS, patient/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 LTSS. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS plus any additional Medicaid measures identified by the State. All existing Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures.

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

In addition, it is the State's objective to recognize and reward both excellence

and improvement in performance by applying a variety of incentives and disincentives for demonstrated STAR+PLUS MMP performance. A subset of Demonstration quality measures reported by the STAR+PLUS MMPs (in Table 7-2 as well as indicated with an asterisk (*) in Table 7-1 below) will be reported through various STAR+PLUS program reporting mechanisms. Table 7-2 consists of a combination of national and State-specific metrics appropriate for Texas’s Demonstration population, including measures for acute care and HCBS.

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

Table 7-1: Core Quality Measures under the Demonstration

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
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	X*

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	X*
Follow-up After Hospitalization for Mental Illness	Percentage of discharges for enrollees six years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	X*
Screening for Clinical Depression and Follow-up Care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	

<p>SNP1: Complex Case Management</p>	<p>The organization coordinates services for enrollees with complex conditions and helps them access needed resources.</p> <p>Element A: Identifying Enrollees for Case Management Element B: Access to Case Management Element C: Case Management Systems Element D: Frequency of Enrollee Identification Element E: Providing Enrollees with Information Element F: Case Management Assessment Process Element G: Plan of Care Element H: Informing and Educating Practitioners Element I: Satisfaction with Case Management Element J: Analyzing Effectiveness/Identifying Opportunities Element K: Implementing Interventions and Follow-up Evaluation</p>	<p>NCQA/ SNP Structure & Process Measures</p>	<p>X</p>	
<p>SNP 6: Coordination of Medicare and Medicaid Benefits</p>	<p>The organization coordinates Medicare and Medicaid benefits and services for enrollees.</p> <p>Element A: Coordination of Benefits for Dual Eligible 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</p>	<p>NCQA/ SNP Structure & Process Measures</p>	<p>X</p>	
<p>Care Transition Record Transmitted to Health Care Professional</p>	<p>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.</p>	<p>AMA-PCPI</p>	<p>X</p>	

Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS	X	
SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions Element B: Supporting Enrollees 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	
CAHPS, various settings including: -Health Plan plus supplemental items/questions, including: -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home	Depends on Survey.	AHRQ/CAHPS	X	X* ¹
Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the drug plan’s pharmacy help desk.	CMS Call Center data	X	
Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by enrollees who called the drug plan’s customer service phone number.	CMS Call Center data	X	

¹ For certain surveys only.

Part D Appeals Auto-Forward	<p>How often the drug plan did not meet Medicare's deadlines for timely appeals decisions.</p> <p>This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.</p>	IRE	X	
Part D Appeals Upheld	<p>How often an independent reviewer agrees with the drug plan's decision to deny or say no to an enrollee's appeal.</p> <p>This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100.</p>	IRE	X	
Part D Enrollment Timeliness	<p>The percentage of enrollment requests that the plan transmits to the Medicare program within 7 days.</p>	Medicare Advantage Prescription Drug System (MARx)	X	
Part D Complaints about the Drug Plan	<p>How many complaints Medicare received about the drug plan.</p> <p>For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).</p>	CMS CTM data	X	

Part D Beneficiary 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	
Part D Enrollees Choosing to Leave the Plan	The percent of drug plan enrollees who chose to leave the plan in 2013.	CMS Medicare Beneficiary Database Suite of Systems	X	
Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan	X	
Part D High Risk Medication	The percent of the drug plan 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	
Part D Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X	
Part D Medication Adherence for Oral Diabetes Medications	Percent of plan 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	

Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan 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	
Part D Medication Adherence for Cholesterol (Statins)	Percent of plan 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	
Plan Makes Timely Decisions about Appeals	Percent of plan enrollees who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage.	IRE	X	
Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to an enrollee's appeal.	IRE	X	
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by enrollees who called the health plan's customer service phone number.	CMS Call Center data	X	
Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X	
Beneficiary Governance Board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.	CMS defined process measure	X	

Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. <ul style="list-style-type: none"> In the last six months, how often did your health plan's customer service give you the information or help you needed? In the last six months, how often did your health plan's customer service treat you with courtesy and respect? In the last six months, how often were the forms for your health plan easy to fill out? 	AHRQ/CAHPS	X	
Assessments	Percent of enrollees with initial assessments completed within 90 days of enrollment.	CMS	X	
Care plans	Percent of enrollees with care plans by specified timeframe.	CMS	X	
Real time hospital admission notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS	X	
Risk stratification based on LTSS or other factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS	X	
Discharge follow-up	Percent of enrollees with specified timeframe between discharge to first follow-up visit.	CMS	X	
Self-direction	Percent of care coordinators that have undergone State-based training for supporting self-direction under the Demonstration.	CMS	X	
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	
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	X*
Diabetes Care – Kidney Disease Monitoring	Percent of enrollees with diabetes that had a kidney function test during the year.	NCQA/HEDIS	X	
Diabetes Care – Blood Sugar Controlled	Percent of enrollees with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS	X	X*
Rheumatoid Arthritis Management	Percent of enrollees with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS	X	
Reducing the Risk of Falling	Percent of 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	
Plan All-Cause 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	
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	
Comprehensive medication review	Percentage of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA) Part D Reporting Data	X	
Complaints about the Health Plan	How many complaints Medicare received about the health plan. Rate of complaints about the health 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	

Beneficiary 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 enrollees directly. A higher score is better, as it means Medicare found fewer problems.	CMS Beneficiary database	X	
Enrollees Choosing to Leave the Plan	The percent of enrollees who chose to leave the plan in 2013.	CMS	X	
Getting Information From Drug Plan	<p>The percent of the best possible score that the plan earned on how easy it is for enrollees to get information from their drug plan about prescription drug coverage and cost.</p> <ul style="list-style-type: none"> • In the last six months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? • In the last six months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? • In the last six months, how often did your health plan give you all the information you needed about prescription medication were covered? • In the last six months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine? 	AHRQ/CAHPS	X	

Rating of Drug Plan	<p>The percent of the best possible score that the drug plan earned from enrollees who rated the drug plan for its coverage of prescription drugs.</p> <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 prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs? 	AHRQ/CAHPS	X	
Getting Needed Prescription Drugs	<p>The percent of best possible score that the plan earned on how easy it is for enrollees to get the prescription drugs they need using the plan.</p> <ul style="list-style-type: none"> In the last six months, how often was it easy to use your health plan to get the medicines your doctor prescribed? In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy? 	AHRQ/CAHPS	X	
Getting Needed Care	<p>Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.</p> <ul style="list-style-type: none"> In the last six months, how often was it easy to get appointments with specialists? In the last six months, how often was it easy to get the care, tests, or treatment you needed through your health plan? 	AHRQ/CAHPS	X	

Getting Appointments and Care Quickly	<p>Percent of best possible score the plan earned on how quickly enrollees can get appointments and care.</p> <ul style="list-style-type: none"> In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last six months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time? 	AHRQ/CAHPS	X	
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	X	
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 plan possible and 10 is the best health plan possible, what number would you use to rate your health plan? 	AHRQ/CAHPS	X	
Breast Cancer Screening	Percent of female enrollees aged 40-69 who had a mammogram during the past two years.	NCQA/HEDIS	X	X*
Colorectal Cancer Screening	Percent of enrollees aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X	

Cardiovascular Care – Cholesterol Screening	Percent of enrollees with heart disease who have had a test for —bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Diabetes Care – Cholesterol Screening	Percent of enrollees with diabetes who have had a test for —bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X	X*
Annual Flu Vaccine	Percent of enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	X	
Improving or Maintaining Mental Health	Percent of all enrollees whose mental health was the same or better than expected after two years.	CMS HOS	X	
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	
Access to Primary Care Doctor Visits	Percent of all enrollees who saw their primary care doctor during the year.	HEDIS	X	
Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X	
Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS	X	
Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS	X	
Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X	
Health Status/Function Status	Percent of enrollees who report their health as excellent.	AHRQ/CAHPS	X	

Table 7-2: Texas-Specific Duals Quality Measures

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Use of Appropriate Medications for People with Asthma	The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	NCQA/HEDIS		X
Cervical Cancer Screening	The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.	NCQA/HEDIS		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Adult BMI Assessment	The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	NCQA/HEDIS		X
Medication Management for People with Asthma - Medication Compliance 75%	The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: <ul style="list-style-type: none"> The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period. 	NCQA/HEDIS		X
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	NCQA/HEDIS		X
LDL-C Controlled	HEDIS Hybrid Measure	NCQA/HEDIS		X
Medical Attention for Nephropathy	A nephropathy screening test or evidence of nephropathy, as documented through administrative data. Note: <i>A process flow diagram is included in the HEDIS Manual to help implement this specification.</i>	NCQA/HEDIS		X
Potentially Preventable Emergency Department Visits	Percent of emergency department procedures that were potentially preventable	3M Potentially Preventable Events		X
Potentially Preventable Hospital Readmissions	Percent of candidate inpatient admissions that had a potentially preventable readmission within 30 days	3M Potentially Preventable Events		X
Potentially Preventable Hospital Admissions	Percent of eligible inpatient admissions that were potentially preventable	3M Potentially Preventable Events		X
Diabetes Short-Term	Admissions for a principal	AHRQ/ Prevention		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
Complications Admission Rate	diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions.	Quality Indicators (Adults)		
Diabetes Long-Term Complications Admission Rate	Admissions for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions.	AHRQ/ Prevention Quality Indicators (Adults)		X
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.	AHRQ/ Prevention Quality Indicators (Adults)		X
Hypertension Admission Rate	Admissions with a principal diagnosis of hypertension per 100,000 population, ages 18 years and older. Excludes kidney disease combined with dialysis access procedure admissions, cardiac procedure admissions, obstetric admissions, and transfers from other institutions.	AHRQ/ Prevention Quality Indicators (Adults)		X
Congestive Heart Failure Admission Rate	Admissions with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older. Excludes cardiac procedure admissions, obstetric admissions, and transfers from other institutions.	AHRQ/ Prevention Quality Indicators (Adults)		X
Dehydration Admission Rate	Admissions with a principal diagnosis of dehydration per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions.	AHRQ/ Prevention Quality Indicators (Adults)		X
Bacterial Pneumonia Admission Rate	Admissions with a principal diagnosis of bacterial pneumonia per 100,000 population, ages 18 years and older. Excludes sickle cell or hemoglobin-S admissions, other	AHRQ/ Prevention Quality Indicators (Adults)		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	indications of immuno-compromised state admissions, obstetric admissions, and transfers from other institutions.			
Urinary Tract Infection Admission Rate	Admissions with a principal diagnosis of urinary tract infection per 100,000 population, ages 18 years and older. Excludes kidney or urinary tract disorder admissions, other indications of immuno-compromised state admissions, obstetric admissions, and transfers from other institutions.	AHRQ/ Prevention Quality Indicators (Adults)		X
Angina w/o Procedure Admission Rate	Admissions with a principal diagnosis of angina without a cardiac procedure per 100,000 population, ages 18 years and older. Excludes cardiac procedure admissions, obstetric admissions, and transfers from other institutions.	AHRQ/ Prevention Quality Indicators (Adults)		X
Uncontrolled Diabetes Admission Rate	Admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions.	AHRQ/ Prevention Quality Indicators (Adults)		X
Lower Extremity Amputation among Patients with Diabetes Rate	Admissions for any-listed diagnosis of diabetes and any-listed procedure of lower-extremity amputation per 100,000 population, ages 18 years and older. Excludes any-listed diagnosis of traumatic lower-extremity amputation admissions, toe amputation admission (likely to be traumatic), obstetric admissions, and transfers from other institutions.	AHRQ/ Prevention Quality Indicators (Adults)		X
Prenatal and Postpartum Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. <ul style="list-style-type: none"> • <i>Timeliness of Prenatal Care.</i> 	NCQA/HEDIS		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure
	<p>The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester <i>or</i> within 42 days of enrollment in the organization.</p> <ul style="list-style-type: none"> • <i>Postpartum Care.</i> The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. 			
Low Birth Weight Admission Rate	Low birth weight (< 2,500 grams) infants per 1,000 newborns.	AHRQ/ Prevention Quality Indicators (Adults)		X
Diabetes Care - HbA1c Testing	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who received testing.	NCQA/HEDIS		X
Diabetes Care- HbA1c Control (<8.0%)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who met standard.	NCQA/HEDIS		X
Diabetes Care - LDL Screening	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who received screening.	NCQA/HEDIS		X
Adult Asthma Admission Rate	Low birth weight (< 2,500 grams) infants per 1,000 newborns.	AHRQ/ Prevention Quality Indicators (Adults)		X
Rand Health Medical Outcomes Study: 12-Item Short Form Survey Instrument	SF-12 is a set of generic, coherent, and easily administered quality-of-life measures. These measures rely upon patient self-reporting and are now widely utilized by managed care organizations and by Medicare for routine monitoring and assessment of care outcomes in adult patients.			X
Nursing facility/HCBS measure	TBD (based on ongoing stakeholder process and subject to CMS approval)	State-defined measure		X
LTSS	TBD LTSS measure (based on ongoing stakeholder process and subject to CMS approval)	State-defined measure		X

LTSS	TBD LTSS measure (based on ongoing stakeholder process and subject to CMS approval)	State-defined measure		X
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CMS will work closely with the State to monitor other measures related to community integration. CMS and the State will continue to work jointly to refine and update these quality measures in years two and three of the Demonstration.

XIII. Stakeholder Engagement

Texas will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. This will be accomplished through ongoing public meetings and monitoring individual and provider experiences through a variety of means, including surveys, focus groups, website updates, and data analysis. In addition, Texas will require that STAR+PLUS 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 eligible individuals. The State will maintain additional processes for ongoing stakeholder participation and public comment, including through stakeholder and enrollee participation in the Promoting Independence Advisory Committee, the Quality Improvement Advisory Committee, the STAR+PLUS stakeholder meeting, STAR+PLUS Quality Council, Managed Care Advisory Committee, and other various advisory and stakeholder meetings devoted to services for Medicare-Medicaid enrollees. The State will also develop consumer notices and related materials about the Demonstration that are easily understood by persons with limited English proficiency, and will translate materials into prevalent languages as determined by CMS and the State.

XIV. Evaluation

CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the financial alignment models, including this Demonstration, on beneficiary experience of care, quality, utilization, and cost. The evaluator will also explore how the Texas initiative 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):

- Enrollee health status and outcomes;
- Quality of care provided across care settings;
- Enrollee access to and utilization of care across care settings;
- Enrollee satisfaction and experience;
- Administrative and systems changes and efficiencies; and

- Overall costs or savings for Medicare and Medicaid.

The evaluator will design a Texas-specific evaluation plan for this 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, utilization of services, and costs (pending data availability). The evaluator will also submit Texas-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

Texas is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. Texas and STAR+PLUS 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.

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

- Enrollee level data identifying beneficiaries eligible and enrolled in the Demonstration:
 - Medicare Beneficiary Claim Account Number (HICN)
 - MSIS number
 - Social Security Number
 - CMS Beneficiary Link Key
 - Person First and Last Name, Birthdate, and Zip code
 - Eligibility identification flag - Coded zero if not identified as eligible for the Demonstration, 1 if identified by administrative criteria, and 2 if by non-administrative criteria (e.g. BMI, smoking)

- Monthly eligibility indicator - Each monthly eligibility flag variable would be coded 1 if eligible, and zero if not.
- Monthly enrollment indicator - Each monthly enrollment flag variable would be coded 1 if enrolled, and zero if not.
- Summary level data for the State Data Reporting System, including but not limited to:
 - The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries *not* eligible for the Demonstration (e.g., individuals who are under the age of 21 and individuals not required to participate in the STAR+PLUS program)
 - The number of beneficiaries enrolled in the Demonstration
 - The number of beneficiaries who opt-out of the Demonstration
 - The number of beneficiaries who disenroll from the Demonstration

Texas will also have the capability to track beneficiary level data on grievances and appeals that identify the STAR+PLUS MMP and providers involved.